NIBTS LIST OF TERMS OF REFERENCE

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Documents :

TOR:10:QD:001:01:NIBT

NIBTS Agency Board

The operation of the NIBTS Agency Board is described within the Standing Orders and the Management Statement for the Agency.

TOR:QD:002:01:NIBT

TERMS OF REFERENCE

NAME OF COMMITTEE/SUB-GROUP	**AUDIT COMMITTEE**
SUMMARY OF ROLE:	**Constitution** The Board hereby resolves to establish a Committee of the Board to be known as the Audit Committee (The Committee). The Committee is a Non-Executive Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference. **Authority** The Committee is authorised by the Agency Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Agency Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders .
REPORTS TO:	**Reporting** The minutes of Audit Committee meetings shall be formally recorded by the Board Secretary and submitted to the Agency Board. The Chair of the Committee shall draw to the attention of the Agency Board any issues that require disclosure to the full Agency Board, or require executive action. The Audit Committee will provide the Agency Board with a written Annual Report, timed to support finalisation of the accounts and the Statement of Internal Control, summarising its conclusions from the work it had done during the year.
RESPONSIBLE FOR (SUB-GROUPS):	-

CHAIRED BY:	Mr. P. Cathcart
MEMBERSHIP:	The committee shall be appointed by the Board from amongst the Non-Executive Directors of the Board and shall consist of not less than 3 members. One of the members will be appointed as Chair of the Committee by the Chairman of the Board. **Attendance** The Finance Manager and appropriate Internal and External Audit representatives shall normally attend meetings. However at least once a year the Committee should meet privately with the External and Internal Auditors. The Chief Executive should be invited to attend at least annually, to discuss with the Audit Committee the process for assurance that supports the Statement on Internal Control. The Board Secretary shall be Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chairman and committee members.
QUORUM:	A minimum of two members of the Audit Committee will be present for the meeting to be deemed quorate.
MEETING FREQUENCY:	The Audit Committee will meet four times per year. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary. The Chair of the Audit Committee may convene additional meetings, as they deem necessary. The Audit Committee may ask any other officials of the organisation to attend to assist with its discussions on any particular matter. The Audit Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters. The Agency Board may ask the Audit Committee to convene further meetings to discuss particular issues on which they require the Committee's advice.
SECRETARIAT:	Chief Executive's Office
DOCUMENTATION REQUIRED:	<u>For each meeting the Audit Committee will be provided with:</u> A progress report from the Head of Internal Audit summarising: • Work undertaken • Keys issues emerging from Internal Audit work

	• Management response to audit recommendations • Action plans and changes to periodic plan • Any resourcing issues affecting the delivery of Internal Audit objectives A progress report from the External Audit representative will also be provided summarising work done and emerging findings <u>As and when appropriate the Committee will also be provided with:</u> • Proposals for Terms of Reference for Internal Audit • The Internal Audit Strategy • The Controller Internal Audit's Annual Opinion and Report • Quality assurance reports on the Internal Audit function • The draft accounts of NIBTS • The draft statement of Internal Control • A report on any changes to accounting policies • External audit's management letter • A report on co operation between Internal and External Audit

REMIT:	The Audit Committee will advise the Agency Board on: • the strategic processes for internal control, controls assurance and the Statement on Internal Control in conjunction with the Governance and Risk Committee. • the accounting policies, the accounts, and the annual report of the organisation, including the process for the review of the accounts prior to submission for audit, levels of error identified and management's letter of representation to the external auditors • the adequacy of the policies for ensuring compliance with relevant regularity, legal and code of conduct requirements, including the Agency's Standing Orders and Standing Financial Instructions • the planned activity and results of both internal and external audit • the adequacy of management's response to issues identified by audit activity including external audits management letter • assurance relating to the corporate governance requirements for the organisation • anti fraud policies, whistle- blowing processes and arrangements for special investigations • the Audit Committee will also periodically review its own effectiveness and report the results of that review to the Agency Board. In carrying out its work, the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these functions. It will also seek reports and assurances from other Agency Committees, Heads of Service and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. **<u>Internal Audit</u>** The Committee shall ensure that there is an effective internal audit function established by management that meets the DHPSSPS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Agency Board. This will be achieved by: • consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal • review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework • consideration of the Chief Internal Auditor's annual report, major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources • ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation • annual review of the effectiveness of internal audit. The Head of Internal Audit and representatives of External Audit will have

free and confidential access to the Chair of the Audit Committee.

External Audit

The Committee shall review the work and findings of the External Auditor (NI Audit Office) and consider the implications of, and management's responses to, their work. This will be achieved by:

- consideration of the performance of the External Auditor
- discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan
- discussion with the External Auditors of their local evaluation of audit risks and
- assessment of the Agency
- review of all External Audit reports, including consideration of the annual Management Letter before submission to the Board and any work carried out outside the annual audit plan, together with the appropriateness of management responses.

Financial Reporting

The Audit Committee shall review the financial extract of the Agency's Annual Report and the Financial Statements before submission to the Board, focussing particularly on:

- the wording in the Statement on Internal Control and other disclosures relevant to the terms of Reference of the Committee
- changes in, and compliance with, accounting policies and practices
- unadjusted mis-statements in the financial statements
- major judgemental areas
- significant adjustments resulting from the audit

The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

Value For Money

The Audit Committee shall oversee the adequacy of the Agency's arrangements for ensuring that value for money is obtained in the expenditure of all public funds entrusted to its care. This will include a review of the findings from, and management's response to, all value for money audit reports issued to the Agency as part of the regional VFM programme sponsored by DHSS&PS.

Other Matters

The Committee shall be supported administratively by the Board Secretary, whose duties in this respect will include:

	• Agreement of agenda with the Chairman and attendees • Collation and distribution of papers sufficiently in advance of each meeting to facilitate their full consideration and discussion at the meeting • Taking the minutes and keeping a record of matters arising and issues to be carried forward and advising the Committee on pertinent areas.
COMMUNICATION LINKS WITH OTHER GROUPS	Agency Board

TOR:10:QD:003:01:NIBT

TERMS OF REFERENCE

NAME OF COMMITTEE/GROUP:	SENIOR MANAGEMENT TEAM
SUMMARY OF ROLE:	This team includes the senior managers of each department in NIBTS and it has wide ranging roles. These include the following: • Has a key co-ordinating role in relation to: - All corporate and interdepartmental issues - The provision of support functions within the Service • Supports the Chief Executive by determining and agreeing: - Strategic and Business Plans for the Service - In-year priorities and adjustment of plans - Relevant policies prior to going to the Agency Board for approval - Performance targets - Allocation of capital expenditure
REPORTS TO:	Agency Board through Chief Executive
RESPONSIBLE FOR (SUB-GROUPS):	None
CHAIRED BY:	Chief Executive
MEMBERSHIP:	Medical Director Donor Services General Manager Finance Manager Head of HR and Corporate Services Laboratory Manager Quality Manager Regulatory Affairs and Compliance Manager Secretary: PS to Chief Executive
MEETING FREQUENCY:	Monthly
QUORUM	4 Members
SECRETARIAT:	The Chief Executive shall provide secretariat facilities
DOCUMENTATION REQUIRED:	Minutes, Objectives/KPI reports and relevant supporting papers
REMIT:	As above
COMMUNICATION LINKS WITH VARIOUS GROUPS:	Minutes are sent to Agency Board members and made available to all staff

TOR:15:QD:004:01:NIBT

NORTHERN IRELAND BLOOD TRANSFUSION AGENCY

GOVERNANCE AND RISK MANAGEMENT COMMITTEE

TERMS OF REFERENCE

1 CONSTITUTION

The Board hereby resolves to establish a Committee of the Board to be known as the Governance and Risk Management Committee (The Committee). The Committee is a Non-Executive Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

2 MEMBERSHIP OF THE COMMITTEE

The committee shall be appointed by the Board from amongst the Non-Executive Directors of the Board and shall consist of not less than 2 members. A quorum shall be 2 members. One of the members will be appointed the Chair of the Committee by the Board.

3 ATTENDANCE

The following senior staff shall be invited to attend meetings:

- Chief Executive
- Medical Director
- Finance and IM&T Manager
- Head of Human Resources & Corporate Services
- Donor Services General Manager
- Laboratory Manager
- Regulatory Affairs and Compliance Manager
- Business Continuity and Risk Manager

Other members of Agency staff may be required to attend meetings as the Committee considers necessary.

Appropriate secretarial support will be provided to the Chairperson and Committee members.

4 FREQUENCY OF MEETINGS

Meetings shall be held not less than four times a year.

5 AUTHORITY

The committee is authorised to investigate any activity within its terms of reference

6 REMIT

The Committee is authorised to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee, and will be given the resources necessary to carry out its role. The committee will be given full access to any information within the NIBTS Agency that it requires to fulfil its function. The Committee is authorised by the Board to obtain external professional advice and to invite appropriate external parties with relevant experience to attend if it considers this necessary.

The remit of the Committee is to ensure that:

There are robust and regularly reviewed systems and structures in place to support the effective implementation and development of integrated governance and risk management across the organisation.

Risk management is a planned and systematic approach to identifying, evaluating and responding to risks and providing assurance that responses are effective.

Effective systems are in place to ensure and manage effective staff practice

Principal risks and significant gaps in controls and assurances are considered by the Board.

Timely reports are made to the Board including recommendations and remedial action proposed or taken if there is an internal failing in systems or services.

There is sufficient independent and objective assurance as to the robustness of key processes across all areas of governance and risk management.

In carrying out its work, the committee will utilise information from:

- Licensing and Regulation
- Controls Assurance standards
- Risk assessment and risk management
- Health & Safety
- Adverse Incident Management
- Clinical Audit
- Complaints management
- Personal and Public Involvement
- Learning and Development and Continuing Professional Development
- Evidence based practice
- Litigation
- Quality and Professional standards
- Research and education
- External assessments and inspections
- Information Governance
- Investors In People

7 REPORTING

Any business conducted in a confidential session by the Governance and Risk Management Committee will be reported to a confidential session of the Board of Directors.

8 OTHER MATTERS

The minutes of the Governance and Risk Management Committee shall be formally recorded and submitted to the Board. The Board secretary duties in this respect will include:

- Agreement of an agenda with the chairman and attendees.
- Collation and distribution of papers 3-working days in advance of the meeting.
- Producing the minutes of the meeting and taking forward matters arising and issues to be carried forward.

TOR:10:QD:005:01:NIBT

TERMS OF REFERENCE

NAME OF COMMITTEE/SUB-GROUP	RISK MANAGEMENT SUB-GROUP
SUMMARY OF ROLE:	The Risk Management Sub-Group is a sub-section of the NIBTS Governance and Risk Management Committee, responsible for supporting development and implementation of business resilience and risk management solutions. • Development, implementation and review of policies and procedures to minimise business risk in compliance with appropriate Risk Management standards • Development, implementation and maintenance of business continuity plans.
REPORTS TO:	Governance and Risk Management Committee
RESPONSIBLE FOR (SUB-GROUPS):	None
CHAIRED BY:	Business Continuity and Risk Manager
MEMBERSHIP:	Representatives from Donor Services, Laboratory Services, Corporate Services (including Health and Safety), and Finance/IM&T and Regulatory Affairs and Compliance.
QUORUM:	Four members
MEETING FREQUENCY:	Quarterly
SECRETARIAT:	Secretariat facilities will be provided by the Business Continuity and Risk Manager
DOCUMENTATION REQUIRED:	Minutes, Risk Registers, Risk Assessments, Business Continuity Plans

REMIT	Specific activities of the Sub-group will include overseeing: • Promotion of good risk management practice throughout NIBTS. • Implementation of risk reduction policies and measures to respond effectively to incidents, which may otherwise prevent normal activity. • Development of departmental and an organisation-wide risk registers. • Development and implementation of business continuity plans throughout the organisation. • Implementation and maintenance of processes for audit and testing of the policies and measures relating to business continuity and risk reduction, including relevant Controls Assurance Standards on Risk Management and Emergency Planning. • Development of a coordinated approach across the NIBTS to business risk and business continuity matters. • Planning of the testing of the business continuity plans to ensure the plans remain effective. • Identification of training and education requirements of NIBTS managers and staff in business risk assessment and business risk reduction. • Identification of risk management performance indicators. • Monitoring and reporting of risk management performance within NIBTS to the Clinical Governance and Risk Management Committee. • Initial prioritisation of departmental risks within NIBTS for presentation to SMT/Clinical Governance and NIBTS Board
COMMUNICATION LINKS WITH OTHER GROUPS	Governance & Risk Management Committee and other functional groups as required

TOR:10:QD:006:01:NIBT

TERMS OF REFERENCE

NAME OF COMMITTEE/GROUP:	TRAINING AND CLINICAL AUDIT SUB-GROUP
SUMMARY OF ROLE:	The Training and Clinical Audit Sub-group is a sub-section of the NIBTS Clinical Governance and Risk Management Committee and as such has an oversight function for training and audit arrangements that are in place within NIBTS.
REPORTS TO:	Clinical Governance and Risk Management Committee
RESPONSIBLE FOR (SUB-GROUPS):	None
CHAIRED BY:	Medical Director
MEMBERSHIP:	HR & Corporate Services Manager; Personnel and Training Manager; Departmental Heads of Quality Control; Reference Laboratory; Automated Serology Laboratory; Donor Administration Manager and two Senior Nurse/Unit Managers.
MEETING FREQUENCY:	Three monthly
QUORUM:	4
SECRETARIAT:	Secretariat facilities will be provided by the Deputy Medical Director
DOCUMENTATION REQUIRED:	Agenda, minutes and supporting papers
REMIT:	• The Committee will satisfy itself that satisfactory arrangements are in place. • It is not responsible for delivery of training and audit for each individual member of NIBTS staff. • There are other initiatives in this area eg knowledge and skills framework (KSF) which intend to develop a training plan and document training needs for each member of staff. • The audit function currently performed by QA is comprehensive but aspects of medical and nursing clinical audit can be added to this. • The overlapping and interleaving with KSF and Agenda for Change will mean that some of the work of the Training and Clinical Audit Sub-group will be taken forward by these initiatives.
COMMUNICATION LINKS WITH OTHER GROUPS:	Clinical Governance & Risk Management Committee

TOR:10:QD:007:01:NIBT

TERMS OF REFERENCE

NAME OF COMMITTEE/GROUP	QUALITY IMPROVEMENT REVIEW GROUP
SUMMARY OF ROLE:	To plan, review and monitor the effectiveness of all aspects of the Quality Management System within NIBTS.
REPORTS TO:	Reports from the Group will be presented regularly to the Agency Board.
RESPONSIBLE FOR (SUB-GROUPS)	Incident Management, Change Control Groups and Quality Monitoring Review Group who report regularly to the Group
CHAIRED BY:	Regulatory Affairs and Compliance Manager
MEMBERSHIP:	Senior Management Team, RA&C Lead
QUORUM:	Chair plus three members
MEETING FREQUENCY:	Monthly
SECRETARIAT:	RA&C Department shall provide secretariat facilities
DOCUMENTATION REQUIRED:	Agenda, minutes, supporting papers The Regulatory Affairs and Compliance Manager will be responsible for the provision of general reports and analysis for the meeting but each member will be responsible for reporting on performance within their respective departments
REMIT:	• To plan, review and monitor the effectiveness of all aspects of the Quality Management System (QMS) within NIBTS. • To ensure compliance with the relevant legislation and accreditation standards, specifically the Blood Safety and Quality Regulations 2005 (as amended), the Human Tissue (Quality and Safety for Human Application) Regulations 2007 and Clinical Pathology Accreditation Standards/United Kingdom Accreditation Service. To develop and review relevant key performance indicators by which performance in relation to quality can be monitored and continuously improved. To agree/approve action plans developed to address areas of the QMS where KPI's indicate poor performance. To plan, review, and monitor a quality audit programme within NIBTS. To review serious incidents referred from the Incident Review Group.

Communication links with other groups:	Governance & Risk Management Committee, SMT, NIBTS Board

TOR:10:QD:008:03:NIBT

TERMS OF REFERENCE

Name of committee/group:	Health and Safety Committee
Summary of role:	The Health and Safety Committee is responsible for the implementation of all aspects of health and safety including Fire Safety Management and Security Management
Reports to:	Governance and Risk Management Committee
Responsible for (sub-groups):	None
Chaired by:	Facilities Manager or Head of HR & Corporate Services
Membership:	Representatives from each section within the Agency; union representatives; member of the Regional Tissue Typing staff.
Meeting frequency:	At least 8 times per year.
Quorum:	Four, and at least three departments represented
Secretariat:	Administration Officer, in Facilities
Documentation required:	Agenda, minutes, supporting papers
Remit:	Specific activities of the Sub-group will include: • Developing an action plan for the year ahead • Ensure health and safety arrangements are in place in each department and corporately and that there is a consistent approach to health and safety management throughout the organisation • Reviewing and developing policies and procedures for NIBTS on health and safety to ensure consistency/coherence across all departments and compliance with current legislation. • Assist Department Managers with risk assessments within their departments, ensuring that these are reviewed as required. This will include but are not limited to COSHH, DSE, Lone worker, New & Expectant Mothers, etc. • Maintain Centralised Record for Risk Assessment • Co-ordination and maintenance of a Health and Safety Audit Programme • Review health and safety incident statistics and agree actions to be taken as a result • Ensuring staff are appropriately trained in health and safety • Produce 6-monthly reports on health and safety matters within the organisation for presentation to the Governance and Risk Management Committee and Agency Board
Communication links with other groups:	Governance & Risk Management Committee, SMT, NIBTS Board

TOR:10:QD:009:01:NIBT

TERMS OF REFERENCE

NAME OF COMMITTEE/GROUP:	BLOOD DONATION CO-ORDINATING GROUP
SUMMARY OF ROLE:	To oversee the blood collection programme with particular emphasis on coordination of the operational, clinical, quality/regulatory and marketing aspects
REPORTS TO:	Chief Executive
RESPONSIBLE FOR (SUB-GROUPS):	None
CHAIRED BY:	Donor Services General Manager (DSGM)
MEMBERSHIP:	Donor Services General Manager, (Acting) Medical Director, Speciality Doctor, Consultant with responsibility for donor care, senior nursing representatives, Regulatory and Compliance Manager, (Laboratory Manager as required)
MEETING FREQUENCY:	Two monthly
QUORUM:	Three [including DSGM or (Acting Medical Director)]
SECRETARIAT	DSGM
DOCUMENTATION REQUIRED:	Agenda, minutes, supporting papers
REMIT:	Specific activities of the Committee will include overseeing: • Review of donor programme strategy/activity • Arrangements for the selection of donors(whole blood, plateletpheresis, bone marrow) • Clinical care of donors • Compliance with BSQR, national policies and quality standards • Review quality incidents and risk management issues • Procurement of session equipment and supplies • Training of blood donation session staff • Arrangements for meeting the needs of internal as well as external customers
COMMUNICATION LINKS WITH VARIOUS GROUPS:	• Minutes of meeting are discussed at Donor Services Team meetings • Other team meetings • Governance and Risk Management Committee Within NIBTS – Donor Services Team meeting (as appropriate); Update meetings (RGNs/MOs); Training/Communication

	meetings (session staff). External groups of particular relevance are: 1 Local - Blood Transfusion Service Communities Partnership 2 UK Forum – Donor Services sub-group 3 National - JPAC (SAC on Care and Selection of Donors); SaBTO 4 International – European Blood Alliance (EBA), DOMAINE

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TERMS OF REFERENCE

NAME OF COMMITTEE/GROUP:	DONOR SERVICES TEAM
SUMMARY OF ROLE:	To oversee matters concerning the blood collection strategy/programme and associated corporate issues
REPORTS TO:	Donor Services General Manager
RESPONSIBLE FOR (SUB-GROUPS):	Donor Recruitment and Organisation, Donor Administration, Belfast and Omagh-based mobile units, and HQ unit
CHAIRED BY:	Donor Services General Manager
MEMBERSHIP:	Donor Recruitment & Session Organisation Manager, Donor Administration Manager, Senior Nurse/Unit Manager (2)
MEETING FREQUENCY:	Every 4-6 weeks
QUORUM:	Three members
SECRETARIAT:	DS Hub staff
DOCUMENTATION REQUIRED:	Agenda, minutes, supporting papers
REMIT:	• To oversee the implementation of the Donor Strategy, and Donor Programme. • Takes action on relevant matters from SMT, GRM Committee, BDCG etc. • Considers issues arising from UK Blood Services (normally via BDCG), and HPSS/HSC NI.
COMMUNICATION LINKS WITH VARIOUS GROUPS:	Minutes of meeting are reported to the Chief Executive and relevant aspects communicated to appropriate SN/ULs and other Donor Services section staff. Other links: ° Blood Transfusion Service Communities Partnership (BTSCP) ° UK Forum DS sub-group. ° European Blood Alliance (EBA); DOMAINE. ° Regional Personal and Public Involvement Forum (PPIF)

TOR:10:QD:011:02:NIBT

TERMS OF REFERENCE

NAME OF COMMITTEE/GROUP:	HOSPITAL SERVICES COMMITTEE
SUMMARY OF ROLE:	To oversee the work of the Hospital Services Department with a particular emphasis on the coordination of operational, clinical and quality/regulatory aspects
REPORTS TO:	Autonomous
RESPONSIBLE FOR (SUB-GROUPS):	None
CHAIRED BY:	Head / Deputy Head of Hospital Services Department
MEMBERSHIP:	Head / Deputy Head of Hospital Services department, laboratory manager, representatives from quality function and Medical Director/ consultant medical staff
QUORUM:	Medical representation, quality representation and overall 50% of membership
MEETING FREQUENCY:	Two monthly
SECRETARIAT	Secretariat facilities provided by laboratory secretary
DOCUMENTATION REQUIRED:	Agenda, minutes, supporting papers, monthly Blood Components Monitoring report, Quality metrics, risk register, Planned Quality Objectives for the Department and concessionary release file.
REMIT:	Specific activities of the Committee will include overseeing: • Arrangements for preparation and supply of blood components • Procurement and supply of plasma products • Procurement and evaluation of equipment, including blood packs • Compliance with BSQR, national policies and quality standards • Arrangements for meeting the needs of clinical users and hospital blood banks (in keeping with evidence based, best practice) • Review quality incidents, quality monitoring reports and risk management issues and concessionary release issues. • Determine and agree priorities for the department • Encourage innovation and development
COMMUNICATION LINKS WITH VARIOUS GROUPS:	• Minutes of meetings will be made available to all relevant staff within the organisation including specifically ,Hospital Services Department and Quality Control Laboratories • Other team meetings • Within Hospital Services two separate groups meet regularly, involving respectively, BMS staff and MLA staff. Here the focus is on detailed operational, quality/regulatory compliance and staff/training issues. • Other NIBTS groups with links to Hospital Services' activities include: Laboratory Management Team meeting, Blood

	Donation Coordinating Group and apheresis groups, Governance and Risk Management Committee (and its sub-groups), Pulse Expert Group. • External groups and committees of particular relevance are: Hospital Users Meeting (annual), JPAC (SACBC).

TOR:10:QD:012:02:NIBT

TERMS OF REFERENCE

NAME OF COMMITTEE/GROUP:	MICROBIOLOGY COMMITTEE
SUMMARY OF ROLE:	To oversee the work of the Microbiology Department with a particular emphasis on coordination of the operational, clinical and quality/regulatory aspects
REPORTS TO:	Autonomous
RESPONSIBLE FOR (SUB-GROUPS):	None
CHAIRED BY:	Head Deputy Head of Microbiology
MEMBERSHIP:	Head / Deputy Head of Microbiology Department, laboratory manager, representatives from quality function, Medical Director / consultant medical staff
QUORUM:	Medical representation, quality representation and overall 50% of membership
MEETING FREQUENCY:	Two monthly
SECRETARIAT:	Secretariat facilities provided by Microbiology Department
DOCUMENTATION REQUIRED:	Agenda, minutes, supporting papers, NEQAS reports, Quality metrics, Risk Register, Planned Quality Objectives for the Department
REMIT:	Specific activities of the Committee will include overseeing: • Arrangements for screening/testing donors (blood, bone, bone marrow, cord blood) and for meeting the needs of internal users • Arrangements for screening/testing of antenatal patients and for meeting the needs for clinical users (in keeping with evidence based practice) • Arrangements for outsourced/reference testing • Procurement and evaluation of equipment • Regulatory compliance: donors – BSQR, national policies and quality standards antenatal testing – CPA standards, national policies etc • Review quality incidents and risk management issues • Review of External Quality Assessment Scheme results • Determine and agree priorities for the department • Encourage innovation in the development of this service
COMMUNICATION LINKS WITH VARIOUS GROUPS:	• Minutes of the meeting will be made available to all relevant staff including staff within the microbiology department • Other team meetings and committees • Intradepartmental meetings involving all staff in microbiology are held regularly. Here the focus is on detailed operational, quality/regulatory and staff/training issues.

	• Other NIBTS groups with links to microbiology include: Laboratory Management Team meetings, Pulse Expert Group, Governance and Risk Management Committee (and its sub-groups). • External groups of particular relevance are: DHSSPS Advisory Committee on Antenatal Screening, Hospital Users Meeting (annual), Microbiology Test Evaluation Group (SNBTS/NIBTS), JPAC (SACTTI), MSBTO.

TOR:10:QD:013:01:NIBT

TERMS OF REFERENCE

NAME OF COMMITTEE/GROUP:	CORD BLOOD BANK COMMITTEE
SUMMARY OF ROLE:	To oversee the work of the Cord Blood Department with a particular emphasis on coordination of operational, clinical and quality/regulatory aspects
REPORTS TO:	
RESPONSIBLE FOR (SUB-GROUPS):	None
CHAIRED BY:	Designated Individual / Medical Director
MEMBERSHIP:	Consultant with medical responsibility for cord blood banking, Laboratory Manager, representatives from cord blood laboratory, Cord Blood Coordinator (nursing), Quality Representative (Quality Manager or Head of Quality Control)
MEETING FREQUENCY:	Two monthly
QUORUM:	DI /Medical Director, plus two.
SECRETARIAT:	Secretariat facilities are provided by the Cord Blood Bank
DOCUMENTATION REQUIRED:	Agenda, minutes, supporting papers, Component Production Quality Monitoring Report
REMIT:	Specific activities of the Committee will include overseeing: • Arrangements for the recruitment and selection of donors and collection of cord blood. • Processing, testing, storage and distribution of cord blood units • Procurement and evaluation of equipment • Compliance with national policies and regulations including Human Tissue (Quality and Safety for Human Application) Regulation 2007, and Human Tissue Act • Links with key stakeholders in hospital maternity units, H&I Laboratory, British Bone Marrow Registry • Review quality incidents and risk management issues • Determine and agree priorities for the department • Encourage innovation and development
COMMUNICATION LINKS WITH VARIOUS GROUPS:	• Minutes of meetings will be made available to all staff in cord blood department and quality control laboratory • Other team meetings • Within NIBTS – Other relevant groups include Microbiology Committee, Update and Training meetings for RGNs, Pulse Team, Laboratory Management Team meeting, Clinical Governance and Risk Management Committee • National – British Bone Marrow Registry, JPAC (and SACs for Tissue and Cells, Donors and TTI), MSBTO

TOR:10:QD:015:01:NIBT

TERMS OF REFERENCE

Name of committee/group	Estates Management Working Group
Summary of role:	To plan, review and monitor the effectiveness of all aspects of the Estates Management Systems within NIBTS and ensure compliance with relevant standards including GMP and Controls Assurance Standard.
Reports to:	Reports from the Group will be presented regularly SMT and QIR Group.
Responsible for (sub-groups)	No sub-groups are defined at present
Chaired by:	Quality Manager
Membership:	Facilities Manager and Department representatives
Quorum:	
Meeting frequency:	At least monthly
Secretariat:	HR and Corporate Services provide the secretariat for this group
Documentation required:	Agenda, minutes, supporting papers, minutes of meetings held with Belfast Trust Estates.
Remit:	• To plan, review and monitor the effectiveness of all aspects of the Estates Management System within NIBTS. • To ensure compliance with the relevant legislation and standards, notably the Blood Safety and Quality Regulations 2005, the Human Tissue (Quality and Safety for Human Application) Regulations 2007 and the Controls Assurance Standards for Building and Plant Management. To develop and review relevant key performance indicators by which performance in relation to estates management can be monitored and continuously improved. To assist in the development of action plans developed to address areas of Estates Management where KPI's indicate poor performance. To assist in the identification and management of risks associated with Estates To review serious incidents involving estates issues.

TOR:10:QD:016:01:NIBT

TERMS OF REFERENCE

Name of committee/group:	Environmental & Waste Management Committee
Summary of role:	The Environmental & Waste Management Committee is responsible for the achievement of objectives emanating from the relevant Controls Assurance Standards.
Reports to:	Head of HR & Corporate Services
Responsible for (sub-groups):	None
Chaired by:	Facilities Manager or a Senior HR & Corporate Services Representative
Membership:	Representatives from each section within the Agency
Meeting frequency:	Quarterly
Quorum:	Four, and at least three departments represented
Secretariat:	Administration Officer, in Facilities
Documentation required:	Agenda, minutes, supporting papers
Remit:	Specific activities of the Sub-group will include: • To ensure that the organisation continues to adhere to its governance commitments in respect of Environment and Waste Management Controls Assurance standards and any further relevant standards and statutory obligations. • Reviewing environmental and waste arrangements in place in each department and corporately and make recommendations as appropriate • Developing policies and procedures for NIBTS on environmental and waste management to ensure consistency / coherence across all departments • Monitor, review and develop action plans to promote good environmental and waste management systems amongst staff, suppliers and customers. • To engender a spirit of organisational ownership for environmental and 'green' issues. • To ensure that the work of the team is considered a matter of strategic importance within the organisation • To ensure the importance of environmental and waste management issues is when necessary communicated throughout the organisation
Communication links with other groups:	Agency Board and Governance and Risk Management Committee

TOR:11:QD:017:01:NIBT

TERMS OF REFERENCE

Name of committee/group:	Equality and Human Rights Committee (EHRC)
Summary of role:	The EHRC is responsible for the strategic implementation and monitoring of progress against corporate objectives for all aspects of the Agency's Section 75 and Human Rights responsibilities and ensuring that departments apply any necessary actions to comply with legislation and corporate objectives
Reports to:	SMT and Agency Board. Where necessary issues requiring action by departments will be presented to SMT.
Responsible for (sub-groups):	None
Chaired by:	Head of HR & Corporate Services
Membership:	Quorum: Medical Consultant, Donor Services General Manager, Head of HR & Corporate Services, HR Representative. As available a representative from BSO Equality Unit will also attend.
Meeting frequency:	3-4 times a year.
Quorum:	Four with at least two departments represented
Secretariat:	Provided by the HR & CS Department
Documentation required:	Agenda, minutes, supporting papers
Remit:	Specific activities of the Sub-group will include: • Developing an action plan for the year ahead. • Reviewing ongoing screening within departments is taking place • Developing policies and procedures in relation to Equality. • Advising SMT, Board and other forums of issues of note that require corporate and/or departmental action. • Ensuring all staff are appropriately trained in all matters concerning equality and human rights • Produce periodic reports on Equality and Human Rights issues to the Agency Board. • Ensure completion of Annual Review of Progress, Disability Action Plan and Equality Scheme.
Communication links with other groups:	Primarily SMT, and Agency Board.

TOR:12:QD:019:02:NIBT

NAME OF COMMITTEE/GROUP:	LABORATORY MANAGEMENT TEAM
SUMMARY OF ROLE:	To oversee the operational performance of the four laboratory departments. To provide a forum for communication and discussion of matters arising both within and external to the laboratories.
REPORTS TO:	Chief Executive (for any relevant issues)
RESPONSIBLE FOR (SUB-GROUPS):	None
CHAIRED BY:	Laboratory Manager
MEMBERSHIP:	Laboratory Manager, Heads / Deputy Heads of the four Laboratory Departments and Laboratory Training Officer
QUORUM:	Laboratory Manager and representatives from at least three Departments
MEETING FREQUENCY:	Monthly
SECRETARIAT	Laboratory Secretary
DOCUMENTATION REQUIRED:	Agenda DD:1313, minutes, supporting papers including risk register, quality metrics form and planned quality objectives
REMIT:	• To ensure compliance with national policies, regulations and quality standards, including MHRA and The Blood Safety and Quality Regulation (No 50) 2005 (As Amended), Human Tissue (Quality and Safety for Human Application) Regulation 2007, Human Tissue Act and CPA/UKAS ISO 15189 standards and Investors in People sixth generation standard. • To agree allocation and rotation of staff and facilitate training • To oversee procurement and evaluation of equipment, reagents etc. • To review current laboratory procedures and facilitate change, if required • To review quality incidents, quality monitoring reports and risk management issues via departmental risk registers, internal/external audit and Quality Assessment Scheme results • To determine and agree priorities for the department and align Corporate Business objectives into Laboratory objectives. • To encourage innovation and development • To oversee planned quality improvements
COMMUNICATION LINKS WITH VARIOUS GROUPS:	• Minutes of meetings will be made available to all Laboratory Staff, via SharePoint and Hard copy will be posted on Laboratory Notice Boards • Intradepartmental meetings are held in all laboratory departments where the focus is on operational, quality regulatory and staff/training issues. • Other NIBTS groups with links to Laboratory Management activities include: Serology committee, Microbiology committee, Hospital Services committee, H& S committee, Medical Devices and Equipment Group, Blood Donation Coordinating Group and Apheresis groups, Governance and Risk Management Committee (and its sub-groups), Pulse Expert Group, Environmental and Waste Management committee and Investors in People team. • External groups and committees of particular relevance are: Hospital Users Meeting, Antenatal User Meeting, JPAC (SACBC), JPAC (SAC Immunohaematology), JPAC (SACTTI), MSBTO, UK

	NEQAS; DHSSPS Advisory Committee on Antenatal Screening, BCSH, Microbiology Test Evaluation Group

TOR:12:QD:020:02:NIBT

TERMS OF REFERENCE

NAME OF COMMITTEE/SUB-GROUP	**INCIDENT MANAGEMENT GROUP**
SUMMARY OF ROLE:	The Incident Management Group is a sub-group of the Quality Improvement Review Group. The group is responsible for • Supporting the on-going maintenance and development of Quality Incident Management systems in NIBTS • Providing an organisation wide review of incidents reported through the incident management system. • Analysis of trends to provide further recommendations
REPORTS TO:	Quality Improvement Review Group
RESPONSIBLE FOR (SUB-GROUPS):	None
CHAIRED BY:	Regulatory Affairs and Compliance Manager
MEMBERSHIP:	The Business Continuity and Risk Manager, Representatives from Donor Services, Laboratory Services, Corporate Services (including Health and Safety), and Finance/IM&T, Quality and Regulatory Affairs and Compliance Departments.
QUORUM:	Four members
MEETING FREQUENCY:	Monthly
SECRETARIAT:	Secretariat facilities will be provided by the RAC Manager
DOCUMENTATION REQUIRED:	Minutes, Incident Management Performance Data, Specific Incident details as required, Trending data.
REMIT:	Specific activities of the Sub-group will include:: • Review of incident management performance against agreed KPIs related to investigation and closure of incidents. This includes specifically the submission of completed investigations and closure within agreed time frames. • Consideration of onward reporting • Consideration of potential wider effects of individual incidents and any risks arising. • Identification and consideration of trends in incidents • Providing consolidated reports on incident management across the NIBTS to SMT
COMMUNICATION LINKS WITH OTHER GROUPS	Quality Improvement and Review Group, Risk Management Sub-Group through the BC&RM, other operational meetings.

TOR:14:QD:021:02:NIBT

Name of committee/group:	**MEDICAL DEVICES AND EQUIPMENT GROUP (MDE)** **TERMS OF REFERENCE**
Summary of role:	In keeping with Guidance for healthcare and social services organisations, DB2006(05), November 2006 healthcare organisations and Medical Devices Controls Assurance Standard (CAS)should establish an medical devices and equipment management group to develop, implement and review policies related to MDE across the organisation. This group should review the policies at least once a year and submit regular reports to the Governance and Risk Management committee and NIBTS board. It will also: • Improve communication about MDE within the organisation and produce and review CAS self assessment and action plan. • Gain the agreement of clinicians, technical staff and users in relation to any proposed changes • Reduce confusion about who is responsible for MDE management tasks, training and safe device operation. • Take guidance from Guidelines for the blood transfusion services in the UK (red book) and MHRA rules and guidance for pharmaceutical manufacturers and distributors (orange book).
Reports to:	Governance and Risk Management Committee, NIAIC (Northern Ireland Adverse Incident Centre) and NIBTS board as required
Responsible for (sub-groups):	These will be defined as required
Chaired by:	Laboratory manager / RAC manager
Membership:	Representatives from each department within NIBTS as detailed in CAS, who have knowledge of equipment and medical devices within their department. Also to include business continuity and risk manager and facilities manager. Invitation of other personnel when requested to attend.
Meeting frequency:	Quarterly
Quorum:	Four, and at least three departments represented
Secretariat:	Laboratory secretary. Minutes to be viewable electronically.
Documentation required:	Agenda, minutes, and as and when required supporting documentation related to MDE.
Remit:	The remit of such a group(s) should also encompass providing advice when requested on: • Medical devices and equipment purchasing/acquisition issues and comparisons of alternative medical devices or equipment. • Technical specifications, regulatory compliance information and related issues. • Financial data, including consideration of full on-costs, i.e. running, maintenance and consumables costs, when preparing a medical device or equipment purchase bid, including disposable and replacement costs at the appropriate time • Change control and incident reports related to MDE • Standardisation to single models where possible • Risk management considerations • Medical devices and equipment evaluation reports, including user experience and preferences • Drawing up guidelines for medical device and equipment decontamination • Co-ordinating a medical devices and equipment inventory • Monitoring of manufacturer's instructions and training

Communication links with other groups:	Governance & Risk Management Committee, NIBTS board, Quality improvement review group.

TOR:15:QD:022:01:NIBT

TERMS OF REFERENCE

NAME OF COMMITTEE/SUB-GROUP	**Quality Monitoring Review Group**
SUMMARY OF ROLE:	The Quality Monitoring Review Group is a sub-group of the Quality Improvement Review Group. The group is responsible for • Supporting the Quality Monitoring programme in NIBTS • Providing an organisation wide review of Quality Monitoring Results collated on a monthly basis
REPORTS TO:	Quality Improvement Review Group
RESPONSIBLE FOR (SUB-GROUPS):	None
CHAIRED BY:	Head of Quality Control / Deputy Head of Quality Control
MEMBERSHIP:	Head of Quality Control, Deputy Head of Quality Control, Quality Control Bacteriology BMS, Apheresis Senior Nurse Unit Leader, NIBTS Medical Consultant, Component production Manager, MLA Team Leader (as available), RA&C Manager (as required)
QUORUM:	Four members
MEETING FREQUENCY:	Monthly
SECRETARIAT:	Secretariat facilities will be provided by the Head of Quality Control
DOCUMENTATION REQUIRED:	Minutes, Quality Monitoring Monthly Report
REMIT:	Specific activities of the group will include: • Review of Quality Monitoring performance against required specifications • Review of "out of specification" results. Discuss and assign actions (e.g. raising a quality incident) to address out of specification results • Identification of trends away from required specification. Discuss and assign actions, as appropriate, to ensure any drift in conformance is addressed in a timely manner. • Identification and consideration of any specific risks associated with quality monitoring performance • Minutes will be circulated to the members of the group, the RA&C Manager and the Chief Executive. Minutes and outcomes will be circulated to the Quality Improvement and Review Group.
COMMUNICATION LINKS WITH OTHER GROUPS	Quality Improvement Review Group, Risk Management Sub-Group through the BC&RM, other operational meetings.

TOR:15:QD:023:01:NIBT

TERMS OF REFERENCE

NAME OF COMMITTEE/GROUP:	Research Governance Committee
SUMMARY OF ROLE:	To provide governance for research activity conducted within NIBTS and to ensure compliance with the Research Governance Framework for HSC.
REPORTS TO:	Governance and Risk Management Sub-Committee of the Agency Board
RESPONSIBLE FOR (SUB-GROUPS):	n/a
CHAIRED BY:	Medical Director (delegated to Consultant in Transfusion Medicine)
MEMBERSHIP:	Medical Director Consultant in Transfusion Medicine Laboratory Services Manager Donor Services General Manager Regulatory Affairs and Compliance Manager
MEETING FREQUENCY:	Quarterly
QUORUM	Three members
SECRETARIAT:	Research Office Secretary
DOCUMENTATION REQUIRED:	Agenda, minutes and associated papers Study proposals and ad hoc requests for use of non-clinical material
REMIT:	Consider research proposals; approve research proposals; confirm consent and ethical approvals; confirm logistical and operational arrangements for provision of material.
COMMUNICATION LINKS WITH VARIOUS GROUPS:	Heads of Department as appropriate

TOR:15:QD:024:01:NIBT

TERMS OF REFERENCE

NAME OF COMMITTEE/GROUP:	SEROLOGY COMMITTEE
SUMMARY OF ROLE:	To oversee the work of the Automated Serology Department (AS), Blood Group Reference Laboratory (BGRL) and On-Call (OC) activities with a particular emphasis on coordination of the operational, clinical and quality/regulatory aspects
REPORTS TO:	Autonomous
RESPONSIBLE FOR (SUB-GROUPS):	None
CHAIRED BY:	Director / Deputy Director
MEMBERSHIP:	Heads / Deputy Heads of AS and BGRL, laboratory manager, representatives from Quality function, Medical Director / consultant medical staff
QUORUM:	Medical representation, quality representation and overall 50% of membership
MEETING FREQUENCY:	Two monthly
SECRETARIAT:	Secretariat facilities provided by Medical Director
DOCUMENTATION REQUIRED:	Agenda, previous minutes, supporting papers, NEQAS reports, Quality metrics, Risk Registers, and Planned Quality Objectives
REMIT:	Specific activities of the Committee will include overseeing: • Arrangements for screening / testing of patients and for meeting the needs for clinical users • Arrangements for screening / testing donors (blood, bone marrow), and for meeting the needs of external users in keeping with evidence based practice. • Arrangements for outsourced / reference testing • Regulatory compliance: donors – MHRA via BSQR, national policies and quality standards. • Patient testing – CPA / UKAS ISO15189 standards, national policies etc • Review quality incidents and risk management issues • Review of External Quality Assessment Scheme results • Determine and agree priorities for the department / Organisation • Encourage innovation in the development of this service
COMMUNICATION LINKS WITH VARIOUS GROUPS:	• Minutes of the meeting will be made available to all NIBTS laboratory and medical staff via NIBTS Intranet. • Intradepartmental meetings involving all AS and BGRL staff are held regularly. On-Call meetings are held on an ad hoc basis at the behest of either On-Call personnel, the Laboratory Manager or the Medical Director / Consultant Medical Staff. Here the focus is on serology

	cases, detailed operational, quality/regulatory and staff / training issues. • Other NIBTS groups with links with AS, BGRL, and On-Call include: Laboratory Management Team meetings, Pulse Expert Group, Governance and Risk Management Committee (and its sub-groups). Equipment Group • External groups of particular relevance are: DHSSPS Advisory Committee on Antenatal Screening, Antenatal Users Meeting (annual), Hospital Users Meeting (annual).

TOR:QD:026:01

TERMS OF REFERENCE

NAME OF COMMITTEE/GROUP:	Pulse Project Board
SUMMARY OF ROLE:	To review and monitor the operation of PULSE Blood Management System across NIBTS.
REPORTS TO:	ICT Steering Group and SMT as required.
RESPONSIBLE FOR (SUB-GROUPS)	PULSE Users Expert Group (PUEG)
CHAIRED BY:	Donor Services General Manager
MEMBERSHIP:	Chief Executive, Finance Manager, Laboratory Manager, RAC Manager, PUEG Chair, and IM&T Manager
QUORUM:	4 (including PUEG Chair or IM&T Mgr)
MEETING FREQUENCY:	Quarterly – but more frequent when required
SECRETARIAT:	To be confirmed
DOCUMENTATION REQUIRED:	Agenda, minutes, action lists
REMIT:	• To monitor and review all aspects of the ongoing operation of PULSE with NIBTS including hardware; software and support arrangements • To provide direction, control and oversight of PULSE developments and version updates • To review and approve plans for PULSE developments and version updates • To review and approve proposed changes to PULSE software and hardware that are outside the scope of PULSE Renewal • To ensure adequate resources are available for the operation of PULSE and for the implementation of new versions • To undertake appropriate performance management in relation to ongoing operation of PULSE and implementation of new versions • To provide strategic direction and guidance to PULSE Expert Group
COMMUNICATION LINKS WITH VARIOUS GROUPS:	• PUEG • SMT

TERMS OF REFERENCE

NAME OF COMMITTEE/SUB-GROUP	CHANGE CONTROL GROUP
SUMMARY OF ROLE:	The Change Control Group is a sub-group of the Quality Improvement Review Group. The group is responsible for • Supporting the on-going maintenance and development of Change Control systems in NIBTS • Identifying potential impacts of changes in operational/regulatory areas. • Reviewing action plans for changes to ensure identified impacts have been addressed. • Providing an organisation wide review of changes.
REPORTS TO:	Quality Improvement Review Group
RESPONSIBLE FOR (SUB-GROUPS):	None
CHAIRED BY:	Regulatory Affairs and Compliance Manager
MEMBERSHIP:	Representatives from Donor Services, Laboratory Services, Corporate Services, Finance/IM&T, Quality and Regulatory Affairs and Compliance Departments.
QUORUM:	Four members
MEETING FREQUENCY:	Weekly
SECRETARIAT:	Secretariat facilities will be provided by the RAC Manager
DOCUMENTATION REQUIRED:	Minutes, Details of new and revised changes submitted on Q Pulse.
REMIT:	Specific activities of the Sub-group will include:: • Review of changes with a status of 'New'. • Consideration of potential impact of proposed change on all areas and any potential risks. • Where significant risks identified escalate concerns re implementing change to SMT level. • Consideration of completeness of action plan to implement change. • Provision of advice to change owner re additional actions required for inclusion in action plan. • Providing consolidated reports on change management across the NIBTS to SMT
COMMUNICATION LINKS WITH OTHER GROUPS	Quality Improvement and Review Group.