AGENDA ITEM NO:

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS

THURSDAY 22 SEPTEMBER 2011

Title:	**REPORT FROM THE ORGAN DONATION COMMITTEE**
Responsible Director:	Kevin Bolger, Chief Operating Officer Professor Michael Sheppard, Non Executive Director
Contact:	Andrew McKirgan, Deputy Chief Operating Officer

Purpose:	To update the Board on activities undertaken by the Organ Donation Committee in response to the recommendations of the Organ Donation Task Force.
Confidentiality Level & Reason:	None
Medium Term Plan Ref:	N/A
Key Issues Summary:	• The national Organ Donation Task Force has made a series of recommendations aimed at increasing organ donation by 50%. • UHBFT has established a Donation Committee and appointed a Clinical Lead for Organ Donation working closely with in-house donor coordinators. • Donor audits show that UHBFT performance is consistent with the national average and a number of areas for improvement have been identified. • As part of the 2011/12 standard NHS contract with the West Midlands Specialised Commissioning Team (SCT) a CQUIN was agreed for 'Improving Access to Organs for Transplant' with a financial value of £317k. • A Trust Organ Donation Policy was approved by the Trust Policy Review Board in July 2011. • The Trust has secured £1.85m investment to develop a supernumerary 24/7 organ retrieval service and early indications are that this initiative is leading to an increase in retrievals.
Recommendations:	The Board of Directors is requested: 1) To **note** the progress made. 2) To **endorse** the proposed actions and reporting arrangements.

Signed:	**Date:** 14 September 2011

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BOARD OF DIRECTORS

THURSDAY 22 SEPTEMBER 2011

REPORT FROM THE ORGAN DONATION COMMITTEE

PRESENTED BY THE CHIEF OPERATING OFFICER

1. Introduction

The aim of this paper is to update the Board of Directors on the action taken by the Trust's Organ Donation Committee and the Clinical Lead for Organ Donation in support of the Organ Donation Task Force's aim for a 50% increase in organ donation in the UK by 2012. A previous paper was submitted to the BOD in September 2010. A full list of Task Force recommendations is attached for ease of reference in Appendix 1. Progress on all of those relevant to the Trust has been made and is described below.

2. Donation activity in all Trusts should be monitored (Recommendation vi)

2.1 A system of potential organ donation audit and performance monitoring is in place. The audit is conducted by the In-house Donor Coordinators and results are fed back to NHSBT. National standardised performance reports are issued to Trusts on a 6 monthly basis. The audits allow easier identification of missed donation opportunities and areas for improvement. This data is presented at the Trust's Organ Donation Committee meeting and actions to deliver sustained improvement are agreed. Performance for both Non Heart Beating and Heart Beating Organ Donation for 2010/11 is summarised in the tables below.

	National	**UHBFT**
Non Heart Beating:		
Number of Patients Meeting Trigger notification criteria	n/a	76
Patients Referred	44	74%
Family Approached	86	89%
Consent Obtained	51	50%
Collaborative Request Rate (MDT involved in process)	n/a	44%
Number of Organs Retrieved and transplanted	5	16

	National	**UHBFT**
Heart Beating:		
Number of Patients Meeting Trigger notification criteria	n/a	26
Patients Referred	85	96%
Brain Stem Death Test Undertaken (BSDT)	72	69%
Family Approached	93	100%
Consent Obtained	65	61%
Collaborative Request Rate (MDT involved in process)	n/a	71%
Number of Organs Retrieved and transplanted	52	37

Overall 53 organs were retrieved and transplanted a figure slightly down on the 57 recorded in 2009/10. Donor audits show that UHBFT performance is consistent with the national average. It should however be noted that the national performance data is misleading as the majority of

Trusts do not operate a trigger system within their Intensive Care Units to ensure that the total potential donor pool is identified. As the requirement to operate such a system has not been made mandatory the national performance against these indicators is potentially overstated. The main areas of focus for the team are the following:

(i) Patients Referred

The donor team were not notified of 26% of non heart beating patients identified by the trigger notification process within Intensive Care a slight reduction to the 31% recorded in 2009/10. 17 families were not approached formally and offered organ donation because:

- 8 patients were deemed not medically suitable following assessment for suitability.
- 2 families came forward to say they did not wish to donate.
- 4 patients were not identified as potential organ donors (2 in A&E, 2 on area B- all suitable for kidney donation and one for liver donation).
- 2 late referrals, not allowing time for the organ donation process to start i.e. after life sustaining treatment had been withdrawn.
- 1 family not offered the option of organ donation as the family were deemed too upset by the clinician.

(ii) Brain Stem Death Testing (BSDT)

Failure to undertake BSD testing in patients where it is a possible diagnosis is a major cause of “losing” potential donor organs. Over the past three years 30% of such patients in the UK were not tested for BSD. As such BSDT should be carried out on all eligible patients. 8 patients (31%) did not have a BSDT. Analysis of these patients identified that 1 patient suffered cardiac arrest prior to testing, 2 patients were medically unsuitable for organ donation and 5 patients were either haemodynamically unstable or did not meet the criteria for BSDT.

(iii) Consent Rates

Consent rates over the year are consistent with the national average however, although the collaborative request rate for non heart beating at 44% is similar to the figure in 2009/10 there has been a significant improvement in the collaborative request rate for heart beating. This has increased from 32% in 2009/10 to 89% in 2010/11 and reflects significant progress by the Organ Donation Team in ensuring that donor coordinators, who are specifically trained in seeking consent, play a key role in the consent process and work in partnership with the intensivist care team.

2.2 A number of initiatives to address these issues are now in place including:

- The appointment of a 3rd SN-OD in 2011 has enabled a greater focus to be placed on improving donation rates in the Emergency department.

- SN-ODs attending medical handover in ITU to aid early identification and referral of potential organ donors and build relationships with the clinicians on ITU. As there are now 3 SN-ODs in the Trust it is envisaged that handover can be rolled out on ITU - Area C and potentially Neuro Intensive Care.

2.3 As part of the 2011/12 standard NHS contract agreed with the West Midlands Specialised Commissioning Team (SCT) a CQUIN was agreed for 'Improving Access to Organs for Transplant' with a financial value of £317k. The indicators that form this CQUIN provided in Appendix 2.

Performance against the CQUIN indicators is reported monthly to the Clinical Quality Monitoring Group (CQMG) and quarterly to the Organ Donation Committee (ODC). An action plan is in place to support the delivery of the CQUIN and the wider organ donation measures although the Trust is currently awaiting further clarification from the SCT on the indicator definitions. Following clarification the indicators will be assessed internally by the team to ensure they are clinically sound and reflect measures of quality and best practice.

3. Policy and Procedures

A key objective achieved for the year was the completion of the over arching Trust Organ Donation Policy and the procedural documents pertaining to trigger referral, the approach and consent of families, donation after cardio circulatory death, donation in military patients and tissue donation. All of these documents have been circulated for consultation and the policy was ratified at the Trust Policy Review Board in July 2011.

4. National Organ Retrieval Teams – NORS (Recommendation x)

In December 2010 Board of Directors approved the establishment of 24/7 supernumerary rotas for both abdominal and cardiothoracic retrieval. This was in response to the Trust securing £1.85m of additional funding to support this. Recruitment to additional medical and nursing posts in liver, cardiac and theatres has taken place and early indications are that this initiative does appear to support an increase in both the number of call outs to assess organ suitability and as well as retrieval rates. It should be noted that from 2011/12 NHSBT have introduced KPIs into the contract that if not delivered could result in financial penalty. An example would be the failure to meet a 1 hour muster time for either organ retrieval team. To date in 2011/12 all targets have been achieved.

5. Education and Training (Recommendation xi)

The delivery of an effective education programme has also been a key priority for the year and significant progress has been made in this area. Programmes and events included:

- A study day on Organ Donation for Specialist Registrars (SpRs) in Anaesthetics and Intensive Care within the West Midlands region was run by the Clinical Lead.

- Creation of an organ donation module as part of the induction of new trainees on Intensive Care, aiming to increase their understanding and awareness of organ donation.

- Senior Nurses for Organ Donation (SN-ODs) have undertaken a number of initiatives to improve awareness and understanding of donation amongst ITU clinicians. These include attendance at ITU consultant meetings and setting up an Ethics meeting chaired by the Medical Director covering the withdrawal of life sustaining treatment.

6. Research

In order to develop and improve our organ donation practice the team have actively supported a number of research studies:

i) The Trust participated in Phase One of the DonaTE trial in collaboration with Kings College London. This is a 4 year National Institute of Health funded Research Programme looking into interventions designed to increase consent rates from families of potential organ donors from minority ethnic groups.

ii) Professor Julian Bion's research proposal in End of Life (EoL) care, focussing on gaining further knowledge on EoL care for potential donor families, through observation of the futility discussion and subsequent decision making process.

iii) Clinical Triggers research study - focussing upon 2 years data pre introduction of the trigger versus two years post introduction to identify any key benefits of having a clinical indicator tool 'trigger' in place to help in the identification and referral of potential organ donors.

7. Recommendations

The Board of Directors is requested:

7.1 To **note** the progress made.

7.2 To **endorse** the proposed actions and reporting arrangements.

Kevin Bolger
Chief Operating Officer

APPENDIX 1

Recommendations of the Organ Donation Task Force Report

i. A UK-wide Organ Donation Organisation (ODO) should be established.

ii. The establishment of the Organ Donation Organisation should be the responsibility of NHS Blood and Transplant (NHSBT).

iii. Urgent attention is required to resolve outstanding legal, ethical and professional issues in order to ensure that all clinicians are supported and are able to work within a clear and unambiguous framework of good practice. Additionally, an independent UK-wide Donation Ethics Group should be established.

iv. All parts of the NHS must embrace organ donation as a usual, not an unusual event. Local policies, constructed around national guidelines, should be put in place. Discussions about donation should be part of all end-of-life care when appropriate. Each trust should have an identified clinical donation champion and a trust donation committee to help achieve this.

v. Minimum notification criteria for potential organ donors should be introduced on a UK-wide basis. These criteria should be reviewed after 12 months in the light of evidence of their effect, and the comparative impact of more detailed criteria should also be assessed.

vi. Donation activity in all trusts should be monitored. Rates of potential donor identification, referral, approach to the family and consent to donation should be reported. The trust donation committee should report to the trust Board through the clinical governance process and the medical director, and the reports should be part of the assessment of trusts through the relevant healthcare regulator. Benchmark data from other trusts should be made available for comparison.

vii. BSD testing should be carried out in all patients where BSD is a likely diagnosis, even if organ donation is an unlikely outcome.

viii. Financial disincentives to trusts facilitating donation should be removed through the development and introduction of appropriate reimbursement.

ix. The current network of DTCs should be expanded and strengthened through central employment by a UK-wide Organ Donation Organisation. Additional co-ordinators, embedded within critical care areas, should be employed to ensure a comprehensive, highly skilled, specialised and robust service. There should be a close and defined collaboration between DTCs, clinical staff and trust donation champions. Electronic on-line donor registration and organ offering systems should be developed.

x. A UK-wide network of dedicated organ retrieval teams should be established to ensure timely, high-quality organ removal from all heartbeating and nonheartbeating donors. The Organ Donation Organisation should be responsible for commissioning the retrieval teams and for audit and performance management.

xi. All clinical staff likely to be involved in the treatment of potential organ donors should receive mandatory training in the principles of donation. There should also be regular update training.

xii. Appropriate ways should be identified of personally and publicly recognising individual organ donors, where desired. These approaches may include national memorials, local initiatives and personal follow-up to donor families.

xiii. There is an urgent requirement to identify and implement the most effective methods through which organ donation and the ‘gift of life’ can be promoted to the general public, and specifically to the BME population. Research should be commissioned through Department of Health research and development funding.

xiv. The Department of Health and the Ministry of Justice should develop formal guidelines for coroners concerning organ donation.

APPENDIX 2

Organ Donation CQUIN 2011/12 (West Midlands Specialised Commissioning Team (SCT)

The indicators that form this CQUIN are as follows:

1. No. deaths where the diagnosis of neurological death was suspected and the patient met all the criteria for testing as defined by the Code of Conduct and brain stem testing was carried out.

2. No. cases where neurological testing was planned and where the Specialist Nurse for Organ Donation was informed as detailed above.

3. No. cases, in the context of a catastrophic neurological injury, where the clinical decision was made to withdraw active treatment and where the Specialist Nurse for Organ Donation was informed before treatment was actually withdrawn.

4. No. cases 'where death was confirmed by neurological criteria or a decision was made to withdraw active treatment, and there were no absolute medical contraindications to donation' and where an approach was made to the family with regard to donation with the Specialist Nurse for Organ Donation present.

5. Number of times that donation activity in all trusts is formally considered by Donation Committee and reported to the Trust Board.