AGENDA ITEM NO:

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS

THURSDAY 22 JULY 2010

Title:	**REPORT FROM THE ORGAN DONATION COMMITTEE**
Responsible Director:	Kevin Bolger, Chief Operating Officer
Contact:	Professor Michael Sheppard, Non Executive Director Andrew McKirgan, Director of Operations, Division 2

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 exceeds the national average although a number of areas for improvement have been identified. • UHBFT and Cardiff have been confirmed as a joint abdominal retrieval centre and a bid for an enhanced organ retrieval service has now been supported by NHSBT. • A revised Trust Organ Donation Policy will be submitted to BOD in September 2010. • An education programme for organ donation is being developed.
Recommendations:	The Board of Directors is requested: a) To **note** the progress made. b) To **endorse** the proposed actions and reporting arrangements.

Signed:	**Date:** 16 July 2010

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS
THURSDAY 22 JULY 2010

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 of 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 July 2009. 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 summarised below.

2. Donation Committee (Recommendation iv)

The Donation Committee has met quarterly as planned during 2009/10. Its role is to oversee implementation of the taskforce recommendations and review performance monitoring information.

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

3.1 A system of potential organ donation audit and performance monitoring is now in place. The audit is conducted by the In-house Donor Coordinators and results are fed back to NHSBT. National standardised performance reports are then 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 2009/10 is summarised in the tables below.

	National	**UHBFT**
Non Heart Beating:		
Number of Patients Meeting Trigger notification criteria	n/a	76
Patients Referred	49%	71%
Family Approached	86%	87%
Consent Obtained	59%	62%
Collaborative Request Rate (MDT involved in process)	n/a	46%
Number of Organs Retrieved and transplanted		5

	National	**UHBFT**
Heart Beating:		
Number of Patients Meeting Trigger notification criteria	n/a	34
Patients Referred	89%	100%
Brain Stem Death Test Undertaken (BSDT)	75%	74%
Family Approached	92%	100%
Consent Obtained	61%	61%
Collaborative Request Rate (MDT involved in process)	n/a	32%
Number of Organs Retrieved and transplanted	n/a	52

The Trust performance is above the national average for the majority of KPIs. It should 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.

This performance data was presented to the Trust Organ Donation Committee meeting in June 2010 and a number of areas for improvement were identified:

(i) Patients Referred

The donor team were not notified of 29% of non heart beating patients identified by the trigger notification process within Intensive Care. Although on review all but 1 patient was not medically suitable the policy requires the notification of all patients to the donor team.

(ii) BSDT

Failure to carry out brainstem death (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. 9 patients (26%) did not have a BSDT. Analysis of the data identified that reasons included 5 patients suffering cardiac arrest prior to testing, 2 family refusals (it is not best practice for families to have been approached at this stage) and the withdrawal of treatment by the intensivist team before testing was performed.

(iii) Family Approached

Two families (13%) of potential non heart beating donors were not approached to discuss consent as the intensive care team felt it wasn't appropriate, however, the in house donor coordinators were not involved in this decision.

(iv) Consent

Consent rates over the year (unadjusted, consent rate adjusted for ethnicity will be issued by NHSBT in August) are consistent with the national average however, it was noted that the collaborative request rate was low at 46% and 32% for NHB and HB respectively although the majority of approaches were planned between ITU and the donor coordinator. The view of the committee is that it is essential that the 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.

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

- The Clinical Lead has established a program of quarterly lunch time audit and education meetings for all staff involved in organ donation to feedback current performance and for root cause analysis of missed donation opportunities.
- Seven ITU Consultants have undergone specific consent training for organ donation and further courses will be run by NHSBT this year.
- A virtual department for organ donation is being developed on the trust intranet with links to all relevant policy documentation, local and regional guidance and educational resources.

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3.3 It should be noted that NHS West Midlands have piloted KPIs for organ donation and are currently reviewing the data with a view to subsequently embedding them into contracts.

4. Policy and Procedures

Policy and procedure documents covering all aspects of organ donation at UHBFT have been written or revised. The Trust Organ Donation Policy will be submitted to the Board of Directors in September 2010. Procedure documents to support the policy include:

- Identification and referral of potential organ donors
- Approaching families for organ donation
- Organ donation in the Emergency Department
- Organ Donation for Military patients
- Donor management
- Non-heart beating organ donation
- Management of the donor in theatre
- Tissue donation

5. Donor Coordinators (Recommendation ix)

As part of the taskforce recommendations, Donor Coordinators have now transferred to NHSBT employment and are embedded in hospitals. UHBFT now has a total of 3 coordinators as part of a Midlands team of 19.

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

6.1 Since July 2009 NHSBT have confirmed their commissioning strategy for both abdominal and cardiothoracic retrieval. The impact has been threefold:

(a) The establishment of separate teams for cardiothoracic and abdominal retrieval.
(b) The separation of the retrieval zone from that for implantation.
(c) The establishment of Birmingham & Cardiff as a joint abdominal retrieval Centre.
(d) The introduction of a contract including KPIs that if not delivered, for example a failure to meet a 1 hour muster time for the organ

retrieval team or the failure to provide a team, could result in financial penalty.

6.2 A joint bid with Cardiff to fund the infrastructure to deliver the abdominal model in accordance with the proposed contract has now been agreed with NHSBT. A detailed paper requesting BOD approval to approve the agreed investment will be submitted in September 2010.

7. Education and Training (Recommendation xi)

7.1 The Donation Committee has established an education working group to develop curricula for organ donation in partnership with the University of Birmingham. Key members of the Organ Donation Committee are meeting with the University of Birmingham in July 2010 with a view to launching a MSc program in Organ donation to address the needs of Donor Coordinators and Clinical Leads for Organ Donation.

7.2 NHSBT is providing training to all Clinical Lead for Organ Donation (CLOD) through 6 professional development days and is due to organise regional meetings between CLODs and donor coordinators to allow sharing of best practice and experience.

8. Recommendations

The Board of Directors is requested:

8.1 To **note** the progress made.

8.2 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.