NHS Blood and Transplant

Abertawe Bro Morgannwg Health Board

Annual Organ Donation Plan 2014-2015

Contents

1. Executive Summary

From Dr Peter C Matthews (Clinical Lead for Organ Donation at Morriston Hospital)

The purpose of this document is to set out the annual plan for organ donation at the ABM University LHB for 2014-2015. The need for organs by potential recipients is still vastly greater than organs available for donation, and national and local changes are needed to reduce this gap.

In 2008 the Department of Health (DH), with the support of the Scottish Government and the Welsh Assembly Government, published the document "Organs for Transplant – A report from the organ donation taskforce." The 14 recommendations within this report were aimed at increasing organ donation by 50% within 5 years, and this target has broadly been achieved.

This document has now been succeeded by "Taking Organ Transplantation to 2020 – a UK strategy," published by the DH in 2013 and again supported by the Scottish and Welsh Governments; it focuses of improving 4 broad outcomes that will further increase the number of successful transplants that take place.

The Human Transplantation (Wales) Bill was passed by the National Assembly for Wales and received Royal assent to become enacted as The Human Transplantation (Wales) Act 2013. This allows for the introduction of deemed consent (soft opt-out) in Wales from December 2015 – this will require a national information campaign co-ordinated from the National Assembly, and local teaching and training within the Local Health Board.

Donations from ABM University LHB is still not achieving its potential for a variety of reasons, Morriston Hospital having been identified as a place that should be within the top 32 within the United Kingdom for organ donation. Several of the issues identified in the Annual Organ Donation Plan 2013-2014 have been addressed with a variable level of success.

1. Andrea Bradley is now the Lead Nurse in the Morriston Emergency Department (ED) – as a former SNOD she has maintained her interest in organ donation and has proved to remain a valuable link with that department. Michael Tobin has joined Roz Sandford as a SNOD in Morriston – he was a SNOD in London and has been instrumental in some of the new changes.

2. The lack of critical care capacity remains a barrier to organ donation potential. This has been acknowledged in a document by the Welsh Government published in 2013 called "Together for Health – A Delivery Plan for the Critically Ill. A Delivery Plan up to 2016 for NHS." It states that a lack of critical care capacity may be a constraint to maximum organ retrieval. The report emphasizes measures to optimise the use of available capacity but doesn't recommend critical care expansion which would address the issue that Wales has the lowest number of critical care beds per head of population of any European nation.

3. Dr David Webb (Chair ABMU LHB Organ Donation Committee) and myself had a meeting with Mr Paul Roberts (CEO) and Dr Push Mangat (interim Medical Director). There was agreement that organ donation should be considered a priority, and that a pathway to improve admission to the Intensive Therapy Unit (ITU) from the ED should be implemented. However several Consultant Intensivists feel that admission to ITU from the ED purely for organ donation is not appropriate if there are severe capacity problems, with the suggestion that other critical care beds could be used instead (such as beds on the burns unit).

4. A meeting with the ITU consultants has lead to an agreement for them to refer to the SNODs any patient where treatment withdrawal may be considered so that if an end-of-life pathway is put into place then there is an increased likelihood of organ donation going ahead.

5. The figures for organ donation in Morriston are being presented at the monthly ITU clinical governance meetings – cases where it is felt that potential donation could have gone ahead but it didn't happen are examined to see what changes can be made to human or system factors. It is felt that this is better than merely analyzing the NHSBT raw data which may not reflect the reality of donation activity on the unit.

6. The SNODs and CLODs attended the 2-day NHSBT National Congress in Warwick in September 2013. This meeting consisted of lectures on best practice, latest data, future plans and targets and an opportunity to share ideas and learn from UK colleagues.

7. The SNODs and CLODs attended the Wales Organ Donation Transplantation Conference in Cardiff in November 2013 which was a day of lectures and seminars.

8. AMBU LHB was invited to, and has agreed to take part in the NHSBT funded Quality in Organ Donation (QUOD) project. QUOD is a project to establish a biobank, based within Oxford University, of biological samples from organ donors taken at various points through out the donation process. This bio-resource is intended to support the development of future transplant related research studies aimed at improving the number and quality of transplantable organs.

9. ABMU LHB has been asked to comment on provisional new guidance from the UK Donation Ethics Committee (UKDEC) regarding potential changes in practice involving donation after cardiac death (DCD).

9. Monies received as a result of organ donation activity is being used to supply equipment to help with education, and to refurbish areas which patients and relatives use – discreet plaques in these areas will acknowledge that these facilities were only possible due to the generosity of families who had agreed for organ donation to proceed.

Strategic Response to Issues to be addressed

From Dr Peter C Matthews (Clinical Lead for Organ Donation at Morriston Hospital)

Both the Human Transplantation (Wales) Act 2013 and the new guidance "Taking Organ Transplantation to 2020 – a UK strategy" will need national and local policies of education and implementation of new practices and targets. The SNODs and CLODs can do much of this based on a strategy that needs to be planned by the Organ Donation Committee (ODC). There will need to be support from the Health Board, and to improve links with the ODC there has been a request for a non-executive director to join the ODC to be able to advise and improve communication between the two bodies.

The Chief Executive has agreed to write a blog about organ donation which should help highlight the importance of donation, and emphasis that it remains a priority for the LHB.

There is still a spectrum of opinion among the ITU consultants about the priority of donation when capacity is limited, especially with regard to admission from ED purely for donation purposes. The CEO and the previous (interim) medical director have provided guidance but this was not universally accepted. Suggestions by some ITU consultants to explore using other critical care beds such as cardiac or burns could be looked at but it does not seem to be a realistically practical option. Demand for ITU beds is likely to increase as more services are centralised to Morriston Hospital and it may need to be accepted that organ donation rates won't improve until capacity is increased.

Earlier referral to the SNODs seems to have been accepted in principle, and hopefully this will improve consent and conversion rates. Regular discussion about organ donation rates in the ITU clinical governance meetings each month should help to identify factors that can be addressed to minimise potential donations that could have but didn't proceed.

While some of the monies received for each patient consented for donation has been used this financial year there needs to be a more robust plan from the ODC how to use this money each year so that it is used to improve organ donation within the LHB.

2. Report from the Organ Donation Committee (ODC)

From Dr David Webb (chair of Organ Donation Committee)

The major challenges for the committee currently are to continue to support the annual increase in organ donation numbers, and to ensure that the Human Transplantaion Bill (Wales) is given an opportunity to have a positive effect on donation numbers in Wales. The time for debate on the bill is past, it will soon be law, and it must now be made effective. The organ donation committee is a broadly representative body with both lay and professional representation, but is the SNODs and the CLOD who are at the front line. The committee has supported them in the development of clinical services throughout the board, but especially on ITU and in the A&E department. The educational function of the committee has been taken forward with vigour, and the benefits have been evident in ever increasing awareness of the need for increased donation. Now that the money received for each identified donor is held within the committee, the benefits in terms of facilities for the infra structure of donation are already visible in the A&E department, on ITU and in equipment to facilitate the SNOD's function

3. Hospital Organ Donation Team Structure

TRUST

NHSBT

TRUST BOARD

MEDICAL DIRECTOR
Dr Hamish Laing

ITU & Anaesthetics

Morr C L – Dr Craig Jerwood
POW C L – Dr Ant Osborne

ASSISTANT DIRECTOR
Anthony Clarkson

REGIONAL MANAGER
Karen Morgan

TEAM MANAGERS
Louise Colson
Phil Walton

REGIONAL CLINICAL LEAD
Dr Chris Hingston

DONATION COMMITTEE CHAIR
Dr David Webb

CLINICAL LEAD (CLOD)
Morr – Dr Pete Matthews
POW – Dr Richard Self

SPECIALIST NURSE (SNOD)
Roz Sandford
Michael Tobin
Guy Heathcote

ABM NHS TRUST

DONATION COMMITTEE

CRITICAL CARE

Sr Ellis-Evans
Sr Williams

EMERGENCY DEPARTMENT

Sr Bradley

THEATRES

CN Hughes

END OF LIFE

Rev Griffiths
Dr Baker

DONOR FAMILY REPRESENTATIVE

MORTUARY REPRESENTATIVE

COMMUNICATIONS REPRESENTATIVE

Mrs Bailey

Abertawe Bro Morgannwg

Donation after Brain Death

2013/14 **(2012/13 figs in brackets)**	DBD Critical Care	DBD Emergency Dept.
Patients with Suspected Neurological Death	16 (14)	3 (2)
Referred	14 (12)	2 (0)
BSDT Performed	12 (10)	0 (0)
Confirmed BSD	12 (10)	
Family Approached	11 (10)	
Consent Given	8 (7)	
Donation Proceeded	8 (6)	
Organs Retrieved	20 (13)	
Identification of Neurological Death (ND)%	75 (71)	
Neurological Death Testing (NDT) %	75 (71)	
Referral Rate of Patients Confirmed %	88 (85)	
Approach Rate%	92 (100)	
Consent Rate %	73 (70)	
Conversion Rate %	67 (60)	

Donation after Circulatory Death

2013/14 **(2012/13 figs in brackets)**	DCD Critical Care	DCD Emergency Dept.
No. Patients for whom Imminent Death was Anticipated	167 (181)	18 (11)
Referred to the SNOD	80 (89)	6 (1)
No. Where Treatment was Withdrawn	145 (161)	16 (11)
No. Eligible DCD Donors	93 (66)	11 (9)
Family Approached	24 (26)	2 (1)
Consent to Donation	17 (9)	0
Donation Proceeded	7 (4)	0
Organs Retrieved	14 (13)	0
Referral Rate %	48 (49)	33 (9)
Approach Rate %	26 (39)	18 (11)
Consent Rate %	71 (34)	

Princess of Wales

Donation after Brain Death

2013/14 **(2012/13 figs in brackets)**	DBD Critical Care	DBD Emergency Dept.
Patients with Suspected Neurological Death	4 (8)	0 (1)
Referred	4 (6)	
BSDT Performed	4 (5)	
Confirmed BSD	4 (5)	
Family Approached	4 (5)	
Consent Given	4 (2)	
Donation Proceeded	4 (2)	
Organs Retrieved	(7)	
Identification of Neurological Death (ND)%	100 (70)	
Neurological Death Testing (NDT) %	100 (62)	
Referral Rate of Patients Confirmed %	100 (100)	
Approach Rate%	100 (100)	
Consent Rate %	100 (40)	

Donation after Circulatory Death

2013/14 **(2012/13 figs in brackets)**	DCD Critical Care	DCD Emergency Dept.
No. Patients for whom Imminent Death was Anticipated	28 (34)	1 (2)
Referred to the SNOD	18 (12)	0 (0)
No. Where Treatment was Withdrawn	28 (33)	1 (2)
No. Eligible DCD Donors	17 (9)	0 (2)
Family Approached	6 (5)	
Consent to Donation	3 (2)	
Donation Proceeded	2 (1)	
Organs Retrieved	(3)	
Referral Rate %	64 (35)	
Approach Rate	35 (55)	
Consent Rate %	50 (40)	

Morriston

Donation after Brain Death

2013/14 **(2012/13) figs in brackets)**	DBD Critical Care	DBD Emergency Dept.
Patients with Suspected Neurological Death	12 (6)	3 (1)
Referred	10 (6)	2 (0)
BSDT Performed	8 (5)	
Confirmed BSD	8(5)	
Family Approached	7 (5)	
Consent Given	4 (5)	
Donation Proceeded	4 (3)	
Organs Retrieved	(5)	
Identification of Neurological Death (ND)%	67 (100)	67 (0)
Neurological Death Testing (NDT) %	67 (83)	
Referral Rate of Patients Confirmed %	83 (100)	
Approach Rate%	88 (100)	
Consent Rate %	57 (100)	

Donation after Circulatory Death

2014/15 **(2013/14 figs in brackets)**	DCD Critical Care	DCD Emergency Dept.
No. Patients for whom Imminent Death was Anticipated	139 (146)	17 (9)
Referred to the SNOD	62 (76)	6 (1)
No. Where Treatment was Withdrawn	117 (127)	15 (9)
No. Eligible DCD Donors	76 (56)	11 (7)
Family Approached	18 (20)	2 (1)
Consent to Donation	14 (6)	0 (0)
Donation Proceeded	5 (3)	
Organs Retrieved	(10)	
Referral Rate %	45 (50)	35 (11)
Approach Rate %	24 (32)	18 (14)
Consent Rate %	78 (29)	0

5. Summary of Past Years performance

Princess of Wales

- 100% BSDT on ITU
- DCD referral rate has doubled
- DCD consent rates have increased by 10%
- The reduction in DCD approach rate can to some extent be explained by donor unsuitability following assessment.

Morriston

- CITU had 1 patient BSDT who went on to donate
- 4 not BSDT on ITU, 3 were haemodynamically unstable and 1 was already on DCD pathway
- 3 not BSDT in ED, 2 were referred, 1 not BSDT as haemodynamically unstable, 1 because no beds were available in ITU/recovery, 1 family were approached by ED SpR family declined donation so not referred.
- DCD referral rates down 5%
- DCD approach rate is down due to donor unsuitability
- DCD consent rate has more than doubled to 78%
- DCD referral rate in ED has almost tripled

6. Review of Previous Years Objectives

Objectives for the next year	Actions required to deliver objective	Measurable outcome/KPIs	Person responsible for leading action	Completion date	Evaluation
Earlier identification and 100% referral of all potential DCD donors.	Education of nursing and medical staff via strategy Individual feedback to consultants regarding missed potentials Embed and refine existing minimum notification criteria with consultants i.e try to introduce daily hand over sheet therefore identifying any potential DCD donors. Feedback audit figures and organ donation outcomes at morbidity and mortality meetings monthly. Continue work on organ donation policy Improve communication and processes for referring all potential donors.	Measurable improvement on the PDA data	SNODs	Ongoing	Education is ongoing ongoing concept of daily handover has been rejected by consultant body at present discussions continue regarding minimum notification criteria. At POW ICU minimum notification criteria are published in existing customs document. M&M meetings were discontinued in June of last year monthly data is sent to all consultants via email. POW have had feedback via grand round meetings. Policy awaiting Health Board approval.

	Formalise these processes i.e introduce daily handover sheet to senior nursing staff and onto the doctors handover sheet to allow earlier identification of potential donors.				As above this idea has been rejected by consultants at present.
Aim for BSDT to be carried out in all patients where this is a likely diagnosis	Continue to promote this policy through education of HCPs within ICU and ED Through education continue to promote AoMRC (2008) Code of Practice for the Diagnosis and Confirmation of Death. Introduce and promote adoption of "Form for diagnosis of death using neurological criteria" with consultant body. Ensure their availability in clinical areas. Publish link on Critical Care Share Point or equivalent for abbreviated and full guidance versions. Update Existing customs at PoW.	As above	SNOD and CLOD		At both hospitals all potentially brain stem dead patients were recognised and tested where possible in ICU. Education continues in ED to ensure recognition of BSD and input from ITU for testing where necessary.

Ensure all families of patients where organ donation is a possibility are approached to discuss this option and Improve the consent rate for both DBD and DCD donors within the ICU and ED	Promote adoption of strategy for referral and approach of potential donor families found within “NHSBT Approaching the Families of Potential Organ Donors – Best Practice Guidelines”. Provide education for HCPs in ED, ICU and Theatre/Recovery areas based upon this publication. Ensure it’s availability for reference within critical care areas. Negotiate updating local policy at PoW with consultant body and revise “Existing Customs”.	Improvement in consent rates in PDA	SNODs CLOD	April 2014	Approach rates appear poor and down on last year however many of the potential donors were deemed unsuitable following enquiries and therefore the families were not approached. Consent rates have improved partcularly for DCD donors across the health board. Planning and collaborating with consultants when approaching families has improved and work continues in this area.
Hospital wide education strategy	Re evaluate current education taking place within the hospital. Carry out educational needs analysis. Book sessions for the year ahead both with nursing staff medical staff and in all areas of ITU, ED and theatres. Use all opportunities to educate staff including missed potentials. Educate all staff regarding the NHSBT 2020 strategy	Improved understanding of organ and tissue donation in all critical care areas	SNODs CLOD	June 1st 2013	Regular sessions have been established with groups of HCPs including Student nurses, medical students, junior doctors. Teaching on the foundations in crtical care course has been a recent regular addition.

Improve referrals and facilitation of donation from ED	Continued meetings between ITU and ED staff regarding a way forward in relation to pathway for donation from ED. Develop an ED specific policy and pathway which engages with all stakeholders involved, negogiating agreement from all. Use NICE guidelines to develop policy.	Improved referral rates from ED	SNODs CLOD	Ongoing	Referral rates have increased from 11 % to 35 % at Morriston ED. There has been recent formal agreement from theatre recovery to accommodate potential donors. Negotiations have taken place this year at Morriston between ITU consultants, clinical lead, medical director and chief executive and CLOD regarding admission from ED to ITU for donation this is not yet resolved. PDA data from POW ED suggests minimal potential from ED and that eligible donors are admitted to ICU.
To maximise the number and quality of organs retrieved for transplantation through improved optimisation of DBD donors.	Negotiate introduction of "NHSBT Donor Optimisation Guideline for Management of the Brain Stem Dead Donor" with HCPs on ICU and ED to replace existing local care bundle. Provide education sessions for HCPs in ICU,ED and Theatre recovery unit based on these guidelines. Ensure availability of guideline and documentation in clinical area. Add to Critical Care Sharepoint or local equivalent.	Data from PDA and National transplant database	SNOD and CLOD		These docments are available and have been largely adopted by unit staff at POW.

Benchmarking against best practice	Arrange visit of SNOD and committee chair to visit Preston Hospital. Evaluate and adopt systems that will help improve practice in Morriston hospital.	Improvement in all key perfomance indicators	SNOD ODC chair	June 2013	Telecon took place in October and best practice noted and fed back to committee.
Appointment of a CLOD for ED dept at Morriston	Discussions with senior consultants in ED to appoint a suitable candidate as CLOD	Improved recognition and referral of potential donors from ED	South Wales ODST team leader, regional manager, Regional CLOD NHSBT	Oct 2013	This idea has been explored but was not supported.
Review Organ Donation Committee	Review membership of the ODC. Review and clarify terms of reference of the committee.	Improved functioning of the committee	SNODs and Chair	June 2013	Membership has been reviewed and additional members joined including senior nurses from theatres and ITU at Morriston and POW and Cardiff transplant surgeon. Work continues on clarifying terms of reference.

6. Action Plan for 2014/15

Outline the strategic action plan necessary to realise the potential for Organ Donation stated above for your hospital

Objectives for the next year	Actions required to deliver objective	Measurable outcome/KPIs	Person responsible for leading action	Review date	Evaluation
Further improve identification and referral of all potential DCD donors.	Education of nursing and medical staff via strategy Individual feedback to consultants regarding missed potentials Embed and refine existing minimum notification criteria with consultants i.e try to introduce daily hand over sheet therefore identifying any potential DCD donors. Feedback audit figures, organ donation outcomes and missed potential to clinical stakeholders on a monthly basis. Await adoption of Health Board organ donation policy and promote awareness when available.	Measurable improvement on the PDA data	CLODs and SNODs	October	

Aim for BSDT to be carried out in all patients where this is a likely diagnosis as per NICE and National guidance	Continue to promote this policy through education of HCPs within ICU and ED Through education continue to promote AoMRC (2008) Code of Practice for the Diagnosis and Confirmation of Death. Continue to ensure availability of "Form for diagnosis of death using neurological criteria" with consultant body. Publish link on Critical Care Share Point and COIN for abbreviated and full guidance versions. Finalise Update to "Existing Customs" document at PoW.	As above	CLODs and SNODs	October	
To continue to improve approach to families of potential donors maintain momentum with rising consent rates	Promote adoption of strategy for referral and approach of potential donor families found within "NHSBT Approaching the Families of Potential Organ Donors – Best Practice Guidelines". Provide education for HCPs in ED and ICU based upon this publication training package (DVD) Ensure it's availability on the intranet. Explore possibility of holding "Advanced Communication workshop" for HB staff. Negotiate use of funds from Organ Donation Committee.	Improvement in consent rates in PDA	SNODs CLODs	October	

Health Board education strategy	Book education sessions with nursing and medical staff in all areas of ITU, ED and theatres. Use all opportunities and invitations to educate staff. Educate all staff regarding the NHSBT 2020 strategy	Improved understanding of organ and tissue donation in all critical care areas	SNODs CLOD	October	
Improve referrals and facilitation of donation from ED	Continued meetings between ITU and ED staff regarding improved identification and referral of potential donors. Maintain dialogue and contact with Andrea Bradley Lead Nurse ED Refine, disseminate pathway engaging all stakeholders involved.	Improved referral rates from ED	CLODs SNODs	October	
To maximise the number and quality of organs from DBD donors	Continue to promote use of "NHSBT Donor Optimisation Guideline for Management of the Brain Stem Dead Donor" with HCPs on ICU and ED . Provide education sessions for HCPs in ICU,ED and Theatre recovery unit based on these guidelines. Ensure availability of guideline on Hospital intranet.	Improved numbers of organs transplanted on PDA	CLODs SNODS	October	

Promotion of organ donation within the Health Board and local population	Revisit, improve and update Health Board Organ Donation Intranet Webpage and hospital information . Engage with Sue Bailey and HB Communication Department. Follow up on Morriston Memorial window within new build. Cooperate with WAG and its promotion of the new law.		Comms Dept Sue Bailey Nigel		

7. Risks to Delivery of Objectives and Mitigating Actions

Objectives for 2014/15	Risk to Delivery	Action to be Taken to Minimise Risk	Delivery Lead
Improve referrals and facilitation of donation from ED	Capacity issues for transferring potential donors to ITU at Morriston	Further dialogue between ED, ITU and theatres and CLOD regarding admission of patients for donation.	Pete Matthews (CLOD)

All objectives for the coming year are acheivable dependant upon successful education of health care professionals and adoption of consistant practice in line with national guidance.

8. Any Other Information