Cautionary Tales
in Organ Donation and Transplantation

NHS Blood and Transplant

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Introduction

The NHS is constansly changing and people move on, and ODT is no different. This month we say a fond farewell to Professor John Dark; He will be greatly missed by all within the ODT Clinical Governance Team (and I am sure by many others too!). But as they say, when one door closes another one opens, and we are very excited that we will be working alongside both Dr Richard Baker and Professor Derek Manas in the future, for expert advise and input.
The day to day work continues however and this change will not alter this. Incident reporting continues to increase, with October 2018 being the second highest ever number reported. It is believed that this increase is due to increased reporting rather than increases in incidents and should be seen as a positive.

Unfortunatly, reporting an 'incident' is still seen as a negative by some; someone to 'blame'. We are hearing and seeing comments such as 'I going to submit an incident report about you', 'if you don't do this I'm going to report an incident', 'they keep reporting us', 'we've had a number of reports against us' and so on. Reporting an incindet is not about the individual, and its not about 'holding people to account' or 'finding out *who* was wrong', its about strengthening processes, looking at a systems approach and moving away from the sticking plaster theory. So please see incident reporting as a positive, and a way to reflect on practice through the eyes of human factors and a systems approach. Often the way to strengthen a process isn't to put more steps and 'checks' in (which is often the first thought), but to remove steps, so in actual fact making processes easier rather than more cumbersome!

https://www.organdonation.nhs.uk/IncidentSubmission/Pages/IncidentSubmissionForm.aspx

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A farewell from our National Clinical Lead for Governance

Professor John Dark has worked alongside the ODT Clinical Governance Team from almost the start and has helped support and develop where we are now. Here he reflects on his time in post and how things have changed within clinical governance over the years:

What did I think when first joining NHSBT, with this "Governance" tag? Was I to be like Robocop, or maybe Judge Dredd, meting out "justice" to the wrongdoers? In practice, and to continue the comic-book analogies, I started more as Robin to James Neuberger's Batman, initially very much the side-kick.

But then the Governance team expanded, and the current personnel became established. But what stands out over the years since 2013?

"What has clinical governance ever done for me"

This is a frequently heard comment, and after six years in the post I can try to reflect on an answer. The starting point has to be “how can we make Governance a useful service to the organ donation and transplant community?”

We know that whilst it is not the real purpose of incident reporting, individuals at every level, and in every speciality, do use it to get things off their chest; when they are upset about things going wrong or an opportunity being missed for what seems to be a pointless reason. People often report, send emails or even call incandescent with anger over a situation. However, once that emotive report is received, a well-oiled process swings into action and you can be guaranteed an objective, rationale review takes place, lessons are learnt where appropriate and complete response sent. It helps that we are a small community and having been involved for now more than 35 years, I know most the names if not the faces.

But the main and most useful function, and the thing that has given the most satisfaction, is learning from errors, mistakes or quite often, just unfortunate situations where the process (or lack of it) did not work for whatever reason despite all best intentions and being able to feedback in a useful fashion.

An early example was that of a kidney dropped on the floor. We all know this can happen and I had thought that the only real debate was whether to rinse under hot water or cold. But when the kidney was discarded because of concerns over the risk of contamination we were able to get a view that it would have in fact been safe to transplant. We then feedback that view via KAG and the National Retrieval Group to all the teams. No more kidneys have gone in the bin merely because they ended on the floor.

Sometimes the process has been more complicated, but the ability of the governance team to collect and analyse a sequence of events has been invaluable. A recent example was the rise in the number of QUOD punch biopsy associated bleeding problems. It had been assumed that the punch technique would be safer but there was a rush of reports at the end of 2018, and we could form a useful picture. For instance, that no particular NORS team was involved suggested it was the technique that was an issue. Gathering robust data enabled us to feedback to the key people and the improved technique has been rapidly incorporated into the national service. Without the governance structure there would have been gossip and hearsay but no framework for change, and importantly no framework for shared learning.

Some of the interesting projects are not yet complete. We had noted regular problems when unexpected lesions found at retrieval requiring histology. Not only were organs lost because of a lack of service but sometimes this lack tipped surgeons into taking needless risks. In addition, there were major issues with communication and dissemination of results.

The governance team took this on board, assembling a working party which developed a standardised pathway for communication, including a request form which is used across the country.

Whilst we still receive ad hoc reports, incidents surrounding poor communication have almost disappeared. We are still left with the problem of provision of the service. As histopathologists become increasingly specialised and on-call availability evaporates we are often faced with the situation when no results can be available at a useful timescale. This clearly needs a national solution and several promising avenues are being explored in collaboration with the Royal College of Pathologists.

The best thing about working with NHSBT is the people, and my time with the Governance team exemplifies this. It has been hugely enjoyable, has opened my eyes to problems and difficulties throughout organ donation and transplantation and has, I hope enabled me to make a small contribution. I think my successors, Derek Manas and Richard Baker, will have a lot of fun, working with some wonderful people.

Hub Operations Donor Lead

Some time back, following an incident review, recommendations were made around one person in Hub Operations being the single point of contact for a donor process; the ‘Donor Lead’. This supports Hub Operations staff in knowing the details of a donor, the progress of organ offering, recording organ decisions and undertaking all communication for that donor. It also reduces the touch points of those involved in passing over information; we all know that handovers are a weak point in any system and the Donor Lead will reduce this. This change was not able to be implemented prior to the new phone systems that are now in place in Hub Operations, however pending some further updates in this phone system, the plan is to introduce in May 2019. It is expected that SNODs and transplant colleagues will notice an improvement in service as they will only have one person to liaise with regarding a donor, rather than the whole team. Further information will be shared nearer the time.

Learning point

- Donor Lead will provide a single point of contact in Hub Operations
- The expectation is that this will strengthen communication between SNOD, Hub Operations and Transplant Centres

Offering; ‘Right’ patient, ‘right’ centre, right timings?

One of the aims for all in organ donation and transplantation is that access to transplantation is fair and equitable and that organs are offered to the ‘right’ patient or centre. There are clearly agreed processes and policies to ensure that this happens, however there are occasions, for whatever reason, when things don’t go to plan.

On a recent case concerns were raised by Hub Operations around difficulties in contacting a centre to make a named patient offer. Due to the reported time taken to try and contact the centre, via multiple routes with no response, it was agreed to move onto the next centre – which meant the named patient did not receive the offer. On review, as is often the case, this highlighted learning for all involved.

Within the NORS standards it is documented that ‘If there is no response…after 45 minutes of trying to make contact, then the on-call NHSBT Regional Manager, SNOD or ODT Hub Operations may move on to offer the organ to another transplant centre’. At the time it was felt that this was adhered

to, however in retrospect it raised questions around what are ‘reasonable’ attempts to contact the on-call person? What one-person thinks is reasonable may be very different to the next; with something so important it was agreed that this should not be left to interpretation.

This has now been discussed with all the Advisory Group Chairs and Hub Operations and recommendations have been made to clarify what is ‘reasonable’ and how this should work in practice. Once these have been agreed they will of course be shared wider.

As well as the need to clarify this aspect, this case also highlighted the responsibility of centres to ensure they respond to offers as quickly possible. It is acknowledged there are occasions where pagers and phones cannot be answered immediately, however where this is the case, others may be able to answer on their behalf.

Clearly whilst there is a need for Transplant Centres to respond to offers, NHSBT also need to ensure that there are robust methods for making those offers. Phone contact is an easy one as you physically speak to someone, but it is time consuming for both sides. There will also be times when on -call staff simply can’t get to the phone as they may be scrubbed in theatres or with patients. Also, whilst we know if a pager or SMS message has been sent, currently there is no clear way of ensuring they have been received. Therefore, a project team is being set up with a view of improving the process of making an organ offer, by exploring the possibilities for future communication methods.

Learning point

- Clarity over what are ‘reasonable’ attempts to contact a centre to make an organ offer
- Transplant centres have a responsibility to ensure they have systems in place to enable offers to be received within reasonable timeframes
- NHSBT need to ensure robust methods of communicating offers and a Project Team is being set up to review this process and explore the possibilities for future communication methods