NHS
Blood and Transplant

OTDT Clinical Governance

Jane Rowlands

Claire Mitchell

October 2022

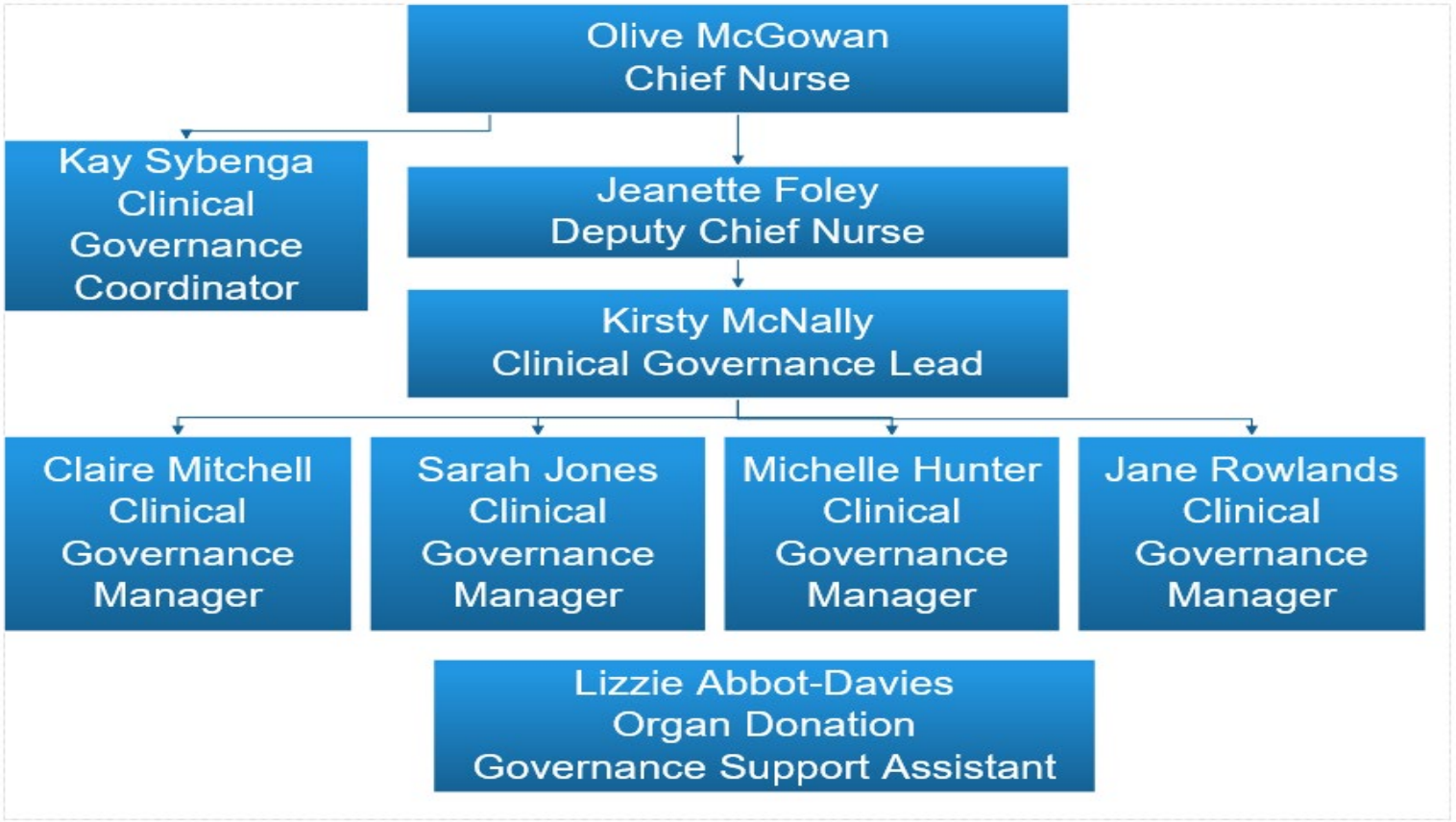
Learning, Sharing, Strengthening

What is Clinical Governance?

Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which clinical excellence will flourish.

Department of Health 2012

Team Structure



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What is an OTDT incident?

- Any event in the organ donation and/or transplantation process which can or does affect the donor, recipient, safety or the quality of the organs for transplantation
- May have national or wider learning
- Legal requirement to report under HTA regulations
- May relate to organs being sent/received from overseas

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Culture

"I have told them that I would report to Clinical Governance"

"I'm not reporting it against them"

"I told them this wasn't acceptable and I will be reporting to Clinical Governance"

Human Factors Definition

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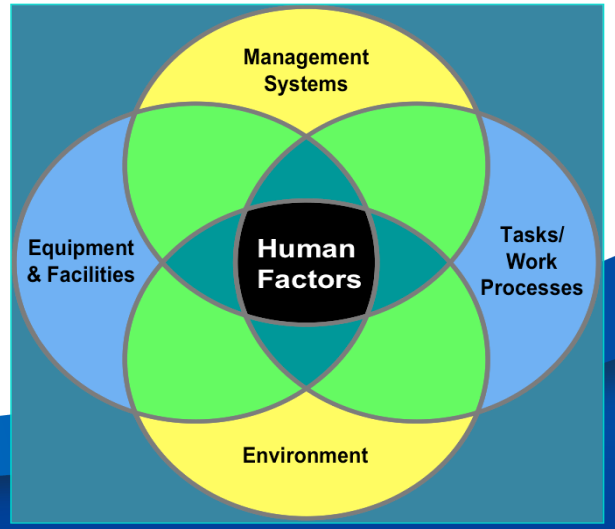
An organisation or department is made up of three main aspects:

1. **Hardware** – the physical attributes, anything you can touch e.g. IT systems, the buildings equipment.

2. **Software** – how the organisation defines itself – the policies and procedures, guidelines and rules.

3. **Humanware** – the people within the organisation who make the business happen

Human Factors approach considers **how** the people within the organisation interact with the **hardware**, **software** and **each other**.



What is a Just Culture? - Reminder

Cultivating an atmosphere where people have confidence to report safety concerns without fear of blame. Employees must know that confidentiality will be maintained and that the information they submit will be acted upon, otherwise they will decide that there is no benefit in their reporting.

Errors and unsafe acts will not be punished if the error was unintentional. However, those who act recklessly or take deliberate and unjustifiable risks will still be subject to disciplinary action.

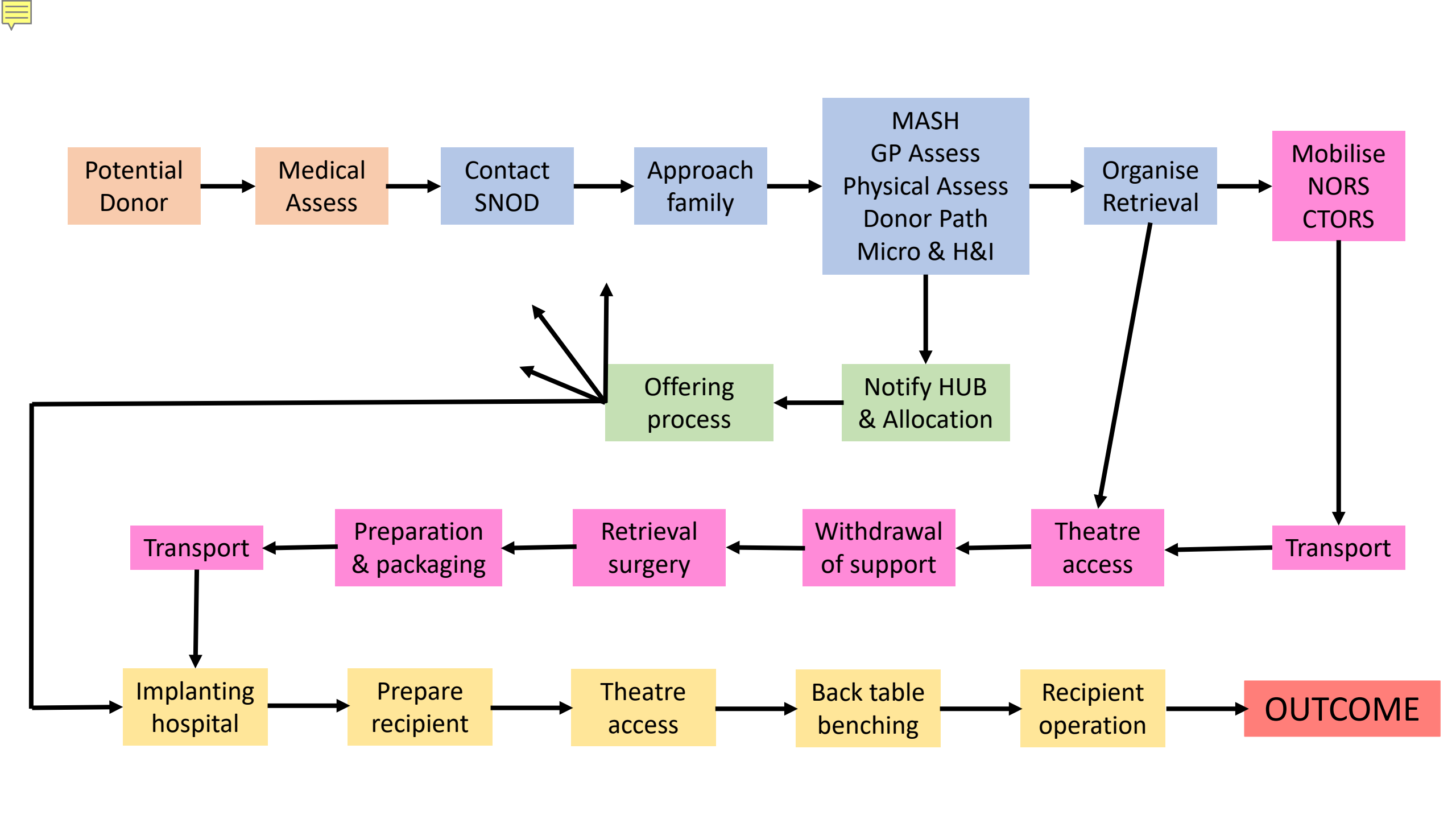
Organisation collects and analyses relevant data, and actively disseminates safety information.

Organisation is able to learn from its mistakes and make changes. It will also ensure that people understand the SMS processes at a personal level.

Organisation and the people in it are capable of adapting effectively to changing demands.

Areas of responsibility

- Donor Characterisation
- Allocation and the NTXD
- Team Mobilisation
- Retrieval
- Transport
- Transplantation
- Disease Transmission
- Outcome monitoring


Potential Donor
Medical Assess
Contact SNOD
Approach family
MASH
GP Assess
Physical Assess
Donor Path
Micro & H&I
Organise Retrieval
Mobilise
NORS
CTORS
Offering process
Notify HUB & Allocation
Transport
Preparation & packaging
Retrieval surgery
Withdrawal of support
Theatre access
Transport
Implanting hospital
Prepare recipient
Theatre access
Back table benching
Recipient operation
OUTCOME

HTA Human Tissue Authority
The regulator for human tissue and organs

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Assisted Function

Serious Adverse Event (SAE) - any event that occurs that impacts or has the potential to impact on a patient

Serious Adverse Reaction (SAR) - An unintended reaction that impacts on the patient

Serious Incident (SI) – Unexpected or avoidable death, serious harm, abuse. Major loss of confidence in service. Near Miss- Risk of system failure and potential to cause serious harm.

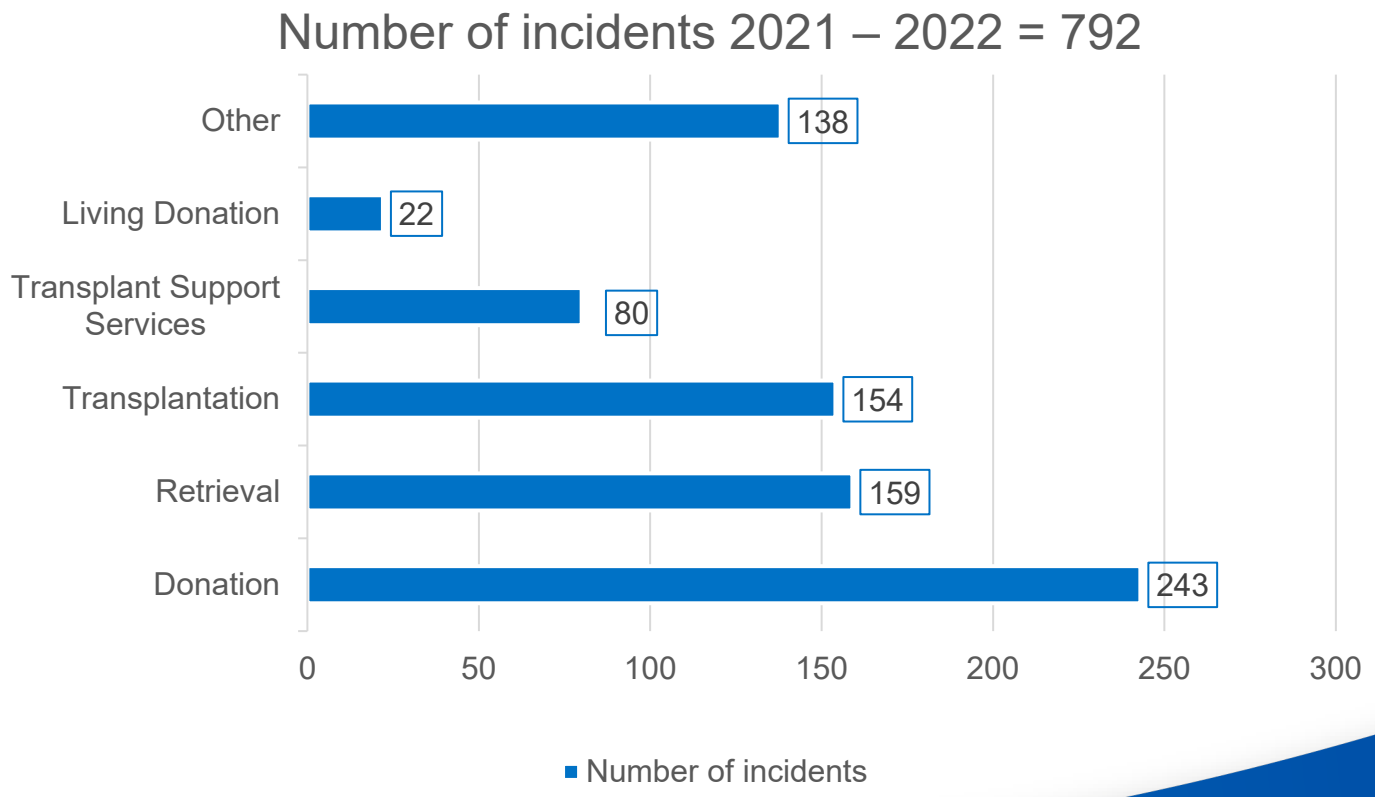
Never Event- Preventable incidents and events that should never occur, dictated by NHSE and NHSI and reportable.

Incidents across the ODT pathway per month

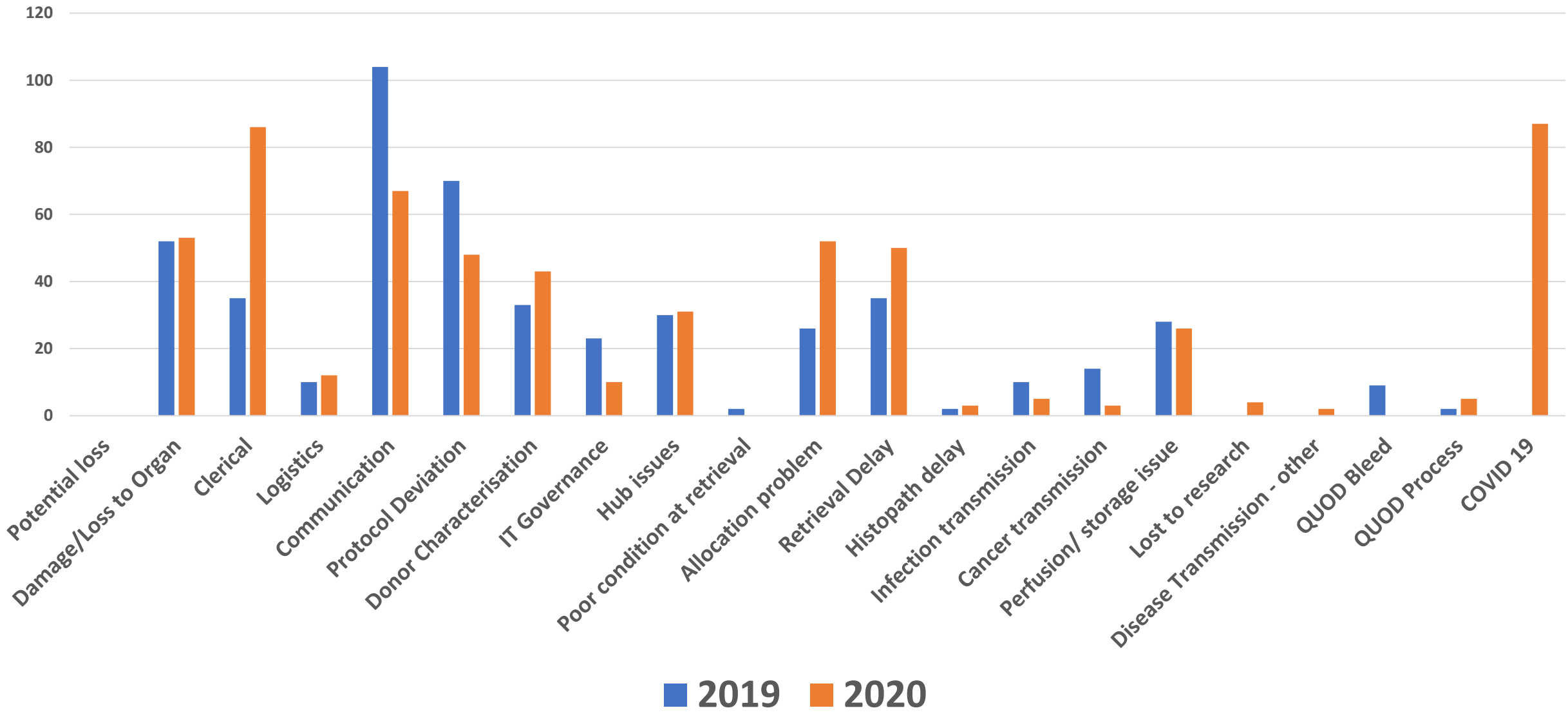
Incidents reported and requiring investigation

Month Reported	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Number of incidents	63	67	70	70	53	64	40	78	67	71	74	66

Incidents across the OTDT pathway



What is reported?



Trends 2021

- Communication breakdown
- Centres not accepting organs within agreed timeframes
- Requests for delays in retrieval – recipients/ multiple transplants/ resource
- Organs declined late after initial acceptance- resource/ recipients
- Organ damage
- Delays to mobilising retrieval teams/ arriving on time and resource
- Living donation that does not proceed or an error occurs in the pathway and has recipient impact

NHSBT, ODT, clinical website https://www.odt.nhs.uk/

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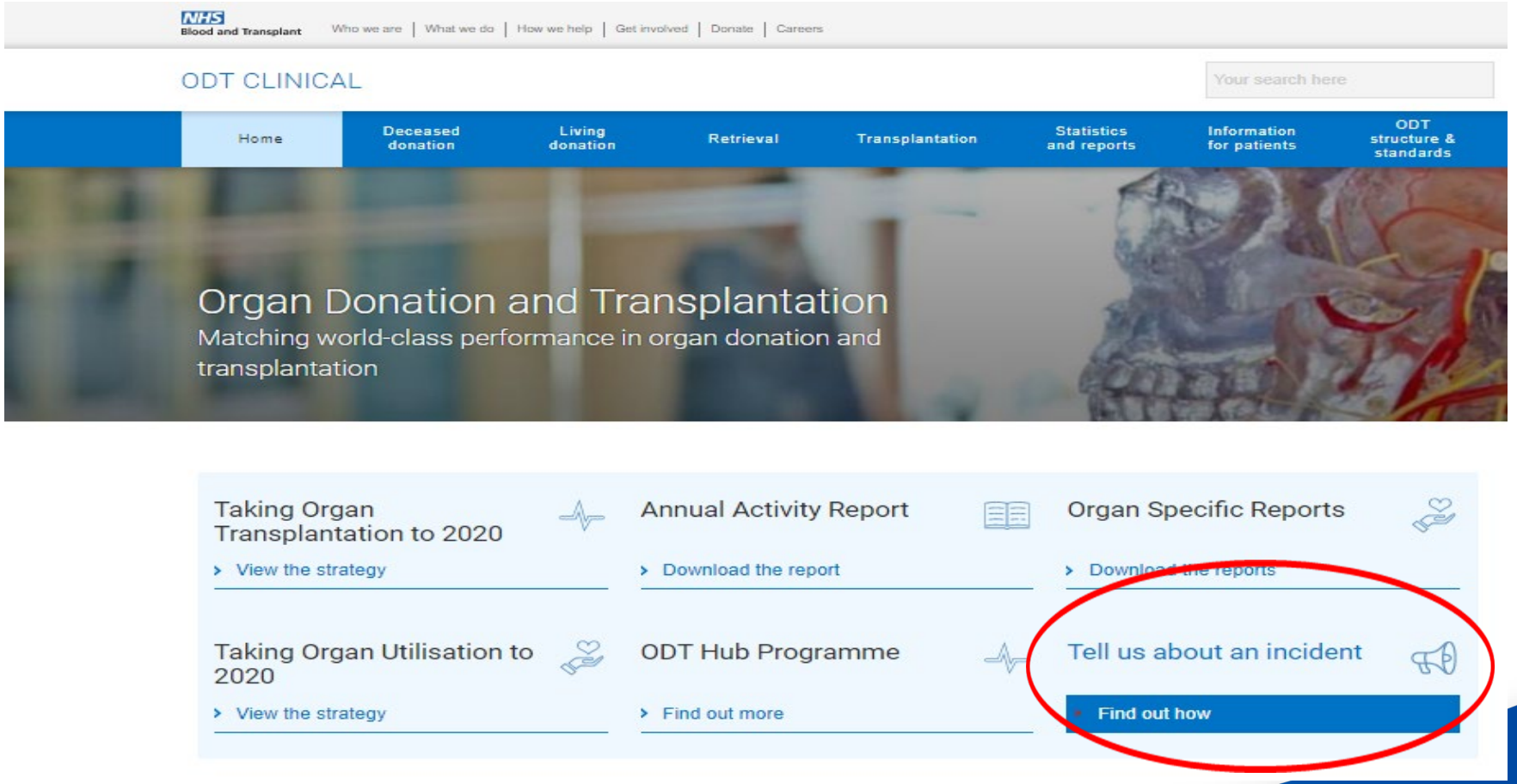

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https://www.odt.nhs.uk/odt-structures-and-standards/governance-and-quality/tell-us-about-an-incident/

Incident Reporting

Urgent incidents

Call ODT Hub Operations on 0117 975 7580 if the incident is urgent and may affect the quality and safety of an organ for transplantation or the treatment of recipients or potential recipients.

This call should be followed by completing this online form

Tell us about an incident

Tell us about an incident by completing this online form

Positive transport fluid results

Tell us about positive transport fluid results by downloading and completing the Rapid Alert – Positive transport fluid results form and emailing it to odthub.operations@nhsbt.nhs.uk

In this section

Shared Learning

Incident Reporting

Learning from excellence

INCIDENT SUBMISSION FORM

NHS Blood and Transplant

Is incident deemed urgent and requires immediate action? No | Yes, not notified by phone | Yes, already notified by phone

You will be unable to complete the rest of this form until you answer the question above.

- Fields marked with * are mandatory, all other fields can be completed, if relevant, to provide information about the incident. For help completing fields, click on
- To avoid losing data, please be aware this form will time out after 30 minutes of inactivity and must be completed and submitted at the same time; it is not possible to partially complete the form and return to it later.
- In order to complete the form, please ensure that you have the relevant details and patient reference numbers to hand.

SUBMITTER DETAILS

First name

Last name

Phone number

Job title

Email address

Re-enter Email address

INCIDENT DETAILS

Date and time incident identified*

dd-mm-yyyy hh:mm

Details of incident and further action taken*

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Details of incident and further action taken*

Max. 2000 characters

Attachments
Attachments are limited to a maximum of 10mb in size each. A maximum of 5 attachments may be added

Choose File | No file chosen

Donor ID status*
- ID not allocated
- Not related to an individual donor
- Donor ID

NHSBT donor ID number(s) and type(s) involved in this incident

Please Select

Recipient ID status*
- ID not allocated / not known
- Not related to an individual recipient
- Recipient ID

ID number(s) of the recipient involved in this incident?

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Choose File | no file selected

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Recipient ID status *
- ID not allocated / not known
- Not related to an individual recipient
- Recipient ID

ID number(s) of the recipient involved in this incident?

Details Of Those Involved Relevant To The Report

Organ Donation Services Team (ODST)
Please Select

Transplant Centre
Please Select

Retrieval Team
Please Select

Coroner / Procurator Fiscal jurisdiction
Enter Coroner / Procurator Fiscal jurisdiction name

Donating hospital – search by town / city
Please type town and select from list, if not listed enter name and town

Microbiology / Virology lab
Please type town and select from list, if not listed enter name and town

NHSBT site where incident occurred
Please Select

Haematology / Biochemistry lab
Please type town and select from list, if not listed enter name and town

H & I lab
Please Select

Histo-pathology lab
Please type town and select from list, if not listed enter name and town

Additional Information

The incident has also been reported to these organisations
Select organisation(s)

Please Select

Reference numbers for reports to other organisations
One per line. Please list organisation reference number

- To print a copy of this form and the incident details please use the browser's print function BEFORE submitting the form
- Form data can be saved in pdf format AFTER the incident has been submitted

Submit

Reporting Checklist

- Be factual, stick to the point – use bullet points
- Avoid being emotional
- Don’t write an essay
- Don’t use identifiable personal data
- Consider asking someone to check - do they understand your report?
- Add attachments and time lines if appropriate (photos of damage)
- Summarise incident and ensure concerns are clear
- Anonymous reporting?

Example 1

Percutaneous catheter guidewire found at retrieval in the aorta

Example 2

Consent XX/XX 18:30. Language support family no English. Spanish Nurses, hospital adm to BSD to donation very quick. Organs placed NORs mob~10:00hrs XX/XX.Met with Family ~12:00hrs XX/XX.Family very tired/confused.Support family overnight, further support required/confused unclear about donation process/BSD. Wife feeling pressured. All conversations with spanish speaking staff. We agreed to slow down process & give her some more time.NORs mobilised&organs accepted-updated both NORS & transplant centre-SNOD dealing donation side, family support myself. Consent SNOD OC night/ SNOD TM relieving outgoing SNOD. Transplant centre had accepted urgent heart. Unsure of status of consent, weneed family to be given time. Necessary to slow process - teams understanding. Htransplant centre Rec Co-ord supportive. Comm continued Rec Co-ord spoken to transplant Cons. would not accept any further offers from this donor for both Urgent hearts. He believed consent invalid. RM updated. We explained speaking to family within 2 hours, likely to have definite confirmed consent, declined. Family decided to proceed with donation after further support. Heart accepted and transplanted further down urgent list.

Example 3

Live donor nephrectomy abandoned during procedure as recipient U&E results on same-day bloods showed low sodium and raised potassium.
Donor was anaesthetised and surgery started, dissection of renal veins had not begun.
Recipient had not been anaesthetised.
Donor woken from anaesthetic and explanation given.
Both patients discharged home same day.

Incident review process

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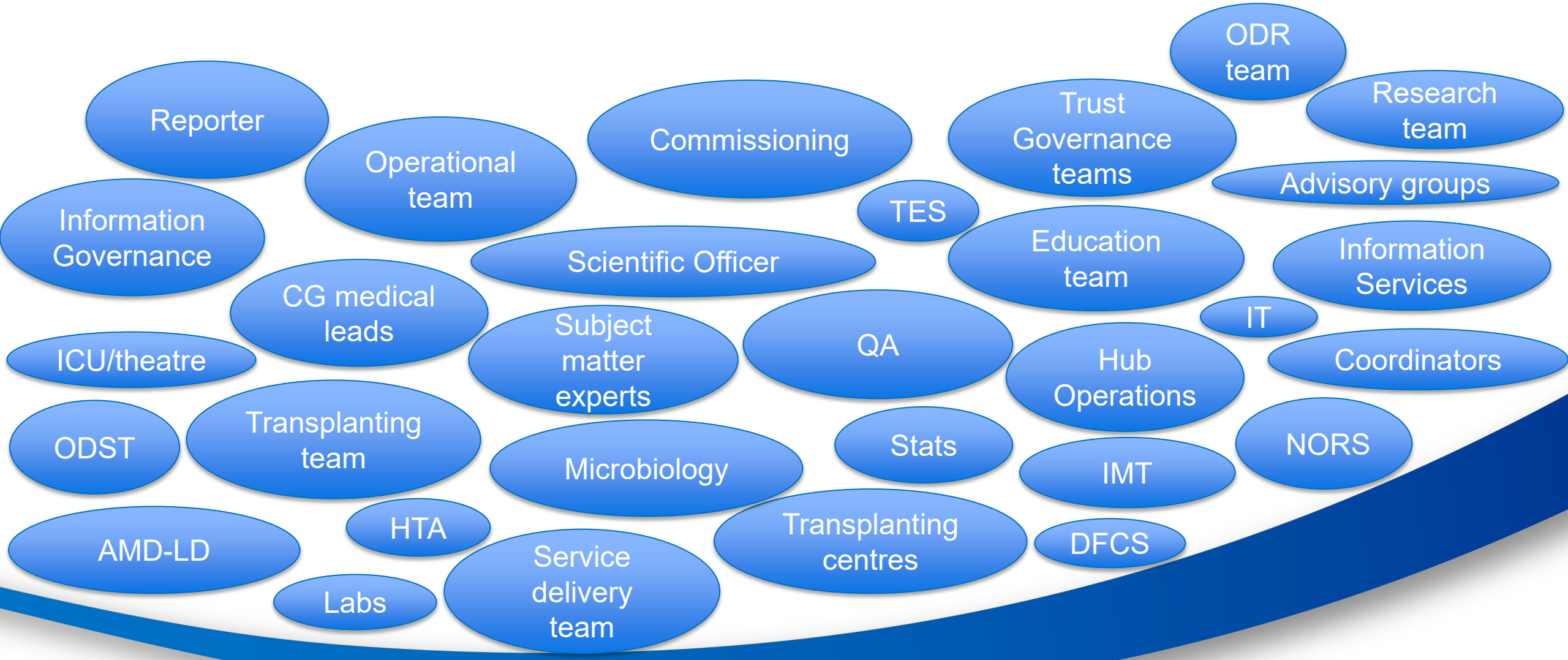

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Shared Learning

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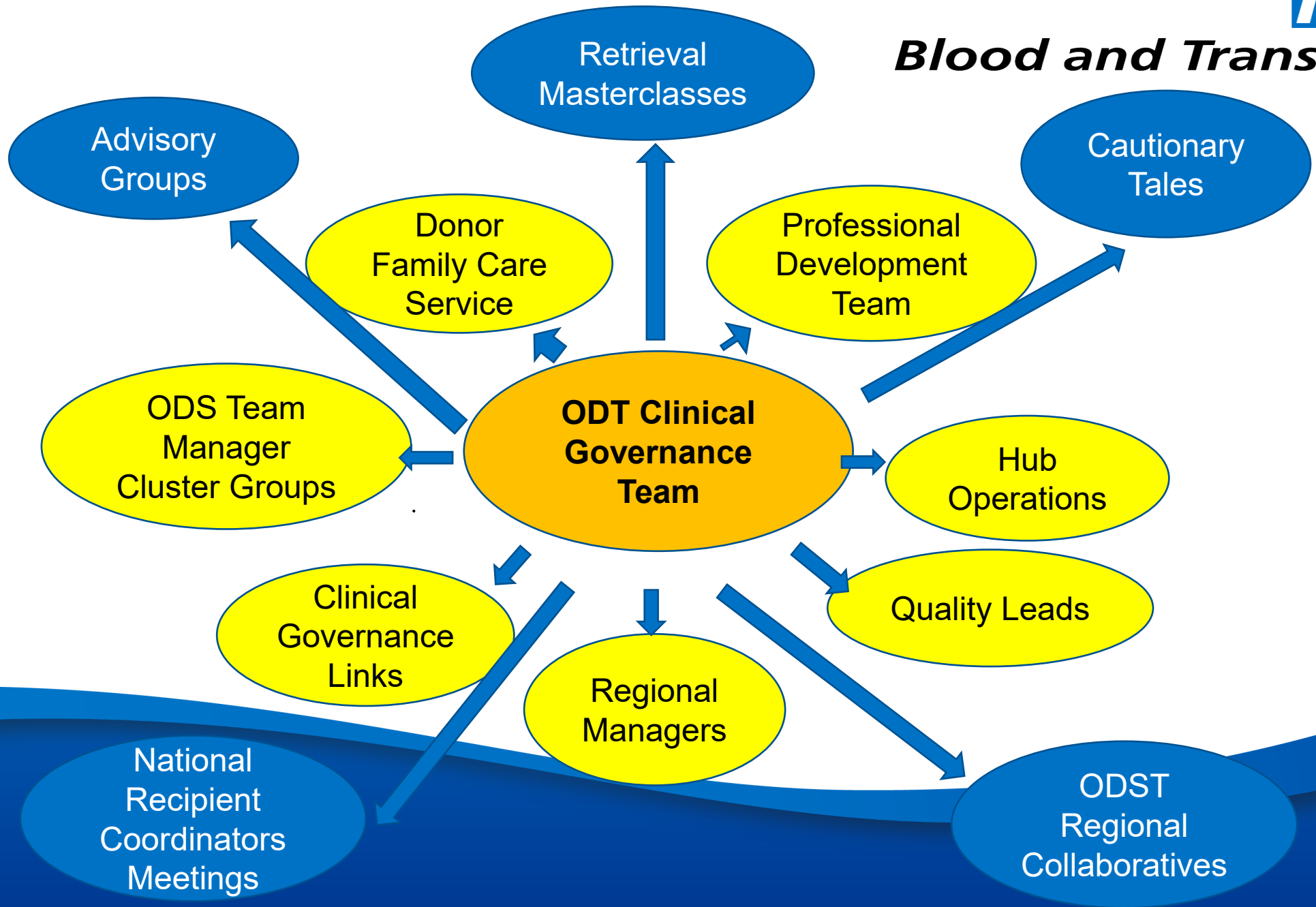

Learning from Excellence

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- Recognition of great practice
- Focus on what can be learnt from events.

https://nhsbloodandtransplant.sharepoint.com/sites/OrganDonationandTransplantation/SitePages/Learning-from-Excellence.aspx

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learning from excellence

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Duty of Candour, Legal Requests and Freedom of Information

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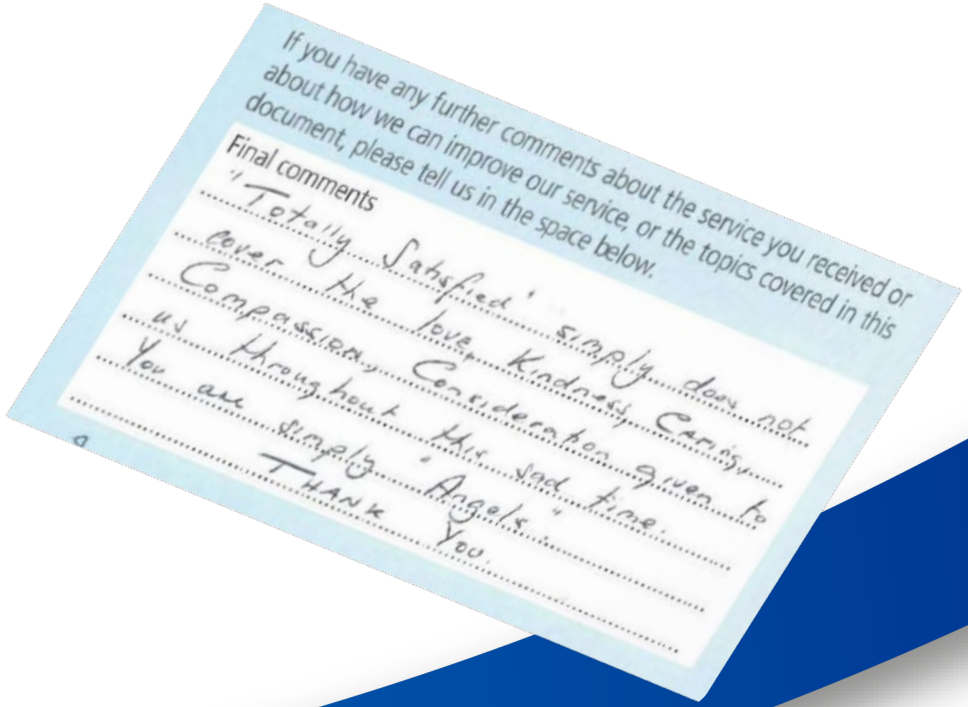
Complaints and Compliments

What is a complaint?

"An expression of dissatisfaction about NHSBT service provision which requires a response"

What is a compliment?

"An expression of satisfaction / gratitude about NHSBT service provision"



Complaintsandcompliments@nhsbt.nhs.uk

Conclusion

- Who are we?
- What do we do?
- Why do we do it?
- Your role?

Clinicalgovernance.odt@nhsbt.nhs.uk