

Clinical Outcomes / Adverse Events in Scotland
Organ Retrieval and Transplantation Programmes
Overview for Providers and Commissioners of Services

Organ retrieval or organ transplantation service delivery

Routine activity includes:

- local governance meetings (e.g. MDM / MDT) within Provider team
- routine outcome reports provided to Commissioner

Adverse events:

- Ad-hoc reports recorded using provider host board adverse event reporting procedures

Escalation to Host NHS Board Clinical Governance structure for internal review

simultaneous

Early alert to Commissioner (NHS BT or NSD) that an adverse event has occurred

Risk assessment and immediate actions identified to minimise harm.
Assessment of need for either SAE or RCA.

Commissioner to provide support to Host NHS Board to investigate adverse incident and Root Cause Analysis as required

- NHS BT to notify NSD (&vv)
- NSD to notify SG if needed

Investigation Undertaken

Action report and conclusions to NHS Board Clinical Governance committee

Copy of outcome report shared with commissioner, with statement of assurance that NHS Board are confident that an action plan has been agreed. Commissioner has responsibility to ensure actions undertaken in timescale advised.

Note:

When a SAE formal review or RCA is commenced, consideration should be given to inclusion of all other parties in care pathway, including any other NHS Boards involved, with focus on patient (donor/ recipient) and their family.

Shared learning offered to other retrieval / transplant centres through meetings of Scottish Donation and Transplant Group and NHSBT Advisory Groups