NHS BLOOD AND TRANSPLANT

National Organ Donation Committee

Reporting of missed opportunities in organ donation

Background

1 Missed opportunities occur throughout the organ donation process in all hospitals within the UK and may lead to potential organ donors not proceeding to donate solid organs. In order to maximise the number of deceased donors it is vital that missed opportunities are monitored and reduced as much as reasonably possible.

2 Missed opportunities are identified as occasions where best practice has not been adhered to within the organ donation process. These data are monitored within Organ Donation Services Teams (ODSTs) and hospitals however, NHSBT do not currently provide any documentation detailing this data. It is felt that regular reporting of missed opportunities is needed for both ODSTs and hospitals to access.

Proposal

3 Reports detailing organ donation data for each Trust/Board, ODST, and nation are produced six-monthly, the content of these reports is currently under review. It is proposed that missed opportunities data could be presented within these existing reports in future. This data would enable easy interpretation of areas for improvement for both Trusts/Boards and ODSTs and would provide an overview when presented by nation.

4 A proposal of the missed opportunities to be presented can be found in **Table 1** for each Trust/Board organ donation level and in **Table 2** for each of the ODSTs. Missed opportunities are counted at each point in the process separately; therefore a patient could be recorded more than once if more than one opportunity was missed. Note that on some occasions where a SNOD was not involved in the formal approach the family did still consent to/authorise organ donation.

5 When patients are not neurological death tested, not referred, or consent/authorisation is not ascertained, the reasons why are also recorded. These reasons are already presented in the six-monthly reports. The accompanying reasons data for the missed opportunities presented in this paper are included in the Appendix as UK summaries.

Table 1 – Summary of missed opportunities by Trust/Board level, 1 January – 31 December 2016

Trust/Board level	Number not neurological death tested	Number not referred		Number of families approached without SNOD involvement		Number not consenting/authorising	
		DBD	DCD	DBD	DCD	DBD	DCD
1	132	28	345	49	195	235	396
2	68	8	257	20	80	87	166
3	30	3	168	11	64	61	119
4	30	10	139	11	36	32	65
Total	**260**	**49**	**909**	**91**	**375**	**415**	**746**

Table 2 – Summary of missed opportunities by Organ Donation Services team, 1 January – 31 December 2016

ODST	Number not neurological death tested	Number not referred		Number of families approached without SNOD involvement		Number not consenting/authorising	
		DBD	DCD	DBD	DCD	DBD	DCD
Eastern	29	4	97	8	36	21	76
London	34	6	56	10	31	88	76
Midlands	53	15	159	15	83	46	124
North West	37	5	141	5	24	54	89
Northern	5	0	39	2	22	29	39
Northern Ireland	13	1	49	2	9	14	24
Scotland	14	8	60	11	52	24	69
South Central	16	2	113	9	28	30	48
South East	27	5	51	15	26	49	54
South Wales	7	1	44	0	14	8	40
South West	14	2	36	6	28	18	51
Yorkshire	11	0	64	8	22	34	56
Total	**260**	**49**	**909**	**91**	**375**	**415**	**746**

6 To enable the investigation of individual missed opportunities, detailed routine reports could be generated by hospital or ODST to identify specific cases and enable action to be taken to minimise the number of missed opportunities. An example of such a report is provided in **Table 3**.

Action

7 Committee members are asked to review the missed opportunities data presented and agree the key opportunities to focus on and the best method for reporting them.

8 Members are also asked to consider the best approach for reporting missed opportunities to ensure action is taken.

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Table 3 – An example of a routine report for hospitals/ODSTs using dummy data

PDA ID	Critical care admission date	Donor type	Was the patient neurological death tested?		Was the patient referred?		Was a SNOD involved in the approach?	Was consent/authorisation ascertained?	
			Y/N	Reason, if applicable	Y/N	Reason, if applicable		Y/N	Reason, if applicable
123456	19/01/2017	DBD	N	Pressure on ICU beds	Y	-	-	-	-
987654	12/12/2016	DCD	-	-	N	Not identified as a potential organ donor/organ donation not considered	-	-	-
567891	01/12/2016	DBD	Y	-	Y	-	N	N	Family were divided over the decision

Appendix
UK Reasons data

Table A – Reasons given for neurological death tests not being performed in the UK,
1 January – 31 December 2016

Reason	N
Family declined donation	20
Family pressure not to test	9
Treatment withdrawn	9
Patient haemodynamically unstable	84
Continuing effects of sedatives	15
Biochemical/endocrine abnormality	25
Hypothermia	3
Inability to test all reflexes	21
Clinical reason/Clinicians decision	40
SN-OD advised that donor not suitable	9
Medical contraindication to donation	3
Patient had previously expressed a wish not to donate	3
Other	13
Unknown	6

Table B – Reasons given why patient not referred in the UK,
1 January – 31 December 2016

Reason	DBD	DCD
Not identified as a potential donor/organ donation not considered	11	337
Coroner/Procurator Fiscal Reason	6	3
Family declined donation prior to neurological testing	5	4
Family declined donation after neurological testing	2	0
Family declined donation following decision to withdraw treatment	1	36
Reluctance to approach family	3	4
Medical contraindications	7	194
Thought to be medically unsuitable	3	175
Thought to be outside age criteria	0	2
Pressure on ICU beds	0	6
Neurological death not confirmed	0	1
Clinician assessed that patient was unlikely to become asystolic within 4 hours	0	6
Patient had previously expressed a wish not to donate	0	4
Other	11	137

Table C – Reasons given why family not formally approached in the UK, 1 January – 31 December 2016

Reason	DBD	DCD
Family stated that they would not support donation before they were formally approached	10	70
Family untraceable	10	32
Family considered too upset to approach	8	16
Coroner / Procurator Fiscal refused permission	34	46
Patient's general medical condition	31	943
Other medical reason	12	283
Resource failure	0	4
Pressure on ICU beds	0	12
Patient outside age criteria	0	2
Other	10	654
Not identified as a potential donor / organ donation not considered	2	367
Patient had previously expressed a wish not to donate	2	19

Table D – Reasons given why family did not support donation in the UK, 1 January – 31 December 2016

Reason	DBD	DCD
Patient previously expressed a wish not to donate	91	155
Family were not sure whether the patient would have agreed to donation	64	126
Family did not believe in donation	21	28
Family felt it was against their religious/cultural beliefs	41	18
Family were divided over the decision	26	29
Family felt the patient had suffered enough	17	59
Family did not want surgery to the body	47	63
Family wanted to stay with the patient after death	2	14
Family had difficulty understanding/accepting neurological testing	2	1
Family felt the length of time for donation process was too long	18	125
Family concerned that other people may disapprove/be offended	4	1
Family felt the body needs to be buried whole (unrelated to religious or cultural reasons)	26	22
Family concerned that organs may not be transplanted	6	9
Families concerned about organ allocation	0	2
Family concerned donation may delay the funeral	1	1
Strong refusal - probing not appropriate	22	30
Other	27	63