NHS
Blood and Transplant

Clinical Lead for Organ Donation (CLOD) Review – Summary

September 2017

Background

This paper summarises the review recommendations to the Clinical Lead for Organ Donation (CLOD) and Regional CLOD role. The full version of the review, entitled *Strengthening the Clinical Lead for Organ Donation Role*, includes greater details regarding the history of the CLOD role, international comparison with Australia and Canada, and the stakeholder engagement undertaken.

Objectives of the CLOD review:

- To ensure that the CLOD role is able to fulfil the *Taking Organ Transplantation to 2020* strategy ambitions.
- To ensure the £2.5 million spent on 240 CLODs achieves best value for money.

The review was not tasked with making any cost savings.

The role of CLOD was established in the UK following a recommendation in the 2008 Organ Donation Taskforce report.

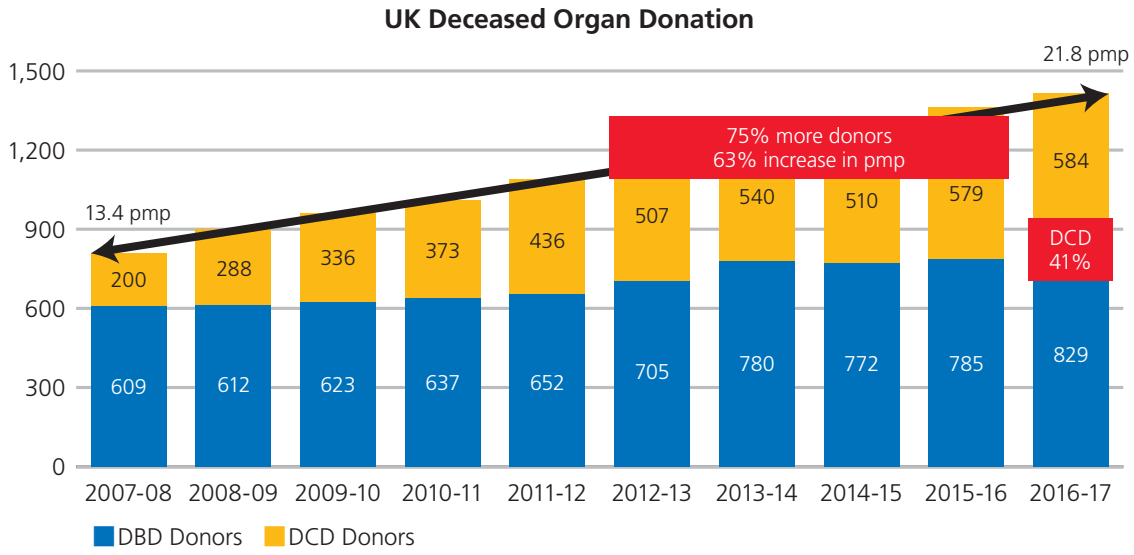
"All parts of the NHS must embrace organ donation as a usual, not an unusual event. Local policies, constructed around national guidelines, should be put in place. Discussions about donation should be part of all end-of-life care when appropriate. **Each Trust should have an identified clinical donation champion** and a Trust donation committee to help achieve this." (emphasis added)

The local donation team of CLOD, specialist nurse for organ donation (SNOD) and Organ Donation Committee (ODC) Chair is the foundation stone upon which the UK success story in deceased organ donation was built. Exploring the opportunity for donation has become a usual event in end of life care for mechanically ventilated patients dying in intensive care units and emergency departments.

Since the benchmark 2007/08 year there has been a 75% increase in UK deceased donors (see Figure 1) and the transplant waiting list has fallen for seven consecutive years.

CLODs, working together with embedded SNODs, led this change in emergency departments and intensive care units. As senior physician leaders, CLODs ensured that SNODs were welcomed as members of the ICU team, that donation was valued, that hospital donation policies were established, that referral did occur, that collaborative requesting became the norm and that missed opportunities were investigated and tackled. While the nature of these initiatives is that they are never ending, the role of CLOD, especially in the setting of traditional hospital hierarchical structures, was foundational, and remains foundational, for the improvements that have occurred in UK deceased organ donation.

Figure 1. UK deceased organ donation over time



DBD, Donation after Brainstem Death
DCD, Donation after Circulatory Death

To achieve the *Taking Organ Transplantation to 2020* vision of world class performance, it is essential we have a motivated and enthusiastic team of CLODs across the country, encouraging best practice and taking responsibility for their Trusts/Boards performance. Our success to date is attributable to the many CLODs who demonstrate these qualities. Figure 2 details the current distribution of CLODs in the UK.

The recommendations in this review are grouped around the topics of 'employment', expectations, expanded roles and Regional CLOD role (R-CLOD). These will give greater transparency and professionalism to the CLOD role with a revised role description and strengthened annual 1:1 template for both CLODs and Regional CLODs. This will enable CLODs to meet the 2020 ambitions and deliver a world class service.

Figure 2. Regional Distribution of CLODs – as of 31st March 2017 (verified by ODT teams)

	R-CLOD PAs	Number of CLOD posts (excluding R-CLOD)	CLOD PAs (including R-CLOD)	Number of Trusts/ Boards (per CLOD PA)	Number of Trusts/ Boards at level 1,2,3,4	Number of CLODs on >1 PA (including R-CLODs)	Number of CLODs on <1 PA	Number of Hospitals* where > 1 CLOD in role (excluding R-CLODs)	Number of CLOD PA Vacancies	Number of appointed CLODs not receiving payment#
Eastern	1	22	20	20 (1.0)	3,6,7,4	2	4	1	1	0
London	1	23	23	15 (0.7)	4,4,1,6	1	7	5	0.5	1
Midlands	2	20	23	18 (0.8)	5,5,2,6	3	3	2	1	0
North West	2	30	32	26 (0.8)	3,6,7,10	0	1	3	1	0
Northern	1	14	14	9 (0.6)	2,2,3,2	1	4	2	0	0
South Central	1	15	15	12 (0.8)	2,3,6,1	0	2	2	1	0
South East	2	18	20	18 (0.9)	3,5,4,6	1	0	2	0	2
South West	1	17	16	14 (0.9)	3,3,5,3	0	3	2	0	0
Yorkshire	1	20	20	16 (0.8)	3,4,4,5	0	7	3	2.5	0
Northern Ireland	1	6	7	5 (0.7)	1,2,1,1	0	0	1	0	0
Scotland	2	26	28	12 (0.4)	3,2,5,2	0	0	3	0	0
South Wales	1	13	11	6 (0.5)	1,3,2,0	0	5	4	0	0
UK	16	224	229	171 (0.7)	33,45,47,46	8	36	30	7	3

Owing to differences in health care organisation, direct comparison of Northern Ireland, Scotland and South Wales with the rest of the UK is not encouraged. North West also includes the hospitals from North Wales.

* CLODs are appointed to cover hospitals at the Trust/Board level. Some Trusts/Boards have a number of different sites with multiple CLODs.

number of CLODs who choose not to take any payment e.g. the Channel Islands.

Recommendations

The proposed recommendations are in four categories. See appendix A for Key dates in the implementation plan.

'Employment'

a. Employment of CLODs will remain with their employing hospital Trust/Board and NHSBT will reimburse the employer for the agreed CLOD time, based on a proportionate Programmed Activity (PA) allocation. NHSBT will not reimburse for local and national clinical excellence awards.

b. There will be a new formalised agreement between NHSBT and hospitals regarding the CLOD role, which will include the sharing of the updated role description.

c. NHSBT must be represented at every CLOD appointment interview for CLOD reimbursement to occur. Organ Donation Committee Chairs should be invited to sit on any interview panel.

d. The duration of the CLOD role will be for three years, renewable for one further term (subject to satisfactory annual reviews). Thereafter the position will be re-advertised, although there will be no prohibition on the post-holder reapplying.

e. The decision regarding individual hospital CLOD PA allocation will be decided at a regional level by the Regional Manager and R-CLOD.

f. Every Trust/Board should have at least one CLOD on a minimum of 0.5 PA. The expectation is that the majority of CLODs will be on 1 PA.

- Where there truly is zero potential for deceased organ donation this could be an honorary position.
- Level 1 Hospitals should ordinarily be allocated more than 1 CLOD PA but this may be divided by several CLODs.
- When an individual CLOD is on greater than 1 PA it would be expected that that the influence and leadership they demonstrate has a regional impact.
- Before a CLOD role is considered for < 1 PA the R-CLOD and Regional Manager should first consider:
  i. Is the SNOD presence in that hospital so reduced that greater CLOD time is required?
  ii. Does the CLOD support regional and national initiatives and therefore this justifies 1 PA?
  iii. How does this impact on the R-CLOD PA need?

g. A CLOD chronic sickness guideline is agreed.

h. A master spreadsheet of all UK CLODs will be maintained. All CLOD Annex A forms or changes to CLOD roles and numbers will go via this Master Spreadsheet **before** being forwarded to finance. A CLOD by CLOD check and review will be undertaken to ensure accuracy of information.

Expectations

a. New CLODs must attend CLOD induction within 12 months.

b. Every CLOD will have an annual 1:1 with their respective R-CLOD using the new national template (Appendix B). This template includes a checklist of expected core operational requirements which is built into the new CLOD role description.

Expanded Roles

a. There will be a national paediatric CLOD on 1 PA, who will report to the National CLOD.

b. There will be two national education CLOD/s on 1 PA each.

c. A national CLOD for research and innovation on 2 PA should be appointed when funds allow.

d. Regions are encouraged to consider expanded CLOD roles, on a regional or supra-regional basis, in the areas of education, ED, stretch goals, paediatrics and other roles according to regional need.

- CLODs with expanded roles can be appointed on a short-term basis and not necessarily have to follow the standard CLOD length of service (e.g. 6-year role).
- All new CLODs (if not an existing CLOD) will still be required to attend CLOD induction within 12 months of appointment.
- Funding for these expanded roles should come from within the regional CLOD PA pool.
- It may be possible that some CLODs will be willing to take on expanded regional roles from within their current CLOD PA reimbursement.

Regional CLODs

a. The duration of the Regional CLOD role will be for three years, renewable for one further term (subject to satisfactory annual reviews). Thereafter the position will be re-advertised, although there will be no prohibition on the post-holder reapplying.

b. Every R-CLOD (or CLOD with national responsibilities) will have an annual 1:1 with either the Deputy National CLOD, National CLOD or Associate Medical Director, as appropriate.

c. Each of the 12 NHSBT regions (organ donation services teams) should have at least one PA of R-CLOD time.

d. The current UK range is that 1 R-CLOD PA supervises 6-26 individual CLODs. With the strengthened annual CLOD 1:1, 1 PA of R-CLOD time should allow for the supervision of no more than 10-12 CLODs.

- Only Northern Ireland (1:6), Midlands (1:10) and South East (1:9) currently satisfy this requirement.
- In order of priority this will require additional R-CLOD PA allocation (or the reduction of CLOD numbers) in London (1:26), Yorkshire (1:24), Eastern (1:19), South Central (1:17), South West (1:17) and North West (1:15); and consideration in South Wales (1:13), Scotland (1:13) and Northern (1:13).
- At the current time, any increase in R-CLOD PA allocation will need to come from within the pool of a regions current allocated CLOD PAs.

Measuring success

Primary Measure

- Twenty-six deceased organ donors per million population by 2020.

Secondary Measures

- One hundred percent of CLODs receiving a 1:1 by their R-CLOD each year.
- 95% referral and SNOD involvement in family approach by 2020.

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Appendix A: Implementation Plan

Action	Anticipated Time Frame
Recommendations signed off by the Senior Management Team.	July 2017
Re-advertising in all regions where the current Regional CLOD is time expired.	Interviews October 2017
Letter to all medical directors and CLODs outlining the new formalised agreement between NHSBT and hospitals regarding the CLOD role, which will include the sharing of the updated role description.	November 2017
Re-advertising of all CLOD roles where the current CLOD is time expired.	Interviews November 2017 – April 2018
All CLODs will have had a 1:1 using the new template.	July 2017 – April 2018

Appendix B: CLOD 1:1 template, July 2017

CLOD Annual 1:1 Activity Record

Date:

Name:

Hospital Name:

My current PA allocation is:

If shared role, please outline the arrangement:

Checklist of core operational requirements

ACTIVITY	CHECK
Regular meetings with SNOD (expectation is monthly).	
Attendance at Organ Donation Committees (expectation is ODC should be meeting 3 or 4 times per year).	
Attendance at regional collaboratives (expectation is 3 of 4 over 2 years).	
Annual 1:1 with R-CLOD.	
Annual presentation of PDA data to Trust / Board executive or delegated governance structure.	
Up to date hospital organ donation policies.	
Total Activities Checked Expectation is 5 or 6 checked activities	

Record of activities

Areas of Responsibility
(e.g. multi-campuses, neuro-intensive care, ED, PICU)

Clinical Expertise/Advice

Actions from review of any Missed Donation Opportunities
(e.g. donation numbers, donation metrics, case investigations and actions)

Education
(e.g. local, regional and national education activities)

Promotion
(e.g. local, regional and national promotion activities)

Personal and Professional Development
(e.g. attending CLOD Induction, National Congress)

Academic
(e.g. research / publications, presentations at regional / national / international meetings)

Other

Any feedback received
(e.g. appraisal 360, SNOD, ODC Chair, regional team)

Actions agreed

Send above to Regional Manager.
For R-CLOD, RM and TM use only.

Confidential Discussion with R-CLOD