NODC(17)21

NHS BLOOD AND TRANSPLANT

National Organ Donation Committee

Regional Managers and Regional CLODs are asked to verify the data in this DRAFT as it relates to CLOD numbers and PA reimbursement in their region.

Particularly please review Appendix A for the two tables showing data for Quarter 4 2016/17.

Strengthening the clinical lead for organ donation role.

Contents

1.0 Executive summary

The local donation team of SNOD, CLOD and ODC Chair was the foundation stone upon which the UK success story in deceased organ donation was built. The opportunity for donation has become a usual event in end of life care for many mechanically ventilated patients in intensive care units and emergency departments. But to rank amongst the very best in the world, as set out in the *Taking Organ Transplantation to 2020: a detailed strategy,* we must improve even further.

It is essential the UK continues to have motivated and enthusiastic CLODs, encouraging best practice and taking responsibility for their Trusts/Boards performance. Our success is attributable to the many CLODs who demonstrate these qualities. Greater transparency and professionalisation of the CLOD role is required if we are to move forward. NHSBT needs to be clearer with CLODs about what is expected from a CLOD and how NHSBT can better support CLODs in their role.

Going forward CLODs will be required to have a relentless focus on eliminating missed donation opportunities, so that every patient and their family can be assured that best practice in organ donation will be followed, irrespective of the location of the patient within the hospital at the time of death.

Regional Collaboratives remain NHSBTs primary vehicle for effective and transforming change in hospitals. They are more than a twice yearly gathering but a way of working for CLODs, SNODs and ODC Chairs, serving as the bridge between national and local initiatives. For this reason, a strengthened annual CLOD 1:1, carried out by the Regional CLOD, is a key recommendation in this review.

Since 2008 the CLOD role has matured. It is respected within the intensive care and donation communities. The recommendations that follow aim to make it even better.

Recommendations

1. 'Employment'

a. Employment of CLODs should remain with their employing hospital Trust / Board and NHSBT will reimburse the employer for the agreed CLOD time, based on a proportionate PA allocation. NHSBT will not reimburse for local and national clinical excellence awards.
b. There should be a new formalised agreement between NHSBT and hospitals regarding the CLOD role, which will include the sharing of the updated job 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. All CLODs will be on a three-year contract 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 CLOD PA allocation should 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 most CLODs will be on 1 PA.
g. A CLOD chronic sickness guideline is agreed.
h. A master spreadsheet of all UK CLODs should be maintained. All CLOD Annex A forms or changes to CLOD roles and numbers should go via this Master Spreadsheet **before** being forwarded to finance. A CLOD by CLOD check and review should be undertaken to ensure accuracy of information.

2. 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. This template includes a checklist of expected core operational requirements which is built into the new CLOD job description.

c. Every Regional 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.

3. Expanded Roles

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

4. Regional CLODs

a. Each of the 12 NHSBT regions (organ donation services teams) should have at least one PA of R-CLOD time.
b. The current UK range is that 1 R-CLOD PA supervises 6-26 individual CLODs. With the strengthened annual CLOD 1:1, one PA of R-CLOD time should allow for the supervision of no more than 10-12 CLODs.

2.0 Objectives of the CLOD review

1. To ensure that the CLOD role is able to fulfil the *Taking Organ Transplantation to 2020* strategy ambitions.
2. To ensure the £2.5 million spent on 234 CLODs achieves best value for money.

There has been no direction for the CLOD review to lead to cost saving.

3.0 Background

3.1 History of the CLOD role

The role of Clinical Lead for Organ Donation (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)

As can be seen the role of CLOD was originally entitled as 'Clinical Donation Champion'. The Organ Donation Taskforce gave the following reasons for the creation of this new clinical role in hospitals:

1. Deceased organ donation is an infrequent event in intensive care units and emergency departments.
2. Organ donation can therefore at times become an afterthought or an optional extra.
3. There was strong evidence that donation was not being explored in many patients where there was potential for donation after death.
4. The Taskforce strongly recommended that organ donation should become usual, rather than unusual – i.e. a standard part of end-of-life care for suitable patients.
5. International experience – particularly of the Spanish model – has demonstrated the value of the formal appointment of clinical 'champions' – typically consultant-level clinicians, responsible for ensuring that all opportunities for donation are realised.
6. Clinical donation champions should be employed for 4–12 hours per week, depending on the size and donor potential of the Trust, and will be responsible for developing and implementing local policies to maximise donation, ensuring that all appropriate staff receive

necessary training, and reporting donation activity to the Trust donation committee.

7. This person should be partnered by a non-clinical donation champion, perhaps a patient or well-known local figure, chairing a donation committee accountable to the Trust Board.
8. There should be a close and defined collaboration between clinical donation champions and donor transplant co-ordinators, who would be embedded within critical care areas.

Working in partnership with an expanded and embedded donor transplant coordinator service and the newly established non-clinical donation champions and donation committees, the Taskforce and the four devolved Health Administrations had clear expectations of what success would look like. Success would be a 50% increase in deceased donation by April 1st, 2013.

CLODs began to be appointed in late 2008 through most were first appointed in 2009. In line with NHS consultant contracts CLOD remuneration was time based, where 1 Programmed Activity (PA) is equivalent to 4 in-hours, activity. While there were local variations a rough guide to how CLOD PAs were allocated is seen in Table 1. This allocation was in an era when deceased donation was predominantly Donation after Brainstem Death (DBD) and the potential for Donation after Circulatory Death (DCD) was not significantly considered for hospital level allocation.

Table 1 A rough guide to how CLOD PAs were allocated in 2008.

Hospital Group Ranking Two-three hospitals in the UK, if geographically linked, are often managed as one hospital 'group'.	Donation Potential per year	Clinical Lead Funded time	Number of 'embedded' Specialist Nurses for Organ Donation
Level 1	>10	4-8 hours	2
Level 2	5-10	4 hours	1
Level 3	<5	4 hours	1 or shared with another small Level 3 hospital

By Quarter 1 2010 there were 181 CLODs in post at an annual cost of £2,150,971, excluding 21 vacancies. The annual CLOD budget, including vacancies, was in the order of £2.4 million with an average annual cost per CLOD PA of £10,000. (See Appendix A)

In 2010, an ambitious Professional Development Programme (PDP) was commenced to give all CLODs and ODC chairs the knowledge and skills to transform deceased donation in the UK. Dr Rafael Matesanz, the architect of the 'Spanish model', had advised the Taskforce that since organ donation is a rare event, even for doctors working in large hospitals, knowledge of deceased organ donation should not be assumed. Therefore, the UK PDP utilised the professional services network Deloitte and was well funded (approximately £350,000, said at the time to be equivalent to the NHS cost saving one additional donor can bring). An outline of the comprehensive programme that was delivered can be seen in Figure 1a. The clinical content was based around 6 Big Wins (see Figure 1b) and tools for changing practice were emphasised. Giving clinicians the confidence and the skills to challenge the clinical practice of colleagues was a key design principle.

The PDP was delivered through multiple regional masterclasses and bookended by two national events. The PDP won a Guardian Public Services Award in 2010 for 'increasing donor numbers by 15% through the design and delivery of a Professional Development Programme for hospital donation champions' and was a Health Service Journal 2010 award finalist. Looking

back, it is hard not to be impressed by the vast amount of content which was built and delivered through the PDP to 200 newly appointed CLODs and the transformational impact it had on UK deceased donation in the years that followed.

Figure 1a. Professional Development Programme for CLODs and ODC Chairs, 2010.

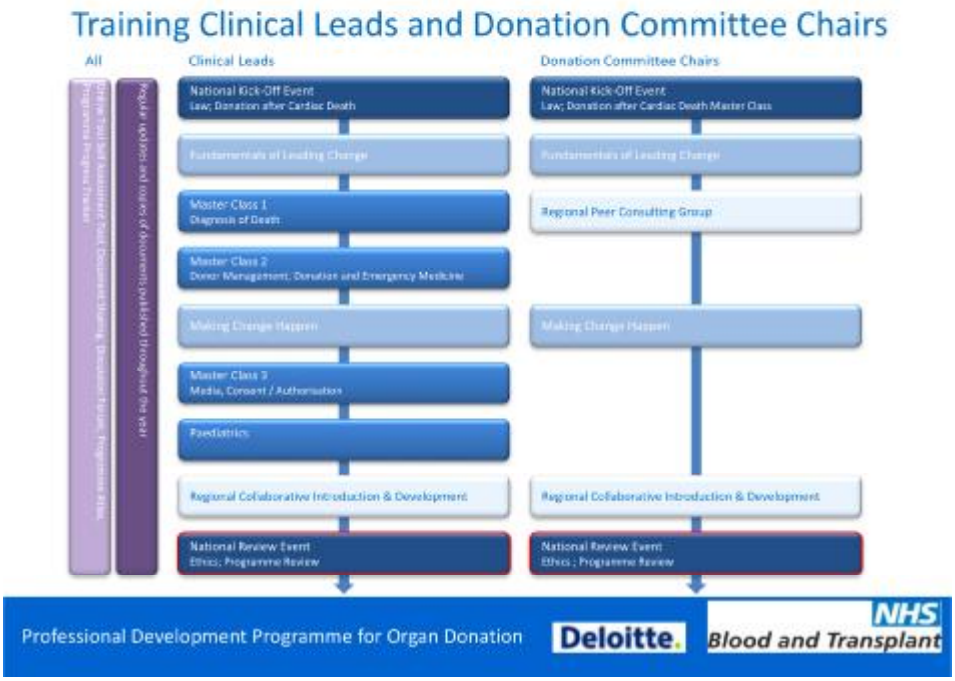


Figure 1b. The 6 Big Wins.

In 2011, a regional collaborative structure was commenced whereby the CLOD, SNOD and ODC Chairs within each of the 12 Organ Donation Services (ODS) teams would meet to enable all hospitals and the communities they serve to maximise the gift of organ donation by serving as the bridge between national and local initiatives. To support this structure regional clinical leads (R-CLOD) were appointed on one PA in each of the 12 regions, with London[1], Midlands and North West allocated two PAs. It was envisaged that the regional collaborative structure, particularly through the biannual regional collaborative meetings, would build off the PDP both in terms of supporting CLODs educationally in their role and in maintaining the focus on achieving continual increases in deceased donation.

Since 2011 the R-CLOD, together with the Regional Manager, have developed and lead their respective regional collaborative network and provided oversight of their hospital based CLODs. A key focus of the R-CLOD role is in identifying areas of clinical practice where significant increases in regional deceased organ donation could be achieved and the development of robust and sustainable action plans to realise these. R-CLODs, together with Regional Managers, are members of the National Organ Donation Committee, which meets three times per year.

[1] When St Georges was moved from London to the South East Region the R-CLOD PA allocation was transferred with the move giving the South East two PAs of R-CLOD support and London 1 PA.

On April 1st, 2013, NHSBT announced that the desired 50% increase in deceased donation over five years, had been achieved. UK deceased organ donation had been transformed by the passionate and skilful implementation of the Taskforce recommendations. A testament to the newly created NHS Blood and Transplant, working through CLODs, SNODs and ODC Chairs, together with hundreds of health care professionals from both the donation and transplant community and the generosity of donors and their families.

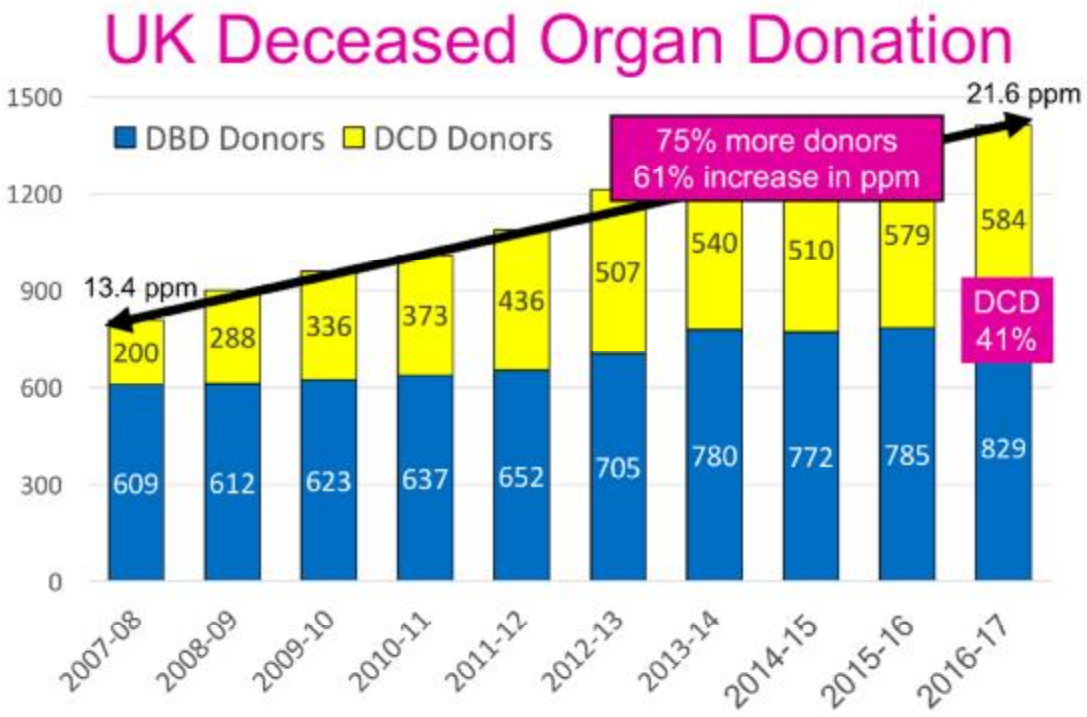
The key element to the UK success was the change that had occurred within the Emergency Department (ED) and Intensive Care Units (ICU). While the family consent / authorisation rate has changed little since 2007, in the ED and ICU we now approach 23% more families for DBD and a staggering 456% more families for DCD. If the consent / authorisation rate is 60% and one asks 100 families, then 60 families will say yes. If instead 1000 families are asked, then 600 will say yes. This simple law of mathematics explains the increase in UK deceased donation. Doctors and nurses were being braver and asking many more families about the option of organ donation for their loved one. It would however be wrong to conclude that this change simply represents the solving of a mathematical problem. Instead it reflects the profound cultural change which was occurring in UK EDs and ICUs. A change long hoped for by the Taskforce. Donation was no longer being viewed as something to be inflicted upon patients and families after end of life care. Rather, the offer and exploration of donation was being considered as a fundamental component of good end of life care. The NHS was embracing organ donation as usual.

This progress allowed the UK to move, compared to our international peers, from a low donating country to a middle order donating country. A new Strategy, *Taking Organ Transplantation to 2020,* was required if the UK was to rank amongst the best in the world. A key component to this strategy was support for Regional Collaboratives to lead local improvement in organ donation, retrieval and transplant practice and the promotion of organ donation. In June 2013, Dr Dale Gardiner was appointed as deputy national

CLOD to support Dr Murphy, the national CLOD, to realise this ambition for the regional collaboratives and the CLOD workforce.

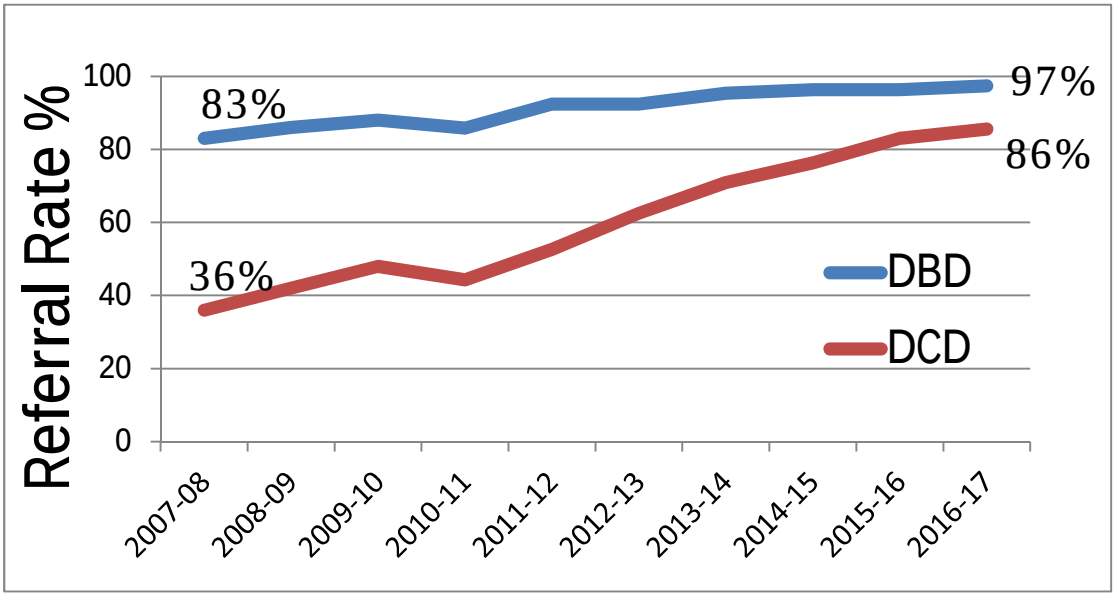
UK Deceased Donation has continued to grow year on year (see Figure 2). Since the benchmark 2007/08 year there has been a 75% increase in deceased donors and the transplant waiting list has fallen for seven consecutive years.

Figure 2. UK deceased organ donation over time.



Substantial and sustained success in changing health care professional behaviour in the ICU and the ED has continued, as can be observed in the metrics of the referral of potential donors (see Figure 3) and in collaborative requesting (clinicians working with SNODs when approaching the families, now at 85.9% compared to 67.8% in 2012/13).

Figure 3. UK referral rate over time.



Our UK success story was driven by the influence of doctors and nurses working within EDs and ICUs to champion donation. CLODs, working with embedded SNODs, drove this change. CLODs, as senior physician leaders ensured that SNODs were welcomed as members of the ICU team, that donation was valued, that donation policies were safe and hospital approved, 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.

3.2 Current description CLOD role

3.2.1 Key findings from the National CLOD Survey, 2014

In 2014 a national CLOD survey, together with a national ODC Chair survey, was carried out (see Appendix B).

Key findings were:

- 91% of CLODs were on 1PA.
- 87% of CLODs were from an anaesthetic professional background, 84% intensive care medicine, 4% emergency medicine, 1.6% acute medicine, and 1.6% renal medicine (*i.e.* the vast majority were intensive care clinicians).
- 42% of CLODs had been appointed after 2010 and therefore had missed the PDP 2010 education programme.
- 39% of CLODs self-reported their role takes less than four hours per week while 17% of CLODs report their role takes more than 4 hours per week.
- CLODs felt their influence was greatest with their local organ donation committees and with their intensive care colleagues.
- On a scale of 1: not very important / effective to 5: essential CLODs scored regional collaboratives as 4.08 and their effectiveness as 3.61.

3.2.2 Current job description, July 2015

The current CLOD job description (July 2015) is available in Appendix C. The three core expectations of the CLOD role are that CLODs will:

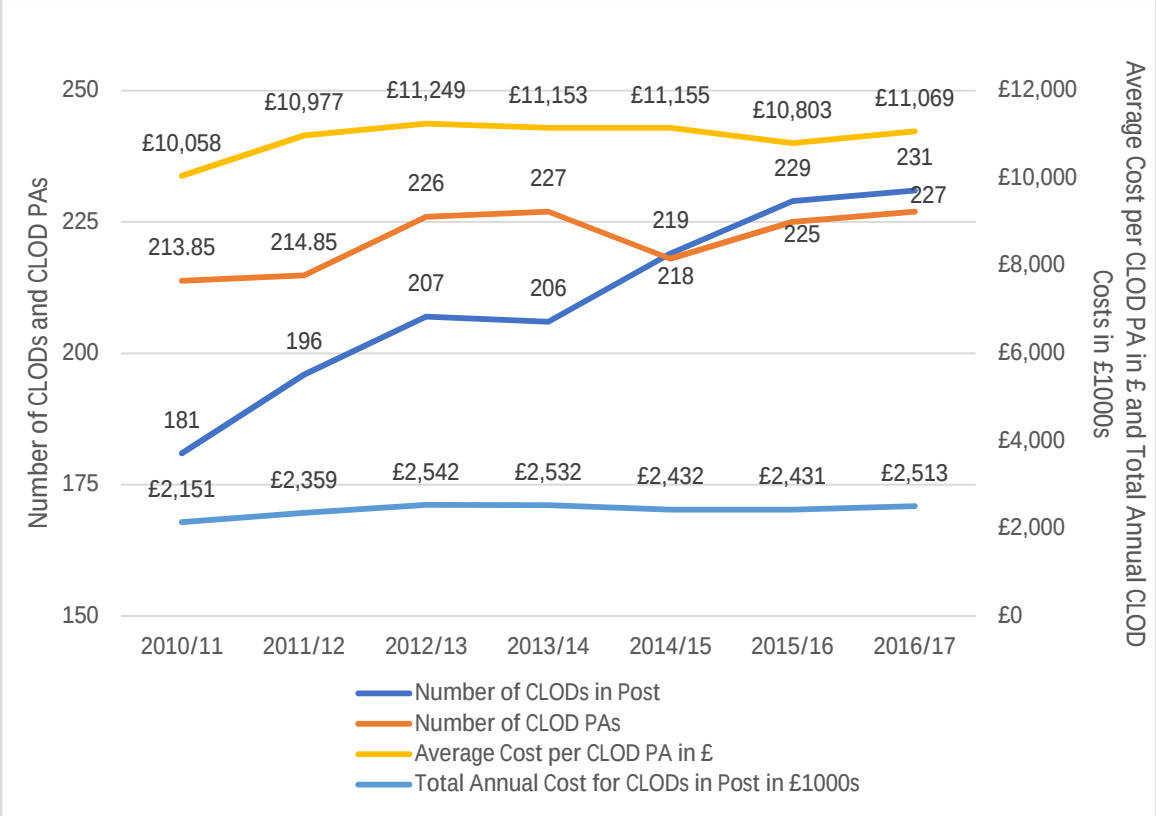
1. Provide clinical leadership within the hospital, to champion and promote the value of organ donation.
2. Maximise donation potential, by facilitating the removal of barriers to donation and by implementing the recommendations of national guidelines across the whole hospital, focusing on those areas with greatest potential.
3. Establish effective working relationships, with key stakeholders throughout the hospital.

3.2.3 Current CLOD numbers and associated costs

Appendix A gives detail of the historic and current CLOD numbers and budget as well as regional variation in CLOD distribution. As at Quarter 4 2016/17, excluding the two national CLOD (National CLOD 6 PA, deputy national CLOD 4 PA) there were 247 CLOD posts receiving 231 PAs worth of reimbursement from NHSBT to their employing hospitals at a cost of £2,512,606.

CLOD numbers and associated costs over time can be seen in Figure 4. What Figure 4 and Appendix A demonstrate is that there has been an increasing number of CLODs appointed over time. This reflects that the CLOD role has increasingly become a shared role, particularly in larger hospitals. In 2010/11, there were only 4 CLODs on < 1PA and in 2016/17 there were at least 33.

Figure 4. UK CLOD numbers and associated costs over time.*



* The numbers in this chart are finance figures (what was paid) and do not account for unfilled CLOD posts or accurately reflect changes to CLOD positions within a given year. Excluding the two national CLODs, there are currently 247 CLOD posts receiving 231 PAs.

Despite these changes the CLOD budget peaked in 2012 at £2.542 million and is currently £30,000 cheaper. This may reflect that, whereas in the early days more senior consultants (and therefore on a higher incremental salary) were needed as CLODs to drive culture change, whereas more recently, CLODs with less consultant experience have been able to take on the CLOD role in well-established donating ICUs, still supported by senior colleagues who were once the CLOD.

3.2.4 International comparisons

Australia

The Australian National Medical Director role is appointed on 0.6 FTE, like Dr Paul Murphy National CLOD UK.

In Australia, there are 5 full time equivalents (FTE) of State Medical Directors (equivalent to UK R-CLODs) occupied by approximately 11 staff. They are remunerated at an amount commensurate with what they would be earning as an intensive care specialists, which varies between Australian states and hospitals i.e hospitals are reimbursed much as NHSBT does in the UK. Larger Australian states (NSW, VIC, QLD) have two people sharing a full FTE or less e.g. 0.6 or 0.8 FTE. Smaller states/territories have a single lead at a lower fraction e.g. 0.4 to 0.6 FTE.

There are 20 FTE of Donation Specialist Medical occupied by approximately 73 staff. These doctors are mostly intensivists with a few ED physicians. Larger hospitals may have several people sharing a larger fraction e.g. 0.6 FTE whereas smaller hospitals may have a single person at 0.2 FTE. For comparison, a CLOD in the UK on 1 PA is on 0.1 FTE, based on the standard 10 PA NHS consultant contract. Like the CLOD role, the Donation Specialist Medical is predominantly responsible for championing donation in their hospital, rather than having a direct responsibility for potential donor medical and family care.

A comparison between the UK and Australia can be seen in Table 2.

Table 2. A comparison between the UK and Australian donation physician role.

Role	Australia	UK
National Director / National CLOD	1 individual 0.6 FTE	1 individual 0.6 FTE (6 PA)
Deputy National CLOD	N/A	1 individual 0.4 FTE (4 PA)
State or Territory Medical Director / R-CLOD	11 individuals sharing 5 FTE Average = 0.45 FTE	16 individuals sharing 1.6 FTE Average = 0.1 FTE (1 PA)
Donation Specialist Medical / CLOD	73 individuals sharing 20 FTE Average = 0.27 FTE	247 individuals sharing 23.1 FTE Average = 0.09 FTE (1 PA)

Australian information – personal communication

Canada – hoping to add

Spain

Spain is the acknowledged best donating country in the world. Rafael Matesanz the director of Spain's National Transplant Organisation (ONT) gives this explanation for Spanish success,

> "Spain has not been a leader in surgery or research; we have hardly chalked up any firsts in transplant operations. What we have brought to this area is organisation. Following a philosophy that states that donors do not simply fall from the heavens, we have provided organisation and professionalisation."

The health care professional roles which support organ donation reflect the philosophy of organisation and professionalisation of deceased donation in Spain.

In Spain, unlike Australia, Canada and the UK, the transplant coordinators are intensive care specialists rather than nurses. This is sufficiently different to make international comparisons difficult. According to Matesanz, the UK did not adopt the Spanish model of intensive care physician transplant coordinators because in the UK there is a relatively small number of well-paid doctors, who are less likely to be tempted by the more administrative role of a transplant coordinator. More explanation of the Spanish system and why they believe their programme has been so successful can be read at http://www.newsweek.com/2015/02/20/spain-has-become-world-leader-organ-donations-305841.html.

2.2.5 Current CLOD Development – medical education

From the 2014 national CLOD survey it was apparent that there would soon be a majority of CLODs appointed after the 2010 PDP. This was problematic as there was no induction programme for the new CLODs who were being appointed.

In late 2014 NHSBT approved the proposal that from April 2015 an annual £500 would be reserved back from every Organ Donation Committee (from the annual £1,000 that was being given by NHSBT for the support and expenses of committees). This created a Medical Education Fund of approximately £85,000 per year.

This money would be used for:

- Commencing ODC Chair induction for new Chairs – 1 day course.
- Commencing CLOD induction for new CLODs – 2 day course.
- Recommence Level Meetings, formerly ‘Club 32’ (meeting of CLODs and SNODs (with some ODC chairs) grouped together by donating size of hospital). In 2015/16 a Level 1 meeting was held and in 2016/17 level meetings were held for each of the four hospital levels.
- Provide ongoing professional development for ODC Chairs and CLODs.

- Commencing an Intensive Care Trainee Deceased Donation Simulation Course. In 2016/17 three courses were run with an ambition to grow to six courses per year.

In the 2015/16 financial year four CLOD induction events were held and since then two CLOD inductions have been held each financial year. This number of induction courses appears sufficient for CLOD turnover and can be flexibly increased if required. An example of the CLOD Induction Programme can be seen in Appendix D.

Of the 93 CLODs who provided feedback in the six courses we have run to date, 79% rated the induction overall as excellent and 21% good. There was no other lower rating by any attendee. A key component of Day 2 is an afternoon of simulated collaborative requesting, working with the SNOD to break bad news and raise organ donation with a family, played by professional actors. While more mixed in feedback, 77% rated this session as excellent.

There was a hope that the medical education fund would provide ongoing professional development opportunities for existing CLODs, *e.g.* media training courses for those who wished it, or change management education. This training has yet to commence. On a small number of occasions the fund has paid for R-CLODs and CLODs to attend external NHSBT courses relevant to their professional development.

4.0 Future needs of the CLOD role

4.1 Hospital Level Comparisons

In July 2016 UK hospitals were re-allocated into one of 4 levels depending on the actual number of donors they have had, averaged over two years. The original allocation had been based on three levels (see Table 1) and this was felt no longer fit for purpose. For example, the original definition of a Level 1 hospital was a hospital with a donation potential of greater than 10 donors per year and a Level 3 of less than 5 donors per year. Due to better auditing of potential donors and the establishment of donation after circulatory death as routine end of life care in the UK, the range of yearly donation potential in UK hospitals in 2016 was 0-152 donors and actual 0-46 donors.

While there had been several redefinitions of the levels over the years, this had not kept pace with the centralisation of services that was occurring in the NHS (*e.g.* major trauma centres and surgical specialisation), and there was a growing divide between the largest hospitals' donation activity and the smallest. The new definitions agreed in July 2016 can be seen in Table 3.

What is apparent is that UK deceased organ donation is dependent on hospitals of all size, promoting and supporting donation. It is said that in the USA, 20% of the hospitals provide 80% of the donors. The UK Level 1s represent 19% of the hospitals and they have 46% of the potential and 54% of the actual (see Figure 5). UK donation is broad.

Through December 2016 – April 2017, NHSBT ran four level meetings, one for each level, and one paediatric GoToMeeting. Additionally, NHSBT Statistics data was shared at these meetings comparing performance by level (Figure 6).

While Referral, Neurological Death Testing, SNOD involvement and Consent / Authorisation rates have increased in the UK and the percentage by which these activities is occurring is high, none-the-less considerable missed opportunity remains. The charts used in the level meetings indicate that there

is still room for improvement. While the opportunity for the greatest increase in donor numbers does remain highest in the largest hospitals, every sized hospital must play its part. The need for local CLODs to champion donation remains every bit as important as it did in 2008.

Table 3. Categorisation of donation activity by level.

Level 1	12 or more proceeding donors per year (averaged over two years)	33
Level 2	5-12 (> 5 to < 12) proceeding donors per year (averaged over two years)	45
Level 3	3-5 (≥ 3 to ≤ 5) proceeding donors per year (averaged over two years)	47
Level 4	< 3 proceeding donors per year (averaged over two years)	46
		Trusts or Boards

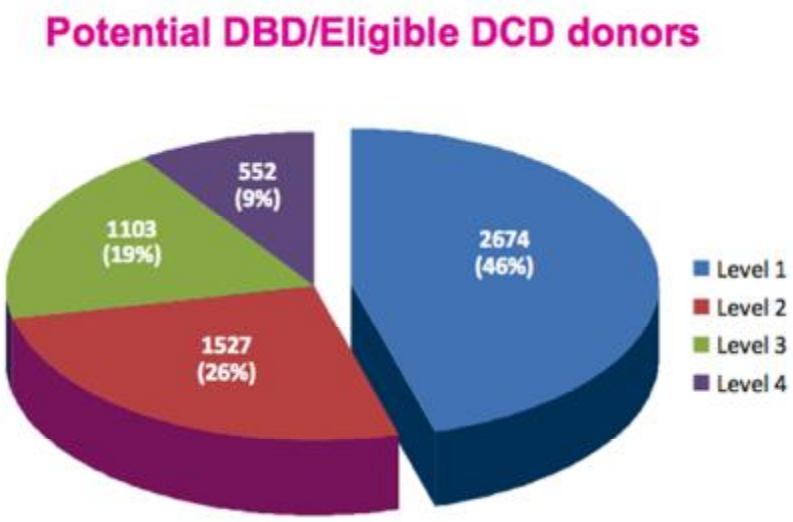
For clarity
12 donors = Level 1
5 donors = Level 3
3 donors = Level 3

An additional descriptor is applied to each hospital, as appropriate.
N = Adult Neuro ICU (29)
P = Paediatric ICU (25)
T = Major Trauma Centre (21) – currently only applies in England pending possible changes in Northern Ireland, Scotland and Wales

Examples
Level 1 (NPT), is a hospital Trust / Board that has 12 or more proceeding donors per year and also has a Neuro ICU, is a Major Trauma Centre and has a Paediatric ICU.
Level 3 (P), is a hospital Trust / Board that has ≥ 3 to ≤ 5 proceeding donors per year and has a Paediatric ICU.

Figure 5. UK Donation by level (1st October 2015 – 30th September 2016).

5a.



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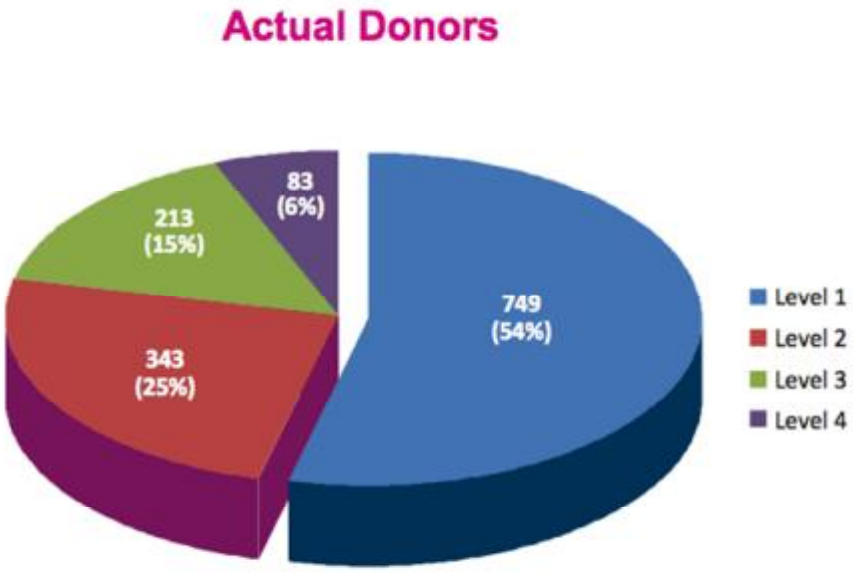
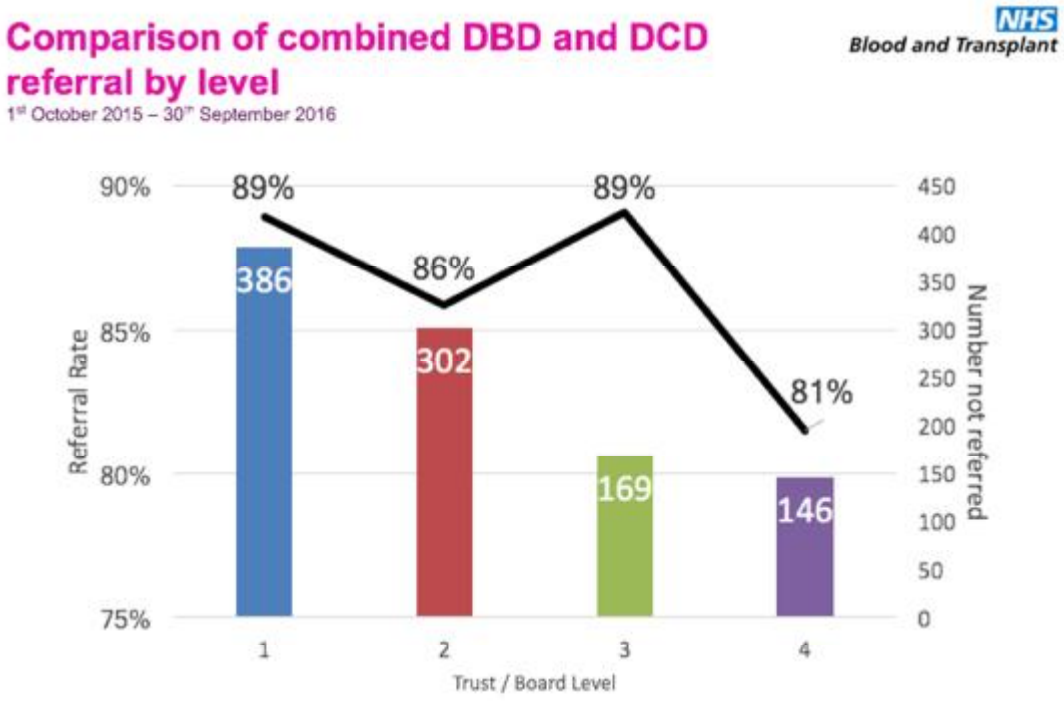


Figure 6. Comparative data charts by hospital level.

6a.



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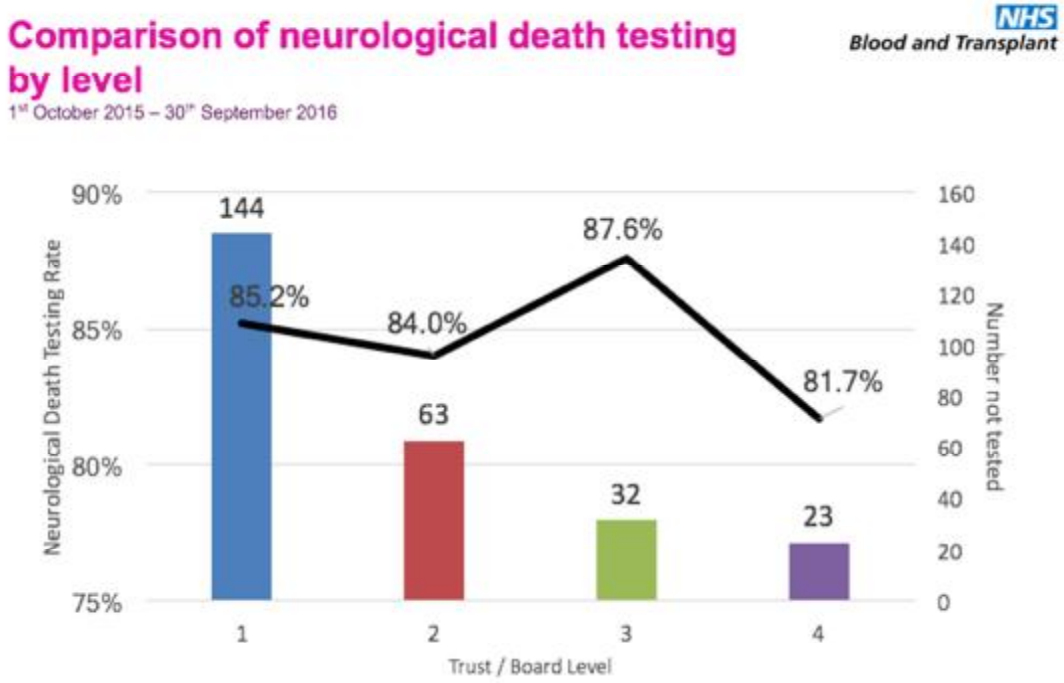
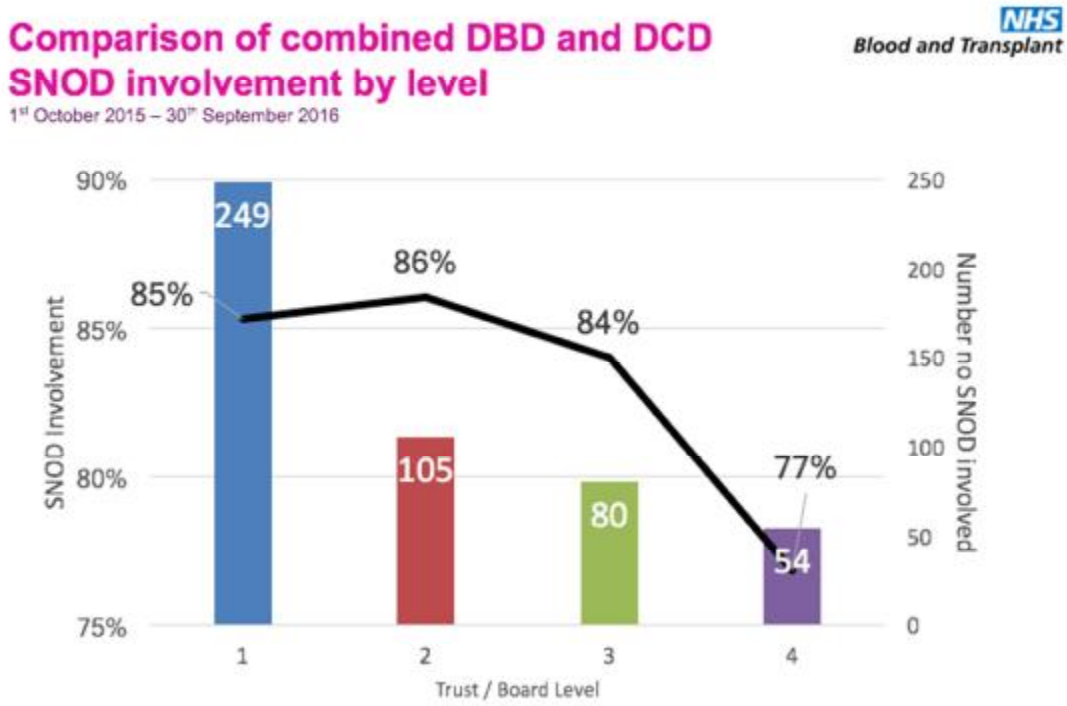
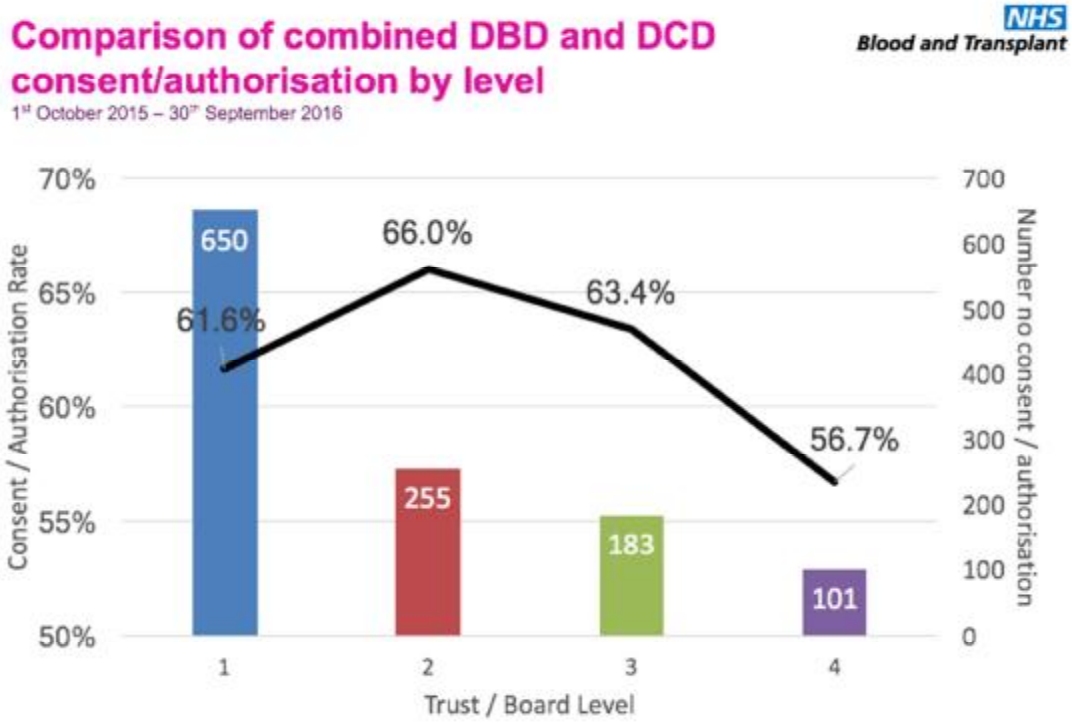


6c.


Comparison of combined DBD and DCD SNOD involvement by level
1st October 2015 – 30th September 2016
NHS Blood and Transplant
90%
85%
80%
75%
SNOD Involvement
250
200
150
100
50
0
Number no SNOD involved
249
105
80
54
85%
86%
84%
77%
1
2
3
4
Trust / Board Level

6d.


Comparison of combined DBD and DCD consent/authorisation by level
1st October 2015 – 30th September 2016
NHS Blood and Transplant
70%
65%
60%
55%
50%
Consent / Authorisation Rate
700
600
500
400
300
200
100
0
Number no consent / authorisation
650
255
183
101
61.6%
66.0%
63.4%
56.7%
1
2
3
4
Trust / Board Level

4.2 Changes to the embedded SNOD role

The ambition of the 2008 Taskforce report was that:

> "In order to support **all critical care teams on a day-to-day basis, the [SNOD]s should all be made available to be embedded within a designated critical care team**, managed by a team leader from a regional office. The Taskforce recommends that there should henceforth be a much closer working relationship between [SNOD] and local ICUs, and furthermore believes that such collaboration between embedded SNOD and [CLOD] is key to the success of these recommendations." (emphasis added)

The UK model for local donation personnel was established as representing am embedded SNOD, CLOD and ODC Chair (see Figure 7). It was through the hard work of this triumvirate of individuals that the UK success story was achieved.

Figure 7.

For several years, however this model of working has been under increasing strain. The smallest hospitals in the UK can no longer be said to have an embedded SNOD in the way envisaged by the Taskforce or first enacted. It is now frequent that the smallest hospitals see their assigned SNOD only on a weekly or fortnightly basis. SNODs are more often cluster working where

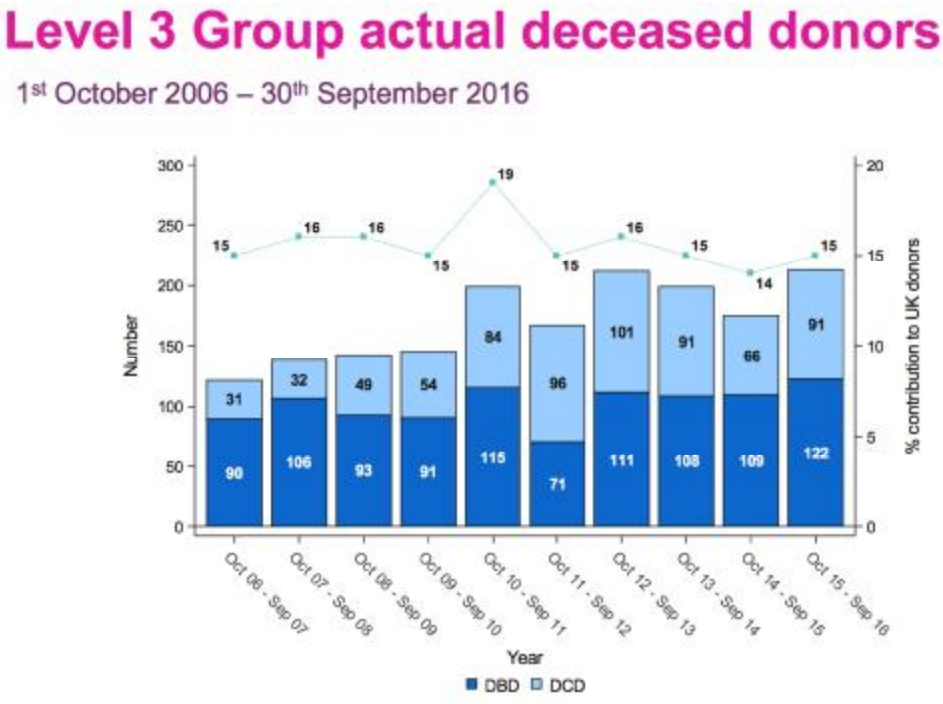
several SNODs based in a Level 1 will cover the smaller surrounding hospitals, even if there is one designated SNOD for each hospital.

The drivers for this change were multi-factorial. The financial pressures on the NHS are considerably higher than in 2008. In addition, it was clear that the workload between SNODs could be disproportionate given that donation activity varied considerably and this could on occasion lead to resentment and deskilling. The biggest driver however was the need to embed SNODs where the workload was highest.

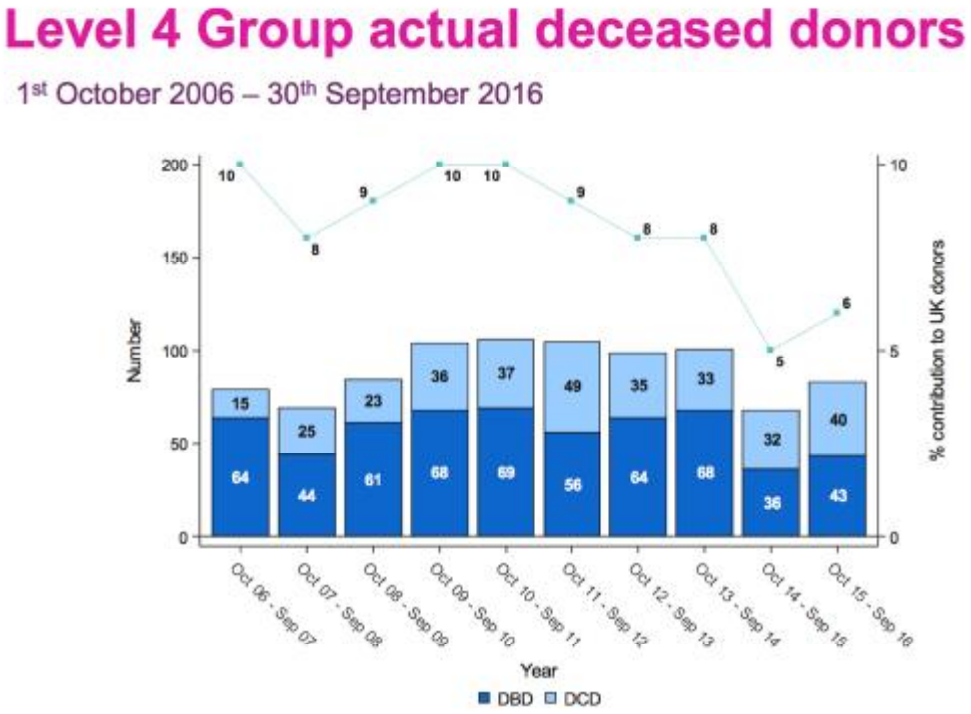
It is to the credit of the CLODs and ODC Chairs, and the attending SNODs, that deceased donation in these hospitals has continued to grow and their share of UK deceased donation has not changed dramatically over time (see Figure 8). Though perhaps we are seeing changes in Level 4s but this could equally be the effect of centralisation of trauma and neurologic services.

Figure 8. Contribution of Level 3 and Level 4 hospitals to UK deceased donation over time.

8a.



8b.



What this represents for the CLOD role is that in the smallest hospitals SNOD presence has reduced over time. The need for local leadership and the championing of deceased donation has not however diminished. Therefore, there is an opportunity to strengthen the CLOD role to support ongoing improvements in deceased donation, whatever the size of the hospital.

Given the 2014 national survey finding that 42% of CLODs did not use the full 1 PA per week allocated for their role (Appendix B), the smallest (and some larger) hospitals may not require a full 1 PA of CLOD time. Where however the local CLOD in Level 3 and Level 4 hospitals takes over the traditional education and promotion roles once performed by the embedded SNOD, then 1 PA may still be required.

4.3 The needs of the 2020 Strategy

Taking Organ Transplantation to 2020: a detailed strategy, has the ambition of having the UK rank amongst the best in the world. The strategy was published in June 2013 and specifically aims to achieve the following four objectives by 2020:

1. A consent / authorisation rate of 80% (currently 62.7%)
2. 26 deceased donors per million population (currently 21.8 pmp)
3. An aim to transplant 5% more of the organs offered from consented, actual donors (currently -0.4%)
4. A deceased donor transplant rate of 74 per million population (currently 57.3 pmp)

Table 4 outlines the role CLODs could have in delivering and supporting the TOT2020 Action Plan. The CLOD role remains essential for achieving the 2020 objectives, as it remains one of the key, and indeed one of the few, ways NHSBT has for influencing practice within the hospital setting.

Table 4. The role CLODs could have in delivering and supporting the TOT2020 Action Plan. (Bold highlight = key role)

Delivery Role	Supportive Role
Outcome 1: Action by society and individuals will mean that the UK's organ donation record is amongst the best in the world and people donate when and if they can.	
Ensure that the introduction of a system of deemed consent in Wales is as successful as possible and learn from this experience.	Develop national strategies to promote a shift in behaviour and increase consent.
Ensure that it is easy to pledge support for organ donation **and once a pledge has been given, to honour the individual's decision**.	Increase Black, Asian and Minority Community awareness of the need for donation, to benefit their own communities and **provide better support for people in these communities to donate.**
	Explore with Education Departments the possibility of incorporating donation and transplantation issues into schools curricula.
	Develop a community volunteer scheme to support trust/health board donation committees to promote the benefits of donation in local communities.
Outcome 2: Action by NHS hospitals and staff will mean that the NHS routinely provides excellent care in support of organ donation and every effort is made to ensure that each donor can give as many organs as possible.	
Increase adherence to national standards and guidance.	End of Life Care practices should be reviewed to establish whether they might be adjusted so as to **promote donation after brain death**.
Families of potential donors will only be approached by someone who is both specifically trained and competent in the role, training packages and accreditation will be provided to those who wish to develop this competence.	Establish a National Referral Service to improve support to hospitals.
Provide hospital staff with the support, training, resources and information they need to provide an excellent organ donation service.	Increase the number of people who can donate following circulatory death **and learn from the Scottish pilot on donation after failed resuscitation.**
Work collaboratively to reduce instances of objection to organ donation from the coroner and procurator fiscal service and the police.	

Delivery Role	**Supportive Role**
Outcome 3: Action by NHS hospitals and staff will mean that more organs are usable and surgeons are better supported to transplant organs safely into the most appropriate recipient.	
Increase the number of organs that are retrieved from both DBD and DCD donors.	**Improve donor management for potential cardiothoracic donors,** providing a 24/7 service to assist if pilot schemes prove effective.
	Develop a system of peer review that is underpinned by a set of agreed standards for retrieval/transplant centres.
	Publish centre `specific risk` adjusted patient survival from listing as well as from transplantation.
Outcome 4: Action by NHSBT and Commissioners means that better support systems and processes will be in place to enable more donations and transplant operations to happen.	
Develop a workforce strategy for the organ donation service which will tailor the service to the needs of individual hospitals and seek to provide a workforce that is focused on supporting the potentially conflicting demands of providing a service to the donor family, donor management and donor coordination.	Optimise the processes, timescales, resources and supporting IT at every stage of the pathway from donor identification to long term survival.
Subject to variations in Government policy, agree a formal contract for organ donation with hospitals specifying how hospitals and the NHSBT donation service work together to achieve excellence.	
Support Regional Collaboratives to lead local improvement in organ donation, retrieval and transplant practice and promote organ donation.	
Develop training programmes to sustain and increase clinicians' organ donation understanding and expertise.	

5.0 Stakeholder engagement

5.1 SWOT analysis

In June 2016 at the National Organ Donation Committee, which Regional Managers and R-CLODs are all members, a SWOT analysis of the CLOD role was carried out. The summary results from this analysis can be seen in Table 5 and a more detailed version in Appendix E.

Table 5. SWOT analysis of the CLOD role.

CLOD ROLE	
Strengths	**Weaknesses**
1. Organ Donation Champion 2. Local Knowledge 3. Clinical credibility amongst Dr's 4. Process driven expertise 5. Influential as drivers of change locally	**1. Variable engagement** 2. No incentive to motivate or improve 3. Undefined time management / demands 4. No 'stick', all carrot 5. Difficult to remove from post if not effective
Opportunities	**Threats**
1. Specialist Roles I. Education II. Paediatrics III. Promotion / Collaborative Goal 2. Stronger performance management 3. Specific direction by NHSBT of CLOD activity	**1. Increasing pressure on NHS** 2. Disengagement of ITU / hospital / community **3. Loss of goodwill** 4. Don't "take sweets away from kids"

5.2 CLOD review stakeholder meeting

On the 14th September 2016 a one day stakeholder meeting was held in Birmingham to consider the CLOD role. Representation to this day included NHSBT (Regional Managers, R-CLODs, SNODs, Human Resources), CLODs (from large and small hospitals), ODC Chairs and the Donor Family Network.

The topic themes explored through the day were:

1. 'Employment' of CLODs
2. Expectations of CLOD
3. Expanded Roles for CLODs

5.3 Level meetings

Through December 2016 – April 2017, NHSBT ran four level meetings (starting with Level 2 then 1, 3, 4) and one paediatric GoToMeeting. Discussion points and recommendations from the September stakeholder meeting were tested at these meetings allowing all CLODs, from all sized hospitals, together with SNODs and Chairs, to hear and influence the recommendations in this review. An iterative process was adopted whereby the recommendations of the CLOD review were modified, based on feedback, for each subsequent meeting. Essential feedback was received, particularly in relation to the CLOD 1:1 template which changed considerably over time.

Through the level meetings annual CLOD core operational requirements were agreed (Table 6). This was estimated to take 20 PA / year, which equals 10 days / year. One half of a PA approximates 11 days per year based on an 8-hour day and an annualised 42-week year. There remains therefore considerable scope within the current role and reimbursement of CLODs to not only satisfy the core operational requirements but still have time to champion donation, investigate and remedy any missed donation opportunity and establish effective working relationships, with key stakeholders throughout the hospital.

Table 6. Annual CLOD core operational requirements and their estimated time.

ACTIVITY	Estimated time
Regular meetings with SNOD (expectation is monthly)	2 hours / month = 24 hours / year = 6 PA = 3 days / year
Attendance at Organ Donation Committees (expectation is ODC should be meeting 3 or 4 times per year)	2 hours x four times / year + 2 hours preparation for each meeting = 16 hours = 4 PA = 2 days
Attendance at regional collaboratives (expectation is 3 of 4 over 2 years)	4 PA = 2 days / year
Annual 1:1 with R-CLOD	4 hours / year = 1 PA = 0.5 day / year
Annual presentation of PDA data to Trust / Board executive or delegated governance structure.	4 hours / year = 1 PA = 0.5 day / year
Up to date hospital organ donation policies	4 PA = 2 days / year
Based on an annualised 42-week year.	**20 PA / Year = 10 days / year ½ PA ~ 11 days per year**

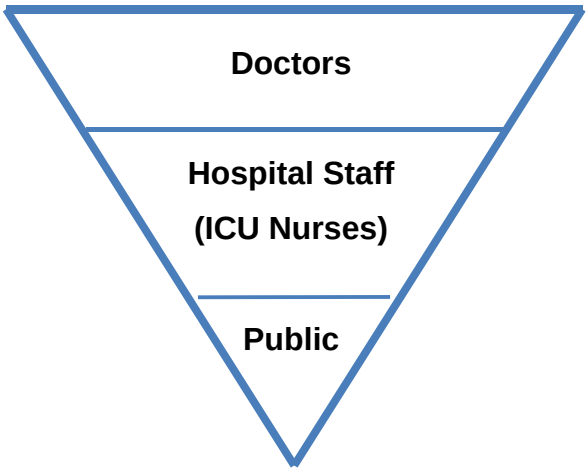
6.0 Strengthening the CLOD role

The triumvirate of SNOD, CLOD and ODC Chair was the foundation stone upon which the UK success story in deceased organ donation was built. Clinical practice changed and deceased donation is now a usual event in end of life care for mechanically ventilated patients in intensive care units and emergency departments. The 75% increase in deceased organ donors in 9 years is a remarkable achievement and one that everyone in the donation and transplantation community should be proud.

The job however remains unfinished. If we are going to achieve our ambitions, as set out in the *2020 Strategy,* to rank amongst the very best in the world, we must continue to improve.

It is worth considering what those who do rank amongst the best in the world consider as the secret of their success. In Spain, Rafael Matesanz, attributes success to the organisation and professionalisation of the health care professional roles which support organ donation. Howard Nathan, President and CEO of the Philadelphia-based Gift of Life Donor Program (44 donors ppm) puts doctors (the clinical decision makers in patient care) at the top of his education and promotion strategy (see Figure 9). The message from both countries is clear, the need for local clinical champions in UK hospitals has not diminished.

Figure 9. Howard Nathan's education and promotion strategy.



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 is attributable to the many CLODs who demonstrate these qualities. However, there is a known disparity in the motivation and effectiveness of CLODs, with some CLODs exceeding expectations in their commitment to organ donation, while others not meeting them.

Greater transparency and professionalisation of the CLOD role is required if we are to move forward. NHSBT needs to be clearer with CLODs about what is expected from a CLOD and how NHSBT can better support CLODs in their role. This will enhance the CLOD role in terms of professionalisation and respect.

While culture change in end of life practice has occurred in intensive care, with referral and SNOD collaborative requesting now routine, going forward CLODs will need to take more of a whole hospital approach (*e.g.* NHSBT's strategy, *Organ Donation and the Emergency Department*) and a greater whole donation process perspective (*e.g.* NHSBT's strategy, *Taking Organ Utilisation to 2020*). CLODs will be required to have a relentless focus on eliminating missed donation opportunities, so that every patient and their family can be assured that best practice in organ donation will be followed, irrespective of the location of the patient within the hospital at the time of death.

Regional Collaboratives, led by the R-CLODs and Regional Managers, must be more than a twice yearly gathering. They are a way of working for CLODs, SNODs and ODC Chairs, serving as the bridge between national and local initiatives, so that the sum is greater than the individuals. The collaborative remains NHSBTs primary vehicle for effective and transforming change in hospitals, the wider organ donation and transplantation community and the public. For this reason, it is essential that the R-CLOD carries out an annual 1:1 with the CLODs in their region. A strengthened template for this 1:1 is a

key part of the recommendations in this review and had the most stakeholder engagement through the 2016-17 level meetings.
R-CLODs and Regional Managers should consider the CLODs in their region within the context of both local and regional need. It is therefore for the region to decide on CLOD PA allocation and expanded regional roles for CLODs, within the boundaries given in the recommendations found in this review.

The words of Margaret Mead, so influential to the Taskforce, resonate just as loud as they always have, “Never underestimate the power of a small but committed group of people to change the world. Indeed, it is the only thing that ever has."

Since 2008 the CLOD role has matured. It is respected within the intensive care and donation communities. The recommendations that follow aim to make it even better.

7.0 Recommendations

1. 'Employment'

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

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

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. All CLODs will be on a three-year contract 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 CLOD PA allocation should 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 most 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 outlined in Appendix G.
h. A master spreadsheet of all UK CLODs should be maintained. All CLOD Annexe A forms or changes to CLOD roles and numbers should go via this Master Spreadsheet **before** being forwarded to finance. A CLOD by CLOD check and review should be undertaken to ensure accuracy of information.

2. 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 H). This template includes a checklist of expected core operational requirements which is built into the new CLOD job description.
c. Every Regional 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.

3. Expanded Roles

a. There should be a national paediatric CLOD on 1 PA, who will report to the National CLOD.
b. There should 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 on short term ‘contracts’ for a specific purpose and not follow the standard CLOD terms and conditions (eg 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.

4. Regional CLODs

a. Each of the 12 NHSBT regions (organ donation services teams) should have at least one PA of R-CLOD time.
b. The current UK range is that 1 R-CLOD PA supervises 6-26 individual CLODs. With the strengthened annual CLOD 1:1 (Appendix H) 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.

An implementation plan is outlined in Appendix I.

8.0 Measuring success

Primary Measure

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

Secondary Measures

1. One hundred percent of CLODs receiving a 1:1 by their R-CLOD each year.

2. 95% referral and SNOD involvement in family approach by 2020.

3. 75% of CLODs answer yes to this theoretical question by 2020.
   "If CLOD funding was stopped tomorrow, is your role so valued by your hospital that they would find the PAs to continue you in your role?"

Appendices

Appendix A: CLOD numbers and budget

Quarter 1 2010/11

	Number of Hospitals*	Number CLOD Posts	Number of CLOD PAs	Number of CLODs on >1 PA	Number of CLODs on <1 PA	Number of Hospitals* where > 1 CLOD in role	Number of CLOD Vacancies	Appointed CLODs not receiving payment	Total Annual Cost for CLODs in Post in £
England	155	143	170.85	11	4	6	20	5	1,701,775
Scotland	12	25	27	1	0	0	1	0	287,072
Wales	6	8	10	2	0	1	0	0	118,259
Northern Ireland	5	5	6	1	0	0	0	2	43,865
TOTAL	**178**	**181**	**213.85**	**15**	**4**	**7**	**21**	**7**	**2,150,971**

* CLODs are appointed to cover hospitals at the Trust / Board level. Some Trusts / Boards have a number of different sites with multiple CLODs. This number is based on finance report 2010/11 which is slightly different to Quarter 4 2016/17 (below) which corresponds to the hospital donation activity level allocation.

There were no Regional CLODs in 2010/11.

Average Cost per CLOD PA = £10,058.32
If CLOD vacancies filled and at average Cost per CLOD PA = CLOD Budget of £2.4 million.

Quarter 4 2016/17

	Number of Trusts / Boards	Number CLOD Posts[#]	Number of CLOD PAs[#]	Number of CLODs on >1 PA[#]	Number of CLODs on <1 PA	Number of Hospitals[*] where > 1 CLOD in role[%]	Number of CLOD Vacancies	Appointed CLODs not receiving payment	Total Annual Cost for CLODs in Post in £
England & North Wales	148	198	185	7	29	21	3	0	2,056,399
Scotland	12	28	28	0	0	1	0	0	272,685
South Wales	6	14	11	0	4	3	0	0	107,628
Northern Ireland	5	7	7	0	0	1	0	0	75,894
TOTAL	**171**	**247**	**231**	**7**	**33**	**35**	**3**	**0**	**2,512,606**

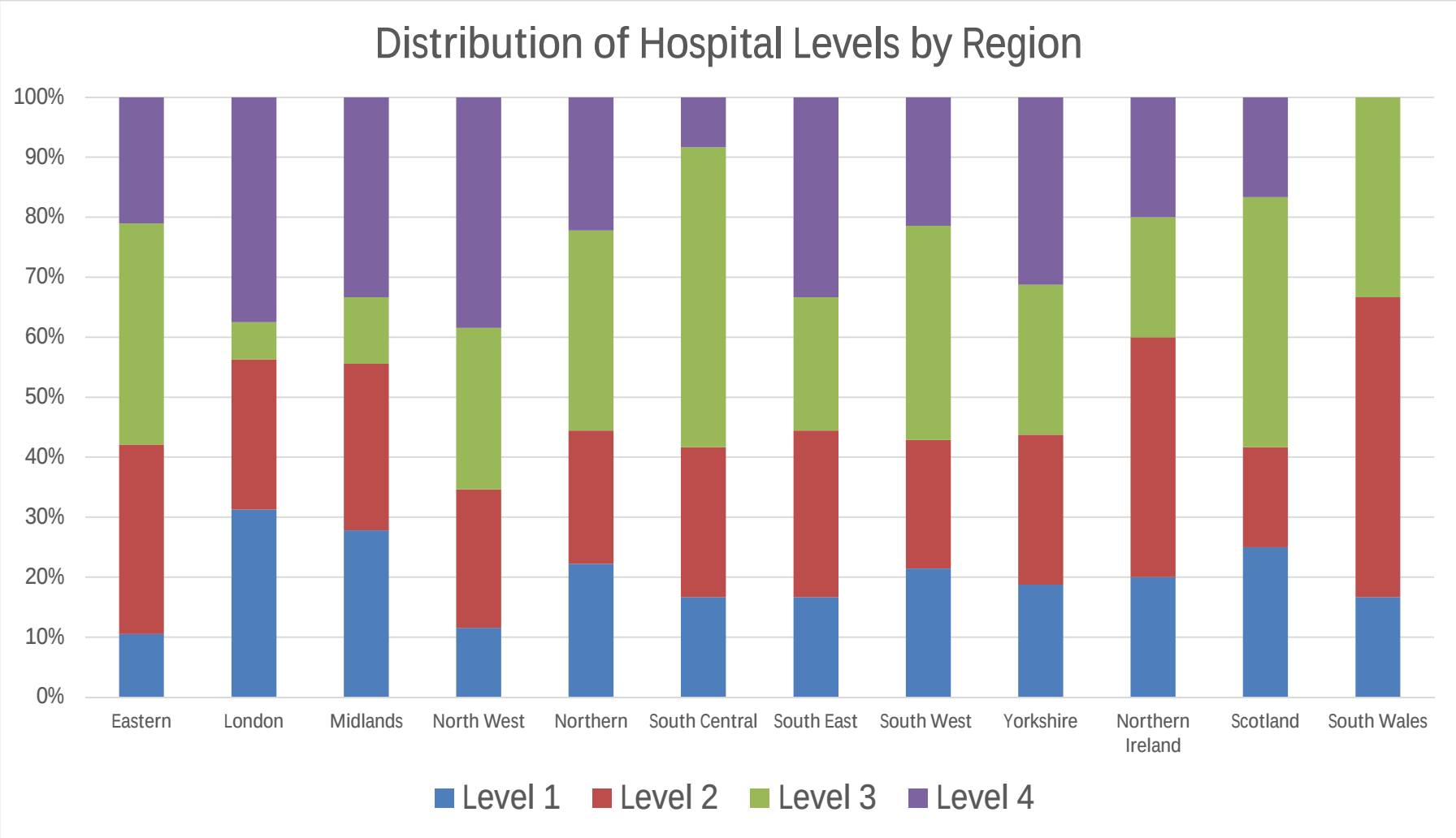
[#] Includes Regional CLODs
[%] Excludes Regional CLODs

Average Cost per CLOD PA = £11,068
If CLOD vacancies filled and at average Cost per CLOD PA = CLOD Budget of £2.5 million.

Quarter 4 2016/17: Regional Distribution of CLODs compared to regional Potential Donor Audit data.

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.

	R-CLOD PAs	Number of CLOD Posts (excluding R-CLOD)	CLOD PAs (including R-CLOD)	Number of Trust / Boards (per CLOD PA)	Number of Hospitals at Level 1,2,3,4	Audited Deaths (per CLOD PA)	Patients Meeting Referral Criteria (per CLOD PA)	Eligible DBD and DCD Donors (per CLOD PA)	Actual Donors (per CLOD PA)
Eastern	1	22	19	19 (1.0)	2,6,7,4	2557 (135)	748 (39)	530 (28)	130 (6.8)
London	1	26	25	16 (0.6)	5,4,1,6	3833 (153)	782 (31)	591 (24)	157 (6.3)
Midlands	2	20	23	18 (0.8)	5,5,2,6	4853 (211)	930 (40)	713 (31)	155 (6.7)
North West	2	30	32	26 (0.8)	3,6,7,10	5196 (162)	1127 (35)	820 (26)	178 (5.6)
Northern	1	13	13	9 (0.7)	2,2,3,2	1947 (150)	542 (42)	433 (33)	85 (6.5)
South Central	1	17	17	12 (0.7)	2,3,6,1	2437 (143)	626 (37)	474 (28)	109 (6.4)
South East	2	18	20	18 (0.9)	3,5,4,6	2594 (130)	774 (39)	546 (27)	155 (7.8)
South West	1	16	17	14 (0.8)	3,3,5,3	1911 (112)	413 (24)	312 (18)	91 (5.4)
Yorkshire	1	24	19	16 (0.8)	3,4,4,5	3201 (168)	763 (40)	451 (24)	115 (6.1)
Northern Ireland	1	6	7	5 (0.7)	1,2,1,1	849 (121)	263 (38)	152 (22)	41 (5.9)
Scotland	2	26	28	12 (0.4)	3,2,5,2	2898 (104)	438 (16)	391 (14)	130 (4.6)
South Wales	1	13	11	6 (0.5)	1,3,2,0	1806 (164)	348 (32)	268 (24)	47 (4.3)
UK	16	231	231	171 (0.7)	33,45,47,46	34082 (148)	7754 (34)	5681 (25)	1393 (6.0)



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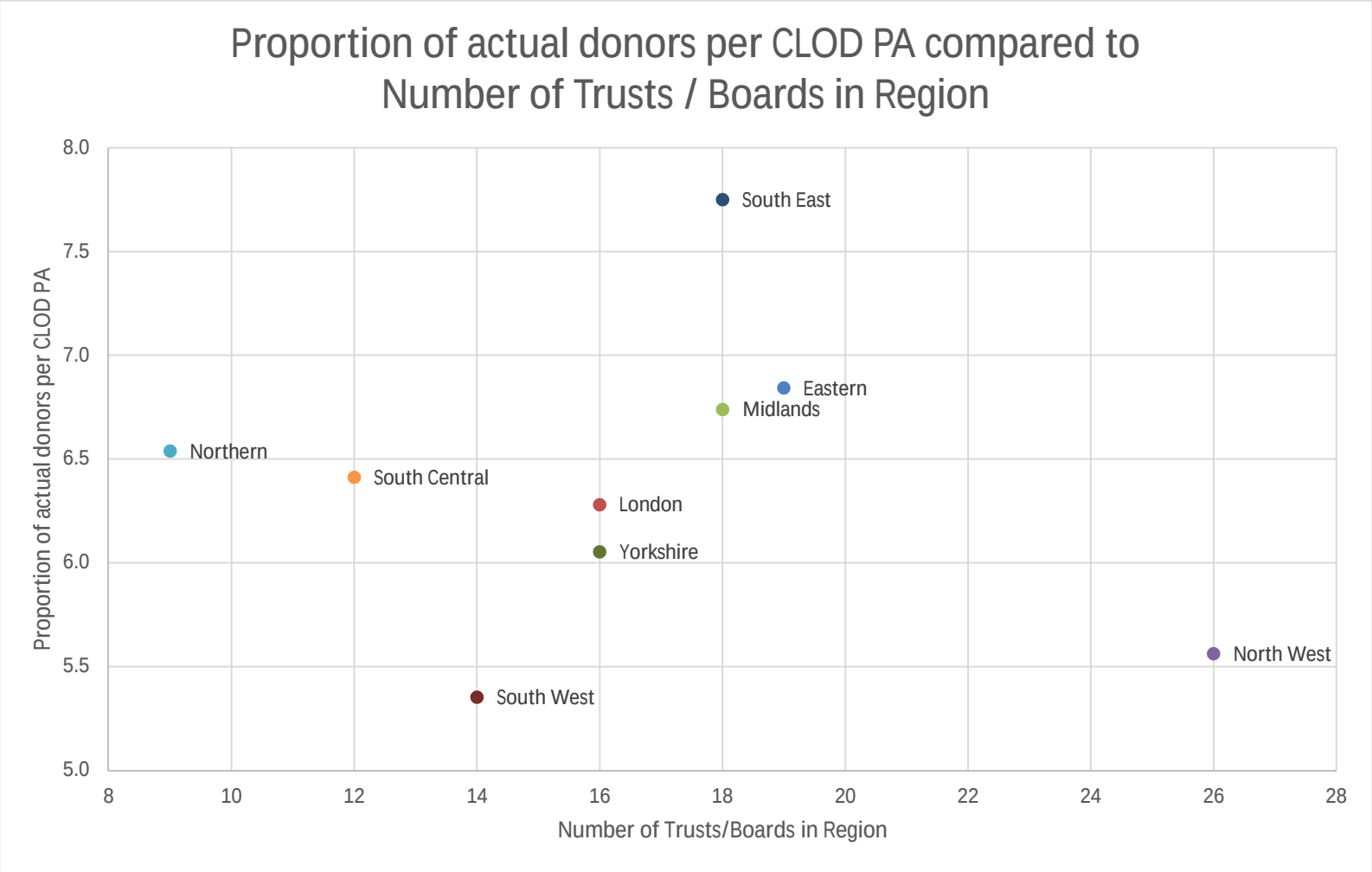

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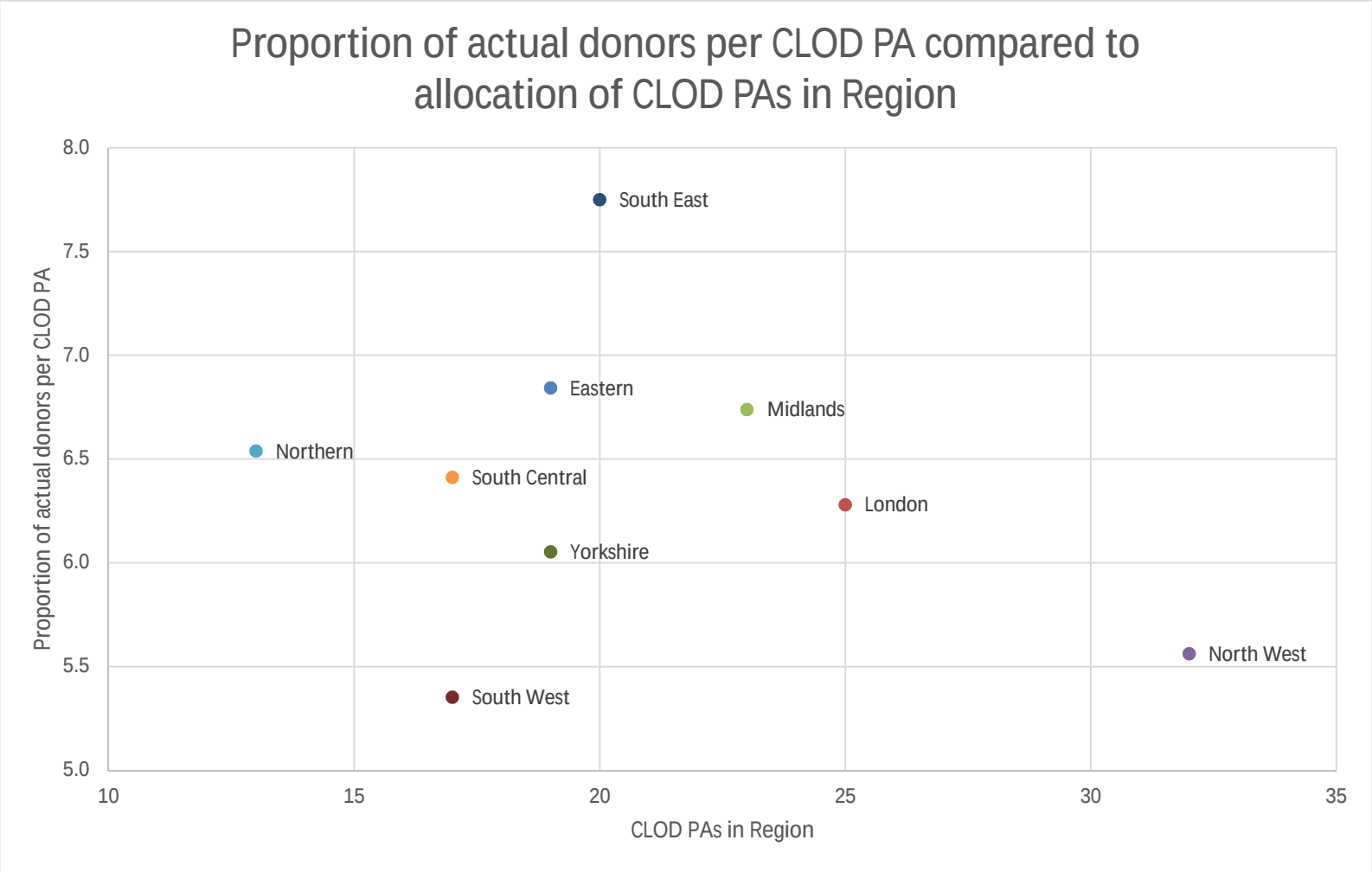
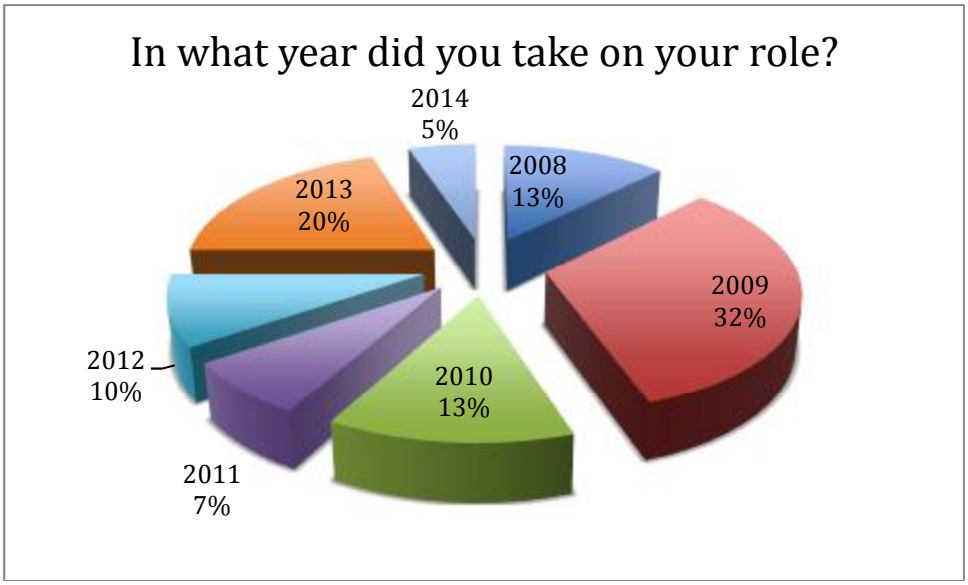


Owing to differences in health care organisation, direct comparison of Northern Ireland, Scotland and South Wales with the rest of the UK is not encouraged and these regions were therefore not included in this chart. North West also includes the hospitals from North Wales.

Appendix B: Key findings CLOD National Survey, February 2014

- **137 CLOD responses**



- **42% of CLODs missed the PDP 2010 education programme.**
- **33% of CLODs would like more training for their role**

- 87% of CLODs have an anaesthetic professional background, 84% intensive care medicine, 4% emergency medicine, 1.6% acute medicine, and 1.6% renal medicine.

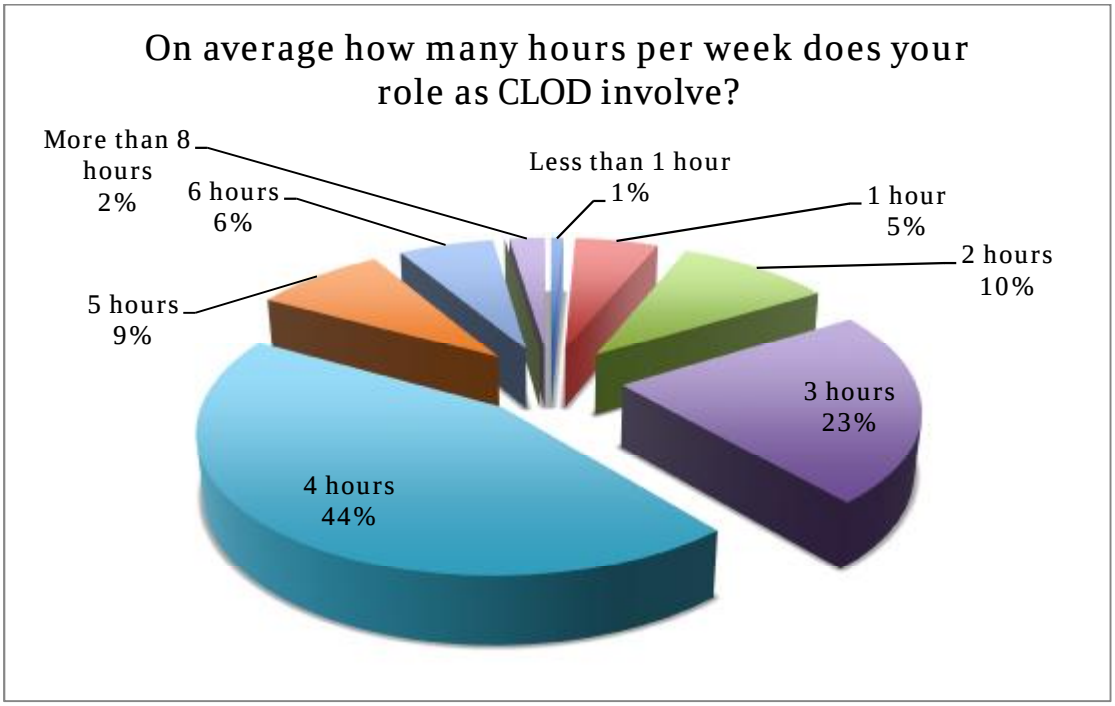
- 91% of CLODs are on 1PA

- **88% of CLODs have their role recognised in their job plan but only 68% personally get paid the money NHSBT provides for their role.**
  e.g. Job Plan is 13 PAs, paid 12
  e.g. CLOD role taken on over and above PAs in job plan

- 74% of CLODs have their role discussed at their annual appraisal.

- No clear preference for length of service was identified by CLODs, with five years being the highest choice (32%) but indefinite and 'other' combined represented nearly 40% of choices. A clear preference was given for the right person rather than any set length of time.

- **39% of CLODs self report their role takes less than four hours per week while 17% of CLODs report their role takes more than 4 hours per week.**



- **Influence**
  In order of influence using the scale 5: Very strong influence to 1: Very little influence, CLODs as a group felt their influence was:

Local organ donation committee	4.49
Intensive care colleagues	4.36
Anesthesia colleagues	3.84
Emergency medicine colleagues	3.36
Regional CLOD	3.34
Hospital's governing hierarchy	3.30
Regional collaborative	3.20
Regional manager	3.02
National NHSBT	2.20

- **85% of CLODs have delivered more than two education events over the last year and 39% more than four, predominantly to intensive care and anesthesia staff.**

NHSBT Money

- 60% of CLODs can access the £1000 provided by NHSBT for the education and travel expenses of the Organ Donation Committee members but 25% did not know this money was available.
- 34% of CLODs have been financially out of pocket in their role.
- **Only 69% of committees have access to at least some of the £2086 reimbursement money** with 63% of the funds held by the general hospital finance department. Around 30% have no access to the funds, 38% < £10,000, 23% < £50,000 and 9% > £50,000.
- **49% of CLODs identified this money as essential and an additional 17.7% felt they could do more with access to more money.**

NHSBT Education Events and Collaboratives

- Just under half of CLODs found it easy or very easy to attend education events organised by NHSBT but 12% found it difficult. None identified it as extremely

difficult / impossible. Obtaining leave was the main reasons given for difficulty.
- 40% of CLODs meet together in their local area outside of Regional Collaboratives and National Events.
- **On a scale of 1: not very important / effective to 5: essential CLODs scored regional collaboratives as 4.08 and their effectiveness as 3.61.**

SN-ODs and ODC Chairs
- 64% of CLODs meet with their SN-OD more than once per week, with nearly 25% of CLODs meeting twice or more per week. SN-OD presence at the hospital identified in the comments as the most significant obstacle. 19% of CLODs felt more frequent meetings with the SN-OD would be beneficial but only 12% for the Chairs.
- CLODs usually interact with their chairs via the local committee meeting, email or the regional collaboratives. 30% of CLODs are involved with their Chair in pre local committee planning meetings.

Organ Donation Committees
- **22% of committees will meet less than three times over the 2013/14 year and 7 committees will not meet at all.**
- **CLODs were generally positive about their organ donation committee but attendance and lack of administrative support were highlighted as the biggest challenges.**

Appendix C: Historic CLOD Job Description, July 2015

Job Title	Clinical Lead for Organ Donation (CLOD)
Grade	Consultant Clinician
Location	Employing Hospital(s)
Accountable to:	Hospital(s) Medical Director and Regional CLOD
Hours:	1 PA per week
Contract Duration	3 years with annual review (renewable one further term)

In order for NHSBT to reimburse the hospital(s) for this position the Regional CLOD or Regional Manager must represent NHSBT on the interview panel.

Job Summary

- Provide clinical leadership within the hospital, to raise the profile of organ donation.
- Maximise donation potential, by facilitating the removal of barriers to donation. Implement the recommendations of national guidelines across the whole hospital, focusing on those areas with greatest potential,
- Champion and promote the value of organ donation.
- Establish effective working relationships, with key stakeholders throughout the hospital.

Key Relationships

Internal

Critical Care clinicians and nursing staff
Emergency medicine clinicians and nursing staff
Embedded/Local Specialist Nurse for Organ Donation
Organ Donation Committee
Organ Donation Committee Chair
Hospital Medical Director

External

NHS Blood and Transplant
Regional Clinical Lead for Organ Donation
Regional Manager, NHSBT
National Organ Donation Committee

Conditions of Service

1) Available at least 1 PA per week (up to 2 PAs by prior agreement)
2) A commitment from primary employing organisation to incorporate these PA's into the appointee's job plan
3) An annual job plan with objectives for each year will be agreed with the Medical Director (may be delegated into annual local appraisal process) and NHSBT (Regional CLOD)
4) This job description is intended as a guide and may change to meet the changing needs of the service.

CLOD Governance:
Operational requirements for 1 PA per week

Frequency	Operational Requirements
Ad Hoc	Ensure that all areas of the hospital where potential organ donors are treated have appropriate local policies in place, developed in line with national policy and guidelines. These should include minimum (or better) notification criteria, donor management and withdrawal guidelines.
	Act as a source of knowledge regarding the ethical and legal aspects of organ donation and provide advice as required.
	Progress, review and assist in developing an End of Life Care Pathway locally where it does not yet exist, emphasising national guidance on inclusion of solid and tissue organ donation discussions in such Pathways.
	Lead the development of local educational and training opportunities for all staff likely to be involved with the care of a potential organ donor.
	Act as a spokesperson/ advocate for donation locally as required. Attend NHSBT Media skills course as appropriate.
	Escalate both locally and via NHSBT Clinical Governance structures any critical incident or 'near miss' relating to organ donation practice. Particular emphasis should be placed on Missed Donation Potential.
	Ensure appropriate remedial action taken if any potential donor not identified, referred or appropriately managed or if the SNOD team not contacted.
	Take appropriate remedial action if any appropriate Patient does not undergo brain stem death testing Ensure Death confirmed hospital wide in line with Academy guidelines. These should include confirmation by cardio-respiratory and neurological criteria.
	CLODs in Level 1 donating hospitals and/or hospitals with PICUs, are expected to attend relevant education or performance meetings.
Weekly	Undertake correspondence in respect of role and donation issues as required. Allocate time in line with contracted PA(s)
Monthly	Meet with embedded or local SNOD to analyse PDA data and ensure accurate reporting.
	Discuss and progress action plan for areas of missed potential

Quarterly	Prepare for and proactively attend the Organ Donation Committee and ensure it functions effectively. Deputise for the committee's non clinical chair in their absence.
In the first 6 months of appointment	In conjunction with embedded SNOD assist in production of a local infrastructure report, which will include outlining local barriers to donation.
In the first 12 months of appointment	Attend a formalised induction programme.
Bi annually	Sign off the 6-monthly PDA report.
	Attend Organ Donation Collaborative events [75%] eg 3 out of four regional collaborative meetings over two years
Annually	Have a 1:1 meeting with the R-CLOD (may be by telephone in some circumstances) to agree job plan in accordance to agreed national CLOD standards.
	Produce in conjunction with embedded SNOD/ Local SNOD and Donation Committee a detailed action plan for the coming year.
	Ensure presentation of PDA data to hospital executive and hospital clinical governance structure.
	Attend the annual Donation Congress (not always annually).
	CLODs will check their hospital has an up-to-date organ donation policy, which is appropriately approved by the relevant internal hospital governance structures.
	Meet with the Regional CLOD or Regional Manager / Team Manager to discuss performance of the hospital/s and the notes of this meeting to feed into annual appraisal.
	Include the CLOD role as part of the annual appraisal process and include in Professional Development Plan.
3 yearly	All CLODs will be on a three-year contract renewable for one further term (subject to satisfactory annual reviews). It is intended that the position will be re-advertised at the completion of a second term.

1PA
Standard Payment for all hospital CLODs
Additional PAs, in negotiation with NSHBT, may be considered for:
CLOD level 1 hospital with neurological speciality, transplantation activity or other specially agreed situations

Person Specification, Clinical Lead for Organ Donation

Professional Knowledge and experience	Essential	Desirable	Method of assessment
1. A medical qualification and experience of working at consultant level in critical care medicine or another discipline	*		Application
2.Knowledge and experience of all aspects of deceased organ donation including ethical and legal aspects	*		Application / Interview
3. Awareness of current national policy and guidelines relevant to organ donation	*		Application / Interview
4. Understanding of National strategy regarding Organ Donation and Taskforce and TOT2020 recommendations	*		Application / Interview
Interpersonal skills and leadership	**Essential**	**Desirable**	**Method of assessment**
5. Evidence of experience in working positively and effectively with NHS staff at all levels and the ability to lead and work within a multi-professional team	*		Application / Interview
6. Ability to inspire and energise colleagues	*		Application / Interview
7. Experience in working with and influencing advisory bodies		*	Application / Interview
8. Personal commitment to ensuring TOT2020 recommendations and National Guidelines are implemented and functioning at hospital level	*		Application / Interview
Personal Skills	**Essential**	**Desirable**	**Method of assessment**
9. An effective communicator	*		Application / Interview
10. Positive, persuasive and inclusive style	*		Application / Interview
11. Experience in handling media or public relations issues at a local level		*	Application / Interview

Produced by
Paula Aubrey
Huw Twamley
Arpan Guha
(Approved by the National Organ Donation Committee)

Updated January 2015, Dale Gardiner (Deputy National Clinical Lead for Organ Donation)

Appendix D: Example CLOD induction programme, March 2017

CLOD Induction Programme

14/15 March 2017

The Wesley Hotel, 81-103 Euston Street, London, NW1 2EZ

Day 1

Time	Topic	Speaker
1000-1030	**Arrival and Coffee**	
1030-1040	**Introduction**	**Dale**
1040-1110	**UK deceased donation in context**	**Paul**
1110-1130	**Coffee**	
1130-1300	**Diagnosis of Death** 1. The British Criteria – theory and practice 2. Dead or Not Dead Quiz	 **Dale** **Andre**
1300-1400	**Lunch**	
1400-1500	**Ethical, Legal and Professional Framework for Deceased Donation**	**Dale**
1500-1530	**Coffee**	
1530-1700	**Being an effective CLOD** 1. Expectations on the role 2. Donation Committees and the role of the SN-OD (delivered by SNOD) 3. Understanding and using the PDA	 **Andre** **Sarah** **Andre**
1700-1730	**Taking Organ Transplantation to 2020**	**Paul**
1900	**Dinner**	

Hotel accommodation available.

Day 2

Time	Topic	
0900-0915	**Welcome and Goals of Day 2**	**Dale**
0915-1000	**Identification and Referral**	**Andre**

1000-1025	**Improving Organ Utilisation**	**Dale**
1025-1045	**Coffee**	
1045-1200	**Consent / Authorisation and Approaching Families** - Why families say no - Best practice - The role of the SNOD in family approach	**Dale**
1200-1300	**Lunch**	
1300-1430	**Simulated Scenarios (max group size = 8)**	**Dale and Andre**
1430-1450	**Coffee**	
1450-1620	**Simulated Scenarios (max group size = 8)**	**As above**
1620-1630	**Wrap up and CLOSE**	

Speakers

Dr Dale Gardiner – Deputy National Clinical Lead for Organ Donation, Consultant Neuro Intensivist, Nottingham.

Dr Paul Murphy – National Clinical Lead for Organ Donation and Consultant Neuro Intensivist, Leeds

Dr Andre Vercueil – Regional Clinical Lead for Organ Donation, Consultant Intensivist, Kings College Hospital, London

Ms Sarah Beale – Service Development Manager, Organ Donation & Transplantation

Appendix E: More detailed SWOT analysis of the CLOD role from the National Organ Donation Committee June 2016.

Strength	Weakness
Local knowledge • Politics/Personalities • Resources/Geography/Depts • Support within trust & for SNOD maintaining profile of Organ Donation • Clinical Expertise locally • Process driven expertise • Clinical credibility amongst Drs • Wider networks/networking • Assistance/local comms activity/education Leader/Vision • Feed in National Knowledge • Support/expertise on Committee • OD Champion • Influence • Help increase donor numbers • Innovation • The seat of the institutional memory • Accountability • Proven model (SNOD, CLOD & Chair) • Influential as drivers of change locally • Become more influential within hospital, even when move on to new roles • Education, credibility, visibility of donation into ICU/Trust/HR business • Advocates for End Of Life Care	• No external incentive to do well • Not performance managed – *Staleness* • Very different for RCLODS to do this • Poor induction locally (*some self-appointed (still)*) • Lack of influence • Lack of clarity regarding appointment process • Undefined time management/demands • Limited influence (for younger CLODS) • Variable engagement with teams/Collabs locally • Not enough time within job plan – it is a peripheral/extra role • Difficult to remove from post if not effective • Expensive • Some weak • Lack of vigour • Lack of leadership skills/how to manage change • Lack of training • Spread too thin • Complacency • Geographically distant • Until recently no appraisal • No 'stick', all carrot • No incentive to motivate or improve
Opportunities	**Threat**
• Specific direction by NHSBT of CLOD activity – currently variable time and energy spent • Monitor performance • Volunteer Role - £££ • Stronger performance management • NHSBT involvement in appointments - rethink appointment process • Redistribution of PAs – momentum from NHSBT • Training of advanced trainees as future CLODs • NHSBT Comms with CLODS & RCLODS Specialist Roles - Education - Paediatrics - Promotion Hospital development (to replace SNODS) Better induction More R-CLOD to CLOD mentoring	• Not influential on ITU/hospital/community • Disengagement of ITU/hospital/community and whole Trust • No increase in donors • Loss of skill/knowledge • Don't "*take sweets away from kids*" • Loss of goodwill • Performance • Bad message – ultimately money is how we value • 1/2 PA = can't ring-fence (a session) • Review of role/PAs within region • Alienate Trusts if withdraw PAs • Increasing pressure on NHS • Challenges to recruit Oct – should we employ/pay directly? • (NHSBT) financial pressures • Risk of losing ground • Risk of losing SNODS

Appendix F: CLOD Job Description, July 2017

Job Title	Clinical Lead for Organ Donation (CLOD)
Grade	Consultant Clinician
Location	Employing Hospital(s)
Accountable to:	Hospital(s) Medical Director and Regional CLOD
Hours:	0.5-1 PA per week (exceptionally > 1PA)
Contract Duration	3 years with annual review - renewable one further term (no prohibition on the post-holder reapplying)

In order for NHSBT to reimburse the hospital(s) for this position the Regional CLOD or Regional Manager must represent NHSBT on the interview panel. Organ Donation Committee Chairs should be invited to sit on any interview panel.

Role summary

1. Provide clinical leadership within the hospital, to champion and promote the value of organ donation.
2. Maximise donation potential, by minimising missed opportunities in donation and by implementing the recommendations of national guidelines across the whole hospital, focusing on those areas with greatest potential.
3. Establish effective working relationships, with key stakeholders throughout the hospital.

Key Relationships

Internal

Critical Care clinicians and nursing staff
Emergency Medicine clinicians and nursing staff
Local Specialist Nurse for Organ Donation
Organ Donation Committee (ODC)
ODC Chair
Hospital Medical Director
A designated hospital governance structure to report donation activity

External

NHS Blood and Transplant
Regional Clinical Lead for Organ Donation
Regional Manager, NHSBT
Regional Collaborative Membership of CLODs, SNODs and ODC Chairs

Conditions of Service

1) Able to deliver the allocated PAs per week.
2) A commitment from primary employing organisation to incorporate these PA's into the appointee's job plan.
3) Annual satisfaction of the checklist of core operational requirements as assessed in a 1:1 with the regional CLOD where annual objectives for each year will also be agreed.
4) This job description is intended as a guide and may change to meet the changing needs of the service.

Annual 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.	

Additional activities

ACTIVITY	Expected Frequency
Areas of responsibility *e.g.* multi-campuses, neuro-intensive care, ED, PICU Undertake correspondence in respect of role and donation issues as required. Allocate time in line with contracted PA(s).	Weekly correspondence. Monthly contact with areas of responsibility.
Prepare for and proactively support the local Organ Donation Committee and ensure it functions effectively. Deputise for the committee's non-clinical chair in their absence.	Quarterly
Ensure all areas have appropriate local policies in place, developed in line with national policy and guidelines. Assist in developing local end of life care plans or intensive care admission policies, where required, emphasising national guidance as it applies to deceased donation. Ensure death is confirmed hospital wide in line with Academy guidelines. These should include confirmation by circulatory and neurological criteria.	Annual review of any policies.
Report local donation activity to a designated hospital governance structure (ideally to the hospital Board).	Annual report

Clinical Expertise / Advice Act as a source of knowledge regarding the ethical and legal aspects of organ donation and provide advice as required. Escalate both locally and via NHSBT Clinical Governance structures any critical incident or 'near miss' relating to organ donation practice.	Ad hoc
Act on any Missed Donation Opportunities With SNOD, review PDA data, donation numbers, donation metrics, case investigations and actions required. Challenge colleagues and local barriers as required to eliminate missed opportunities, particularly in the areas of referral and SNOD involvement. In conjunction with local SNOD assist in production of detailed local reports, as required, which will include outlining local barriers to donation and where missed opportunities for donation can be best addressed.	Monthly review Ad hoc Ad hoc
Education *e.g.* deliver local, regional or national education activities Lead the development of local educational and training opportunities for all staff likely to be involved with the care of a potential organ donor.	Quarterly
Promotion *e.g.* local, regional and national promotion activities Act as a spokesperson/ advocate for donation locally as required. Attend NHSBT Media skills course as appropriate.	Ad hoc and as per personal interest
Personal and Professional Development *e.g.* attend CLOD Induction, National Congress or Level meetings The CLOD role should be incorporated into the hospital annual appraisal process and be included in any Professional Development Plan.	CLOD induction within 12 months of appointment. National Congress every two years. Other activities ad hoc.
Academic *e.g.* research / publications, presentations at regional / national / international meetings	Ad hoc and as per personal interest
Other activities to champion donation as per personal interest	Ad hoc

Person Specification, Clinical Lead for Organ Donation

Professional Knowledge and experience	Essential	Desirable	Method of assessment
1. A medical qualification and experience of working at consultant level in critical care medicine or another appropriate discipline.	*		Application
2. Knowledge and experience of all aspects of deceased organ donation including professional, ethical and legal aspects.	*		Application / Interview
3. Awareness of current national policy and guidelines relevant to organ donation.	*		Application / Interview
4. Understanding of the TOT2020 Strategy.	*		Application / Interview
Interpersonal skills and leadership	**Essential**	**Desirable**	**Method of assessment**
5. Evidence of experience in working positively and effectively with NHS staff at all levels and the ability to lead and work within a multi-professional team.	*		Application / Interview
6. Ability to inspire and energise colleagues.	*		Application / Interview
7. Experience in working with and influencing advisory bodies.		*	Application / Interview
8. Personal commitment to ensuring TOT2020 recommendations and national guidelines are implemented and functioning at the hospital level.	*		Application / Interview
9. Personal commitment to minimising missed opportunities in donation in one's own hospital, particularly in the areas of referral and SNOD involvement.	*		Application / Interview
Personal Skills	**Essential**	**Desirable**	**Method of assessment**
10. An effective communicator.	*		Application / Interview
11. Positive, persuasive and inclusive style.	*		Application / Interview
12. Experience in handling media or public relations issues at a local level.		*	Application / Interview

Appendix G: CLOD chronic sickness guideline.

NHSBT will work closely with the hospital employer to ensure we act in accordance with any local policies and any occupational health, return to work actions.

In broad principle, the CLOD sickness policy will be that at:

< 3 months	No action, ad hoc use of other consultants in that hospital to take on that role.
3-6 months	Formalise ad hoc arrangements in an acting capacity.
6-12 months	NHSBT will reimburse employing hospital 50% of usual arrangement and any acting CLOD receives up to the additional 50% of PA allocation.
> 12 months	NHSBT will reimburse employing hospital 0% of usual arrangement and any acting CLOD receives up to the additional 100% of PA allocation. Consideration for re-advertising of the position.

Appendix H: 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
(eg multi-campuses, neuro-intensive care, ED, PICU)

Clinical Expertise / Advice

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

Education
(eg local, regional and national education activities)

Promotion
(eg local, regional and national promotion activities)

Personal and Professional Development
(eg attending CLOD Induction, National Congress)

Academic
(eg research / publications, presentations at regional / national / international meetings)

Other

Ask the CLOD to answer the following theoretical question.
(Answer is binary, no maybes)
"If CLOD funding was stopped tomorrow, is your role so valued by your hospital that they would find the PAs to continue you in your role?"

YES / NO

Actions agreed

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

Confidential Discussion with R-CLOD

Appendix I: Implementation plan

- Stakeholder discussion of draft review in June 2017 at the National Organ Donation Committee.
- Sign off recommendations at Senior Management Team, July 2017.

Recommendation	Action	Timetable
'Employment'		
1a. Employment of CLODs should remain with their employing hospital Trust / Board and NHSBT will reimburse the employer for the agreed CLOD time, based on a proportionate PA allocation. NHSBT will not reimburse for local and national clinical excellence awards.	No change.	Immediate.
1b. There should be a new formalised agreement between NHSBT and hospitals regarding the CLOD role.	Letter to all medical directors and CLODs.	September 2017.
1c. 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.	All future interviews.	Immediate.
1d. All CLODs will be on a three-year contract 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.	Starting with CLODs appointed the longest, all CLODs in post > 6 years (unless this has already occurred) will have their post re-advertised and re-interviewing will commence.	50% complete December 2017. 100% complete April 2018.
1e. The decision regarding individual CLOD PA allocation should be decided at a regional level by the Regional Manager and R-CLOD.	No change.	Immediate.
1f. Every Trust / Board should have at least one CLOD on a minimum of 0.5 PA. The expectation is that most CLODs will be on 1 PA.	Review of CLOD PA allocation within each region will run alongside the action and timetable of 1d.	As per 1d.
1g. CLOD chronic sickness guideline.	All future sickness.	Immediate.
1h. A master spreadsheet of all UK CLODs should be maintained. All CLOD Annexe A forms or changes to CLOD roles and numbers should go via this Master Spreadsheet before being forwarded to finance. A CLOD by CLOD check and review should be undertaken to ensure accuracy of information.	Agreement on administration of spreadsheet. CLOD by CLOD check and review.	October 2017.
Expectations		
2a. New CLODs must attend CLOD induction within 12 months.	No change.	Immediate.
2b. Every CLOD will have an annual 1:1 with	Commencement of	50% of

their respective R-CLOD using the new national template (Appendix H). This template includes a checklist of expected core operational requirements which is built into the new CLOD job description.	new annual CLOD 1:1 process.	complete December 2017. 75% complete April 2018. 100% complete July 2018.
2c. Every Regional 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.	Strengthened 1:1 for CLODs with regional and national roles.	100% complete by April 2018.
Expanded roles		
3a. There should be a national paediatric CLOD on 1 PA, who will report to the National CLOD.	No change.	Immediate.
3b. There should be two national education CLOD/s on 1 PA each.	No change.	Immediate.
3c. A national CLOD for research and innovation on 2 PA should be appointed when funds allow.	Business Case	April 2018.
3d. 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.	As decided by regional teams.	Ongoing.
Regional CLODs		
4a. Each of the 12 NHSBT regions (organ donation services teams) should have at least one PA of R-CLOD time.	No change.	Immediate.
4b. One PA of R-CLOD time should allow for the supervision of no more than 10-12 CLODs.	Regional review, led by respective regional manager and R-CLOD, of CLOD PA allocation to identify CLOD PAs that will allow this recommendation to be satisfied.	April 2018.