NHS
Buckinghamshire Healthcare
NHS Trust

Meeting: Trust Board Meeting in Public

Date: 30 October 2024

Agenda item	Ophthalmology managed service contract update
EMC Lead	Jon Berry – Director of Operations SCC
Author	Jon Berry – Director of Operations SCC Jim Forsyth – Procurement Lead
Purpose	Approval
Previously considered	F&BPC 29.10.2024

Executive summary

This paper asks for Board approval for an extension of existing contracts with Alcon for consumables and equipment in Ophthalmology. The extension has combined two separate contracts to deliver an upgrade of current equipment and consumables, a small cost saving and a benefit from insulation from any cost increases. The contract extension also allows time for a wider open procurement to be undertaken potentially with Acute Provider Collaborative (APC) partners.

The two-year contract value is £1,385,616 and The Board is asked to approve the contract extension. This paper was considered by the Finance & Business Performance Committee on 29 October 2024 and a verbal update of the discussion will be provided to Board.

Decision	The Board is asked to approve the contract extension.

Relevant strategic priority

Outstanding Care ☒	Healthy Communities ☐	Great Place to Work ☐	Net Zero ☐

Relevant objective

☐ Improve waiting times in ED ☒ Improve elective waiting times ☐ Improve safety through clinical accreditation	☐ Give children living in most deprived communities the best start in life ☐ Outpatient blood pressure checks	☐ Zero tolerance to bullying

Implications / Impact

Patient Safety	These items are crucial to the deliver of sight saving surgery and treatment.
Risk: link to Board Assurance Framework (BAF) and local or Corporate Risk Register	Principal Risk 1: Failure to provide care that consistently meets or exceeds performance and quality standards Provision of Elective services
Financial	2 Yr Contract value £1,385,616 (£692,808 per annum)
Compliance NHS Regulation Person-centred Care	Procurement compliant SFIs
Partnership: consultation / communication	Procurement Clinical & Operational teams
Equality	Easy access to this service will be maintained for all.

Quality Impact Assessment [QIA] completion required?	N/A - No change to service provision

1.1 The Trust currently has a managed service with a major Ophthalmology supplier for both the Mandeville Wing consumables and those for the Cataract service which has been delivered in the standalone cataract unit. It also purchases more general non-pay items through NHS Supply Chain from this supplier. These contracts are summarised in the table below:

Contract	Value	Items purchase
Cataract Unit activity	c.£485k	Cataract procedure packs
Mandeville Wing activity	c.£141k	Combined procedures and Vitreous retinal packs
Supply chain consumables (via NHSSC, no contract in place)	c.£75k	Laser probes, Forceps & Vitrectomy probes etc

1.2 A contract review has identified better value for money through combining two contracts and the general non-pay items for the next two years whilst we undertake a full tender and procurement process potentially with APC partners.

1.3 By bringing together the two managed contracts with commonly used consumables we have been able to update equipment and consumable packs, protect against proposed inflationary cost increases and deliver a small saving of £7.7k per annum. The gross saving when compared against continuing the contracts separately is £13.2k per annum.

1.4 The saving comes from combining commonly used items into the contract such as laser probes, specialist forceps & Vitrectomy probes enabling us to offset to total VAT cost and achieve cost per piece saving as opposed to buying them at the NHS Supply Chain rate.

1.5 If the contract over performs then we only get charged at cost price for the consumables meaning a financial benefit to the Trust if this can be covered by income.

1.6 These costs of these contracts/spend is currently in our budgets/run-rate and we are not expecting significant reductions in service demand or change in delivery models in the coming years.

2 Proposal, conclusions recommendations and next steps.

2.1 This paper asks for Board approval of a two-year contract extension with the current supplier which can be taken forward through approved frameworks at a total value of £1,385,616.

3 Action required from the Board/Committee

3.1 The Board is requested to:

a) Approve the recommended option to proceed with the contract renewal for 2 yrs.

Meeting: Trust Board Meeting in Public

Date: 30 October 2024

Agenda item	Buckinghamshire Special Educational Needs and Disabilities (SEND) and Inclusion Strategy 2025-2030
Board Lead	Karen Bonner – Chief Nurse and DIPC
Author	Mitchell Fernandez – Deputy Chief Nurse
Appendices	Appendix 1: Buckinghamshire SEND and Inclusion Strategy 2025-2030
Purpose	Information
Previously considered	Q&CGC 16.10.2024

Executive summary

Buckinghamshire's local area partnership has developed a 5-year Special Educational Needs and Disability (SEND) and Inclusion Strategy.

The strategy demonstrates the commitment of partners to improve services for children and young people with SEND in Buckinghamshire, working collaboratively to drive change. This strategy builds on Buckinghamshire 2021 – 2023 strategy and reflects the progress made since the publication of the Ofsted and the Care Quality Commission SEND Inspection outcome report in March 2022.

The SEND Strategy 2025 – 2030 has been developed with a wide range of stakeholders across the local area. The strategy has high aspirations and aims to narrow the achievement gap by providing the right support at the right time. It has a focus on early support, reflecting a needs-based approach to supporting children and young people with SEND. The shared ambition is for every child and young person with SEND to feel included and supported when they access education and be able to take part in meaningful opportunities within the community as they transition into adulthood.

Included in the strategy are the governance monitoring of associated action plans review to remain focused on the right things and continue to improve outcomes for children and young people with SEND in Buckinghamshire.

The impact of this strategy will be reported through the SEND Partnership Board which provides multi-agency governance of SEND in Buckinghamshire. This board role is to hold the partnership to account for the delivery of the outcomes, to ensure actions are leading to positive changes for children, young people and their families.

On 16 October 2024, the Quality & Clinical Governance Committee considered the strategy, noting the aspirational nature and the potential challenges related to delivery.

Decision	The Board is requested to note the Buckinghamshire SEND and Inclusion Strategy 2025-2030
Relevant strategic priority			
Outstanding Care ☒	Healthy Communities ☒	Great Place to Work ☐	Net Zero ☐
Relevant objective		
☐ Improve waiting times in ED ☐ Improve elective waiting times	☒ Give children living in most deprived communities the best start in life	☐ Zero tolerance to bullying

☐ Improve safety through clinical accreditation	☐ Outpatient blood pressure checks	

Implications / Impact	
Patient Safety	Impact on quality and safety standards and patient experience
Risk: link to Board Assurance Framework (BAF) and local or Corporate Risk Register	1. Failure to consistently provide outstanding quality care that is compassionate, cost effective & safe, 2. Inability to lead an organisation with the capacity and capability to deliver our best in everything we do, 3. We do not recover services adequately, fail to meet public / regulator expectations, and do not play a leading role in the health, economic and social recovery of Buckinghamshire.
Financial	Financial impact of clinical variation, avoidable harm and length of stay and complaints.
Compliance CQC Standards Person-centred Care	Person centred care, safety, safeguarding, complaints
Partnership: consultation / communication	Working with key stakeholders in quality, safety and experience. Local area partnerships
Equality	Potential for inequality due to known health inequalities across the county. Risk of discrimination of patients from diverse backgrounds and poorer socio-economic communities.
Quality Impact Assessment [QIA] completion required?	No

Special Educational Needs and Disabilities (SEND) and Inclusion Strategy 2025 – 2030

August 2024

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Foreword

This strategy has been made with the SEND young people of Buckinghamshire at its heart. Shout Out for SEND is a county-run youth project that aims to give SEND young people a voice. In this case, it's given me an opportunity to write this foreword. But as a group, we also had several meetings focussing on the strategy and many of the statements written in the work streams have come directly from us, in our own words.

Still, when I read this for the first time, I was emotional to see such a strong youth voice present. We live in a world that isn't built for those with SEND and many of us work through daily challenges that we feel totally alone in facing. This leads to a lot of us feeling like we do not matter and aren't respected. But the statements are centred around individuals for a reason, because the work you do, impacts us directly. Behind every statement is a SEND young person's lived experience and it matters. This strategy listens to us, includes us and in turn, respects us as well. It sends a message that Buckinghamshire values its SEND young people in a way I haven't seen or felt before. So, I urge you to continue that narrative in your work and prove to the SEND young people of Buckinghamshire that we matter. That we have a place in our community. And that when we are given a chance to have a voice, it creates positive change for everyone.

Pippa Hiles

Shout Out for SEND (Young People's Participation Group)

Buckinghamshire's local area partnership is pleased to present this Special Educational Needs and Disability (SEND) and Inclusion Strategy.

This strategy demonstrates the commitment of partners to improve services for children and young people with SEND in Buckinghamshire, working collaboratively to drive change. It is this shared commitment that has enabled the Local Area to make progress in improving services and outcomes for children and young people with SEND since the Local Area SEND Inspection in March 2022.

Our SEND Strategy 2025 – 2030 has been developed with a wide range of stakeholders across the local area and we strongly believe that our culture of co-production will enable us to deliver this strategy.

The strategy has high aspirations and aims to narrow the achievement gap by providing the right support at the right time. It has a focus on early support, reflecting a needs-based approach to supporting children and young people with SEND. Our shared ambition is for every child and young person with SEND to feel included and supported when they access education and be able to take part in meaningful opportunities within the community as they transition into adulthood.

We will review the strategy and associated action plans on an annual basis to ensure that we remain focused on the right things and continue to improve outcomes for children and young people with SEND in Buckinghamshire.

We would like to thank everyone who has contributed to the development of this strategy.

John Macilwraith, Director of Children Services (TBC)

Rachel Corser, Chief Nursing Officer, Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board (TBC)

Introduction

In Buckinghamshire we are ambitious to continue to improve the support we provide to children and young people with Special Educational Needs and Disabilities (SEND) and their families.

'**Local area partnership'** is a term used throughout this strategy. This partnership includes children and young people with SEND, their families/carers, and those in education, health and care (including the voluntary and community sector) who are responsible for the strategic planning, commissioning, management, delivery and evaluation of arrangements for children and young people with SEND who live in Buckinghamshire.

This strategy builds on our 2021 – 2023 strategy and reflects the progress Buckinghamshire has made since the publication of the Ofsted and the Care Quality Commission SEND Inspection outcome report in March 2022. It sets out our key priorities and the steps we are taking to achieve our goals. This strategy is delivered through the local area partnership's SEND Strategic Delivery Plan which incorporates the:

- Buckinghamshire Delivering better Value (DBV) programme

- Buckinghamshire Written Statement of Action (WSoA) (March 22)

- Early Identification and Intervention to Better Support Children and Young People's Therapy Needs | Family Information Service (buckinghamshire.gov.uk)

- All Age Autism Strategy

Buckinghamshire's financial position of the High Needs block is challenging; this is due to the increase in demand for SEN support against the smaller increase in funding. Although this is recognised as a national issue, there is a requirement for Councils to manage this. The strategy sets out the key priorities to meet the demand for SEND. These priorities contribute to reducing the High Needs deficit through better use of resources linked to the Education Provision and High Support Needs workstreams and sufficiency activities. The 5-year strategy will not, however,

address the growing High Needs deficit, although the strategy will contribute to managing the growth in the deficit and increase in demand being seen within the number and complexity of requests for support for SEND needs across the partnership, alongside the increased pressure on local provision and increased reliance on high cost independent placements. This strategy will support the development of Buckinghamshire's SEND Sufficiency Plan to provide local provision that meets the needs of children and young people, allowing our children and young people to remain part of their local community. The financial impact of this demand has been evidenced in the Local Government Association report **Towards an effective and financially sustainable approach to SEND in England** published in July 2024 which is calling for national reform of the SEND system.

Buckinghamshire is committed to maintaining an accurate and honest self-evaluation of our SEND system, so we know what is working well and what needs to improve. This strategy has been written in response to our self-evaluation.

We will continue to engage children and young people with SEND and their families, through our partnerships with young people's groups (including Shout Out for SEND (SOfS) and Article 12), Buckinghamshire's Parent/Carer Forum FACT Bucks, and broader stakeholder engagement. We commit to ensuring that voices are heard and to provide updates on changes made. We will use the feedback to help inform us of our strengths, and to shape the improvement actions we take.

The local area partnership has worked collaboratively to develop this strategy and commits to co-production in delivery of these ambitions in line with Buckinghamshire's Co-production Charter.

Aspirations

Buckinghamshire's local area partnership is committed to making changes that we believe will make a real difference to the lives of children, young people, and families in our SEND community.

Our aspirations are to:

- Embed an early intervention and needs led approach. We want children, young people and their families to be supported at the earliest possible stage, and for this support not to be dependent on a clinical diagnosis.

- Integrate and strengthen service delivery so that the whole system works in a coherent way.

- Strengthen communication, providing clear advice and guidance so that families access the right support at the right time.

- Develop a consistent approach to decision-making about the support provided for children and young people with high support needs. We will use a multi-disciplinary team approach, to make sure the right expertise informs the decisions.

- Develop our SEND Sufficiency Plan to provide local provision that meets the needs of children young people, allowing our children and young people to remain part of their local community.

- Strengthen our approach to Preparation for Adulthood, ensuring there are clear pathways for children and young people to access meaningful opportunities at post-16 and post-19.

Local Area Shared Principles

The following 7 principles underpin the delivery of this strategy.

> We will:
>
> 1. Continue to seek feedback from children, young people and their families so that we understand their **lived experience** and take steps to continually improve it.
>
> 2. Further develop **co-production** at all levels (individually, operationally and strategically) in line with the Co-production Charter
>
> 3. Support and develop the **workforce** so they can deliver excellence in SEND. This will include developing interpersonal skills and a learning culture across the local area.
>
> 4. Champion **early intervention,** engaging families at the earliest opportunity when needs are identified, providing the right support at the right time.
>
> 5. Adopt a solution focused approach that values **creativity and flexibility** in meeting the needs of children and young people.
>
> 6. Ensure **efficient use of resources** through sharpening our focus on the impact and outcomes for children and young people.
>
> 7. Embed a culture of **trust, openness and transparency** which encourages mutual support and constructive challenge.

The Buckinghamshire Context

SEN Support

The number of children and young people receiving SEN support in Buckinghamshire is below the national average. The gap between Buckinghamshire, the South-East and England has narrowed slightly since 2017 but figures are still significantly lower.

Across the academic year 2023/24, 11.4% of Buckinghamshire school age children were identified to require SEN support, compared to the national average of 13.6%. This suggests that needs are not being identified as early as they could be.

% of CYP with SEN Support in Buckinghamshire schools

● Buckinghamshire ● South East ● England
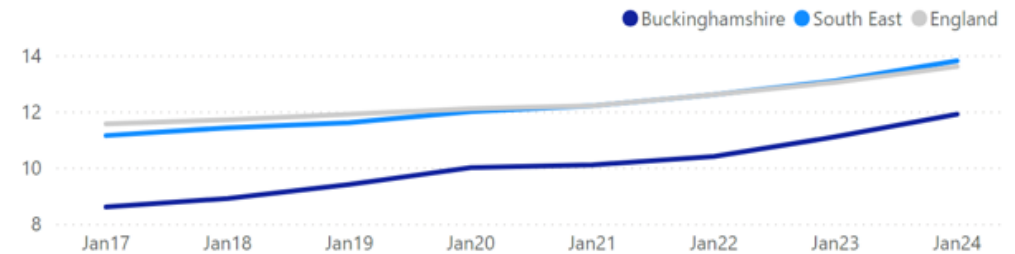
KPI	Jan17	Jan18	Jan19	Jan20	Jan21	Jan22	Jan23	Jan24
% of CYP with SEN Support in Buckinghamshire schools	8.6	8.9	9.4	10.0	10.1	10.4	11.1	11.9

Latest published benchmarks - % SEN Support

Buckinghamshire	South East	England
11.90	13.80	13.60

Education, Health and Care Plans (EHCPs)

In June 2024, 7008 EHCPs were maintained in Buckinghamshire. This is an increase of 14% on the previous year and equates to 4.8% of children and young people. This is in line with the England and South-East averages.
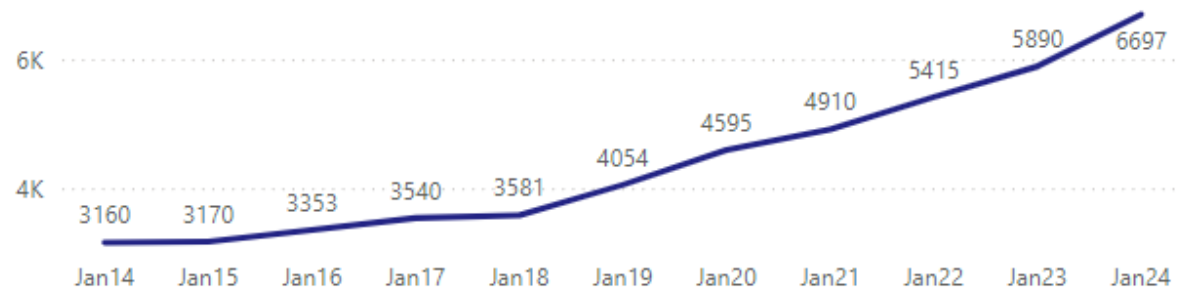
The number of EHCPs maintained in Buckinghamshire has increased by 112% compared to 10 years ago. Nationally, the number of EHCPs maintained has increased by 143% in the same period, and across the South-East has increased by 157%.

Number of EHCPs maintained

Jan14	3160
Jan15	3170
Jan16	3353
Jan17	3540
Jan18	3581
Jan19	4054
Jan20	4595
Jan21	4910
Jan22	5415
Jan23	5890
Jan24	6697

trend data includes statements as well as EHCPs

The figures here demonstrate continued growth and demand across the system and indicate that numbers in Buckinghamshire are in line with national data trends.

This increase in demand is being seen within the number and complexity of requests for support for SEND needs across the partnership, alongside the increased pressure on local provision and increased reliance on high-cost independent placements. The cost of meeting these demands has caused and continues to cause vast financial pressures on the Buckinghamshire Local Area with action needing to be taken to work towards an effective and financially sustainable approach.

The financial impact of this demand has been evidenced in the Local Government Association report **Towards an effective and financially sustainable approach to SEND in England** published in July 2024 which is calling for national reform of the SEND system.
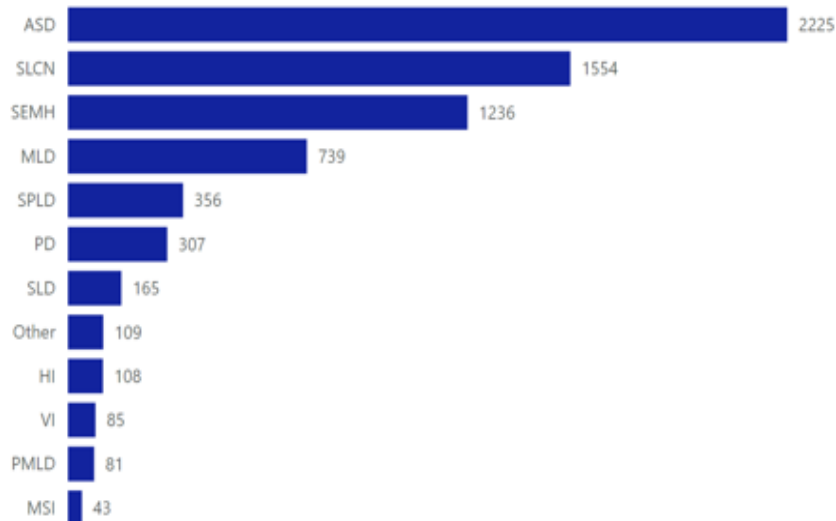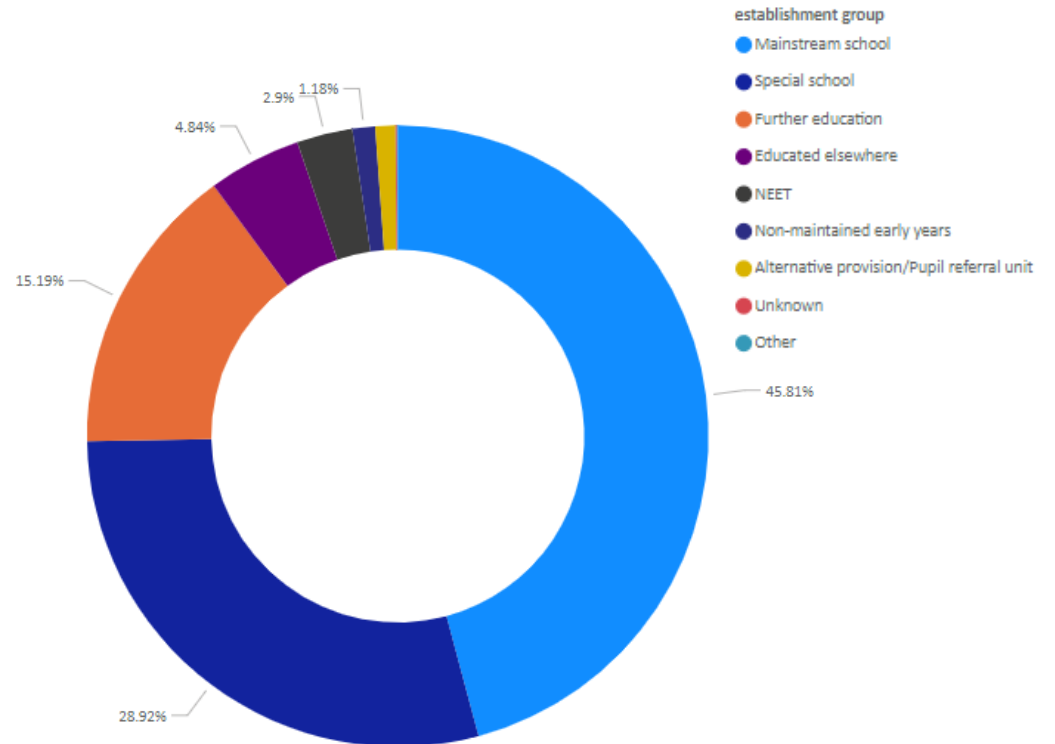
Placements

In 2024, 1937 (29%) of Buckinghamshire CYP with EHCPs were placed in special schools. Nationally 32% were placed in special schools, and in the South-East 34%. 10 years ago, 43% of CYP with ECHPs in Buckinghamshire were placed in special schools, compared to 44% nationally and 48% in the Sout-East.

Between 2014 and 2024 the number of Buckinghamshire CYP with EHCPs placed in independent special schools has increased from 95 to 175 – an increase of 44%. Nationally, independent special school placements increased by 66%, and in the South-East these placements increased by 71%.

PERCENTAGE OF PLACEMENTS   BY ESTABLISHMENT GROUP

establishment group
- Mainstream school
- Special school
- Further education
- Educated elsewhere
- NEET
- Non-maintained early years
- Alternative provision/Pupil referral unit
- Unknown
- Other

45.81%
28.92%
15.19%
4.84%
2.9%
1.18%

Current maintained EHCPs by primary need

Need	Count
ASD	2225
SLCN	1554
SEMH	1236
MLD	739
SPLD	356
PD	307
SLD	165
Other	109
HI	108
VI	85
PMLD	81
MSI	43

Areas of Need

Over 50% of pupils with an EHCP in Buckinghamshire have a primary need linked to Autism Spectrum Disorder (ASD) or Speech, Language and Communication Difficulties. 32% of pupils with an EHCP have a primary need of ASD which is line with the national average of 33%.

The local offer for children and young people with SEND (0-25 years) provides information for families about the support available in Buckinghamshire.

Governance

The SEND Partnership Board provides multi-agency governance of SEND in Buckinghamshire, driving change and improvement. The Board has ownership of this strategy and has a critical role in scrutinising and challenging the progress made against its priorities. It ensures there is a collaborative approach to understanding local need and the delivery of services for children and young people with SEND and their families.

The Board sits within a broader governance structure across Buckinghamshire Council and the Integrated Care Board, detailed below.

Governance Map for SEND in Buckinghamshire
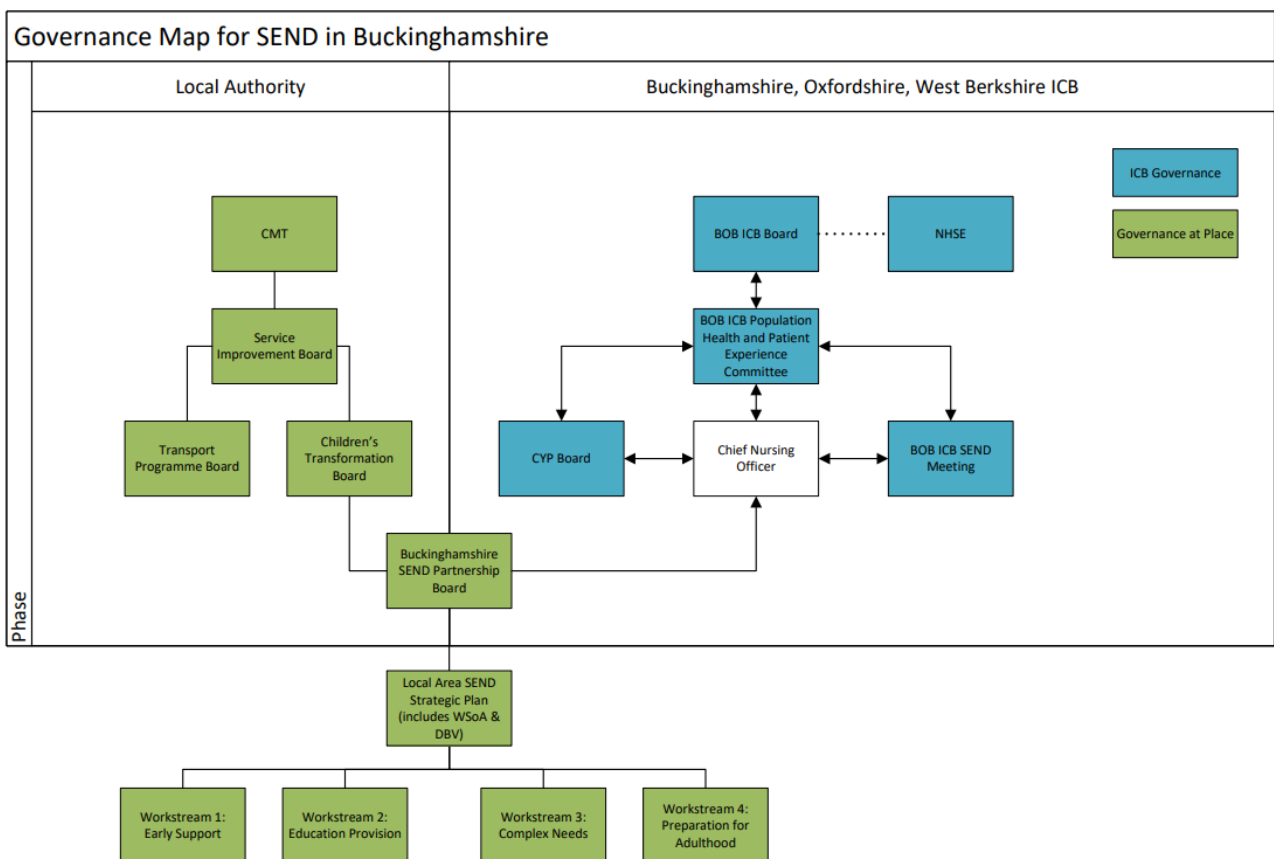
Impact and Outcomes

The impact of this strategy will be reported through the SEND Partnership Board which provides multi-agency governance of SEND in Buckinghamshire. This board role is to hold the partnership to account for the delivery of the outcomes, to ensure actions are leading to positive changes for children, young people and their families.

The SEND Partnership Board will monitor the impact of this strategy using the following tools:

- The Children and Young People's **Impact and Outcomes Framework**. This is aligned to our priorities and aims to triangulate quantitative and qualitative information so we can understand the difference any changes have made to the lived experience of children and young people with SEND, and their families.

- The **Local Area Outcomes Dashboard**. This will measure key performance indicators that tell us how well services are performing to meet children and young people's needs.

Children and young people with SEND have helped us to identify what good would look like. Their feedback is integral to measuring progress, and we have used their direct quotes to shape the success measures for each priority.

Strategic Priorities

Buckinghamshire's Strategic Plan* provides the detail for how the Local Area will deliver our 4 strategic priorities which are:

*(Hyperlink to be provided to Strategic Plan once published on the local offer)

1. Early Support

2. Education Provision and Decision-making

3. High Support Needs

4. Preparing for Adulthood

Progress against this plan is report bi-monthly at the SEND Partnership Board.

Priority 1: Early Support

Children with SEND and their families will have their needs met at the earliest opportunity and be able to easily access a wide range of effective support to help them thrive.

Children and young people have shared the following aspirations:

- "I feel in control of how I receive support"

- "I know about what support from health services I am entitled to, including mental health support through CAMHS, and won't wait a long time to access this"

- "I access specialised support if I received trauma at an early age"

- "I can access my GP with no barriers for me to receive the support I need"

- "I won't experience trauma that can be prevented, which impacts on the rest of my life"

- "I will be safeguarded by the people that support me, which will reduce further disabilities or trauma"

- "My mental health needs are supported on an ongoing basis, not only at crisis point"

- "I access age-appropriate activities with the right support"

- "I am allowed to engage in activities that don't match my peers"

We will:

- work across the whole system to make sure children and young people's needs are understood as early as possible so that all partners can provide the right support at the right time.

- deliver the graduated approach. Early years settings and mainstream settings will be able to clearly demonstrate how Ordinary Available Provision (OAP) is implemented and monitored.

- communicate with professionals and families more effectively by developing a consistent approach. This will mean that parents, carers and professionals will know about the support and training available and be able to signpost appropriately.

We will know we have been successful when families tell us:

- Their child's needs were identified at the right time.

- It is easy to access the services they require for information and support.

- They are aware of the Local Offer which is comprehensive, accessible and includes information about employment and other meaningful activities.

- Waiting times, and/or clinical diagnosis are not a barrier to accessing the information and support they require.

- Training and information is making a positive difference to their lived experience.

- The EHCP is reflective of their child's needs and provision has been appropriately identified.

- They feel supported and are able to access early help.

We will know we have been successful when data tells us:

- Sustained numbers of professionals, families and CYP accessing the revised training offer and universal support services
- Increase in the percentage of CYP with SEND on the SEN Support Register with consideration surrounding type of setting

Priority 2: Education Provision and Decision Making

There will be sufficient high quality education provision to meet the continuum of SEND educational needs including post 16 mainstream, ARPs and units, specialist and alternative provision.

Children and young people have shared the following aspirations:

- "I have teachers who read my EHCP, understand my needs and have the time to support me"

- "I can access timely and consistent mental health support, which includes 1:1 drop-in support when at school"

- "I can access extracurricular activities and school trips"

- "I feel safe in school"

- "I feel my peers understand my needs and include me in school life"

- "I am supported effectively by school when moving to a new class, educational setting, or employment"

- "If I can't attend school, I receive the same standard of education and support at home"

- "I have opportunities to have a say in how my school supports me and my peers with SEND"

- "I want to learn beyond the school curriculum and shouldn't be measured solely on this"

We will:

- Ensure that all children and young people with SEND can access high quality education provision as close to home as possible that meets their needs and helps them achieve positive outcomes.

- Support settings and partners to have confidence in the graduated approach.

- Develop strategic plans for alternative provision to ensure partners have the right type, quantity and range of alternative provision to meet children and young people's needs.

- Develop a culture of inclusivity across educational settings and wider community providers in Buckinghamshire.

We will know we have been successful when families tell us:

- Their child has access to the right learning environment, at the right times, helping them to thrive and achieve their aspirations.

- The network of professionals, and the wider community around them really understand their needs and can offer the right support when required.

- The EHCP represents a holistic view of their child's needs and provision has been appropriately identified.

- Their voice is seen as important and heard by the local area.

- Training they have accessed has made a tangible difference to their lived experience.

We will know we have been successful when data tells us:

- There are sufficient educational placements to meet growing demand at all levels.

- That SEND children and young people are achieving their identified outcomes

- Quality assurance processes highlight and influence good quality annual reviews, and EHC Plans

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- Increase in the percentage of SEND CYP accessing provision in Buckinghamshire

Priority 3: High Support Needs

Agencies will work together to ensure that children and young people with high support needs or wider vulnerabilities receive timely, appropriate and integrated support.

Representatives of children and young people with high support needs have shared the following aspirations on their behalf:

- I am able to socialise in appropriate groups/activities outside of school with confidence, which I am currently unable to do.

- I can access a strong support network to assure my well-being both now and in the future.

- I am supported outside of the family home in an appropriate setting that will cater for my needs but also nurture and enable me to grow.

- I can lead a happy and fulfilling life despite my difficulties, with the right support.

- I am part of a society that treats me with the respect I deserve.

- I am seen for who I am, and not my complex needs.

- "I am valued as an individual who will have varying needs across a wide range of services"

- "I can live in in-patient care which is closer to my friends, family and community who can also act as support for me"

- "I am seen as someone with high support needs, not complex needs"

- "The people who support me (family/carers, friends and professionals) will be supported to help me in achieving my potential"

- "My achievements are not graded on a checklist but against my personal goals"

We will:

- Develop systems to enable services to work together to ensure we are effectively supporting children and young people with high support needs.

- Improve access to short breaks, respite and wider care provision.

- Review and simplify processes and systems so it is easier to access the right support at the right time.

- Contribute to education sufficiency planning for those with high levels of need.

- Contribute to key strategic priorities linked to Preparation for Adulthood for those with high levels of need.

We will know we have been successful when families tell us:

- Their child has access to the right learning environment, at the right times, helping them to thrive and achieve their aspirations.

- The network of professionals, and the wider community around them really understand their needs and can offer the right support when required.

- It is easy to access wider support for the family for education, health and/or social care needs.

- They feel valued and heard by the network around their child.

- Training they have accessed has made a tangible difference to their lived experience.

- The EHCP represents a holistic view of their child's needs and informs future planning.

We will know we have been successful when data tells us:

- Quality Assurance measures highlight good quality health and social care contributions to new EHCPs and annual reviews
- Increase in the percentage of children and young people with high support needs accessing provision in Buckinghamshire
- A reduction in the percentage of children and young people with SEND who are NEET (Not in Employment Education or Training) or unplaced in Buckinghamshire

Priority 4: Preparation for Adulthood

Young people will be able to access a range of suitable post 16 progression routes and support for independence where necessary. Transitions to adult services will be smooth and effective.

Children and young people have shared the following aspirations:

- "I understand my own citizenship, including budgeting, paying taxes and my rights"

- "I meet new people, build positive relationships, and explore new opportunities"

- "I can access the relevant training and qualifications I need in my chosen career path"

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- "I am given support and resources to find the career path that is right for me"

- "I have full autonomy over my decisions about my future"

- "I have the skills to ask for help when I need it"

- "I am given opportunities to socialise outside of education settings"

- "I achieve independence through affordable housing that meets or is adapted to meet my needs"

- "I can buy the things I need to live my life (by making OT equipment, etc. affordable)"

- "I have the choice to live in supported living, close to where I work"

- "I have a variety of choices for my supported internship, not just in hospitality or business admin"

- "I feel supported by my employer who will understand what I need to succeed in a role"

- "I am aware of what employers and jobs are the right match for me"

- "I am given the proper care in the present moment, to allow me to prepare for adulthood"

We will:

- Support settings in Buckinghamshire to use the Preparation for Adulthood framework to develop the knowledge, skills and independence of children and young people with SEND.

- Develop pathways and processes to facilitate children's services and adult services working together, promoting positive transitions for young people.

- Ensure children and young people are supported to advocate for themselves, make choices and benefit from being part of inclusive communities.

- Develop the post 16 offer, including further education, work with training, volunteering and/or meaningful opportunities and improve the support provided for transitions.

- Develop the work with post-16 providers so they can prepare young people for increased independence ahead of post-19 transitions.

We will know we have been successful when families tell us:

- They have been able to easily access the most appropriate provision for the child/young person throughout their journey.

- They are supported and heard by a knowledgeable network of professionals around them to manage transition periods throughout their journey.

- Information and support was easily accessible for key transition points throughout their journey.

- Their feel connected to their community.

- They have been supported to live their most independent lives.

We will know we have been successful when data tells us:

- Young people are experiencing positive transitions (health, education and care) and accessing meaningful opportunities.

- Increase in the percentage of children and young people with SEND post 16 accessing provision in Buckinghamshire

- Increase in the percentage of children and young people with SEND entering higher education, employment or meaningful activities within their local communities

- A reduction in the gap between children and young people with SEND and non not in Employment Education or Training (NEET) CYP in Buckinghamshire

- Quality assurance processes highlight and influence good quality annual reviews and EHC Plans with a clear focus planning across the four pillars of preparation for adulthood

Conclusion

In summary, this strategy aims to keep driving improvements in the SEND system. It will ensure children and young people with SEND are well supported and able to achieve their aspirations. We are committed to working collaboratively with families and professionals on the identified priorities.

Associated Strategies and Programmes:

- Children's Services Transformation and Improvement

Draft Buckinghamshire's SEND and Inclusion Strategy 2025-2030

- Early Identification and Intervention to Better Support Children and Young People's Therapy Needs | Family Information Service (buckinghamshire.gov.uk)

- All Age Autism Strategy

- Buckinghamshire's Education Strategy

- BOB ICB Joint Forward Plan

Glossary

- **SEND**

Special Education Needs and Disabilities

- **Local area partnership**

This refers to those in education, health and social care who are responsible for the strategic planning, commissioning, management, delivery and evaluation of arrangements for children and young people with SEND who live in a local area.

- **FACT Bucks**

FACT Bucks is the Parent Carers Forum for Buckinghamshire (Bucks PCF). It is an independent, pan-disability, parent-led charity.

- **Shout out for SEND (SOFS)**

Shout out for SEND (SOFS) is a group for young people with a Special Educational Need or Disability to represent the wider 'youth voice' in Buckinghamshire.

- **Preparation for Adulthood**

Preparing for Adulthood (often shortened to PfA) is about planning and taking steps so that young people with SEND can enjoy independent living as much as possible, achieve as much as possible, reach their goals, dreams and ambitions in adult life.

Abbreviations:

- ASD - Autism Spectrum Disorder

- SLCN - Speech and Language Communication Needs

- SEMH - Social Emotional Mental Health

- MLD - Moderate Learning Difficulties

- SPLD - Specific Learning Disability

- PD - Physical Disability

- SLD - Severe Learning Disability

- HI - Hearing Impairment/Hearing Support

Draft Buckinghamshire's SEND and Inclusion Strategy 2025-2030

- VI - Vision Impairment

- PMLD - Profound Multiple Learning Disabilities

- MSI - Multi-Sensory Impairment

- CP - Child Protection

- CWD - Children with Disabilities

- CLA - Child Looked After

- CIN - Child in Need

More common SEND terms can be found here

Agenda item	Q2 Strategic Programmes Update
Board Lead	Duncan Dewhurst, CDTO
Author	Debbie Hawkins, Head of QI & Transformation
Appendices	
Purpose	Information
Previously considered	Transformation Board 22/10/24 F&BPC 29/10/2024

Executive summary

This report is the quarterly update on the Trust's Strategic Programmes. The purpose is to provide visibility on the status of each programme, for shared understanding.

Each strategic programme has an Executive Lead and SRO and is governed via a programme board. All programmes report into Transformation Board with quarterly or monthly updates as appropriate.

The six strategic programmes

- Healthy Communities
- Improving Together
- Digital Health
- Workforce Transformation
- Acute Provider Collaborative (APC)
- Buckinghamshire Executive Partnership (BEP) Priorities.

Note that separate reports are presented to Trust Board on Digital Health, BEP and APC, which provide the primary updates on these programmes. The quarterly report on our breakthrough objectives is also presented to Trust Board which includes information relevant to the strategic programmes (Q2 update to be presented in November), specifically Healthy Communities and Bullying & Harassment. Breakthrough Objectives are also reported monthly through the Integrated Performance Report.

As part of the development of the Place Strategy and BHT's strategic planning, the strategic programmes are being refreshed for 2025/26 onwards, with scoping currently underway.

Decision	The Committee is requested to • NOTE the update.

Relevant strategic priority

Outstanding Care ☒	Healthy Communities ☒	Great Place to Work ☒	Net Zero ☒

Relevant objective

☒ Improve waiting times in ED ☒ Improve elective waiting times ☒ Improve safety through clinical accreditation	☒ Give children living in most deprived communities the best start in life ☒ Outpatient blood pressure checks	☒ Zero tolerance to bullying

Implications / Impact	
Patient Safety	Any impacts on patient safety of specific change initiatives are identified and addressed as part of the QIA process.
Risk: link to Board Assurance Framework (BAF) and local or Corporate Risk Register	Principal Risk 1: Failure to provide care that consistently meets or exceeds performance and quality standards
Financial	The strategic programmes support the achievement of financial sustainability.
Compliance Select an item. Select CQC standard from list.	This report provides assurance on the delivery of the Trust's strategic programmes.
Partnership: consultation / communication	Teams across the Trust are involved in the delivery of the strategic programmes. The assessment of achievement has had input from the relevant leads.
Equality	Any equality impacts of specific initiatives are identified and addressed as part of the EQIA process.
Quality Impact Assessment [QIA] completion required?	QIAs are completed for specific initiatives as required.

1. Introduction

For 2024/25, the Trust agreed the strategic programmes key to the delivery of our strategic goals, as set out below.

- Healthy Communities

- Digital Health

- Improving Together

- Workforce Transformation

In addition, there are strategic programmes at system and place level which contribute to the delivery of our shared strategic goals

- Acute Provider Collaborative

- Buckinghamshire Executive Partnership (BEP) Priorities.

While not in scope of this report, there are also a number of Operational Improvement Programmes which are key to the delivery of our core performance metrics, including UEC, Planned Care, Diagnostics and Cancer programmes. Key measures for these are reported monthly via the IPR, with detail on drivers, actions and mitigation where off track.

This report provides a summary of the status of each strategic programme, for shared understanding.

Management of delivery and risks is via the programme board for each strategic programme, and each programme has an SRO and Executive Lead. Programmes report into Transformation Board for overall assurance. Note Transformation Board membership includes all members of the Executive Management Committee and Care Group Leadership.

2. Strategic Programme Updates

2.1. Healthy Communities

The Healthy Communities programme includes two breakthrough objectives, as below. Progress on these is reported separately in the Quarterly Breakthrough Objectives Update (Q2 to be presented to Trust Board in November

- Blood pressures check for adult outpatient appointments
- Children's 12-month review.

Other key achievements in the Healthy Communities Programme include:

Health on the High Street - 600 people have had a mini health check and a further 367 people have had their blood pressure checked in the last 6 months, with a public engagement score of 4.89 out of 5. New services which have started in the unit in the last quarter include the Community Head Injury Team, and Parents of Queer Youth group. Events have also been run to support organ donation week and to promote Stoptober. The contract for the unit has been extended for 12 months to August 2025 and a location has been identified to open a unit in Wycombe, later in the financial year.

Getting fit for surgery service launched in August and is supporting patients from two of the most deprived PCNs in Buckinghamshire to support them to make lifestyle changes to reduce their risks for surgery. The service uses a population health dashboard to identify patients who have risk factors, and health coaches support them to set goals and make changes. Patient feedback has been positive to date.

Tobacco dependency: We have secured Public Health funding to employ another tobacco dependency advisor to be based in the Emergency Department at Stoke Mandeville hospital, aiming to increase referrals to smoking cessation services and increase quit rate. In addition, 66.34% of eligible staff have completed 'Very Brief Advice for Smoking Cessation' training.

We also continue the rollout of MECC (Making Every Contact Count) through increasing uptake of training; and projects have been initiated to support reducing discrepancies in access (higher DNA, wait times and/or cancellation) for those from deprived areas or specific ethnicities as identified by the health inequalities dashboard.

Key risk: The development of the alcohol care team business case has identified that with the current data available it is unlikely to be financially viable for the trust. Work is underway to try and identify funding to support this business case, as the evidence base shows there will be a wider impact across a variety of partners.

2.2. Digital Health

The scope of the Digital Health is as below. This programme reports separately to Trust Board on a monthly basis which is the primary update, not replicated in this report.

- Acute (Clinical Narrative)
- Maternity BadgerNet implementation
- ePMA
- Community
- Enabling Systems
- Community
- Business Intelligence.

2.3.   Improving Together

Improving Together is about the culture of continuous improvement we want to create and the way in which we want to improve, underpinned by the right organisational capabilities.

Improving Together has three workstreams

- How we set strategy in the context of system and place – Align
- Embedding improvement in management systems – Improve
- Putting in place the right leadership behaviours – Empower.

Align: In collaboration with place partners, the Place Strategy has been in development over a number of months, with the vision, priorities and outcomes measures now defined. We are exploring this aligning to the Buckinghamshire Health & Wellbeing Strategy, and as such is expected to be formally agreed by July-25. In support of the Place Strategy, BHT is currently developing our 2030 strategic goals, outcomes measures and strategic programmes, along with the 2025/26 breakthrough objectives. Board 'Go and See' visits also started earlier in the year, with a plan in place to help embed and sustain this.

Empower: The focus for this year is on development of the right leadership behaviours starting with the Senior Leadership Forum (SLF), comprising executive directors and colleagues who report directly to them. Regular SLF development sessions have been running since February with key meetings supported by an external facilitator.

Improve: The Executive Team visited Berkshire Health to learn about their QMIS system (Quality Management & Improvement System), with key learning to inform the further development of our improvement system. Work is underway in consolidating our Improvement Approach within an Improvement Handbook.

2.4.   Workforce Transformation

This programme consists of the following workstreams

- 2024/25 Workforce Plan (incl. temporary and substantive workforce)
- Medical workforce
- Nursing workforce
- AHP workforce
- Admin & Clerical
- Long Term Workforce Plan
- Bullying & Harassment (breakthrough objective).

Alongside a priority focus on addressing Bullying & Harassment (progress reported separately in Q2 Breakthrough Objectives report, to be presented to Trust Board in November), the priority focus to date across most workstreams has been on the range of interventions to support sustainable delivery of our overall financial plan for 2024/25, including temporary and substantive staffing.

This workstream is reported weekly to the Executive Management Team, with bi-monthly updates to Strategic People Committee and also F&BPC via the Finance Report.

In terms of wider workforce transformation:

AHP workforce: A programme is underway for the AHP workforce, with a focus on skill mix to ensure the right people, with the right skills, are delivering AHP care in the right place at the right time. Director of AHP is also part of the long-term workforce planning group.

Medical workforce: a key focus has been on rostering to enhance productivity, with a new system being procured, alongside a rota review.

A&C workforce: A Smart Working programme is being scoped, to include Care Group Admin & Clerical workforce. For Corporate Admin & Clerical, this is being taken forward as part of the Acute Provider Collaborative Corporate Services workstream – initial system-wide workshop held in Q2 to scope and prioritise next steps.

Longer Term Workforce Plan: Longer term workforce planning is underway, for 2025–30 with some external support commissioned to develop the plan, with the first draft due in Q3. This is using the NHS Long term workforce plan as a reference, noting the new government is anticipated to issue an updated plan circa March 25. Alongside correlating with workforce transformation programmes, meetings with key areas across Care Groups taking place in October.

2.5.   Place – Buckinghamshire Executive Partnership (BEP) Priorities

The key priorities for BEP are as below. There is a separate update to Trust Board on Place and System Working, not replicated here.

- Transforming SEND
- Joining up Care
- Tackling Health inequalities

2.6.   System working – Acute Provider Collaborative (APC) Priorities

The key priorities for the Acute Provider Collaborative are as below. There is a separate update to Trust Board on Place and System Working, not replicated here.

- Elective Care
- Clinical services
- Corporate Services

Meeting: Trust Board Meeting in Public

Date: 30 October 2024

Agenda item	Detailed Report – Actual and Deceased Organ Donation 1 April 2023 – 31 March 2024
EMC Lead	Mr Andrew McLaren
Author	Rosanna Sharples / Dr Matthew Sames
Appendices	Appendix 1 – Detailed Report – Actual and Deceased Organ Donation 1 April 2023–31 March 2024, including Explanation of abbreviations and specific terms used
Purpose	Discussion
Previously considered	BHT Organ and Tissue Donation Committee EMC 08.10.2024 Q&CGC 16.10.2024

Executive summary

1. In 2023/24, from 6 consented donors the Trust facilitated 5 actual solid organ donors resulting in 11 patients receiving a life-saving or life-changing transplant. In addition to the 5 proceeding donors there was one consented donor that did not proceed.
2. All of the patients who fulfilled the criteria to be referred from ICU or ED were referred to be assessed by the on call Specialist Nurse – Organ Donation (SNOD) or to the embedded SNOD within the Trust. Once again we had no missed referrals, one of the criteria measured within this Audit.
3. All of the conversations where families were formally approached for organ donation had a SNOD present, which supports Best Practice Guidelines.
4. We saw an increase in patients who had opted out of organ and tissue donation, either on the Organ Donor Register or verbally to their families. This reflects that more people are discussing this subject with their families which was the message promoted during last year's Organ Donation Week.

Decision	The Board is requested to continue supporting the ongoing role of Organ and Tissue Donation, and the embedded SNOD within Buckinghamshire Healthcare NHS Trust.

Relevant strategic priority

Outstanding Care ☒	Healthy Communities ☐	Great Place to Work ☐	Net Zero ☐

Relevant objective

☐ Improve waiting times ☒ Improve safety ☒ Improve productivity	☐ Improve access and effectiveness of Trust services for communities experiencing the poorest outcomes	☐ Improve the experience of our new starters ☐ Upskill operational and clinical managers

Implications / Impact

Patient Safety	Patient safety is embedded in the referral criteria.
Risk: link to Board Assurance Framework (BAF) or relevant Risk Register	There are no risks.

Financial	The Trust receives payment from NHS Blood and Transplant for each proceeding solid organ donor.
Compliance	Organ and Tissue donation referral criteria is in line with the Academy of Medical Royal Colleges recommendations.
Partnership: consultation / communication	There is a close partnership working between NHS Blood and Transplant, South Central Organ Donation Services and the BHT Organ and Tissue Donation Committee.
Equality	Organ and Tissue donation suitability is measure by specific clinical criteria and no individual is disadvantaged because of their protected characteristics.
Quality Impact Assessment [QIA] completion required?	Not required for this paper.

Organ donation – what is the situation nationally?

In the UK there are over 7000 people currently waiting for a life-saving organ transplant. Typically 400 people will die each year whilst waiting.

Around 10,000 people die each week in the UK, resulting in up to 10,000 sets of organs being cremated or buried.

Many people believe that as we now have to 'opt out' from the Organ Donor Register (ODR) their organs would be used, this is not the case. If an individual has NOT signed up on the Organ Donor Register statistics show that only 56% of their organs are used due to lack of family consent. This increases to 86% if they have registered their organ donor decision by signing up on the ODR.

Registering a decision about organ donation takes less than two minutes to do and each donor can save the lives of up to 9 people.

1   Introduction/Position

1.1   During 2023-24 we had five proceeding deceased solid organ donors leading to eleven patients receiving a life-saving transplant.

1.2   Comparing this data in our region one comparable Trust had one deceased solid organ donor (one DBD donor), one Trust had six deceased solid organ donors (four DBD donors and two DCD donors) and another level three Trust, SEE APPENDIX 1, had one deceased solid organ donor (one DCD donor).

1.3   We work hard to promote tissue donation across the Trust, to explore end of life wishes with patients and families. We are fortunate in this Trust that we are able to retrieve multiple tissues on site due to geography/location of the Tissue Banks.

2   Problem

2.1   Throughout the year, we had two family declines/unsupported Deemed Consents.

2.2   We had no missed opportunities to perform neurological death testing where indicated as per the Academy of Medical Royal Colleges recommendations.

3   Possibilities

3.1   Each patient referred as a potential organ and tissue donor requires a thorough assessment of their current and past medical history, as well as social/behavioural and travel history to identify any potential risk of transferrable disease or infection. This can mean that we have to at times decline a patient but would carry out a rigorous assessment and also occasionally screen a patient with the transplant teams to see if they would accept an organ from the potential donor for one of their patients on the transplant waiting list. This would not be due to a lack of resources, but safety reasons.

       We would try to carry this out before approaching the family for organ donation as the approach and conversations are very time-consuming at a very traumatic time in a family's journey. If the patient has made a decision on the Organ Donor Register either to opt in or opt out, we would raise this with the family and explain why organ and tissue donation could not occur.

4   Proposal, conclusions recommendations and next steps.

4.1   To continue to share the messages around Organ and Tissue Donation with members of the Trust and the general public. We recognise that it is important to share the information and explore misconceptions with members of all faith groups in the community.

4.2   To continue highlighting to ED/ICU clinical staff the importance of early referral of patients where treatment has been deemed futile or when the unit are planning to carry out Neurological Death Testing to confirm brainstem death.

4.3   To continue to highlight the importance of not mentioning organ donation to families early on in their ICU journey, particularly when referral criteria has not been achieved. It is seen that families need time to process the initial devastating news and mentioning too early can be understandably viewed in a negative way by families. NHS Blood and Transplant (NHSBT) Best Practice Guidance recommends that this approach and discussion should be a collaborative process with the SNOD and the ICU Consultant, that it is timely and planned, as this increases consent rate and also the quality of support and information that is given.

4.4   To continue to identify ways of improving and supporting staff through the Organ

Donation Process using a variety of methods including formal teaching, SIM study days and general promotion around organ and tissue donation.

5   Action required from the Board/Committee

5.1   The Committee / Board is requested to:

a)   Continue their ongoing support of the work of Organ Donation and Transplantation with NHS Blood and Transplant and the embedded SNOD within the Trust.

APPENDICES
Appendix 1: Detailed report, including explanation of abbreviations and specific terms used.

NHS

Detailed Report

Actual and Potential Deceased Organ Donation

1 April 2023 - 31 March 2024

Buckinghamshire Healthcare NHS Trust

Table of Contents

Further Information

- Appendix A.1 contains definitions of terms and abbreviations used throughout this report and summarises the main changes made to the PDA over time.
- The latest Organ Donation and Transplantation Activity Report is available at https://www.organdonation.nhs.uk/supporting-my-decision/statistics-about-organ-donation/transplant-activity-report/
- The latest PDA Annual Report and our Power BI reports with up to date Trust metrics are available at https://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit-report/.
- Please refer any queries or requests for further information to your local Specialist Nurse - Organ Donation (SNOD)

Source

NHS Blood and Transplant: UK Transplant Registry (UKTR), Potential Donor Audit (PDA) and Referral Record.
Issued May 2024 based on data meeting PDA criteria reported at 8 May 2024.

1. Donor Outcomes

A summary of the number of donors, patients transplanted, average number of organs donated per donor and organs donated.

Data in this section is obtained from the UK Transplant Registry

Between 1 April 2023 and 31 March 2024, Buckinghamshire Healthcare NHS Trust had 5 deceased solid organ donors, resulting in 11 patients receiving a transplant. Additional information is shown in Tables 1.1 and 1.2, along with comparison data for 2022/23. Figure 1.1 shows the number of donors and patients transplanted for the previous ten periods for comparison.

Table 1.1 Donors, patients transplanted and organs per donor,
1 April 2023 - 31 March 2024 (1 April 2022 - 31 March 2023 for comparison)

Donor type	Number of donors		Number of patients transplanted		Average number of organs donated per donor			
					Trust		UK	
DBD	2	(2)	5	(4)	3.0	(2.5)	3.6	(3.4)
DCD	3	(2)	6	(4)	2.3	(2.0)	2.9	(2.8)
DBD and DCD	5	(4)	11	(8)	2.6	(2.3)	3.2	(3.2)

In addition to the 5 proceeding donors there was one additional consented donor that did not proceed, where DCD organ donation was being facilitated.

Table 1.2 Organs transplanted by type,
1 April 2023 - 31 March 2024 (1 April 2022 - 31 March 2023 for comparison)

Donor type	Number of organs transplanted by type											
	Kidney		Pancreas		Liver		Heart		Lung		Small bowel	
DBD	2	(2)	0	(1)	2	(2)	0	(0)	2	(0)	0	(0)
DCD	6	(4)	0	(0)	0	(0)	0	(0)	0	(0)	0	(0)
DBD and DCD	8	(6)	0	(1)	2	(2)	0	(0)	2	(0)	0	(0)

Figure 1.1 Number of donors and patients transplanted, 1 April 2014 - 31 March 2024
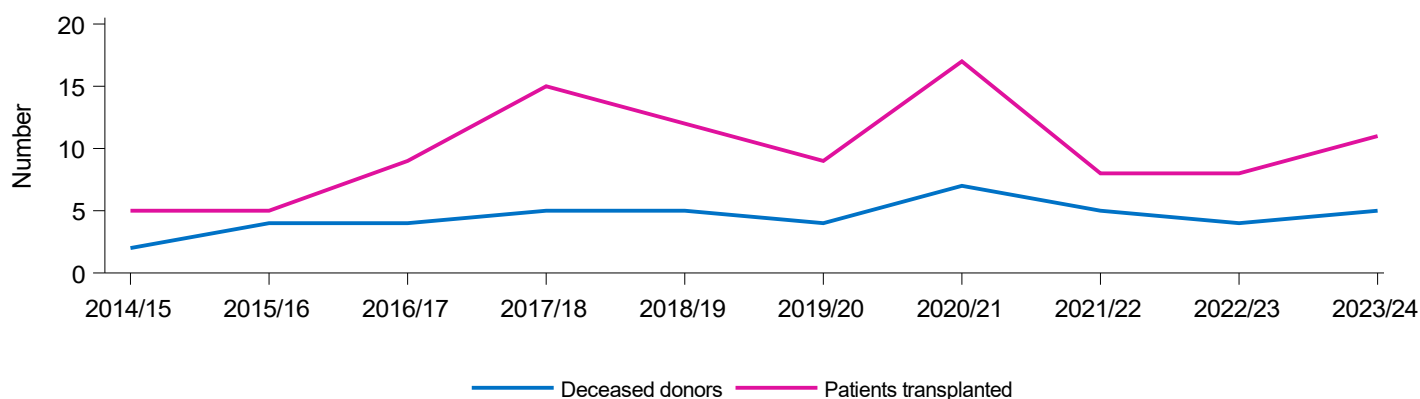
2. Key Numbers in Potential for Organ Donation

A summary of the key numbers on the potential for organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section presents key numbers in potential donation activity for Buckinghamshire Healthcare NHS Trust. This data is presented in Table 2.1 along with UK comparison data. Your Trust has been categorised as a level 3 Trust and therefore percentages in this section are only presented on a national level. A comparison between different level Trusts is available in the Additional Data and Figures section.

It is acknowledged that the PDA does not capture all activity. There may be some patients referred in 2023/24 who are not included in this section onwards because they were either over 80 years of age or did not die in a unit participating in the PDA.

**Table 2.1 Key numbers comparison with national rates,
1 April 2023 - 31 March 2024**

	DBD		DCD		Deceased donors	
	Trust	UK	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria¹	3	2029	17	5331	20	6911
Referred to Organ Donation Service	3	2017	17	4949	20	6522
Referral rate %		99%		93%		94%
Neurological death tested	3	1534				
Testing rate %		76%				
Eligible donors²	3	1426	12	3635	15	5061
Family approached	3	1259	5	1849	8	3108
Family approached and SNOD present	3	1215	5	1672	8	2887
% of approaches where SNOD present		97%		90%		93%
Consent ascertained	2	858	4	1023	6	1881
Consent rate %		68%		55%		61%
- Expressed opt in	0	533	4	637	4	1170
- Expressed opt in %		95%		85%		89%
- Deemed Consent	2	246	0	323	2	569
- Deemed Consent %		58%		47%		51%
- Other*	0	78	0	63	0	141
- Other %*		52%		34%		42%
Actual donors (PDA data)	2	788	3	710	5	1499
% of consented donors that became actual donors		92%		69%		80%

¹ DBD - A patient with suspected neurological death
  DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

² DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
  DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

* Includes patients where nation specific deemed criteria are not met and the patient has not expressed a donation decision in accordance with relevant legislation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

3. Best quality of care in organ donation

Key stages in best quality of care in organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section provides information on the quality of care in your Trust at the key stages of organ donation. The ambition is that your Trust misses no opportunity to make a transplant happen and that opportunities are maximised at every stage.

3.1 Neurological death testing

Goal: neurological death tests are performed wherever possible.

Figure 3.1 Number of patients with suspected neurological death, 1 April 2019 - 31 March 2024

■ Patients not tested   ■ Patients tested
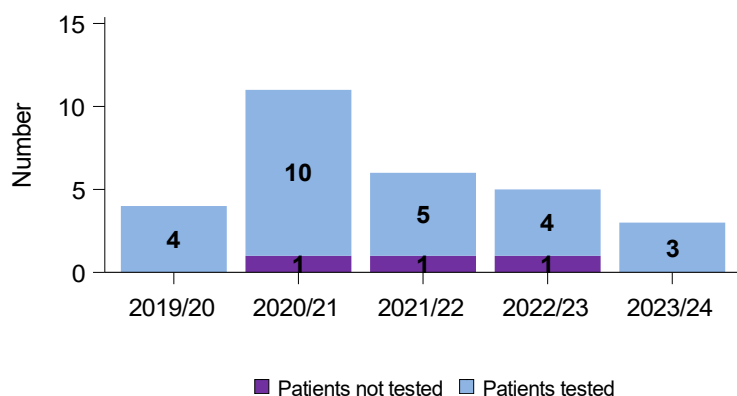
Table 3.1 Reasons given for neurological death tests not being performed, 1 April 2023 - 31 March 2024

	Trust	UK
Biochemical/endocrine abnormality	-	32
Clinical reason/Clinician's decision	-	72
Continuing effects of sedatives	-	15
Family declined donation	-	40
Family pressure not to test	-	55
Hypothermia	-	1
Inability to test all reflexes	-	20
Medical contraindication to donation	-	5
Other	-	58
Patient had previously expressed a wish not to donate	-	4
Patient haemodynamically unstable	-	151
Pressure of ICU beds	-	1
SN-OD advised that donor not suitable	-	13
Treatment withdrawn	-	20
Unknown	-	8
Total	**-**	**495**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.2 Referral to Organ Donation Service

Goal: Every patient who meets the referral criteria should be identified and referred to the Organ Donation Service, as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors[2].

Aim: There should be no purple on the following charts.

Note that patients who met the referral criteria for both DBD and DCD donation will appear in both bar charts and both columns of the reasons table.

Figure 3.2 Number of patients meeting referral criteria, 1 April 2019 - 31 March 2024
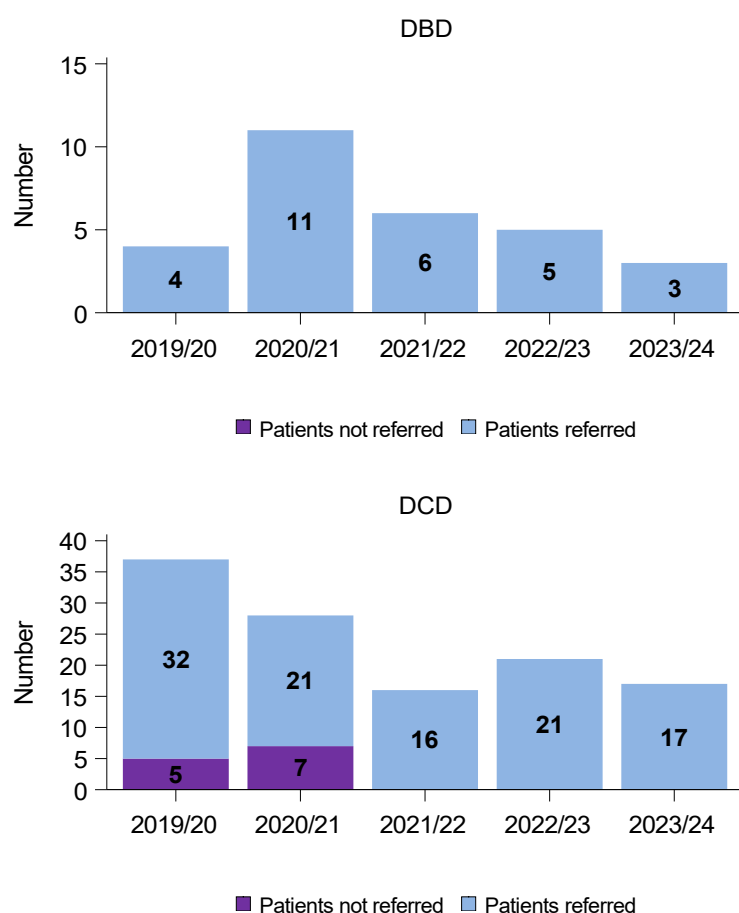
DBD

DCD

Table 3.2 Reasons given why patient not referred to SNOD, 1 April 2023 - 31 March 2024				
	DBD		DCD	
	Trust	UK	Trust	UK
Clinician assessed that patient was unlikely to become asystolic within 4 hours	-	-	-	4
Coroner / Procurator Fiscal reason	-	1	-	-
Family declined donation following decision to remove treatment	-	-	-	9
Family declined donation prior to neurological testing	-	-	-	1
Medical contraindications	-	-	-	42
Not identified as potential donor/organ donation not considered	-	8	-	260
Other	-	1	-	9
Patient had previously expressed a wish not to donate	-	-	-	2
Pressure on ICU beds	-	-	-	5

If 'other', please contact your local SNOD or CLOD for more information, if required.

**Table 3.2 Reasons given why patient not referred to SNOD,
          1 April 2023 - 31 March 2024**

	DBD		DCD	
	Trust	**UK**	**Trust**	**UK**
Reluctance to approach family	-	-	-	2
Thought to be medically unsuitable	-	-	-	42
Uncontrolled death pre referral trigger	-	2	-	6
Total	**-**	**12**	**-**	**382**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.3 Contraindications

In 2023/24 there were 12 potential donors in your Trust with an ACI reported, 7 DBD and 12 DCD donors. Please note, the number of potential DBD and DCD donors with an ACI reported may not equal the total stated as a patient can meet potential donor criteria for both DBD and DCD donation.

3.4 SNOD presence

Goal: A SNOD should be present during the formal family approach as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance.[3]

Aim: There should be no purple on the following charts.

In the UK, in 2023/24, when a SNOD was not present for the approach to the family to discuss organ donation, DBD and DCD consent/authorisation rates were 23% and 14%, respectively, compared with DBD and DCD consent/authorisation rates of 70% and 60%, respectively, when a SNOD was present.

Every approach to those close to the patient should be planned with the multidisciplinary team (MDT), should involve the SNOD and should be clearly planned taking into account the known decision of the patient. The NHS Organ Donor Register (ODR) should be checked in all cases of potential donation and this information must be discussed with the family as it represents the eligible donor's legal consent to donation.

Figure 3.3 Number of families approached by SNOD presence, 1 April 2019 - 31 March 2024

DBD

DCD
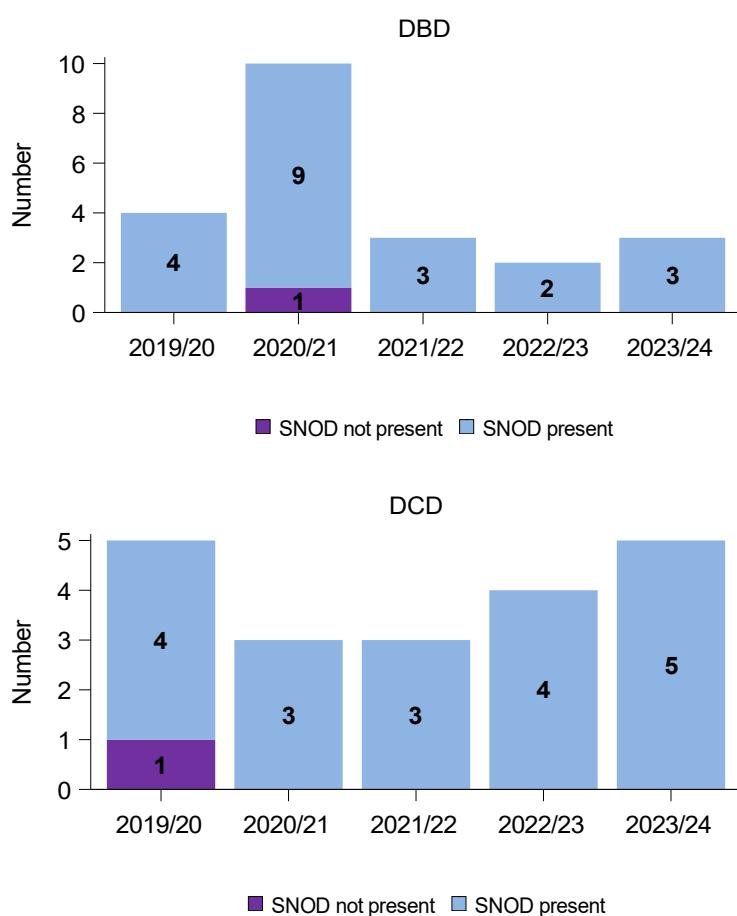
[1] NICE, 2011.
NICE Clinical Guidelines - CG135
[accessed 8 May 2024]

[2] NHS Blood and Transplant, 2012.
Timely Identification and Referral of Potential Organ Donors - A Strategy for Implementation of Best Practice
[accessed 8 May 2024]

[3] NHS Blood and Transplant, 2013.
Approaching the Families of Potential Organ Donors – Best Practice Guidance
[accessed 8 May 2024]

3.5 Consent

In 2023/24 less than 10 families of eligible donors were approached to discuss organ donation in your Trust therefore consent rates are not presented.

Figure 3.4 Number of families approached, 1 April 2019 - 31 March 2024
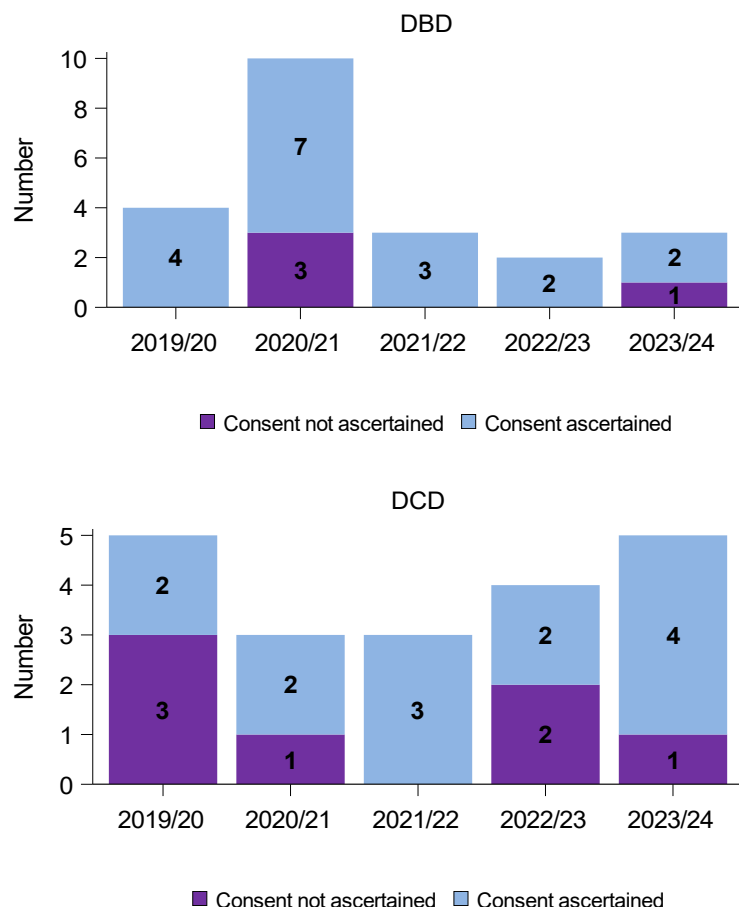
DBD

Legend: ■ Consent not ascertained □ Consent ascertained

DCD

Legend: ■ Consent not ascertained □ Consent ascertained

Table 3.3 Reasons given why consent was not ascertained, 1 April 2023 - 31 March 2024

	DBD		DCD	
	Trust	UK	Trust	UK
Family believe patient's treatment may have been limited to facilitate organ donation	-	-	-	1
Family concerned other people may disapprove/be offended	-	3	-	4
Family concerned that organs may not be transplantable	-	2	-	8
Family did not believe in donation	-	5	-	9
Family did not want surgery to the body	-	42	-	57
Family divided over the decision	-	12	-	20
Family felt it was against their religious/cultural beliefs	1	49	-	28
Family felt patient had suffered enough	-	24	1	78
Family felt that the body should be buried whole (unrelated to religious/cultural reasons)	-	13	-	17
Family felt the length of time for the donation process was too long	-	30	-	167
Family had difficulty understanding/accepting neurological testing	-	3	-	-

If 'other', please contact your local SNOD or CLOD for more information, if required.

**Table 3.3 Reasons given why consent was not ascertained,
1 April 2023 - 31 March 2024**

	DBD		DCD	
	Trust	**UK**	**Trust**	**UK**
Family wanted to stay with the patient after death	-	5	-	17
Family were not sure whether the patient would have agreed to donation	-	49	-	113
Other	-	24	-	57
Patient had previously expressed a wish not to donate	-	94	-	167
Patient had registered a decision to Opt Out	-	21	-	43
Strong refusal - probing not appropriate	-	25	-	39
Total	**1**	**401**	**1**	**825**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.6 Solid organ donation

Goal: NHSBT is committed to supporting transplant units to ensure as many organs as possible are safely transplanted.

Table 3.4 Reasons why solid organ donation did not occur, 1 April 2023 - 31 March 2024

	DBD		DCD	
	Trust	**UK**	**Trust**	**UK**
Clinical - Absolute contraindication to organ donation	-	3	-	5
Clinical - Considered high risk donor	-	4	-	8
Clinical - DCD clinical exclusion	-	-	-	2
Clinical - No transplantable organ	-	7	-	12
Clinical - Organs deemed medically unsuitable by recipient centres	-	17	-	58
Clinical - Organs deemed medically unsuitable on surgical inspection	-	9	-	6
Clinical - Other	-	3	-	7
Clinical - PTA post WLST	-	-	1	164
Clinical - Patient actively dying	-	4	-	7
Clinical - Patient asystolic	-	3	-	1
Clinical - Patient's general medical condition	-	1	-	6
Clinical - Positive virology	-	2	-	-
Clinical - Predicted PTA therefore not attended	-	-	-	1
Consent / Auth - Coroner/Procurator fiscal refusal	-	10	-	8
Consent / Auth - Family placed conditions on donation	-	-	-	1
Consent / Auth - NOK declined organ donation	-	1	-	-
Consent / Auth - NOK withdraw consent / authorisation	-	6	-	22
Consent / Auth - Other	-	-	-	1
Logistical - Other	-	-	-	1
Logistical - Retrieval team not available	-	-	-	1
Logistical - Unit unable to maintain patient	-	-	-	1
Total	**-**	**70**	**1**	**312**

If 'other', please contact your local SNOD or CLOD for more information, if required.

4. PDA data by hospital and unit

A summary of key numbers and rates from the PDA by hospital and unit where patient died

Data in this section is obtained from the National Potential Donor Audit (PDA)

Tables 4.1 and 4.2 show the key numbers and rates for patients who met the DBD and/or DCD referral criteria, respectively. Percentages have been excluded where numbers are less than 10.

Table 4.1 Patients who met the DBD referral criteria - key numbers and rates, 1 April 2023 - 31 March 2024

Unit where patient died	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Aylesbury, Stoke Mandeville Hospital													
A & E	0	0	-	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	1	1	-	1	-	1	1	1	1	-	0	-	0
Other, please specify	0	0	-	0	-	0	0	0	0	-	0	-	0
Wycombe, Wycombe General Hospital													
General ICU/HDU	2	2	-	2	-	2	2	2	2	-	2	-	2

Table 4.2 Patients who met the DCD referral criteria - key numbers and rates, 1 April 2023 - 31 March 2024

Unit where patient died	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DCD donors
Aylesbury, Stoke Mandeville Hospital											
A & E	0	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	15	15	100	15	11	4	4	-	3	-	3
Other, please specify	0	0	-	0	0	0	0	-	0	-	0
Wycombe, Wycombe General Hospital											
General ICU/HDU	2	2	-	2	1	1	1	-	1	-	0

Tables 4.1 and 4.2 show the unit where the patient died. However, it is acknowledged that there are some occasions where a patient is referred in an Emergency Department but moves to a critical care unit. In total for Buckinghamshire Healthcare NHS Trust in 2023/24 there were 0 such patients. For more information regarding the Emergency Department please see Section 5.

5. Emergency Department data

## A summary of key numbers for Emergency Departments

Data in this section is obtained from the National Potential Donor Audit (PDA)

Most patients who go on to become organ donors start their journey in the emergency department (ED). Deceased donation is important, not just for those people waiting on the transplant list, but also because many people in the UK have expressed a decision in life to become organ donors after their death. The overarching principle of the NHSBT Organ donation and Emergency Department strategy [4] is that best quality of care in organ donation should be followed irrespective of the location of the patient within the hospital at the time of death.

5.1 Referral to Organ Donation Service

Goal: No one dies in your ED meeting referral criteria and is not referred to NHSBT's Organ Donation Service.
Aim: There should be no blue on the following chart.

Figure 5.1 Number of patients meeting referral criteria that died in the ED, 1 April 2019 - 31 March 2024

■ Patients not referred ■ Patients referred
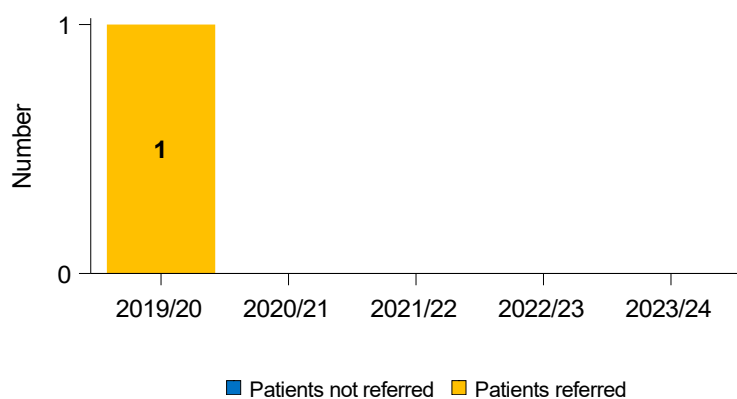
5.2 Organ donation discussions

Goal: No family is approached in ED regarding organ donation without a SNOD present.
Aim: There should be no red on the following chart.

Figure 5.2 Number of families approached in ED by SNOD presence, 1 April 2019 - 31 March 2024

■ SNOD not present ■ SNOD present
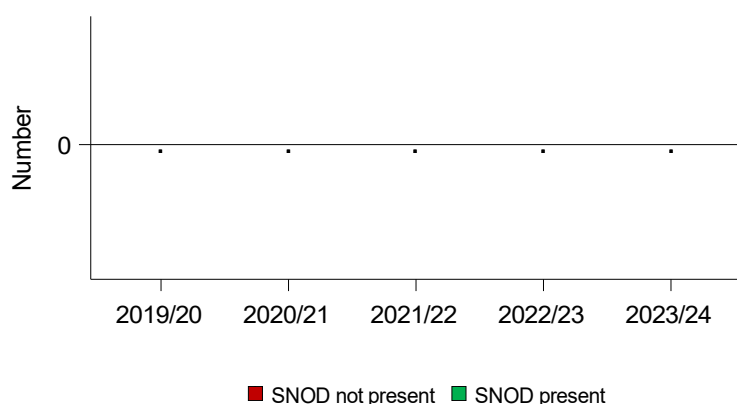
[4] NHS Blood and Transplant, 2016.
Organ Donation and the Emergency Department
[accessed 8 May 2024]

6. Additional data and figures

Regional donor, transplant, and transplant list numbers

Data in this section is obtained from the UK Transplant Registry

6.1 Supplementary Regional data

Table 6.1 Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data	South East*	UK
1 April 2023 - 31 March 2024		
Deceased donors	203	1,510
Transplants from deceased donors	445	3,723
Deaths on the transplant list	29	418
As at 31 March 2024		
Active transplant list	829	7,484
Number of NHS ODR opt-in registrations (% registered)**	4,116,544 (44%)	28,161,705 (42%)
Number of NHS ODR opt-out registrations (% registered)**	227,280 (2%)	2,577,667 (4%)

*Regions are defined using the NHS region definitions
** % registered based on population of 9.29 million, based on ONS 2021 census data

Key numbers and rates on the potential for organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

6.2 Trust/Board Level Benchmarking

Buckinghamshire Healthcare NHS Trust has been categorised as a level 3 Trust. Levels were reallocated in July 2018 using the average number of donors in 2016/17 and 2017/18, Table 6.2 shows the criteria used and how many Trusts/Boards belong to each level.

Table 6.2 Trust/Board level categories		Number of Trusts Boards in each level
Level 1	12 or more ($\geq$ 12) proceeding donors per year	36
Level 2	6 or more but less than 12 ($\geq$ 6 to <12) proceeding donors per year	51
Level 3	More than 3 but less than 6 (>3 to <6) proceeding donors per year	31
Level 4	3 or less ($\leq$ 3) proceeding donors per year	39

Tables 6.3 and 6.4 show the national DBD and DCD key numbers and rates for the UK by Trust/Board level, to aid in comparison with equivalent Trusts/Boards. Note that percentages have been excluded where numbers are less than 10.

Table 6.3 National DBD key numbers and rate by Trust/Board level, 1 April 2023 - 31 March 2024

	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Your Trust	3	3	-	3	-	3	3	3	3	-	2	-	2
Level 1	1183	881	74	1174	99	858	814	715	682	95	483	68	451
Level 2	539	414	77	538	100	402	388	344	339	99	242	70	220
Level 3	169	138	82	167	99	138	130	119	116	97	81	68	72
Level 4	138	101	73	138	100	98	94	81	78	96	52	64	45

Table 6.4 National DCD key numbers and rate by Trust/Board level, 1 April 2023 - 31 March 2024

	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DCD donors
Your Trust	17	17	100	17	12	5	5	-	4	-	3
Level 1	2735	2533	93	2669	1932	1066	965	91	590	55	430
Level 2	1532	1426	93	1494	1039	499	454	91	285	57	187
Level 3	583	547	94	559	353	167	154	92	93	56	54
Level 4	481	443	92	464	311	117	99	85	55	47	39

Appendices

Appendix A.1 Definitions

Potential Donor Audit Definitions

Potential Donor Audit inclusion criteria	1 October 2009 – 31 March 2010 All deaths in critical care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2010 – 31 March 2013 All deaths in critical and emergency care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2013 onwards All deaths in critical and emergency care in patients aged 80 and under (prior to 81st birthday)

Donors after brain death (DBD) definitions

Suspected Neurological Death	A patient who meets all of the following criteria: invasive ventilation, Glasgow Coma Scale 3 not explained by sedation, no respiratory effort, fixed pupils, no cough or gag reflex. Excluding those not tested due to reasons 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', 'neonates – below 37 weeks corrected gestational age'. Previously referred to as brain death
Neurological death tested	Neurological death tests performed to confirm and diagnose death
DBD referral criteria	A patient with suspected neurological death
Specialist Nurse Organ Donation or Organ Donation Services Team Member (SNOD)	A member of Organ Donation Services Team including: Team Manager, Specialist Nurse Organ Donation, Specialist Requester, Donor Family Care Nurse
Referred to Specialist Nurse – Organ Donation	A patient with suspected neurological death referred to a SNOD. A referral is the provision of information to determine organ donation suitability. NICE CG135 (England) : Triggers for clinicians to refer a potential donor are a plan to withdraw life sustaining treatment or a plan to perform neurological death tests
Potential DBD donor	A patient with suspected neurological death
Absolute contraindications	Absolute medical contraindications identified in assessment which clinically preclude organ donation as per NHSBT criteria (POL188) Absolute medical contraindications to donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/17160/clinical-contraindications-to-approaching-families-for-possible-organ-donation-pol188.pdf
Eligible DBD donor	A patient confirmed dead by neurological death tests, with no absolute medical contraindications to solid organ donation
Donation decision conversation	Family of eligible DBD asked to make or support patient's organ donation decision - This includes clarifying an opt out decision
Consent/Authorisation ascertained	Family supported opt in decision, deemed consent/authorisation, or where applicable the family or nominated/appointed representative gave consent/authorisation for organ donation
Actual donors: DBD	Patients who became actual DBD donors following confirmation of neurological death, as reported through the PDA (80 years and below). At least one organ donated for the purpose of transplantation (includes organs retrieved for transplant however used for research)
Actual donors: DCD	Patients who became actual DCD donors following confirmation of neurological death, as reported through the PDA (80 years and below). At least one organ donated for the purpose of transplantation (includes organs retrieved for transplant however used for research)
Neurological death testing rate	Percentage of patients for whom neurological death was suspected who were tested

Referral rate	Percentage of patients for whom neurological death was suspected who were referred to the SNOD
Donation decision conversation rate	Percentage of eligible DBD families or nominated/appointed representatives who were asked to make or support an organ donation decision - This includes clarifying an opt out decision
Consent/Authorisation rate	Percentage of donation decision conversations where consent/authorisation was ascertained
SNOD presence rate	Percentage of donation decision conversations where a SNOD was present (includes telephone and video call conversations)
Consent/Authorisation rate where SNOD was present	Percentage of donation decision conversations where a SNOD was present and consent/authorisation for organ donation was ascertained (as above)

Donors after circulatory death (DCD) definitions

Imminent death anticipated	A patient, not confirmed dead using neurological criteria, receiving invasive ventilation, in whom a clinical decision to withdraw treatment has been made and a controlled death is anticipated within a time frame to allow donation to occur (as determined at time of assessment)
DCD referral criteria	A patient for whom imminent (controlled) death is anticipated following withdrawal of life sustaining treatment (as defined above)
Specialist Nurse Organ Donation or Organ Donation Services Team Member (SNOD)	A member of Organ Donation Services Team including: Team Manager, Specialist Nurse Organ Donation, Specialist Requester, Donor Family Care Nurse
Referred to SNOD	A patient for whom imminent death is anticipated who was referred to a SNOD. A referral is the provision of information to determine organ donation suitability NICE CG135 (England) : Triggers for clinicians to refer a potential donor are a plan to withdraw life sustaining treatment or a plan to perform neurological death tests
Potential DCD donor	A patient who had treatment withdrawn and imminent death was anticipated within a time frame to allow donation to occur.
Absolute contraindications	Absolute medical contraindications identified in assessment which clinically preclude organ donation as per NHSBT criteria (POL188). Absolute medical contraindications to donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/17160/clinical-contraindications-to-approaching-families-for-possible-organ-donation-pol188.pdf
Eligible DCD donor to be assessed	A patient who had treatment withdrawn and imminent (controlled) death was anticipated, with no absolute medical contraindications to solid organ donation.
DCD exclusion criteria	DCD specific criteria determine a patient's suitability to donation when there are no absolute medical contraindications (see absolute contraindications documentation above)
DCD screening process	Process by which an organ may be screened with a local and national transplant centre to determine suitability of organs for transplantation
Medically suitable eligible DCD donor	An eligible DCD donor to be assessed considered to be medically suitable for donation (i.e. no DCD exclusions and not deemed unsuitable by the screening process)
Donation decision conversation	Family of medically suitable eligible DCD donor who were asked to make or support patient's organ donation decision - This includes clarifying an opt out decision.
Consent/Authorisation ascertained	Family supported opt in decision, deemed consent/authorisation, or where applicable the family or nominated/appointed representative gave consent/authorisation for organ donation
Actual DCD	DCD patients who became actual DCD as reported through the PDA (80 years and below). At least one organ donated for the purpose of transplantation (includes organs retrieved for transplant however used for research)
Referral rate	Percentage of patients for whom imminent (controlled) death was anticipated who were referred to the SNOD

Donation decision conversation rate	Percentage of medically suitable eligible DCD families or nominated/appointed representatives who were asked to make or support an organ donation decision - This includes clarifying an opt out decision
Consent/Authorisation rate	Percentage of donation decision conversations where consent/authorisation was ascertained.
SNOD presence rate	Percentage of donation decision conversations where a SNOD was present (includes telephone and video call conversations).
Consent/Authorisation rate where SNOD was present	Percentage of donation decision conversations where a SNOD was present and consent/authorisation for organ donation was ascertained (as above).

Deemed Consent/Authorisation

Deemed consent applies if a person who died in Wales, Jersey or England has not expressed an organ donation decision either to opt in or opt out or nominate/appoint a representative, is aged 18 or over, has lived in the country in which they died for longer than 12 months and is ordinarily resident there, and had the capacity to understand the notion of deemed consent for a significant period before their death.

Deemed authorisation applies if a person who died in Scotland has not expressed, in writing, an organ donation decision either to opt in or opt out, is aged 16 or over, has lived in Scotland for longer than 12 months and is ordinarily resident there, and had the capacity to understand the notion of deemed authorisation for a significant period before their death. Note that, in Scotland, a patient who has verbally expressed an opt in decision is included as a deemed authorisation, whereas a patient who has verbally expressed an opt out decision is not included.

Consent/Authorisation groups

Expressed opt in	Patient had expressed an opt in decision. Opt in decisions can be expressed in writing or via the ODR in all nations and verbal opt in decisions are also included in Wales, England and Jersey. Verbally expressed opt in decisions are not included in Scotland
Deemed consent/authorisation	Patient meets deemed criteria specific to each nation as described above. In Scotland, this includes patients who have verbally expressed a decision to opt in
Expressed opt out	Patient had expressed an opt out decision. Opt out decisions can be expressed verbally, in writing or via the ODR in all nations
Other	Patient has expressed no decision or deemed criteria are not met. Paediatric patients are included in this group

UK Transplant Registry (UKTR) definitions

Donor type	Type of donor: Donation after brain death (DBD) or donation after circulatory death (DCD)
Number of actual donors	Total number of donors reported to the UKTR
Number of patients transplanted	Total number of patients transplanted from these donors
Organs per donor	Number of organs donated divided by the number of donors.
Number of organs transplanted	Total number of organs transplanted by organ type

Appendix A.2 Data Description

This report provides a summary of data relating to potential and actual organ donors as recorded by NHS Blood and Transplant via the Potential Donor Audit (PDA), the accompanying Referral Record, and the UK Transplant Registry (UKTR) for the specified Trust, Board, Organ Donation Services Team, or nation.

This report is provided for information and to facilitate case based discussion about organ donation by the Organ Donation Committee at your Trust/Board.

As part of the PDA, patients over 80 years of age and those who did not die on a critical care unit or emergency department are not audited nationally and are therefore excluded from the majority of this report. Data from neonatal intensive care units (ICU) have also been excluded from this report. In addition, some information may be outstanding due to late reporting and difficulties obtaining patient notes. Donations not captured by the PDA will still be included in the data supplied from the accompanying Referral Record or from the UKTR, as appropriate.

Percentages have not been calculated for level 3 or 4 Trust/Boards and where stated when numbers are less than 10.

Appendix A.3 Table and Figure Description

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1 Donor outcomes

Table 1.1	The number of actual donors, the resulting number of patients transplanted and the average number of organs donated per donor have been obtained from the UK Transplant Registry (UKTR) for your Trust/Board. Results have been displayed separately for donors after brain death (DBD) and donors after circulatory death (DCD).
Table 1.2	The number of organs transplanted by type from donors at your Trust/Board has been obtained from the UKTR. Further information can be obtained from your local Specialist Nurse – Organ Donation (SNOD), specifically regarding organs that were not transplanted. Results have been displayed separately for DBD and DCD.
Figure 1.1	The number of actual donors and the resulting number of patients transplanted obtained from the UKTR for your Trust/Board for the past 10 equivalent time periods are presented on a line chart.

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2 Key numbers in potential for organ donation

Table 2.1	A summary of DBD, DCD and deceased donor data and key numbers have been obtained from the PDA. A UK comparison is also provided. Appendix A.1 gives a fuller explanation of terms used.

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3 Best quality of care in organ donation

Figure 3.1	A stacked bar chart displays the number of patients with suspected neurological death who were tested and the number who were not tested in your Trust/Board for the past five equivalent time periods.
Table 3.1	The reasons given for neurological death tests not being performed in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 3.2	Stacked bar charts display the number of DBD and DCD patients meeting referral criteria who were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.
Table 3.2	The reasons given for not referring patients to the Organ Donation Service in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 3.3	The primary absolute medical contraindications to solid organ donation for DBD and DCD patients have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 3.3	Stacked bar charts display the number of families of DBD and DCD patients approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.
Figure 3.4	Stacked bar charts display the number of families of DBD and DCD patients approached where consent/authorisation for organ donation was ascertained and the number approached where consent/authorisation was not ascertained in your Trust/Board for the past five equivalent time periods.
Table 3.4	The reasons why consent/authorisation was not ascertained for solid organ donation in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 3.5	The reasons why solid organ donation did not occur in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.

4 PDA data by hospital and unit

Table 4.1	DBD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.
Table 4.2	DCD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.

5 Emergency department data

Figure 5.1	Stacked bar charts display the number of patients that died in the emergency department (ED) who met the referral criteria and were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.
Figure 5.2	Stacked bar charts display the number of families of patients in ED approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.

6 Additional data and figures

Table 6.1	A summary of deceased donor, transplant, transplant list and ODR opt-in registration data for your region have been obtained from the UKTR. A UK comparison is also provided.
Table 6.2	Trust/board level categories and the relevant expected number of proceeding donors per year are provided for information.
Table 6.3	National DBD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.
Table 6.4	National DCD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.

Appendix 1: Explanation of abbreviations and specific terms used.

Specialist Nurse Organ Donation (SN-OD) – A Specialist Nurse who is employed by NHS Blood and Transplant supporting Trust staff in the facilitation of the Organ Donation Process. An embedded SN-OD is based within the Trust to carry out teaching, staff support, auditing referrals and working with the Trust Organ Donation Committee

Specialist Requester – A SN-OD who has had additional training in the family approach, collaborative discussion and consent process. They are usually mobilised first to a potential Organ Donor to support Trust staff and start the on-site.

Clinical Lead for Organ Donation (CLOD) - This is an ICU Consultant who works with the embedded SNOD and of behalf on NHS Blood and Transplant to support and facilitate organ donation within the Trust.

DBD – Donation after Brainstem Death. This is a patient who meets all four criteria for Neurological Death Testing to be performed. This tests are used to confirm that a patient has legally died, allowing the patient to be taken to theatre with the ventilator attached and their heart still beating, thus improving the outcome for the recipient as there is less time without oxygen to damage the transplantable organs.

DCD – Donation after Circulatory Death. This refers to the patients who are receiving assisted ventilation and cannot be confirmed dead using Neurological Criteria as the function of the brainstem is still intact. However, a clinical decision has been made by the ICU team to withdraw treatment and death of the patient is anticipated within a time frame to allow Organ Donation to occur.

Neurological Death Testing (NDT)– These tests are used to confirm death when a patient meets all of the following criteria: Apnoea, coma from known cause and unresponsive, ventilated and with fixed pupils (no response to light). The tests look at whether the brainstem reflexes are absent confirming brainstem death. These tests are completed by two clinicians, either two ICU Consultants or one ICU Consultant and one senior ICU Registrar.

Referral Criteria – These are criteria to guide ED and ICU staff as to whether to refer the patient as a potential Organ Donor to SN-OD. These are patients with severe brain injury where:

☐ One or more cranial nerve reflexes is absent and the Glasgow Coma Score is 4 or less and cannot be explained by sedation, or

☐ A decision has been made to perform Neurological Death Tests

Alternatively, patients for whom a decision has been made to withdraw life-sustaining treatment.

Absolute Medical Contraindications – These include specific medical conditions, some types of cancers, in particular active cancers with evidence of spread and active haematological malignancies and other severe infections, including being symptomatic corona virus infection without recovery. There are age limits but these only exclude people over 85 years as Organ Donors. These are the initial questions we ask when we take a referral.

Potential Donor Audit – This is carried out by the embedded SNOD auditing all deaths in ED and ICU to identify whether there were any potential organ donors that weren't referred. There is often an easily identifiable cause for them and this may lead to further teaching to address knowledge gaps or misunderstandings.

Why are ED numbers smaller? – Patients who are identified as those who have severe head injuries, following an intracerebral bleed, hypoxic brain damage following cardiac arrest. These patients are those who are generally admitted to ICU for a period of prognostication to see if there is any clinical improvement before decisions are made regarding End of Life Care.

Why is consent not always gained from relatives? – Often this relates to either knowing that the patient did not want to be an Organ Donor from previous discussions when they were alive, or from misconceptions around Organ Donation, including cultural and religious reasons, which we would always explore with the family. We accept that Organ Donation isn't right for all families and respect their decision. However, some relatives decline donation because they just didn't know what their loved one's decision would have been. The Deemed Consent Act (2020) is proving helpful in these situations as we can explain that if their loved one did not register their decision either to Opt In or Opt Out on the Organ Donor Register, we would assume that they had no objection to becoming an Organ Donor, therefore taking some of the responsibility away from bereaved relatives.

What is meant by the Levels of Trusts?

Level 1   12 or more (≥ 12) proceeding donors per year

Level 2   6 or more but less than 12 (≥ 6 to <12) proceeding donors per year

Level 3   More than 3 but less than 6 (>3 to <6) proceeding donors per year (Buckinghamshire NHS Trust falls into this category)

Level 4   3 or less (≤ 3) proceeding donors per year

Meeting: Trust Board Meeting in Public

30 October 2024

Agenda item	Private Board Summary Report
Board Lead	Chief Executive Officer
Type name of Author	Senior Trust Board Administrator
Attachments	None
Purpose	Information
Previously considered	n/a

Executive Summary

The purpose of this report is to provide a summary of matters discussed at the Board meeting held in private on 25 September 2024.

The matters considered at this session of the Board were as follows:

- Standards of Behaviour and Conduct Report
- Digital Health Programme Update
- Policy stocktake on new government
- Maternity Safety reports
- 2024/25 BOB ICS Financial Recovery Plan / Investigation and Intervention (I&I)
- Assessment of 2024/25 Financial Plan delivery
- Improving Together Update
- Healthcare Support Worker Review

Decision	The Board is requested to note the contents of the report.

Relevant Strategic Priority

Outstanding Care ☒	Healthy Communities ☒	Great Place to Work ☒	Net Zero ☒

Relevant objective

☒ Improve waiting times in ED ☒ Improve elective waiting times ☒ Improve safety through clinical accreditation	☒ Give children living in most deprived communities the best start in life ☒ Outpatient blood pressure checks	☒ Zero tolerance to bullying

Implications / Impact

Patient Safety	Aspects of patient safety were considered at relevant points in the meeting
Risk: link to Board Assurance Framework (BAF)/Risk Register	Any relevant risk was highlighted within the reports and during the discussion
Financial	Where finance had an impact, it was highlighted and discussed as appropriate
Compliance	Compliance with legislation and CQC standards were highlighted when required or relevant
Partnership: consultation / communication	n/a
Equality	Any equality issues were highlighted and discussed as required.
Quality Impact Assessment [QIA] completion required?	No

Acronym 'Buster'

- A&E - Accident and Emergency
- AD - Associate Director
- ADT - Admission, Discharge and Transfer
- AfC - Agenda for Change
- AGM - Annual General Meeting
- AHP - Allied Health Professional
- AIS – Accessible Information Standard
- AKI - Acute Kidney Injury
- AMR - Antimicrobial Resistance
- ANP - Advanced Nurse Practitioner
- APC – Acute Provider Collaborative

B

- BBE - Bare Below Elbow
- BHT – Buckinghamshire Healthcare Trust
- BME - Black and Minority Ethnic
- BMA - British Medical Association
- BMI - Body Mass Index
- BOB – Buckinghamshire, Oxfordshire & Berkshire West
- BPPC – Better Payment Practice Code

C

- CAMHS - Child and Adolescent Mental Health Services
- CAS - Central Alert System
- CCG - Clinical Commissioning Group
- CCU - Coronary Care Unit
- Cdif / C.Diff - Clostridium Difficile
- CEA - Clinical Excellence Awards
- CEO - Chief Executive Officer
- CHD - Coronary Heart Disease
- CIO - Chief Information Officer
- CIP - Cost Improvement Plan
- CQC - Care Quality Commission
- CQUIN - Commissioning for Quality and Innovation
- CRL – Capital Resource Limit
- CSU - Commissioning Support Unit
- CT - Computerised Tomography
- CTG - Cardiotocography

D

- DBS - Disclosure Barring Service
- DGH - District General Hospital
- DH / DoH - Department of Health
- DIPC - Director of Infection Prevention and Control
- DNA - Did Not Attend
- DNACPR - Do Not Attempt Cardiopulmonary Resuscitation
- DNAR - Do Not Attempt Resuscitation
- DNR - Do Not Resuscitate
- DoLS - Deprivation of Liberty Safeguards
- DPA - Data Protection Act
- DSU - Day Surgery Unit
- DVT - Deep Vein Thrombosis

E

- ED&I – Equality, Diversity & Inclusion
- EBITDA - Earnings Before Interest, Taxes, Depreciation and Amortization
- ECG - Electrocardiogram
- ED - Emergency Department
- EDD - Estimated Date of Discharge
- EQIA – Equality & Quality Impact Assessment
- EIS – Elective Incentive Scheme
- ENT - Ear, Nose and Throat
- EOLC - End of Life Care
- EPR - Electronic Patient Record
- EPRR - Emergency Preparedness, Resilience and Response
- ERF – Elective Recovery Fund
- ESD - Early Supported Discharge
- ESR - Electronic Staff Record

F

- FBC - Full Business Case
- FFT - Friends and Family Test
- FOI - Freedom of Information
- FTE - Full Time Equivalent

G

- GI - Gastrointestinal
- GMC - General Medical Council
- GP - General Practitioner
- GRE – Glycopeptide Resistant Enterococci

H

- HAI - Hospital Acquired Infection
- HASU - Hyper Acute Stroke Unit
- HCA - Health Care Assistant
- HCAI - Healthcare-Associated Infection
- HDU - High Dependency Unit
- HEE – Health Education England

- HETV - Health Education Thames Valley
- HMRC – Her Majesty's Revenue and Customs
- HSE - Health and Safety Executive
- HSLI – Health System Led Investment
- HSMR – Hospital-level Standardised Mortality Ratio
- HSW – Healthcare Support Worker
- HWB - Health and Wellbeing Board

I

- ICS – Integrated Care System
- ICB – Integrated Care Board

M

- I&E - Income and Expenditure
- IC - Information Commissioner
- ICP - Integrated Care Pathway
- ICU - Intensive Care Unit
- IG - Information Governance
- IGT / IGTK - Information Governance Toolkit
- IM&T - Information Management and Technology
- IPR - Integrated Performance Report
- ITU - Intensive Therapy Unit / Critical Care Unit
- IV - Intravenous

J

- JAG - Joint Advisory Group

K

- KPI - Key Performance Indicator

L

- LA - Local Authority
- LCFS - Local Counter Fraud Specialist
- LD - Learning Disability
- LHRP - Local Health Resilience Partnership
- LiA - Listening into Action
- LOS / LoS - Length of Stay
- LUCADA - Lung Cancer Audit Data

M
- M&M - Morbidity and Mortality
- MDT - Multi-Disciplinary Team
- MIU - Minor Injuries Unit
- MRI - Magnetic Resonance Imaging
- MRSA - Meticillin-Resistant Staphylococcus Aureus

N

- NBOCAP - National Bowel Cancer Audit Programme
- NCASP - National Clinical Audit Support Programme
- NED - Non-Executive Director
- NHS – National Health Service
- NHSE – National Health Service England
- NHSLA - NHS Litigation Authority
- NICE - National Institute for Health and Care Excellence
- NICU - Neonatal Intensive Care Unit
- NMC - Nursing and Midwifery Council
- NNU - Neonatal Unit
- NOGCA - National Oesophago-Gastric Cancer Audit
- NRLS - National Reporting and Learning System / Service

O

- O&G - Obstetrics and Gynaecology
- OBC - Outline Business Case
- ODP - Operating Department Practitioner
- OHD - Occupational Health Department
- OOH - Out of Hours
- OP - Outpatient
- OPD - Outpatient Department
- OT - Occupational Therapist/Therapy
- OUH - Oxford University Hospital

P

- PACS - Picture Archiving and Communications System / Primary and Acute Care System
- PALS - Patient Advice and Liaison Service
- PAS - Patient Administration System
- PBR - Payment by Results
- PBR Excluded – Items not covered under the PBR tariff
- PDC - Public Dividend Capital
- PDD - Predicted Date of Discharge
- PE - Pulmonary Embolism
- PFI - Private Finance Initiative
- PHE - Public Health England
- PICC - Peripherally Inserted Central Catheters
- PID - Patient / Person Identifiable Data
- PID - Project Initiation Document
- PLACE - Patient-Led Assessments of the Care Environment
- PMO - Programme Management Office
- PPE - Personal Protective Equipment
- PP – Private Patients
- PPI - Patient and Public Involvement
- PSED - Public Sector Equality Duty
- PSIRF – Patient Safety Incident Response Framework

Q

- QA - Quality Assurance
- QI - Quality Indicator

- QIP - Quality Improvement Plan
- QIPP - Quality, Innovation, Productivity and Prevention
- QIA - Quality Impact Assessment
- QOF - Quality and Outcomes Framework

R

- RAG - Red Amber Green
- RCA - Root Cause Analysis
- RCN - Royal College of Nursing
- RCP - Royal College of Physicians
- RCS - Royal College of Surgeons
- RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
- RTT - Referral to Treatment

S

- SAU - Surgical Assessment Unit
- SCAS - South Central Ambulance Service
- SHMI - Summary Hospital-level Mortality Indicator
- SI - Serious Incident
- SIRO – Senior Information Risk Owner
- SID - Senior Independent Director
- SLA - Service Level Agreement
- SLR - Service-Line Reporting
- SLT / SaLT - Speech and Language Therapy
- SMR - Standardised Mortality Ratio
- SoS - Secretary of State
- SSI(S) - Surgical Site Infections (Surveillance)
- SNAP - Sentinel Stroke National Audit Programme
- STF – Strategic Transformation Fund
- STP - Sustainability and Transformation Plan
- SUI - Serious Untoward Incident

T

- TIA - Transient Ischaemic Attack
- TNA - Training Needs Analysis
- TPN - Total Parenteral Nutrition
- TTA - To Take Away
- TTO - To Take Out
- TUPE - Transfer of Undertakings (Protection of Employment) Regulations 1981

U
- UGI - Upper Gastrointestinal
- UTI - Urinary Tract Infection

V

- VfM - Value for Money
- VSM - Very Senior Manager
- VTE - Venous Thromboembolism

W

- WHO - World Health Organization
- WTE - Whole Time Equivalent

Y

- YTD - Year to Date