##

## 2019/20 PSS CQUIN Scheme

## Indicator Template

## *[Section B to be completed before insertion in contracts.]*

## PSS11 Promoting Transplantation (v1 published 19 March 2019)

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| Indicator Name | ***Promoting Transplantation by optimisation of the organ donation pathway and Living Kidney Donor pathway.*** |
| 1. **SUMMARY of Indicator**
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| Indicator Sponsor (with email address) | Internal Medicine Programme of CareSarah Watson*sarah.watson23@nhs.net* *;* Jon Gulliver *Jon.gulliver@nhs.net* |
| Improving Value Reference | *N/A* |
| Duration | One/Two/Three years.  |
| CCG Complementarity | *N/A* |
| **Problem to be addressed (maximum 150 words):*****[****Briefly characterise the shortfall in quality or efficiency that the indicator is designed to address; detailed evidence should be placed in section D1****]*** 1. NHS Blood and Transplant with NHS England have targets for organ donation which are not being met for 2020 and beyond. This may be the result of a number of factors: clinical, organisational, work force or cultural. Other than for renal failure, organ transplant offers patients the only long term option for treatment for their organ failure. Patients die waiting for an organ. A DHSC led opt-out policy in England is under consideration but evidence highlights cultural differences as a factor in families’ willingness to release deceased relative’s organs. NHS Blood and Transplant (NHSBT) and National Black and Ethnic Minority Transplant Association (NBTA) are undertaking a number of initiatives better to understand these issues and to promote donation in minority groups. There are also new technologies available that can increase use of available organs but which require service re-design.
2. Living Donor Kidney Transplant (LDKT) is well established in the UK but rates of Live-Donor offers vary significantly across England and with international comparators. LDKT offers an optimal treatment for patients with kidney failure since it offers a better outcome than dialysis and also excellent long-term transplant and patient survival in comparison with deceased donor kidney transplantation (DDKT). Avoidance of dialysis also makes LDKT the most cost effective treatment option for patients with end stage kidney disease (ESKD).
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| **Change sought:***[Specify what change in behaviour is sought in general terms, with detailed specification set out in section C4****.]*** 1. **To increase the Organ transplantation rate by addressing barriers to organ uptake and optimising the pathway.**

**Optimising Donor Rates** Funding will support a menu of options relevant to the focus of the schemePotential for monies to be allocated depending on how many elements are addressed.* Cultural barriers to families releasing organs for transplant from deceased relatives.
* System and team redesign to reduce decline of organs.
* Addressing capacity constraints on donor acceptance.
* Service redesign to support innovative technologies e.g. regional perfusion.

**Change in behaviour**Clinical team to understand team / individual / system barriers and attitude to organ donation To ensure appropriate discussions with potential donors and families of donors.Improve networks to widen the recruitment of donors and maximise timely resource use to ensure every opportunity to transplant is taken up.Service and or workforce redesign to reduce decline rate of organs and maximise transplantation opportunities.**Change sought:*** To improve the rate of deceased donors per million population (pmp) noting the national target is 26 pmp by 2020.
* To increase organ utilisation rate by a minimum of 5% overall and for each organ type.
* To increase the rate of deceased donor transplant rate noting national target is 74 pmp
* Evidence of improvement of the pathway in a specific organ transplant service
1. **To reduce the work up time for the live donor pathway to promote transplant rates.**

**Living Donor**Each centre and referring unit will have to undertake one or more of the following:* Determining cultural barriers to families releasing organs for transplant from living relatives.
* Team culture to supporting LKD
* Service redesign to reduce decline of organs and increase living donor rates.
* Analysis of pre-emptive and LKD rates
* Mapping, dissemination and Improvement of local LKD referral pathways.
* Recording of activity using mandated HRGs
* Development of action plans.
* Monitoring of waiting times.
* Measuring donor and recipient experience of the donor pathway.

**Live Kidney Donation****Change sought:*** Improve the number of LK Donors, noting the national target rate is 26 pmp by 2020.
* Reduce the work up time for LKD
* Increase the % done pre-emptively
* Evidence of improvement of the pathway in a specific organ transplant service
* Evidence of improved LKD donor / patient experience of the donor pathway
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| 1. **CONTRACT SPECIFIC INFORMATION** *(for completion locally, using guidance in sections C below)*
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| **B1.Provider** (see Section C1 for applicability rules) | *[Insert name of provider]* |
| **B2. Provider Specific Duration.** What will be the first Year of Indicator for this provider, and how many years are covered by this contract? | 2019/20 2020/21 2021/22 *[Adjust locally]*One/two/threeyears *[Adjust locally]* |
| **B3.Indicator Target Payment** (see Section C3 for rules to determine target payment) | Full compliance with this CQUIN indicator should achieve payment of: Target Value:  *[Add locally ££s]* |
| **B4. Payment Triggers.**The triggers, and the proportion of the target payment that each trigger determines, and any partial payment rules, for each year of the indicator, are set out in Section C4.Relevant provider-specific variation, if any, is set out in this table.*[Adjust table as required for this indicator – or delete if no provider-specific information is required.]*

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| **Provider specific triggers** | **2019/20** | **2020/21** | **2021/22** |
| **Trigger 1:** |  |  |  |
| **Trigger 2:** |  |  |  |
| **Trigger 3:** |  |  |  |
| **Trigger 4:** |  |  |  |

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| **B5. Information Requirements** |
| **Obligations under the indicator to report against achievement of the Triggers, to enable benchmarking, and to facilitate evaluation, are as set out in Section C5.** |
| Final indicator reporting date for each year. | Month 12 Contract Flex reporting date as per contract. *[Vary if necessary.]* |
| **B6. In Year Payment Phasing & Profiling** |
| Default arrangement: half payment of target CQUIN payment each month, reconciliation end of each year depending upon achievement. *[Specify variation of this approach if required]* |

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| **C. INDICATOR SPECIFICATION GUIDE: STEP CHANGE INDICATORS** |
| **C1. Providers to whom Applicable** |
| **Nature of Adoption Ambition*:***  | Providers of highly specialised solid organ transplant servicesProviders of kidney transplant services (who will need to involve providers of kidney dialysis services) |
| **List of Providers for whom Indicator is Applicable** | **Optimising Organ Donation*** Liver, Kidney, Heart and Lung transplant specialised centres:

Barts Health NHS TrustGOSH NHS Foundation TrustGuys and St Thomas' NHS Foundation TrustImperial College Healthcare NHS TrustKings College Hospital NHS TrustRoyal Brompton and Harefield NHS Foundation TrustRoyal Free London NHS Foundation TrustSt Georges Healthcare NHS TrustBirmingham Children's Hospital NHS Foundation TrustCambridge University Hospitals NHS Foundation TrustNottingham University Hospitals NHS TrustPapworth Hospital NHS Foundation TrustUniversity Hospital Birmingham NHS Foundation TrustUniversity Hospital of Leicester NHS TrustUniversity Hospitals Coventry and Warwickshire NHS TrustManchester University Hospitals NHS Foundation TrustLeeds Teaching Hospitals NHS TrustRoyal Liverpool and Broadgreen University Hospitals NHS Foundation TrustSheffield Teaching Hospitals NHS Foundation TrustThe Newcastle upon Tyne NHS Foundation TrustManchester University NHS Foundation TrustNorth Bristol NHS TrustOxford University Hospitals NHS TrustPlymouth Hospitals NHS Trust Portsmouth Hospitals NHS Trust |
| **C2. Provider Specific Parameters** |
| **The indicator requires the following parameters to be set for each provider in advance of contract, in order to determine precisely what is required of each provider, and/or to determine appropriate target payment (as per C3.)** | Number of referring services to be included in the remit of the centre – which will determine scale of change sought, and hence appropriate payment.How many change topics are selected for Optimising Organ Donation – which Triggers are to be included: to be noted in Section B. |
| **C3. Calculating the Target Payment for a Provider**  |
| **The target overall payment for this indicator (the payment if the requirements of the indicator are fully met, to be set in Section B3 above) should be calculated for each provider, according to the following algorithm:** Approx £100k per transplant centre plus £50k for each referring services to be included in the remit of the centre. Should also vary depending on how many change topics are selected for Optimising Organ Donation.Default proposal: £150,000.**See Section D3 for the justification of the targeted payment, including justification of the costing of the indicator, which will underpin the payment.** |
| **C4. Payment Triggers and Partial Achievement Rules** |
| **Payment Triggers****The interventions or achievements required for payment under this CQUIN indicator are as follows:**

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| **Descriptions** | **First Year of indicator** | **Second Year** | **Third Year** |
| **Trigger 1:****Establishing a Network** | Working with referring centres:* Set up monitoring of donor work up wait times
* Clearly document and describe local and regional network.
 | * Work with networked providers to develop and formalise best practice network arrangements
 | n/a |
| **Trigger 2****Organ Utilisation** | * Develop and agree with commissioners and national team an action plan to increase organ utilisation.
* Set up monitoring of live donor rates wait times.
* Develop and agree with commissioners and national team an Action Plan to reduce live donor work up wait times.
* Redesign service and or workforce to reduce decline of organs and to increase living kidney donation
 | * Demonstrate reduction in organ decline rates and increase in organ utilisation rates
* Demonstrate reduction in live donor work up wait times

Increase organ utilisation rate by 2.5 percentage points for each of:* Standard criteria donor Donor after Brain Death (DBD)
* Extended criteria donor DBD
* Donation after circulatory death
 | Increase organ utilisation rate by 2.5 percentage points for each of:* Standard criteria donor Donor after Brain Death (DBD)
* Extended criteria donor DBD
* Donation after circulatory death
 |
| **Trigger 3****Donor and Recipient Experience in networked providers** | * Work with appropriate NHS BT leads to develop measures to report upon donor and recipient experience agreed with commissioners and national team
 | * Measure and report upon donor and recipient experience
 | * Measure and report upon donor and recipient experience
 |
| **Trigger 4****Promoting Donation** | * Agree and share educational resources to support decision-making for living donors.
* Develop and agree with commissioners and national team an action plan to increase consent for organ donation and increase living kidney donation.
 | * Increase consent for organ donation to >60% in networked providers
 | * Increase consent for organ donation to >80% in networked providers
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| **Percentages of Target Payment per Payment Trigger****The following table sets out the proportion of the Target payment that is payable on achievement of each of the Payment Triggers.**

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| **Percentages of Target Payment per Trigger** | **First Year of indicator** | **Second Year** | **Third Year** |
| **Trigger 1** | 20% | 5% | n/a |
| **Trigger 2** | 30% | 40% | 40% |
| **Trigger 3** | 20% | 15% | 10% |
| **Trigger 4** | 30% | 40% | 50% |
| **TOTAL** | 100% | 100% | 100% |

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| **Partial achievement rules****Year One****Trigger 1: all-or-nothing****Trigger 2: all-or-nothing****Trigger 3: all-or-nothing****Trigger 4: all-or-nothing****Year Two****Trigger 1: all-or-nothing****Trigger 2: strictly-proportional** **Trigger 3: all-or-nothing****Trigger 4: all-or-nothing****Year Three****Trigger 1: n/a****Trigger 2: strictly-proportional** **Trigger 3: all-or-nothing****Trigger 4: all-or-nothing** |
| **Definitions** |
| **C5. Information Flows: for benchmarking, for evaluation, and for reporting against the triggers.**  |
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| **Reporting of Achievement against Triggers:** |
| **Quarterly Report** |
| **Information for Benchmarking:** |
| **Baseline data on live donor work up wait times** |
| **Information Governance:** |
| **NA** |
| **Reporting Template requirement:** |
| **Locally agreed Action Plan** |
| **C6. Supporting Guidance and References** |
| **Further details on implementation, and references to documents that will support implementation:**Clear recommendations for the approach to take in improving utilisation and donation rates are included in “Taking Organ Utilisation to 2020”. These include: excellence in the assessment and management of potential donors; creating systems whereby surgeons have the information and guidance to enable them safely to accept and transplant organs with patients being able to take an active role in the decision; ensuring retrieval teams attend donors timeously and organs are preserved; maximising use of proven perfusion techniques to increase organ utilisation. To improve live kidney donation rates, clear steps for transplantation centres include: • Determining cultural barriers to families releasing organs for transplant from living relatives. • Analysis of pre-emptive and LKD rates • Mapping, dissemination and Improvement of local LKD referral pathways. • Measuring donor and recipient experience of the donor pathway. “*Taking Organ Utilisation to 2020*” <https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/3579/odt-organ-utilisation-strategy.pdf>provides an overview of excellent organisational performance on organ acceptance and utilisation. Successful implementation of improvements in systems and performance is in part dependent upon close collaboration with NHS Blood and Transplant, and on staff training and sharing of good practice and collaboration between clinical units. Screening, evaluation and work up of live donors can be undertaken in referring renal centres, transplant centres or a combination of the two. It will be necessary for transplant centres to work with referring units to map their local process, agree areas for improvement and measure change. They will also have to work with other departments, e.g. cardiac investigations, to ensure that tests are undertaken in a timely fashion to support the delivery of the 18-week target for work up of live donors as set out in the BTS Guidance "BTS/RA Living Donor Kidney Transplantation Guidelines 2018." There is no requirement for additional investment or training. The focus of this improvement work is to map local process, identify bottlenecks and opportunities for improvement. All of the elements of the pathway are currently commissioned. NHS BT has Clinical Leads appointed at a national level for Organ Utilisation for both abdominal and cardiothoracic organ transplantation. At a local level there are staff with responsibility for Living Donor Transplant, Clinical Leads for Organ Donation and Specialist Nurses for Organ Donation. There is an established Living Kidney Donor Strategy Implementation Group (SIG) responsible for the promotion and dissemination of best practice. Each renal centre has a named lead for living donation and the SIG produce a quarterly newsletter to promote best practice and encourage networking of clinical leads. The first national meeting of the unit clinical leads will take place in January 2019. NHSBT has a Lead Nurse for Living Donation who works with Living Donor co-ordinators across the country and UK to develop best practice and promote live donation. |

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| **D. Indicator Justification and Evaluation** |
| **D1. Evidence and Rationale for Inclusion**  |
| **Evidence Supporting Intervention Sought**Increasing organ donation rates is important as it:* Increases opportunities for transplantation before patients deteriorate and develop co-morbidities that increase operative risk and risk of organ failure post-transplant.
* Some patients are receiving interim high cost implanted mechanical support which increases the complexity of surgery should an organ become available.
* There are developments in techniques to reduce clinical reasons for declining offered organs and / or deterioration in the organ being donated which should increase numbers of organs available. There is evidence this is associated with better outcomes. However providers will need to consider how their services are organised to maximise the impact of these technologies.
* The limited supply of organs means that surgery sessions frequently occur out of hours and when in hours are competing with other emergency and elective waiting lists.
* Patients with organ failure and no organ will die and there is significant cost to the NHS in the last 1 to 2 years of life with patients having frequent and often extended inpatient stays requiring high dependency care.
* Increasing opportunities for pre-emptive transplantation i.e. before a patient commences dialysis, is associated with better outcomes.
* A better pathway minimises the chance that recipients who could have had a live donor will be offered a deceased donor instead. This avoids a recipient with a compatible live donor receiving a deceased organ donation instead.
* Also a live donor will potentially have undergone a lengthy resource intensive assessment process to no clinical benefit to the patient on the waiting list.

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| **Table 1**  | 14/15 | 15/16\* | 16/17 |
| Total Organ transplants against the Target (red) | 40333341 | 36943521 | 40603713 |
| Per Million Population deceased donor transplant rates | 19.7 | 20.9 | 21.1 |
| Kidney | 19801880 | 20682036 | 22972160 |
| Live Donor Kidney  | 11431092 | 12231704 | 12601043 |
| Kidney and Pancreas combined | 205173 | 223167 | 241163 |
| Pancreas | \*\*52 | 4949 | 5350 |
| Cardiothoracic | 423366 | 450382 | 486375 |
| Liver | 916867 | 904881 | 984949 |

**Targets**The strategy to increase organ donation and transplantation is included in Taking Organ Donation to 2020 signed up to by the DHSC and supported by NHS England. This CQUIN supports the achievement of activity targets signed up to by NHS England.Table 2 sets out Organ Donation targets from 17/18 onwards.

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| **Table 2**  | **Year** |
| **Measure description** | **2017/18 Target** | **2018/19 Target** | **2019/20 Target** | **2020/21 Target** | **2021/22 Target** |
| **Number of deceased organ donors** | 1,524 | 1,632 | 1,740 | 1,752 | 1,764 |
| **Deceased donors per million popn** | 23.1 | 24.5 | 26 | 26 | 26 |
| **Deceased donor organ transplants** | 4,116 | 4,548 | 4,956 | 4,992 | 5,028 |
| **Deceased donor organ transplants pmp** | 62.4 | 68.4 | 74 | 74 | 74 |

Table 3 sets out the targets an performance for living donation:

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| **Table 3** | **Years** |
| **Measure description** | **2017/18 Target** | **2018/19 Target** | **2019/20 Target** | **2020/21 Target** | **2021/22 Target** |
| **Number of living organ donors** | 1,392 | 1,524 | 1,740 | 1,752 | 1,764 |
| **Living donors per million population** | 21 | 23 | 26 | 26 | 26 |

The National goals include:1. Increase consent for organ donation to >80% 2. Increase the rate of deceased donors per million population (pmp) 26 pmp3. Increase organ utilisation rate by 5%4. Increase the rate of deceased donor transplant rate to 74 pmp1. Increase the rate of living kidney donor transplant rate noting the highest rates achieved are 26 pmp

There is clinical consensus on achievement of improvements in organ donation and utilisation and the need to increase living kidney donation. The DHSC has recently undertaken a Public Consultation on The Organ Donation (Deemed Consent) Bill 2017-19 and most responses supported a change to the law to allow for deemed consent to organ and tissue donation in England. Professional groups responded positively to this consultation. |
| **Rationale of Use of CQUIN incentive**CQUIN as an instrument is justified if net costs beyond normal service requirements are incurred by providers whilst benefits and cost savings accrue to patients and commissioners.The value of the commissioned services is:* Highly Specialised Solid Organ Transplant services - circa £142m (16/17)
* Renal dialysis services - circa £142m (16/17)
* Renal transplant services – circa £188m (16/17)

 Improving donation and utilisation rates to help to achieve nationally agreed targets for Kidney, Liver, Heart and Lung, and to reduce demand for renal dialysis, high cost interim devices, and to avoid admitted patient care costs. |
| **D2. Indicator Duration and Exit Route** |
| **The appropriate duration of an indicator depends upon how long CQUIN support is required before the change in behaviour sought can be embedded in services specification or otherwise.****Three Years** |
| **D3. Justification of Size of Target Payment** |
| **The evidence and assumptions upon which the target payment was based, so as to ensure payment of at least 150% of average costs (net of any savings or reimbursements under other mechanisms), is as follows:** |
| **D4. Evaluation: Approach, data and resources** |
| **Evaluation Approach:**  |
| **Information for Evaluation** | *[Information flows required for evaluation should be referenced here, building on those set out at C5]* |
| **Resources for Evaluation** |  |