

NHS BLOOD AND TRANSPLANT ORGAN DONATION AND TRANSPLANTATION DIRECTORATE

THE ELEVENTH MEETING OF THE NHSBT CTAG LUNG ADVISORY GROUP ON WEDNESDAY 25th APRIL 2018, 10:00 – 12:00, THE TRAINING ROOM, CORAM CAMPUS, 41 BRUNSWICK SQUARE, LONDON, WC1N 1AZ

PRESENT

Steven Tsui (ST)	CTAG Chair
Jayan Parameshwar (JyP)	In-coming CTAG Chair
Mohamed Al Aloul (MAA)	Respiratory Physician, Wythenshawe Hospital
Nawwar Al Attar (NAA)	Heart Surgeon, Golden Jubilee National Hospital
Lyn Ayton (LA)	Transplant Managers Forum Representative
Martin Carby (MC)	Lung Physician, Harefield Hospital
Vaughan Carter (VC)	British Society for Histocompatibility and Immunogenetics
Steve Clarke (SC)	Lung Physician, Freeman Hospital
Pedro Catarino (PC)	British Transplant Society Representative
John Dark (JD)	Governance Representative, NHSBT
John Forsythe (JF)	Associate Medical Director, NHSBT
Margaret Harrison (MH)	CTAG Lay Member
Rachel Hogg (RH)	Statistician, Statistics and Clinical Studies, NHSBT
Lesley Logan (LL)	SNOD Representative, NHSBT
Jacki Newby (JNe)	Head of Referral and Offering, HUB Operations, NHSBT
Jane Nuttall (JNu)	Recipient Transplant Coordinator, Wythenshawe Hospital
Jasvir Parmar (JsP)	Respiratory Physician, Royal Papworth Hospital
Laura Ramsay (LR)	Lead Nurse Recipient Co-ordinator, NHSBT
Sally Rushton (SR)	Senior Statistician, Statistics and Clinical Studies, NHSBT
Helen Spencer (HS)	Lung Physician, Great Ormond Street Hospital
Richard Thompson (RT)	Respiratory Physician, Queen Elizabeth Hospital
Sarah Watson (SW)	Programme Director, Highly Specialised Services, NHS England
Mike Winter (MW)	Medical Director, NHS National Services Division for Scotland

IN ATTENDANCE

Lucy Newman (LN)	Secretary, NHSBT
Zdenka Reinhardt (ZR)	Paediatric Observer, Freeman Hospital

APOLOGIES

Gareth Brown (GB)	Consultant in Public Health, DOH Scotland
Catherine Coyle (CC)	Public Health NI
Nicky Crouchen (NC)	Recipient Transplant Coordinator, Harefield
Melissa D'Mello (MDM)	CTAG Lay Member
Sue Fuggle (SF)	Scientific Advisor, NHSBT
Anushka Govias Smith (AGS)	National Services Division, NHS Scotland
Ben Hume (BH)	Assistant Director TSS, NHSBT
Jorge Mascaro (JM)	Heart Surgeon, Queen Elizabeth Hospital
Rutger Ploeg (RP)	National Clinical Lead for Organ Retrieval
Andre Simon (AS)	Heart Surgeon, Harefield Hospital

Item	Action
<p>Apologies and welcome ST welcomed the group and thanked members for attending the meeting. Apologies were given and are listed above. ST introduced JyP as the in-coming Chair for the Cardiothoracic Advisory Group</p>	
<p>2 Declarations of Interest: Nawwar Al Attar declared two external interests via email</p> <ul style="list-style-type: none"> • Member of advisory board to Medtronic and Ethicon biosurgery 	

	<ul style="list-style-type: none"> Recipient of travel grant from Edwards for TAVI training 	
2	Minutes of the meeting held on Wednesday 13th September 2017	
2.1	<p>Accuracy Richard Thompson – did not attend the September 2017 meeting. Post Meeting Note: LN amended the minutes and they are approved as a correct record of the last meeting</p> <p>Action Points</p>	
2.2	Prolonged Lung Registrations	
AP1	No changes have been reported to SR to date. The correct route to make corrections to patient registrations is via ODT Online.	
AP2	<p>Submission of UK DCD Lung Transplant Data to ISHLT SR will discuss NHSBT's process for submission of ISHLT data with Wida Cherikh and relay details of any required updates to CTAG</p>	SR
AP3	<p>Clinical Governance Newsletter JD will produce a Clinical Governance Summary for a Newsletter</p>	JD
AP4	<p>Paper outlining variations in listing outcomes JsP submitted and presented his paper at ISHLT; the manuscript was circulated to all centres. JsP thanked SR and RH for their work; the manuscript is near completion following final revisions.</p>	
AP5	<p>Non-Smoking Donor Lungs up to age 75 SR will monitor utilisation of older donor lungs in transplants and report at the next CTAG in October Centre reps to feedback reasons for non-utilisation of older donor lungs to NHSBT</p>	SR Centre Reps
AP6	<p>Lung Incidents for review Completed</p>	
AP7	<p>Review of the first three months of the SULAS See Lungs minutes item 4.1</p>	
AP8	<p>Lung Utilisation See Lungs minutes item 5</p>	
3	Governance Issues	
3.1	<p>Non-compliance with lung allocation Incidents relating to non-compliance within lung transplantation are voluntarily reported. The non-compliance report is standard on the agenda and events reported in this section are rare. Nothing further to report on non-compliance.</p>	
3.2	<p>Lung Incidents for review Reporting incidents relating to lung transplantation is voluntary; there was a 30% increase in incidents reported in the past 6 months. Incidents were mainly around offering and delays mobilising the NORS teams.</p>	
3.2.1	<p>Clinical Governance Report One incident covered by the report involved a Dutch retrieval team who had come to observe a retrieval and were subsequently offered lungs turned down by the Cambridge transplanting/retrieval team. The lead NORS team in attendance should have retrieved the lungs, however, in Europe, the transplanting team carry out the retrieval of the organs. Due to this confusion and a desire to prevent further stresses at the time, the NORS Team in attendance allowed the Dutch team to complete the retrieval. JD wrote to the team to clarify this UK regulation and received an apology from the Dutch team. ST confirmed that</p>	

observers of a retrieval should be treated in the same way as a second NORS Team in attendance; the Leading NORS Team's Surgeon has primary responsibility for the retrieval. Whether the visiting team is involved with the retrieval should be at the discretion of the NORS Lead Surgeon. In future, NHSBT must tell overseas retrieval teams the above process when offers are made to them. SNODs should have further training to clarify the above process to help them understand the NORS standards in case similar situations should arise again.

There were 5 complaints regarding the cannulation stitch in the Pulmonary Artery. Complaints were raised by four abdominal teams and one cardiothoracic team. Following consultation nationally with tissue banks, some were prepared to accept the artery with the stitch in situ and some were not, but this is not something to be tailored by tissue bank. It was decided that the stitch should remain in place and not be removed.

A new SOP will be written and circulated to all NORS Teams and Tissue Banks in due course

JD

One incident involved an incorrect listing of a patient who went on to receive a super-urgent heart and lung transplant ahead of other patients who had been listed earlier. The request to list the patient for Super Urgent Heart Lung transplant was sent to the Adjudication Panel on Christmas Eve 2017 and the Adjudication Panel decision to reject this request was sent on Boxing Day. The Bank Holiday timing likely caused a delay in the Adjudication Panel responding to the requestor. Even though there was no approval by the Adjudication Panel, the Hub made an incorrect decision to add the patient to the Super Urgent Heart list.

There was no guidance on what process to follow should there be an unavoidable delay in the Adjudication Panel responding with their majority decision. The Adjudication Panel should respond to the requestor within 24 hours, and if this does not happen, then the requestor should not list the patient as approval to do so has not been granted. The response from the Panel will be returned to the requestor, and if it is agreed that the patient may be listed, this response is required to be emailed to the HUB with the application to list the patient.

The Hub must insist on seeing evidence of approval where required.

JNe will feed back to the HUB Team, review policies and arrange retraining of staff if necessary

JNe

3.3 Summary of CUSUMs

One CUSUM signal was raised at Birmingham and is under investigation. This will be discussed further at item 3.4

3.3.1 Updating CUSUMS

NHSBT monitor 90 day outcomes of recipients post-transplant and use baseline data from 2008-2011 to measure performance against. Resulting from discussion and changes within other SOAGs, SR requested approval to update the baseline data to more recent years; 2013-2016. Implementing this change would increase the average mortality rate at 90 days following lung transplant from 9.8% to 10.5% among the adult population. In paediatric patients, the average mortality rate at 90 days would decrease from 11.5% to 7.8% following lung transplantation. Centres would continue to receive centre specific CUSUM reports where they trigger against their own average when their centre rate is below the national average. Only those CUSUMS reported higher against the national rate would be investigated formally.

SR will discuss with CUSUM colleagues in the Stats and Clinical Studies Team and report to centres whether they will start with a zero rate, Birmingham, having just triggered a CUSUM signal will probably be placed slightly higher

SR

Within LAG, an agreement has been reached to lower the threshold for Liver CUSUMs due to having very few triggers for several years. Lowering the Lungs threshold from 2.5 to 2 would have generated an additional 5 signals in the last 7 years. CUSUM signals should

3.4	<p>not be seen as pejorative, they present opportunities for MDT as well as internal/external reviews and peer reviews. The group decided that the rate would remain at 2.5.</p> <p>Once the data from the first 12 months of the SULAS has been analysed, it will be possible to determine whether its introduction has altered the mortality national average. At present, there are no significant differences between the figures.</p> <p>Shared Learning Birmingham: JM presented findings of the review of transplantation activity since 2016 which had been steadily increasing. A sudden decrease in cardiac surgical activity at the centre led to a review by the CQC, following which the Trust reduced the number of ITU beds available for, complex procedures, including MCS, and transplantation. As there were a lower number of patients, it is difficult to draw firm conclusions. Of 13 patients transplanted, 5 died within 90 days. 3 were CF patients and for 4 of the patients, donors with extended criteria were used. Mortality rates within fewer cases had a higher impact on CUSUMs. As a result of the review, changes have already been implemented, and include double scrubbing wherever possible and better discussions of donor selection within the team. Early outcomes indicate that recipient factors must also be considered – selecting lower risk patients and managing risks better. It must also be noted that this group of patients presented a number of challenges and this also affected the negative outcome.</p> <p>LN to circulate JM paper with minutes as CTAGL(18)04</p>	LN
4 4.1 4.2	<p>Statistics and Clinical Studies Report</p> <p>Review of 2017 Super Urgent Lung Allocation Scheme</p> <p>SR provided a detailed report, including the slides which she had presented at ISHLT. The report reviews the first 10 months of the SULAS and compares to the same 10 month period last year.</p> <p>Nationally, the report shows 21% of registrations fulfil the urgent lung category and 3% fulfil the super-urgent category. The remaining 75% are non-urgent. Median waiting times are 25 days for urgent and 7 days for super urgent, compared with 244 days for all patients previously. Of the adult donor lungs offered, 7% went to patients on the urgent or super urgent lung allocation schemes, 14% were transplanted into non urgent patients and 79% were not transplanted. 14% were used for paediatric or small adult transplants in the non-urgent tier, showing a small uptake of adult donors by the smaller recipients. There was no significant difference in the 90 day post-transplant survival rates between the non-urgent and urgent/super-urgent recipients.</p> <p>At ISHLT a similar message was communicated, with over half of the patients in the new national priority tiers transplanted within 30 days when analysing the first 6 months. However, mortality rates among patients on the waiting lists were broadly the same as before (3%). There has been a small improvement in organ acceptance rates and a 15% increase in transplant activity.</p> <p>A question was raised about the number of paediatric lungs transplanted into adult recipients. 4/5 paediatric lung donors were used in adults. It was recognised that at least a years' worth of data was needed to properly assess the performance of the new schemes and make any suggestions for improvements.</p> <p>Following the introduction of the Super Urgent Heart Allocation Scheme, Heart members convened the Cardiothoracic Heart Allocation Sub Group (CTHASG) to review the listing criteria and other outstanding issues. ST recommended a similar group should be convened for Lungs to discuss lung allocation issues.</p> <p>JyP to take this forward under his new Chairmanship</p> <p>SULAS Cat 93</p> <p>There is a need to add a further category to the SULAS, for when a patient is deemed super-urgent but does not fulfil the existing categories 91 and 92. It was commented that</p>	JyP

4.3	<p>an “other” super-urgent category was deliberately not introduced because it was felt the SULAS should be preserved for patients on ECMO. Nonetheless a recent case was approved by the Adjudication Panel, therefore there needs to be a facility to record this. SR to arrange for this category to be established</p> <p>Prolonged Registrations Centres to arrange for any patients to be removed from the list if they should no longer appear</p>	<p>SR</p> <p>Centre reps</p>
5	<p>The Ideal Lung Donor Initiative JD thanked the Members who had been dialling in to the Lung Utilisation Telecons; also to SR and LN for providing reports and facilitating the meeting.</p> <p>The initiative was set up to monitor the utilisation rates of ideal lungs, as the percentage reduced from over 60% to barely 50% when considering donors meeting the French Criteria. Since January 2018, the group has looked at 22 donors nationwide in more detail to establish why the lungs from these otherwise ideal donors were unused. The full breakdown is detailed in the report CTAGL(18)08. 10 of the 22 ideal lung donors investigated could have been used, and lessons learned are listed in the report. Some of the reasons these ideal lungs were not used related to:</p> <ul style="list-style-type: none"> • Donor Choice Forms not being consulted • IT glitches • Issues with initial offering and re-offering • Resources and logistics • SABTO guidance surrounding possible transmission of cancers not being followed <p>The outcome of the telecons to date has been largely well received and members are keen to embrace the review process.</p> <p>Within centres it is more commonly reported that where surgeons would traditionally have made decisions about lung acceptance, they now tend to liaise with physicians and transplant co-ordinators to make better joint decisions.</p> <p>The lung utilisation telecons are useful and it was agreed that a process of gathering feedback from the group, and then writing to centre directors would be adopted. This is also of interest when lungs are declined by one centre and then accepted by another, and the outcomes for these patients should be fed back to the centres that declined.</p> <p>Kidney and Pancreas Transplant teams have a model that the group may wish to adopt.</p> <p>Stage 1 – “Ideal” donor are reviewed by utilisation lead Stage 2 – the utilisation lead then writes to centre directors to inform them that the organ could have been used in transplantation, with the outcomes for the patient, and a response from the centre director will be required.</p> <p>JyP/JD to contact clinical reps and work through process, JF will support this.</p>	<p>JyP/JD</p>
6	<p>Any Other Business JD asked JyP to consider holding CTAG Wider Group Meetings across two days. The group values the Shared section of the meeting as a rare opportunity for key figures of the Cardiothoracic community to get together. JyP will discuss further with JF</p>	<p>JyP/JF</p>
7	<p style="text-align: center;">Dates of next meeting: CTAG Patient Group Meeting Tuesday 5th June 2018, 13:00 – 17:00 (Sandwich Lunch 13:00-13:30) The Board Room, West End Donor Centre, 26 Margaret Street, Marylebone, London W1W 8NB</p> <p style="text-align: center;">Autumn CTAG Wider Group (Lungs) Meeting Wednesday 10th October 2018, 15:00-17:00</p>	

to be ratified