NHS BLOOD AND TRANSPLANT

MINUTES OF THE TWENTY-FOURTH MEETING OF THE ADVISORY GROUP CHAIRS COMMITTEE AT 10.30 AM ON TUESDAY 11TH APRIL 2017 AT THE CIWEM VENUE, 106-109 SAFFRON HILL, LONDON EC1N 8QS

PRESENT:

Prof John Forsythe, Associate Medical Director ODT, NHSBT (**Chair**)
Mr John Casey, Pancreas Advisory Group Chair
Prof John Dark, National Clinical Lead for Governance, ODT
Prof Peter Friend, Multi-visceral and Composite Tissue Advisory Group Chair
Mr Ben Hume, Assistant Director, Transplantation Support Services, ODT
Mrs Rachel Johnson, Head of Organ Donation & Transplantation Studies, NHSBT
Ms Sally Johnson, Director of ODT, NHSBT
Prof Derek Manas, Liver Advisory Group Deputy Chair
Ms Lorna Marson, British Transplantation Society representative
Mr Jeremy Monroe, TPRC Chair & Non-Executive Director, NHSBT
Dr Paul Murphy, National Organ Donation Committee Chair
Prof John O'Grady, Liver Advisory Group Chair
Mr Gabriel Oniscu, Research, Innovation & Novel technologies Advisory Group Chair
Prof Rutger Ploeg, National Retrieval Group Chair
Mr Aaron Powell, Chief Digital Officer, NHSBT
Mr Steven Tsui, Cardiothoracic Advisory Group Chair
Prof Chris Watson, Kidney Advisory Group Chair
Mrs Claire Williment, Head of Transplant Development, ODT, NHSBT

IN ATTENDANCE:

Mr Mark Roberts, Head of Commissioning Development, ODT
Mrs Kathy Zalewska, Clinical & Support Services, ODT (Secretary)

ACTION

1 WELCOME & APOLOGIES

Apologies were received from:
Mr John Asher, Medical Health Informatics Lead, ODT
Mr Roberto Cacciola, Assoc National Clinical Lead for Organ Retrieval
Mr Chris Callaghan, National Clinical Lead for Organ Utilisation (Abdominal)
Dr Gail Miflin, Medical & Research Director, NHSBT
Mr Anthony Snape, Head of Service Management, ICT, NHSBT
Ms Helen Tincknell, Lead Nurse Recipient Co-ordination, ODT

1.1 **Declarations of Interest – AGChC(17)1**

There were no declarations of interest.

2 MINUTES OF THE MEETING HELD ON 29TH NOVEMBER 2016 – AGChC(M)(16)4

2.1 The minutes of the previous meeting were agreed as a correct record.

ACTION

3 ACTION POINTS & MATTERS ARISING – AGChC(AP)(17)1

3.1 **Action points:**

AP1 MSHOTC Guidelines: Details of the survey for kidneys had been shared with D Manas in order to adapt for livers.

AP2 Scout Project: The draft external report was emailed to S Tsui.

AP3 Combined liver/kidney allocation: C Watson had liaised with N Torpey to submit a proposal to KAG in December.

4 PROJECT UPDATES

4.1 **ODT Clinical website**

A significant amount of feedback had been received on the changes to the website. A link to the new site would be circulated for review within the next two weeks and members were asked to advise on any inaccuracies or amendments. Views on the restricted area of the website would be particularly useful. It is envisaged this area would serve as a communication tool with information such as contact details for surgeons; and for governance in order to share widely as quickly as possible.

4.2 **Length of organ donation and retrieval process**

J Forsyth gave a presentation on progress with work on the length of the donation pathway. A workshop was held in late January 2017 which focused on 3 key elements:

- Donor referral and characterisation
- Organ allocation and offering
- Organ retrieval and NORS mobilisation

Various proposals were put forward and categorised into possible short, medium and long term solutions. Suggested outcomes from the workshop were:

- Cease the mobilisation of teams between 06:00 and 09:00
- Organ offer to a centre; request to consider for all patients
- Fast track information
- Fast track for specific cases – Hep B surface antigen / HIV
- Standardise provisional organ offers

Members expressed concern around some of the outcomes and it was acknowledged that further involvement from Chairs and Advisory Groups, NODC and NRG would be needed. It was highlighted that, following the work on liver allocation, decisions would have to be made on the next priority for IT. If the donor pathway is considered a priority it would require additional work to release.

4.3 **Donor characterisation Review - AGChC(17)2**

M Roberts attended the meeting to update members on the review, the final recommendations from which will be presented to the NHSBT Board at the end of May. The review has examined in detail:

- Demand and activity for donor characterisation testing
- Location of laboratories

ACTION

- Timings along the donor characterisation pathway
- Collection and transport of blood samples
- Testing of blood samples and reporting of results
- Patient safety
- Funding of the laboratory service

The review examined the demand and activity for each of the 20 H & I laboratories and 18 microbiology laboratories undertaking this testing. Ninety five per cent of the component work is undertaken out of hours, which adds pressure to the laboratories. Some operational issues are being picked up within this review; errors are relatively rare but can have a devastating impact. There is a variation in costs across the country and it is difficult to ascertain specific costs within each laboratory.

There is currently no clear commissioning pathway for donor characterisation and actions arising from the review will involve engagement with the commissioners of the service who are clinical commissioning groups and not specialist commissioners.

Obtaining pathology results on donor biopsies is becoming increasingly difficult, in part due to recruitment within pathology departments and night time working.

4.4 **SaBTO/ODT/BTS aide memoire - AGChC(17)3**

The next revision of the SaBTO 'Guidance on the microbiology safety of human organs, tissues and cells used in transplantation' is close to completion. A summary document 'aide memoire' to help interpret the lengthy guidelines is being produced and, when completed, will be accessible via the ODT website.

5 TOU2020 IMPLEMENTATION STRATEGY: THE FINAL STRATEGY - AGChC(17)4

5.1 The final strategy document for Taking Organ Utilisation to 2020 was received. C Callaghan will be taking forward a significant number of projects within the implementation plan. This strategy differs from the TOT2020 strategy in that it is not specifically a UK Departments of Health supported strategy but is focused on action being taken locally.

5.1.1 **Dissemination:** A meeting with each organ transplant service community will be held to review data on declines and organ utilisation and to share best practice. Additionally, there may be benefit in a forum to bring the donation and transplant communities together to discuss and address issues along the care pathway and to share lessons learned.

5.1.2 **Implementation - AGChC(17)5 & 5a**

A proposed timescale for action was shared with members and comments requested.

5.2 **Preparations for new allocation / offering schemes: Recipient-specific matching criteria and reasons for decline - AGChC(17)8**

R Johnson introduced a paper outlining proposals for the approach to capturing recipient specific criteria and reasons for organ offer decline to be implemented as part of the ODT Hub. Members were asked to approve these approached in principle and discuss the appropriateness of the categories for reasons for decline. J Asher and R Johnson would then liaise

J Asher / R Johnson

ACTION

and discuss the proposals with Advisory Group Chairs to agree final code lists.

5.3 **Improving the recording of reasons for organ offer decline - AGChC(17)6**

Members noted a proposal from J Asher on changing the approach to recording reasons for organ decline as part of the transformations with the Hub. The aim is to enable the capture of the true primary reason for the offer decline. It was noted that the approach would be generic but with specific decline criteria for each organ. Work is taking place on the auditing of local reasons for decline and comparing this against records held by ODT.

Members approved the approach in principle but requested clarification of the first point on page two as some centres may be multi-organ centres. It was agreed that some details of the proposal need to be refined and this would be carried out by J Asher in conjunction with R Johnson, C Williment and a member of the Hub team. **J Asher/ C Williment/ R Johnson**

5.4 **Recipient-specific matching criteria** - **AGChC(17)7**

New waiting list software is to be developed in the next programme increments of the ODT Hub development. In order to minimise inappropriate offers two solutions were proposed:

- Recipient matching criteria (for named patient offers)
- Centre-specific matching codes (for centre offers)

Members agreed to the approach outlined.

6 ALLOCATION POLICIES

6.1 Report from Clinicians

Liver Advisory Group

- In progress and this will be submitted to the Liver Advisory Group for sign off in May.
- Launch date is in the 4th quarter of this calendar year.
- There will be a 6 month delay in introducing DCD into the system to allow any issues with DBD to be resolved first.
- A major piece of work to be included will be the monitoring of organ utilisation and a response strategy.

Cardiothoracic Advisory Group

- The super urgent and urgent lung allocation scheme agreed by the Cardiothoracic Advisory Group is now ready for implementation in mid-May and as a result there will be adjustments to heart and lung policies.

Kidney Advisory Group

- The kidney offering scheme is under review and the next meeting of the working group is scheduled for May.

Multi-visceral Composite Tissue Advisory Group (formerly Bowel)

- In anticipation of the involvement of other composite transplants the Group has been renamed the Multi-visceral Composite Tissue Advisory Group.

- Combined intestinal and pancreatic retrieval – The current agreement is that the pancreas should be removed on the back table, preserving the full length of vessels with the intestine; the pancreas is then offered for islet transplantation. Following discussion at both MCTAG and PAG it was agreed that this arrangement should continue.

Pancreas Advisory Group

- No major changes to report. Work is ongoing comparing islet versus solid organ transplantation at extremes of BMI to ensure these are as effective as possible.
- Simultaneous islet kidney transplantation went live recently.

Research Innovation & Novel Technologies Advisory Group

- The new allocation policy for organs for research is currently being piloted and will be reviewed after 3 months in May.

6.2 **Report from ODT National Hub**

B Hume updated members on the IT platform to build an integrated service supporting world class organ donation, transplantation and follow up in the UK. This would operate with multiple IT platforms using scaled agile working. The heart and routine lung allocation schemes have been implemented and the super-urgent and urgent lung allocation schemes are about to go live in May.

Three key elements moving forward:

1 - By November 2017 a transplant list will be available to allow liver clinicians to register, view and update patient records
2 – By September 2017 the ODT Hub will deliver centralised organ offering and design work for a single referral and assessment process. By the end of March 2018 there will be a donor assessment process.
3 – Offering for liver and intestinal is scheduled to be on the new platforms by December 2017.

Funding of £3.2 m has been secured for this work for 2017/18.

7 EXTERNAL REPORT ON SCOUT PROJECT: FINAL REPORT - AGChC(17)9

Members noted the final report from the external review of the Scout Project. This is being taken forward by K Quinn as part of work on the retrieval service and will involve both J Stirling and S Tsui. The scout steering group will be reconvened to progress this work. It was noted that some data within the report suggested a significant increase in utilisation rates for liver, pancreas and kidney and members felt this should be raised at the steering group meeting.

8 GOVERNANCE UPDATE

8.1 **Governance report**

Following on from an incident where a positive culture was found in a bag of transport fluid J Dark advised that the reporting and onward transmission of these types of findings was proving to be sporadic with many centres reporting on all organisms and not specifically on fungal organisms.

J Dark highlighted that the need for surgeons to have a face to face discussion about consent for complex high risk organs at the time of donation is likely to go against the aims of the work on reducing the donation pathway process.

ACTION

8.2 **CUSUM and responses**

Liver: There have been no CUSUM triggers for some time; however, one liver centre is currently the subject of a formal external review. The current CUSUM indicators for liver were set in 2006 and need to be reviewed. It was noted that all CUSUM settings will be reviewed within the next six months

Kidney and pancreas: Following a quiet period there was a spike in activity in relation to CUSUMs. On a few occasions, either due to the response received or the seriousness of the issue, NHSBT has responded with a visit to the transplant centre concerned in order to discuss within an internal MDT. Most centres involved in this process have found the approach useful.

NHS Specialist Commissioners in the UK have always had an interest in the CUSUM trigger process and their oversight has been useful.

Members discussed the involvement of Trust management within the process and emphasised the need for Trusts to acknowledge that within transplantation there is a need to balance regulation and innovation.

Discussions are taking place on whether retrieval teams can be monitored in a similar way to the CUSUM approach with transplant centres. This would help to identify if multiple incidents are happening within teams and by individual surgeons. Members were supportive of the approach but cautioned that care would need to be taken as some retrieval teams are recurrently involved in particular problems/damage scenarios which are rarely borne out by the evidence when followed up.

9 CONSENT

9.1 A symposium on risk, assessment of risk and consent took place at the BTS Congress. Although a policy on consent was developed by the BTS, NHSBT and SaBTO, participants felt that in light of changes in legislation and duty of candour, more could be done. NHSBT is keen to work with the BTS to seek ways of improving consistency in taking consent across centres.

This issue is also being considered by the BTS Chapter of Surgeons and by both the Pancreas and the Multi-visceral and Composite Tissue Advisory Groups and the importance of a unified approach was stressed. Any guidance produced would, however, need to be adaptable to the risks in each centre which would make a universal approach more challenging.

A workshop with both lay and patient involvement to look at the issue of consent is planned.

10 INCIDENT REGARDING BROACHES OF PROTOCOL DURING REGIONAL RETRIEVAL BY NORS TEAM

10.1 Contrary to the agreed perfusion protocol, some pancreas teams have been using Soltran and not UW solution. It was reiterated that if perfusing in situ the inferior mesenteric vein should not be used if the pancreas is to be retrieved. As pancreas and islet transplant patients are both listed on one transplant list there is a need to ensure that vessels are available.

ACTION

There have been delays reported in pancreas and kidneys leaving theatre whilst awaiting preparation of the liver on the back bench. A letter to retrieval teams will be circulated regarding this matter.

11 Supplying NHSBT Data to other countries

J O'Grady reported that the Liver Advisory Group had agreed a defined dataset which can be released. In a 1st tier request, where a very good protocol has gone through a clinical review, the dataset would automatically be released. A 2nd tier request would be a request for data to support research. In this tier each application would be considered individually on two levels. Firstly it would need to be consistent with the policies of NHSBT and indicate whether there is a requirement for statistical support. Secondly, consideration as to oversight; are other centres carrying out similar work. These will not be supported if they are competing with other priorities.

R Johnson confirmed that the approach used in liver using a standard dataset had proved helpful and would be repeated for kidney.

It was also noted that any requests for data would be covered by the RINTAG Allocation of Research Organs Policy whereby any study in the UK requesting access to organs, tissues or data is classified by category and screened by Statistics and Clinical Audit and Research & Development before being approved.

Advisory Group Chairs were asked to consider the principle of requests for NHSBT data from outside the UK. Although any data would be released to an individual on a single-use basis the issue lay in how to control the use of the data once released abroad. Members agreed that requests from outside the UK should be considered subject to either agreement of a defined set of data from each Advisory Group or requests being considered on a study by study basis by the relevant Advisory Group.

12 ANY OTHER BUSINESS

Ante mortem interventions: P Murphy reported that the Department of Health had been approached re changes to current guidance for ante-mortem interventions. The response received suggested that the current legal guidance be withdrawn and oversight handed to the relevant professional bodies. Confirmation of this response in writing is awaited.

13 DATE OF NEXT MEETING:

13.1 Friday 7th July 2017, Boardroom, West End Donor Centre, London

April 2017