NHS BLOOD AND TRANSPLANT
ORGAN DONATION AND TRANSPLANTATION DIRECTORATE

THE TWENTY-FIRST MEETING OF THE NATIONAL RETRIEVAL GROUP (NRG)
WEDNESDAY 3RD OCTOBER 2018 FROM 10:30 UNTIL 15:30 AT THE
ROYAL COLLEGE OF ANAESTHETISTS, CHURCHILL HOUSE,
35 RED LION SQUARE, LONDON WC1R 4SG

MINUTES

Present:

Prof Rutger Ploeg	National Clinical Lead for Organ Retrieval **(Chair)**
Ms Karen Quinn	Assistant Director UK Commissioning, ODT (**Co-Chair)**
Mr Nawwar Al-Attar	Director of Cardiac Transplantation (part meeting via telecon)
Mr John Asher	Clinical Lead – Medical Informatics, ODT
Mr Nicholas Barnett	Consultant in Transplantation and Vascular Access Surgery
Mr Marius Berman	Consultant Cardiothoracic and Transplant Surgeon, NORS Clinical Lead
Ms Emma Billingham	Senior Commissioning Manager, ODT, NHSBT
Mr John Casey	Pancreas Advisory Group Surgical Representative
Miss Rebecca Curtis	Statistics and Clinical Studies, NHSBT
Prof John Dark	Clinical Lead for Governance, ODT, NHSBT
Ms Melissa D'Mello	Independent Lay Member
Prof John Forsythe	Associate Medical Director, ODT, NHSBT
Prof Peter Friend	Bowel Advisory Group Surgical Representative
Ms Victoria Gauden	National Quality Manager – ODT, NHSBT
Mrs Debbie Macklam	Senior Commissioning Manager – ODT, NHSBT
Ms Olive McGowan	Assistant Director of Education & Excellence, ODT, NHSBT
Ms Alex McGuire	Clinical Services Manager (part meeting via telecon)
Ms Cecelia McIntyre	Retrieval and Transplant Project Lead Specialist
Mr Gavin Pettigrew	Consultant Transplant Surgeon, Addenbrooke's Hospital
Mr Jonathon Olsburgh	Consultant Urologist and Transplant Surgeon (part meeting)
Mr Mark Roberts	Head of Commissioning Development, ODT
Ms Marian Ryan	Regional Manager, Eastern London and South East, ODT
Mr John Stirling	NORS Workforce Transformation Programme Lead
Mr Mick Stokes	Deputising for Jacki Newby – ODT Hub Operations
Mr Rajamiyer Venkateswaran	Cardiothoracic Advisory Group Surgical Representative
Prof Chris Watson	Kidney Advisory Group Surgical Representative
Ms Julie Whitney	Lead Nurse Service Delivery, ODT
Mr Colin Wilson	British Transplantation Society Surgical Representative
Ms Isabel Quiroga	NORS Clinical Lead Representative

In Attendance:

Mrs Jacqui Bennett	PA, Clinical and Support Services, NHSBT

Apologies:

Ms Liz Armstrong	Head of Service Development
Mr Roberto Cacciola	Associate National Clinical Lead for Organ Retrieval
Mr Chris Callaghan	National Clinical Lead for Abdominal Organ Utilisation, ODT
Mrs Victoria Fox	Independent Lay Member
Dr Dale Gardiner	National Clinical Lead for Organ Donation
Ms Sharon Gibson	Finance Business Partner, ODT
Ms Jacki Newby	Head of Referral & Offering, ODT
Mr Gabriel Oniscu	RINTAG Surgical Representative
Ms Fiona Wellington	Head of Operations for Organ Donation (SN-OD Representative)
Mrs Claire Williment	Head of Transplant Development, ODT, NHSBT

Item No	TITLE	ACTION
1	**WELCOME AND DECLARATIONS OF INTEREST IN RELATION TO THE AGENDA – NRG(18)1**	
1.1	R Ploeg welcomed members to the meeting and introductions were made. No declarations of interest were reported.	
2	**MINUTES OF THE RETRIEVAL GROUP MEETING HELD ON WEDNESDAY 18TH APRIL 2018 – NRG(M)(18)1**	
2.1	**Accuracy** The minutes of the previous meeting were agreed as a correct record.	
2.2	**Action Points – NRG(AP)(18)2** • **AP1 Retrieval of Small Intestine & Bowel** Ongoing, discussing in PAG. Feeling is that pancreases could be used and sent for isolation. Keeping under review. No major changes, as previously agreed. • **AP2 Advisory Group Priorities – Pancreas** Continue to liaise with Chair of MCTAG re retrieving both small bowel and pancreas with enough vessels. Ongoing, C/F to the next meeting. • **AP3, AP4 & AP5 NORS Team mobilisation and update from rapid improvement event** Refer to minute 5.2.1. • **AP6 PITHIA Trial** Refer to minute 6. • **AP7 Organ Quality E-Forms update** Refer to minute 7. • **AP8 SaBTO Aide Memoire** J Asher reported 22 responses, request to feedback asap if not already done so. • **AP9, AP10, AP11, AP12 Clinical Governance report** Refer to minute 7. • **AP13 Organ Damage report** Communicate to PAG Chair suggestion of a KPI for pancreas injury below a specified threshold such as <5%. C/F to next meeting. • **AP14 Terms of Reference** Tweaks done, ToR now agreed and recirculated. • **AP15 Scout Business Case** Refer to minute 8.1. • **AP16 Remembrance of donor** Guidance on the format for inclusion in the NORS standards completed. • **AP17 Commissioning Performance report NRG(18)12** Refer to minute 9.1. • **AP18 Any other business: Patient safety alert** Communication to NORS Teams re perfusion bags and fluids completed.	**Clinical & Support Services** (AP2) **All** (AP8) **Clinical & Support Services** (AP13)
2.3	**Matters Arising Not Separately Identified** There were no further matters arising.	
3	**ADVISORY GROUP PRIORITIES**	

Item No	TITLE	ACTION
3.1	**Multivisceral and Composite Tissue** No issues from MCTAG to raise.	
3.2	**Cardiothoracic** R Venkateswaran updated members on issues from CTAG: • Decision from Chair of CTAG; 3 priorities (on agenda today); ▪ DCD heart programme, Glasgow, Newcastle and Birmingham, refer to minute 4.2.1. ▪ Scouting, had number of telecons, refer to minute 8.1. ▪ TANRP protocol requires review, refer to minute 4.3.	
3.3	**Kidney** C Watson updated members on issues from KAG: • Allocation scheme hope to be running late 2018 or early 2019.	
3.4	**Liver** Update C/F as no rep from LAG present again. R Ploeg to contact LAG Chair to ask if rep can be arranged to attend this meeting.	**R Ploeg**
3.5	**Pancreas** J Casey updated members on issues from PAG: • Emphasise need to minimise pancreas damage. • Endeavouring to improve quality assessment of pancreas at time of retrieval. • Also keen to emphasise need for quality assessment. • Relatively minor changes made to pancreas allocation scheme, in line with kidney offering scheme. • Issues of pancreas and islet allocation, solutions sought. • Clear that allocation/offering scheme is not under threat, but ongoing discussions with HTA re regulations. Will go through framework of offering and process for HTA, highlighting responsibilities and governance and how they fit in with regulations.	
4	**UPDATE ON RESEARCH DEVELOPMENTS**	
4.1	**RINTAG** R Ploeg on behalf of G Oniscu briefed members on key points from RINTAG: • INOAR activity, organs for research and DCD heart discussed. • J Forsythe proposed creating foundation for strategy of how to take things forward.	
4.2	**DCD Hearts** **4.2.1 Heart Retrieval Update** • R Venkateswaran reported 70 retrievals and 10 deaths. • 3 units; Papworth, Manchester and Newcastle performed 1 DCD heart transplant due to launch programme on 15 October. • CTAG meeting next week, local lead to facilitate and launch in Glasgow. Need for proctures. • Paying for transport needs agreement. First responsibility of the recipient centre, in process of training locally. Number of proctures available to support to check heart good. Support for all centres to come on board, not funded. • Last year 5 extra heart transplants; need to have 2 DBD for 3	

Item No	TITLE	ACTION
	DCDs. Support for donor hospital required. • Procture surgeon will go back to recipient centre to ensure steps to make safe. • Newcastle will start 3 DCDs. They should have written to local CLODS for them to support DCD activity. Next in line is Glasgow. Met Birmingham, preparing - they have machine but haven't done DBD retrieval yet. Attending Boston for training before starting DBD process. • K Quinn happy with this, D Macklam working closely with teams. **4.2.2 Glasgow DCD Heart Protocol – NRG(18)14** N Al-Attar and A McGuire joined by telecon to present the Functional Restoration, Transportation, Assessment and Transplantation of Human DCD Hearts Protocol for the Golden Jubilee National Hospital, Glasgow. • P Curry is North lead AMCG service manager. Used experience from Manchester and Newcastle. Approached OD team re OCS retrievals. Able to perform DCD heart transplantation. • Significant amount of DCD donors. Reflects on own activity. • Protocol opened for discussion. C Watson noted Page 11 recipient inclusion criteria transplanting was from Freeman. Will make sure corrected. • Donation criteria Maastricht category 3 makes sense (page 6), but why not include Maastricht cat 4 as well? Can be incorporated into protocol, will add to allocation of donors. Will abide by National protocol and amend accordingly. • Stand down criteria (page 9), potentially up to 4 hours after withdrawal of treatment excessive. National agreement 3 hours, will amend protocol. • C Watson commented NRP 5 mg/kg dopamine dose is too high. R Venkateswaran would consider age limit <40. R Ploeg invited experts present to provide comments to colleagues in Glasgow. • P Friend felt discussion about an individual policy was inappropriate and should be requesting National protocol. Papworth and Harefield policies are in place, protocols should be copied then proctored. K Quinn concurred an agreed National protocol made sense and any deviation should be explained. • J Dark questioned how to avoid 2 donor teams attending the same donor and arrangements for lung and heart retrieval. R Venkateswaran said DCD heart had to retrieve lungs as well, if enough team members. If not enough for perfusion, would get 2nd on-call team to come in. Would need at least 2 surgeons for heart and lungs retrieval. However, DCD extra curricular, not BAU. If not possible for both, on-call team for lungs. J Dark pointed out the Glasgow protocol says will always retrieve lungs. NHSBT has agreed to pay, subject to NORS protocol. Glasgow happy to accede with National protocol. A lengthy discussion took place on this subject. • J Forsythe would support a National protocol, interpreted how Papwoth began rather than as they do now. With experience, and maybe over time, dosage volumes may change. • Named version to be kept up to date. DCD working group responsible for developments and alterations. *Actions*	

Item No	TITLE	ACTION
	• Modify protocol • Comments from others • Guidance from D Macklam	**N Al Attar / A McGuire C Watson R Venkateswaran J Dark D Macklam**
4.3	**UK TANRP Protocol – NRG(18)15** J Dark presented protocol for thoraco-abdominal normothermic regional perfusion (TANRP) for DCD organ retrieval. • Protocol put together due to concerns re damage to other organs. Gone through a variety of changes. DCD heart group now chaired by Jayan Parameshwar. • Descending aorta, can theoretically have cerebral perfusion. Still nothing specific in protocol. Potential issue still important. Illustrates lack of clarity re DCD hearts reporting to RINTAG then NRG. • Rollout process for other hospitals implementing TANRP. D Gardiner in discussions with M Ryan. • Protocol needs work, but only implemented at 3 hospitals. Parallel processes happening. • Responsibility for RINTAG; NRG informed if organs in conflict development. Has to go to SMT. All groups applying for technique have to go through NRG. NRG responsible to make sure organ donation happens in a safe way; RINTAG responsible for new techniques. • Needs to be clarified that innovations are discussed at RINTAG and practical things go to NRG, working together to present any new policies to SMT. • Already have DCD heart group. J Forsythe will coordinate and ensure that actions for RINTAG and NRG are made clear. • Paper already describes Scout function and transplant practitioners. Important to ensure using resources, if adding. Cannot rely on development if Scout not finalised.	**J Forsythe**
4.4	**Service Development NRP** • K Quinn (for G Oniscu) reported business case taken to sustainable funding meeting. • Agreed NHSBT will continue to refine business case to DoH to ensure sustainable funding from next financial year. Signs very good, 4 health departments supportive to date. • Additional funding for Edinburgh and Cambridge to ensure we get results needed for business case. • 100 in service development, that figure not yet reached, so interim solution for potential cases. • Looking at bidding for additional funding. If no funding available no fall back plan, so currently concentrating on business case for 1 April 2019. • Opportunity for opt out legislation and funding for NRP and others a focus. • Business case for NRP livers already includes an uplift.	
4.5	**QUOD report – NRG(18)16** R Ploeg presented QUOD Statistics report for August 2018. • No major issues. • Following G Pettigrew's success in Pithia trial, decided to switch in QUOD to 5 punch. Discussions with QA and CARE in NHSBT.	

Item No	TITLE	ACTION
	• G Pettigrew found in Cambridge, punch best quality of biopsy, if needed muscle plug in biopsy hole. • Pending these details G Pettigrew and R Ploeg to draft letter re taking biopsy and ensure inspect for suture. • Two years ago, cardiothoracic CTAG trained how to take samples. Cliona Berman working on Southern teams. C Watson to collect sample from bile duct. Agreement was to ensure LAG concur with that.	**G Pettigrew** **R Ploeg**
4.6	**Evaluation of Hypothermic, Intermittent, Oxygenated Ex-Vivo Heart Perfusion (HIOP) in Extended Human DBD and DCD Hearts** • J Dark reported that research application going to next RINTAG re low cost perfusion technique. Will reach NRG when becomes operational and should not currently be on agenda.	
5	**NHSBT UPDATE**	
5.1	**AMD Update** • Opt-out legislation – Scotland opt out bill now been published with an opportunity to reply. Now goes through processes in Scotland reviewing bill in detail. Various people will be called to give evidence. Also a financial impact assessment and NHSBT fed into that. • England - Bill being used as vehicle for government to put forward bill for opt out. Going before committee and if unanimously passed then next stage House of Lords, where further issues may be raised. • Initial impact assessment which ODT fed into. Said opt out legislation in England will require extra finance. A number of different issues important; ie. retrieval capacity and funding of new preservation and perfusion technology. Argument if want to make next ISE, demands better technology. • Resilience and sustainability of transplant centres means that the impact of more numbers; still concern if more work onto transplant centres. • Donor characterisation – Project is continuing to move forward with a view to securing funding. • Consent and assessment of risk – work done alongside British Transplantation Society with organ specific groups. Progress made in agreeing information available to patients. Looking at new tools to develop with consent. • Sustainability – questionnaire sent to all transplant units and sustainability summit in June with BTS, well attended. Agreement a lot more could be done, should have all received summary. Agreed to look at regional transplant centre meetings / collaboratives. First region to look at is London. Hoping to have a London collaborative meeting in November 2018, which would involve the London Renal and Pancreas units initially. • NHS England asked for preliminary meeting on liver transplant services. English centres invited to attend, with leads from each of the centres. • Spotlight on sustainability and resilience. Further increased with opt-out legislation. • R Venkateswaran agreed it will mean an increase in donors and transplant. Must make sure NHS England supports and ensure doesn't affect the cardiac transplant program.	

Item No	TITLE	ACTION
5.2	**ODT Hub update** M Stokes gave an update on the ODT Hub: • Kidney pancreas scheme being developed, looking at release by March to June 2019. • HTA-B form scheduled for release in December 2018. • NORS team mobilisation - looked at incidents for last 6 months. ▪ 28 incidents been reported re NORS April-Oct 2018, 20 of which reported as mobilisation issues; 5 of these required some learning by Hub Ops. ▪ 4 incidents failed to arrive within desired time due to high donor activity (not enough teams available). ▪ 2 occasions planned to mobilise team out of region when should have waited to mobilise local team. Had we called local teams, they would have been available a lot sooner. Both cases local teams contacted Hub Ops, so stood down outer region teams. Learning to always contact local teams to see if differences so can implement local teams for local donors. ▪ 1 occasion tried to book local team in advance, as was a busy day and anticipated problems. However, recipient coordinator advised we could not discuss mobilisation until team back on base, although only informing of potential call. If can agree team is out, coordinators can call, as this would assist with planning. ▪ 1 occasion where teams turned back from donor as recipient team declined kidneys. Learning – should have kept team on road and waited for fast track. ▪ 1 occasion told SNOD they could not have a team as kidneys still being offered (she had placed a liver). Learning – give correct info to SNOD. ▪ 1 occasion when timings were out for a team to arrive. Learning – if this were not changing, we would need to check timings on the calculator, as some journey times are out. ▪ 2 occasions where team arrived at donor hospital to find accepting team waiting to do NRP. On call team had also arrived; need further guidance re NRP – should they provide whole team or should NORS teams be mobilised? ▪ 3 separate Governance issues re flights – Commissioning to speak to Amvale. ▪ 1 occasion spent hour trying to mobilise and 2 occasions failed to mobilise, invited mobilisation template. ▪ 2 issues when DCD heart had been accepted but centres unable to provide staff to undertake retrieval – Commissioning looking at. ▪ Request from a CT team to retrieve from donor in hospital. RM overrode decision to let local team retrieve; Commissioning considering. ▪ One centre report called out too many times over busy weekend (5 retrievals in 60 hours); with Commissioning. • Unaware of agreement between Leeds and Manchester to start early during weeks on call; requested that Hub Ops should be advised of any other agreements. E Billingham clarified that this process has been discussed and agreed at previous NRG - teams that start early during their weeks on call will receive the	

Item No	TITLE	ACTION
	ad hoc workforce tariff, as will those who mobilise in the two hours prior to the end of their week on call. • K Quinn suggested M Stokes brings a report to NRG so everyone at group can all see issues. • R Ploeg commented that better registration of the time team leaves base and when donor team leaves hospital is highly relevant for efficient use of NORS teams. M Stokes stated this has improved.	**M Stokes**
5.2.1	**NORS Team mobilisation – NRG(18)17** Mick Stokes fed back some of the issues and actions take related to NORS mobilisation: • Delays in teams arriving at donor hospitals; • Issues sourcing flights; • UK wide donor activity leading to unavailability of NORS teams; • Mobilisation of NORS team to a donor then a second team arrive to use NRP/OCS. None of the recorded incidents have to date resulted in the non-retrieval or loss of organs.	
5.3	**Delays at Donor Hospital – NRG(18)18** E Billingham presented a paper regarding an investigation by Commissioning into delays at donor hospitals. Delays at the donor hospital are increasing but to fully understand the reasons for the delays, it is imperative that the RTI form is correctly completed. The use of the category “Other” must only be used when the delay falls outside the reasons offered on the RTI form. A short statement outlining the reason for an “Other” delay must be included in the free text field. Until the RTI data is complete it is not possible to fully analyse the causes of the delays in detail. NRG is asked to: • Notify all NORS centres of the problem with incomplete returns and to reiterate the importance of fully completing the RTI form. • Request that the category “Other” is only used if a delay falls outside of the pre-selected list and an explanation must be given in the free text box on the RTI form. • Review the current list of categories and advise whether additional fields should be included; eg. *‘Delay related to donor – additional tests/investigations, Organ offering’* and *‘Requested by the Recipient Centre’*. • Advise whether the current metric to measure delays on the RTI form is correct (time when the fully staffed team arrives at the donor hospital to the time when the team gains access to the donor theatre). DBD and DCD need different criteria. O McGowan is leading on work to reduce the overall length of the donation pathway. *Action:* • Agreement to enforce completion and to share the RTI form completion guide. E Billingham to draft letter to all NORS Centres on behalf of Chair of NRG.	**E Billingham**

Item No	TITLE	ACTION
6	**DIGITAL PATHOLOGY**	
6.1	**PITHIA Trial** G Pettigrew updated members on progress with the trial: • Pithia trial started 1 October; all approvals at national level. • Trial revolved around 6 histology centres. Approached NHS England who have agreed additional finding. • First 4 months 'bed in' period to observe current practices. In 4 months first 4 centres to get access, then under strict timetable. • Two things to note, meeting with Hub yesterday re biopsy service. Important to biopsy appropriate kidney and which kidney is going to which centre. Ideally for trial, important that biopsy is done at retrieval before NORS team leaves. • Confusion over which kidney went to whom still persists. KAG has again written to recipient centres; highest allocation scheme recipient is allocated left kidney. • O McGowan said top patient offered left kidney at centres. Been asked by Governance to amend policy if when right kidney better, can offer that. C Watson confirmed the circumstances when the centre can ask for a right kidney. • J Forsythe advised letter needs to go out to retrieval teams and kidney centres, as previous message has been interpreted incorrectly. • P Friend asked O McGowan to draft letter and pass on to C Watson before it goes out. • Scanners are not our property and are on lease for trial. Have for 3 years in service provision.	**O McGowan**
7	**CLINICAL GOVERNANCE**	
7.1	**Techniques for Biopsy of Small Renal Masses by NORS Teams – NRG(18)19** J Olsburgh presented a paper on Deceased donor kidneys (DDK) with a small renal mass (SRM): proposed benching and biopsy techniques by NORS surgeons. • Background: SRM found by retrieval team but skin punch incision was performed with unaffected kidney next to that but both kidneys were discarded. Asked to write proposal. • Proposed in paper 8 point approach where each kidney perfused, then one kept if second, then that kidney is bagged and put on ice. *Proposed SOP for Excision of SRM by NORS team:* ▪ Each kidney is carefully inspected on back table for possible SRM with appropriate removal of perinephric fat over parenchyma (but not hilum) to allow inspection for SRM. ▪ If SRM is suspected in one kidney that kidney should be put to one side on the bench in cold slushed ice and the contra-lateral kidney should be carefully re-inspected to ensure no SRM in contra-lateral kidney – If no SRM in the contra-lateral kidney, it should then be bagged and placed in cold storage. This would avoid the risk of tumour seeding after SRM biopsy. ▪ The kidney with the SRM should be photographed with clear marking and measurement of the SRM. This can be	

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<tr><th>Item No</th><th>TITLE</th><th>ACTION</th></tr>
<tr><td></td><td>done by the SNOD using their iPad Genius app.
▪ Discussion should be made with the SNOD to determine where the SRM histopathology assessment can take place. If possible, the NORS surgeon should speak with the pathologist to determine whether the SRM excision biopsy is placed in formalin or kept “fresh”.
▪ A circumferential excision (not incision) biopsy of the SRM should be performed with a scalpel obtaining a 2mm margin around the SRM and ensuring appropriate depth of excision biopsy so the SRM is excised in its entirety and not inadvertently incised at the deep margin.
▪ The kidney should be photographed again to show the biopsy cavity and separate photograph taken of the SRM.
▪ Repair of the kidney after excision of the SRM should not be attempted by the NORS team.
▪ The kidney (after excision of the SRM) should then be bagged and placed in cold storage in the normal manner.
▪ The SRM excision biopsy should be placed in formalin or left “fresh” (as determined by discussion with the pathologist), appropriately labelled and couriered for urgent pathology review. A typed formal pathology report should be available for the SNOD / Duty office within a clinically appropriate time frame for offering of all organs from the deceased donor.

• J Dark advised steps made in histopathology, one theoretical. Had lengthy correspondence with Joe Martin to look at how to set up national service for advice. Yet to finalise a date for meeting with Joe Martin and colleagues. Voluntary ad hoc service of past is no longer viable.
• Current practice liver team histopathology service.
• KAG – are kidney transplant teams happy for NORS teams to take excision biopsies?
• P Friend advised kidney requires scanning first. Paper presented is a pan European paper. France have up to date imaging to understand process. Kidney most likely to be affected is papillary tumour. VHL unlikely to be bi-lateral.
• C Watson will seek approval at KAG.
• J Forsythe said in circumstances described, need expert pathology advice. Promote good communication in kidney transplant centre.
• NRG to take this protocol as a base for discussions.
• To prevent harm, stopping surgeons from doing incision biopsies.
• Subject to KAG agreement, J Forsythe would be happy to approve.</td><td></td></tr>
<tr><td>7.2</td><td>Clinical Governance Report – NRG(18)20
• Change text about donation pathway
• All Advisory Groups now reporting in this format.
• Kidney biopsy, identified incident with wrong size ice cubes. As not all ice machines produce slush, retrieval teams advised to ensure ice machines produce the correct ice required for retrievals and organ packing.
• Video made of how to retrieve heart valves, to be made available for teaching purposes. Suture should be left.
• E-learning modules – request to add specific retrieval related</td><td></td></tr>
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Item No	TITLE	ACTION
	videos – O McGowan and J Dark to liaise for this. • Had 2 set of issues above and below diaphragm. Below consist of teams wanting NRP to be done. Teams either saying to delay until available for NRP, or can we do retrieval. As NRP ruled out, it won't be a problem, but currently potential problem. Greater problems above diaphragm. Standard is NORS team attend and on 2 occasions heart damaged by standard NORS team retrieving. First occasion Manchester flew to Kent to do retrieval and Harefield also attended. Responsibility of NORS team on call to arrange to be there at own cost. • Arrange data collection to gauge impact. M Stokes and K Quinn to liaise re this. • J Dark raised issue re flu. A team were retrieving from a donor who had been in contact with flu, went in with excessive protection. If donor OK for donation, standard theatre precautions are completely acceptable. Advisory docs in place. • Recent case of issue around consent required for untransplantable organs. J Forsythe advised potential for problems. Issue whether to allow dissection for teaching/ training purposes rather than retrieval for transplantation. Family not consented for removal and replacement. Intention was to undertake dissection, not remove. Issue or whether or not should be allowed without proper consent. Primary question: when you are working with colleagues striving for competence, allowed to do teaching? If so, allow for removal then putting back, even though you know not being used for transplantation? V Gauden advised removal is a licensed activity and cannot take effect without a licence. Scheduled purposes defined in the Tissues Act. In absence of INOAR, not permitted to remove organs legally for education and training. HTA Act says scheduled purposes only if have a licence for removal. If teaching, a scheduled purpose will require consent, even if no removal. If scheduled purposes in deceased donor, law says you have to have a licence, cannot take out and put back. • M Berman commented retrieval process is not just surgery; need individuals to train; clear difference between research and training. Dissection would only take place after discussion with SNOD etc. In theory, if discussed with family and consent was given, could be removed subject to licence. To allow dissection is acceptable, but removal is not until INOAR is in place. • J Forsythe felt it is acceptable to dissect (without removal) with research consent from family but not acceptable to perfuse or remove. However, V Gauden said this is not possible as carrying out procedure for education and training. • Using donor for education/training needs consent, removal needs a licence. Education and training needs to take place if we are to have surgeons in future. • INOAR scheduled to be in place December 2018/January 2019. • J Dark suggested reinforcing messages to retrieval teams. • V Gauden will discuss with R Ploeg out of meeting, with a view to seeking clarification from HTA.	**O McGowan / J Dark** **M Stokes / K Quinn** **V Gauden**
7.3	**Reconciling severe damage on HTA B forms and Incident Reporting** A year ago it became apparent that sometimes damage reported on HTA B forms didn't come to attention of clinical group. Since	

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<tr><td>7.4</td><td>Tissue Procurement by NORS Teams from organ donors in theatres – HTA Licensing requirements
V Gauden advised this relates to when NORS team retrieve tissues (heart valves, islets). Agreed procurement under NHSBT licence. Likely to be a couple of minor amendments (in discussion with HTA re finer points. HTA accepted action plan. Took ODT tissues outside.
Still in active discussions re islets. Had meeting to develop generic risk assessment. Felt achievable, revisited requirement for re-testing.
HTA said would consider appropriate to have incident report system, reported on online portal. Requirement to report any tissues retrieved within 24 hours.
HTA advised expect to see training records for NORS teams.
Need to roll out e-learning module. Current one needs tweaking.
Fascia different to abdominal wall. Abdominal wall is an organ, including vasculature (VCA) fascia is tissue.
NORS teams are not trained and competent for fascia, which are carried out by specialist teams.
Risk profile for organs and tissues is different.
If half vessel used, then other required, when vessels banked, those vessels fall under the tissue regulations.
Agreement required with HTA about training to keep organ retrieval.
Need workshop with HTA.</td><td></td></tr>
<tr><td>7.5</td><td>Organ Damage report – NRG(18)21
Members received the results of analysis of data reported on the damage of organs retrieved by NORS retrieval teams in the 24 months from April 2016 to March 2018; moderate or severe damage as recorded on the HTA-B form by the receiving surgeon.

R Curtis covered main points.
Table 1 shows significantly high damage rate for DCD livers from Manchester.
Previous results that showed significantly high damage are no longer present.
Teams receiving monthly breakdown of damage data.
Report isn't being published online.
Each month, data is sent to the NORS teams on organs retrieved, those damaged and those damaged which were not used for transplantation. This is an opportunity for teams to validate whether damage was surgical and any changes should be fed back to the Statistics team.
If a consistent problem, have to have a plan of how to deal with. Is there a process or is it just for info?
J Forsythe wanted Cusum for retrieval teams. If a centre is repeatedly seen to be at fault in these reviews, there should be a letter requiring response, with deadlines. However, discussed with Rachel Johnson and found that this would not be possible.
R Curtis suggestion to add in some sort of chart to display any long term history of significantly high damage rates.</td><td></td></tr>
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Item No	TITLE	ACTION
	• Pancreas, inspect to see whether good enough or not. Is fatty pancreas included under damage – R Curtis will find out. • *Post meeting addition: fatty pancreases are not recorded as damaged on this report as the data is taken from the HTA-B form.* • K Quinn would like a small group of clinicians to determine what should be flagged as an issue of concern, so that the Commissioning team are able to highlight problems with NORS centres.	**R Curtis** **AG Chairs**
7.6	**Organ Quality Assessment (OrQA) Project** C Wilson presented slides. • Medical device consisting of sterile slide put on organ and photographed. • Proposal is to take system to donor hospitals, 1600 images over 18 months. Validate system by finding out. • MHRA adjudicated class 1 medical device, not liaised with HTA. • Photos Newcastle and Edinburgh liver, kidney or pancreas, looking for perfusion. This should go through RINTAG before progressing to NRG. • C Wilson to send protocol to group, as otherwise it will be another 6 months. • Can score a liver between 0-100 and corresponds with a view to speeding up allocation at donor site.	**C Wilson**
7.7	**HTA A/B Forms** • Encouraging progress. HTA B form in development. Making sure all centres can access. Local trust is compatible. • Rather than having to put all details in, populated automatically. Meeting with Emma Bailey in June. • User interface to input data. • System works by a reconciliation, has to be a link to send donor path to CRM. • Plans to move towards opt-out - no guarantee funding available in future. • Full product demonstrated a couple of years ago. • Like a steer, is implementation viable, or is donor form to be mirrored. • All questions documented on paper. Had demo yesterday of HTA B form. Were told there were no plans to do the electronic organ specific forms as part of this project. • Instead of having donor & recipient image, now presented with a B form where damage is recorded. • M Stokes advised needs to be careful what communicated. • HTA A form discovery workshop in Newcastle on 17 October 2018. • Research aspect of A form. Will it have research information on? Workshop on 17 Oct to define. • Last time all agreed electronic definition of variables. Up to IT to take this forwards. • NRG formally said high priority to deliver on electronic retrieval data, including variables on HTA A and B forms.	
7.8	**Deep Dive Process Reviews – NRG(18)22** O McGowan gave update on implementation of 'Deep Dives'.	

Item No	TITLE	ACTION
	• The ODT Clinical Governance team manage incidents from across the organ donation and transplantation pathway and a number of these relate to NORS mobilisation or retrieval incidents. • How these incidents were investigated was reviewed and a 'Deep Dive' approach focussing on processes and wider concerns of a number of reports is being trialled. Triggers for a 'deep dive' to include: • A worrying trend • Waste of resources • Capacity Deep Dives occur every 2 months and on the alternate month an action plan call is held to ensure that any key actions are being taken forward. Led by Clinical Governance team and including reps from: • Commissioning • Hub Operations • Operational • Clinical input The Clinical Governance team have facilitated a number of Deep Dive reviews, which has highlighted recurrent themes/trends and resulted in significant learning and actions that would not have been identified by reviewing incidents in isolation.	
8	**WORKFORCE TRANSFORMATION AND TRAINING**	
8.1	**Scout business case** J Stirling provided an update • Workforce transformation set up to implement NORS transformation. Introduced standardisation on 1 April. • Exploring implementation practitioner. Approved by SMT, awaiting final organ preservation data analysis. Will present report next month. • Scout business case taken to SMT in March. SMT approved majority of recommendations. Models proposed were not deemed cost effective. • Recommendation to look at different delivery models. Different makeup of sub-groups transplant managers. • Trying to work through NORS team taking a financial risk. • Next meeting of sub-group tomorrow; aim to take updated case to SMT. • As NRG won't reconvene until April, need to circulate beforehand (including costs) once get model from sub-group, before presenting to SMT.	
8.2	**Training and Competence** R Ploeg reported that a Masterclass is being organised by faculty under Isobel Quiroga's guidance on 9 and 10 December 2018 with Workforce represented. • J Stirling and R Ploeg to liaise with colleagues re abdominal electronic module.	**J Stirling / R Ploeg**
9	**COMMISIONING**	

Item No	TITLE	ACTION
9.1	**Commissioning Performance Report – NRG(18)23** Members received the Commissioning Performance Report for June 2018. • Fig 4.1 shows slight reduction in number of DBD organs retrieved by NORS teams. • 5.1 shows spike in organ damage in June (not included in report earlier). Shows any peaks and long term history. • 7.1 shows timely arrival at retrieval teams dipped, but came back up again in most recent quarter. • Internal report looked at within Commissioning. Not particularly for this groups reference, but of interest. Reassurance internal report reviewed monthly. Clinical damage criteria been helpful.	
9.2	**Capacity and Demand update – NRG(18)24** Members received an update report on capacity and demand on-call sequences. Equity of current activity has been analysed as part of the Capacity and Demand working group and the need to move to a new allocation system, where only the first and second named NORS teams in an on-call sequence are defined, has been recognised. K Quinn and R Curtis presented a paper on the proposed on-call sequences to be introduced in addition to simulation results when using these sequences. • Group chaired by Keith Rigg. One suggestion was to look at how many more weeks we need for capacity to meet demand - Stats will run some simulations. • Sequence is primarily determined by travel times, but also changes will be made to equalise activity as much as possible. • Similar approach with cardiothoracic. • Some hospitals in more remote parts of the UK have been allocated to quieter teams' second on-call. This could increase the number of flights needed; is this desirable? • Appendices present full list of hospitals showing differences and approval. • Used old scheme as a guide, maybe historical. • The original scheme tried to avoid the expense of flying teams around the country. • Question whether overall capacity needs to be increased. • Ideal preference for each hospital number 1 and number 2 team. Pick out anomalies from list, K Quinn and R Curtis to liaise.	**K Quinn / R Curtis**
10	**FOR INFORMATION**	
10.1	**Terms of Reference** No issues/questions.	
11	**ANY OTHER BUSINESS**	
	• R Venkateswaran was approached last week re availability of a new organ transport box. Conventional ice box with controlled method of cooling the heart, showing temperature all the time, with a CE mark of approval. Paragonix far cheaper than ones currently used and would offered a free trial 5 boxes. Seeking approval from NRG to use. M Berman advised Papworth also	

Item No	TITLE	ACTION
	trialled 5 boxes and were impressed. Will submit to internal committee. • NHSBT does not purchase cardiothoracic boxes, so it is up to the individual teams what they use. R Venkatswaran and M Berman will liaise with results.	**R Venkateswaran / M Berman**
12	**Date of next meeting**	
	Wednesday 24th April 2019 – venue TBC	