NHS BLOOD AND TRANSPLANT
ORGAN DONATION AND TRANSPLANTATION DIRECTORATE

THE TWENTY-SECOND MEETING OF THE NATIONAL RETRIEVAL GROUP (NRG) *(NOW NAMED RETRIEVAL ADVISORY GROUP)* WEDNESDAY 24th APRIL FROM 10:30 UNTIL 15:30 AT THE WESLEY CONFERENCE CENTRE 81-103 EUSTON STREET, KINGS CROSS, LONDON, NW1 2EZ

MINUTES

Present:

Mr Ian Currie	National Clinical Lead for Organ Retrieval **(Chair)**
Ms Liz Armstrong	Lead Nurse – Service Development, ODT, NHSBT
Mr John Asher	Clinical Lead – Medical Informatics, ODT. NHSBT
Mr Marius Berman	Associate Clinical Lead for Organ Retrieval
Mr Chris Callaghan	National Clinical Lead for Organ Utilisation (Abdominal)
Miss Rebecca Curtis	Statistics and Clinical Studies, NHSBT
Professor John Forsythe	Medical Director – ODT, NHSBT
Ms Vicky Fox	Lay Member
Ms Victoria Gauden	National Quality Manager – ODT, NHSBT
Prof Derek Manas	National Clinical Lead, Governance
Ms Olive McGowan	Assistant Director of Education & Excellence, ODT, NHSBT
Ms Cecelia McIntyre	Retrieval and Transplant Project Lead Specialist
Ms Jacki Newby	Head of Referral and Offering, ODT, NHSBT
Mr Gavin Pettigrew	Consultant Transplant Surgeon, Addenbrooke's Hospital
Prof Rutger Ploeg	(Retiring) National Clinical Lead for Organ Retrieval
Ms Karen Quinn	Assistant Director – UK Commissioning – ODT, NHSBT
Ms Isabel Quiroga	NORS Clinical Lead Representative
Mr Mark Roberts	Head of Commissioning Development, ODT, NHSBT
Prof Chris Watson	Kidney Advisory Group, Surgical Representative
Mr Craig Wheelans	National Medical Advisor, NHS Scotland
Ms Julie Whitney	Lead Nurse Service Delivery, ODT, NHSBT

In Attendance:

Ms Caroline Robinson	Clinical and Support Services Manager – ODT, NHSBT **(Minutes)**

		ACTION
1.	**WELCOME, INTRODUCTION & APOLOGIES**	
1.1	The new Chair of the National Retrieval Group (NRG), I Currie welcomed all to the meeting and introduced himself and Associate Lead, M Berman. The previous Chair, R Ploeg was thanked for all his work over many years leading and driving forward the work of the group despite many obstacles along the way. In a short handover ceremony, R Ploeg stated that the core of NRG's mission remains to facilitate retrieval and promote organ donation and he thanked the many groups at ODT for their assistance in helping to make this happen. Gifts were exchanged as formal recognition of the change in Chair for this and subsequent meetings.	
1.2	Apologies were received from John Casey, Melissa D'Mello, Peter Friend, Sian Lewis, Roseanne McDonald, Gabriel Oniscu, Colin Wilson	
2.	**ACCURACY AND FOLLOW UP OF PREVIOUS MINUTES AND ACTION POINTS OF THE NATIONAL RETRIEVAL GROUP - RAG(M)18)2**	
2.1	Minutes - The Minutes of the last NRG meeting on Weds 3rd October 2018 were approved with some amendments as follows:	

	• I Quiroga was added to the list of attendees • D Manas did not attend as stated • Item 4.3 - the words 'cerebral confusion' were changed to 'cerebral perfusion' • Item 5.1 – 'Contents and assessment of risk' should read 'Consent and assessment of risk' • Item 7.6 – should read 'Medical device consisting of sterile slide put on organ and photographed' • Item 7.7 – should read 'Plans to move towards opt-out – no guarantee funding available in future'	
2.2	Action Points - The Action Points **RAG(AP)(19)1** were updated as follows:	
	AP1: Advisory Group Priorities – Pancreas – It was agreed that I Currie would contact J Casey and P Friend regarding retrieval of both the small bowel and pancreas with enough vessels	**I Currie**
	AP2: Organ Damage report – It was agreed D Manas will speak to J Casey regarding a KPI for pancreas injury below a specified threshold such as <5%	**D Manas**
	AP3: Liver – R Ploeg has spoken to the previous Chair of LAG and the new Chair is arranging attendance of a rep from LAG at NRG in future if he cannot attend himself.	**CLOSED**
	AP4: Glasgow DCD Heart Protocol – It was agreed that I Currie would write to N Al Attar requesting an update at the next NRG meeting regarding modification of the protocol	**I Currie**
	AP5: UK TANRP Protocol – J Forsythe reported that there had been a good discussion with Alex Manara to pull together a group to look at the protocol. The group is now active including liaison with Belgian and Canadian colleagues. Further work is to follow.	**CLOSED**
	AP6: QUOD Report – it was agreed at ODT CARE in April that there would be further examination of the use of punch biopsies after several incidents recently involving haemorrhage following implant. Retraining and videos are planned to help improve the process. It was agreed a 5mm punch biopsy is minimum size for QUOD/Pithia.	**CLOSED**
	AP7: ODT Hub Update – Following agreement for a report to come to NRG, a written report from M Roberts is on the agenda.	**See Item 11.2 below**
	AP8: Delays at Donor Hospital – O McGowan reported that a letter has gone to all NORS centres on behalf of the Chair of NRG regarding work to reduce delays in the donation pathway	**CLOSED**
	AP9: PITHIA Trial – O McGowan to check that a letter has gone to retrieval teams and kidney centres as previous message had been interpreted incorrectly.	**O McGowan**
	AP10: Clinical Governance Report – J Dark has spoken to R Ploeg regarding adding e-learning modules for retrieval of heart valves to the retrieval course. M Berman will follow up with J Dark	**M Berman**
	AP11: M Stokes and K Quinn agreed to arrange data collection to gauge impact	**CLOSED**
	AP12: Clinical Governance Report – Clarification is needed around HTA implications of training during organ retrieval surgery. A Fixed Term working group will address this.	**V Gauden / I Currie**
	AP13: Organ Damage Report - It was confirmed that a fatty pancreas should not be included as organ damage	**CLOSED**
	AP14: Organ Damage Report – K Quinn requested that a small group of clinicians investigate what should be flagged as issues for concern as reports currently have several errors. **ACTION: A fixed term working group was agreed to consist of D Manas, I Currie, I Quiroga, M Roberts and J Asher.**	**D Manas / I Currie / I Quiroga / M Roberts / J Asher**

	AP15: Organ Quality Assessment (OrQA) Project – Agreed that D Manas will check if C Wilson has sent through a report for NRG as agreed at the last meeting	**D Manas**
	AP16: Training and Competence – J Stirling and R Ploeg have been liaising with colleagues to refresh the abdominal electronic module. C Wilson to follow up	**C Wilson**
	AP17: Capacity and Demand Update - K Quinn and R Curtis have liaised re ideal preference for each hospital number 1 and number 2 team.	**CLOSED**
	AP18: Any Other Business – NHSBT does not purchase cardiothoracic boxes, so it is up to the individual teams what they use. R Venkateswaran and M Berman will liaise with results.	**R Venkatas-waran / M Berman**
2.3	Matters Arising – there were no matters arising.	
3.	**MAJOR INITIATIVES**	
3.1	Re-Configuration of NRG **–** I Currie stated that NRG was set up some time ago to cover many aspects of the work of the retrieval community. It now has a very large membership, but this does not always represent retrieval surgeons on the ground. In the future, the increased use of novel technologies and the need to involve retrieval surgeons in decision making, means that better representation from all the retrieval teams at NRG is required. There will be a change in structure to bring in 16 representatives along with members from RINTAG, CLOD and SNOD communities, peri-op, cardiothoracic and abdominal members, retrieval co-ordinators, the Hub, clinical governance and lay representatives. Membership is not finalised yet and comments/views on the future of NRG are invited. It is possible that up to 3 NRG meetings per year could replace the need for CRF meetings, although some caution was expressed about increasing costs by having more frequent meetings. Overall, it was agreed that it was a good time to make changes that will reflect and support the workload of the group as well as maintain momentum. In addition, it was noted that the name of this advisory group will become known as *Retrieval Advisory Group (RAG)* in future.	
3.2	DCD Development Group – The Terms of Reference for this group will be finalised in the next few weeks. It was agreed that NRP is here to stay and the expansion of DCD Hearts was discussed.	
4.	**NHSBT UPDATE**	
4.1	AMD update – J Forsythe gave an update of current NHSBT activity. • Opt Out – Legislation will be enshrined in Scotland in the next few months. Royal Assent is now approved in England. The new legislation should increase donors overall, but it was noted that if we are going to make the best use of organs, extra resource in terms of retrieval and technologies is needed. • Donor Characterisation – Thanks were given to all involved in putting NHSBT in a strong position. • New Technology – Extra resource and good planning is needed to make the most of this. • Utilisation – It has been another record year with 1600 donors, but transplant numbers have reduced for deceased donors, particularly for cardiothoracic and lung transplants which is a concern. It was agreed that Opt out work provides an opportunity to seek additional funding to improve capacity and resource.	
5	**ADVISORY GROUP PRIORITIES**	

	There were updates from Marius Berman (Cardiothoracic), Chris Watson (Kidney) and Derek Manas (Liver) representing the Advisory Groups. It was noted that there is increased use of novel technologies for DCD Hearts. The allocation scheme for kidneys will be implemented later this year. There have been some issues for the liver allocation scheme and a report from Mark Hudson is awaited regarding issues regarding transplantation for older recipients. Concern was expressed at NRG that perhaps Newcastle and Edinburgh are being disadvantaged by the scheme at present.	
6.	**UPDATE ON RESEARCH DEVELOPMENTS**	
6.1	RINTAG – There was no update from RINTAG at the meeting	
6.2	QUOD Statistics – **RAG(19)1** – R Ploeg gave a presentation of QUOD Bioresource Key Figures for 3995 donors at 1 April 2019.	
7	**HUB UPDATE**	
	J Newby reported that the change to zonal allocation from geographical allocation is live and following some governance incidents, is working well. However, there are still problems with mobilisation after 2 am and some variation in what teams will do. The issue around use of novel technologies and whether teams should retrieve both heart and lungs if on the road was raised. It was confirmed that resource should not go to waste and both heart and lungs should be retrieved by the same team. The Hub team has increased in number and it was reported that both PITHIA and the Kidney scheme have gone live and are going well.	
8	**ICT REPORT FOR ADVISORY GROUPS - RAG(19)2**	
	N Breeds circulated a summary of ICT developments and services for information.	
9	**DIGITAL PATHOLOGY**	
	G Pettigrew reported that following randomisation of 4 centres (Glasgow, Portsmouth, Coventry and Belfast), initial feedback has been positive with no problems reported on biopsies. In June more centres will be included (Guys, Manchester, Nottingham and Birmingham). Although it can take some time to get biopsy results, it is hoped this is a teething issue and practice will change as learning improves.	
10	**CLINICAL GOVERNANCE – RAG(19)3**	
	The Clinical Governance report for April 2019 was circulated. O McGowan reported one incident where the heart from a DBD donor was accepted for transplant for an urgent patient. Due to a breakdown in communication and process whilst the heart was retrieved and placed in the transport box, it was not handed over to the transport driver for an additional 26 minutes. This extra time incurred meant the cold ischaemic time (CIT) was beyond what was considered usable for the heart transplant. It was confirmed that the organ could not have been used elsewhere at that stage as there was insufficient time to prepare another patient following the delays noted. Work is ongoing to review actions and responsibilities as part of the incident management. NRG noted that abdominal organs can take a long time to retrieve which can delay the process if multiple organs are being retrieved and this can make responsibilities difficult to delineate. In this case however, a breakdown in communications was identified and it was agreed that SNODs need to take overall responsibility for dispatch and communications.	

11	**ORGAN DAMAGE**	
11.1	Organ Damage Report **– RAG(19)4** This paper was circulated prior to the meeting showing analysis of data reported on the damage of organs retrieved in the 24 months from 1 January 2017 to 31 December 2018. Centres also get monthly reports. A significantly high DBD pancreas damage rate was particularly noted at King's. NRG noted that this is an important topic and several questions arose from the report. It was agreed that while NORS retrieval teams own the data, it is a commissioned service by NHSBT and so it is important to understand issues arising from the retrievals. Any report of the data needs to be as watertight as possible prior to any approach of a centre to discuss organ damage and there would be initial dialogue with teams prior to a more formal discussion. Relevant donor numbers will be needed when discussing reviews at contract renewal times. V Fox stated that she would like to be included in any group that investigates this data.	
11.2	Proposal to Improve Organ Damage Reporting – **RAG(19)5** This paper was circulated and the need for shared learning to understand the causes of organ damage was acknowledged. At present, there is insufficient detail of data to understand where the important issues lie and proposals to improve the quality of the report were invited. There has been a slight increase in organs not transplanted due to damage and it was noted that this should be delineated by DCD and DBD donors. It was also agreed that incidents where novel technologies had been used and what type of damage had occurred should be recorded in the report along with any relevant donor factors in the narrative. The categories used in the report were questioned as each organ can have different types of damage that are specific to the type of organ. One issue highlighted is that there is no automatic link between the HTA B form and Clinical Governance and while the report plays an important role in passing on information, this is usually a month after the event when memories can be poor about what happened at the retrieval. The exceptional work of some of the retrieval teams was noted along with the importance of cross pollination of expertise.	
12	**TRAINING AND REGISTRATION**	
	I Currie stated that NHSBT currently keeps a log of those retrieval surgeons who are fully trained and signed off as competent. This has traditionally been called the 'Training and Accreditation' process, but this terminology has generated some concerns as NHSBT is not an accrediting body. In addition, it has proved difficult to get up-to-date information about who is in the teams due to staffing issues in the Clinical and Support Team at NHSBT and lack of response from some retrieval teams. It has been acknowledged that while it is important to gain information on the competence of the teams, the current process is unwieldy and unreliable. In future, this process will be re-badged as 'Training and Registration' and the process will be overhauled to make it more acceptable and easier to manage all round. If surgeons have achieved all training and are on a retrieval rota they will become fully registered. NORS leads will be empowered to determine whether their team members are safe to retrieve organs independently and those surgeons joining teams after working abroad will still be required to attend the Masterclass to gain full registration. The sign off for tissue was raised, particularly as HTA is likely to check that NHSBT is recording competence. It was noted that if tissue retrieval is done alongside the work of the NORS teams, this is likely to be done by someone working at a high level but, as yet, there is no agreement regarding how this will be recorded by NHSBT.	**I Currie / V Gauden**

	ACTION: V Gauden and I Currie will take up this issue outside the meeting.	
13	**INOAR – RAG(19)6, RAG(19)7 and RAG(19)8** L Armstrong presented the current work of this sub group of RINTAG which aims to extend the existing Liverpool Research HTA Licence (12068) permitting the removal of whole organs for research purposes at 41 hospitals in England, Wales and N. Ireland. The INOAR project will be delivered in 2 phases: • Phase 1 – Removal of Heart, Lungs and Diabetic Pancreas • Phase 2 – Removal of all organs Phase 1 will be evaluated before Phase 2 development is started. The project will require support from the NORS teams to remove, perfuse and package organs with the appropriate consent/authorisation to the same standards as those removed for transplantation. HTA A and B research forms have been devised to ensure organ traceability. NORS teams will not be mobilised for the removal of organs for research only and at least 1 organ must have been offered and accepted for transplant. Although INOAR has been presented at a variety of meetings including SMT, RINTAG, Advisory Group Chairs meetings and CRG it was noted that there has not been much dialogue with teams yet about the project. At present, the electronic changes needed for the project's paperwork are not in place and have been subject to delay and a paper workaround has been considered but not yet agreed. It was also noted that the flowcharts for the project are somewhat confusing and it was agreed that these need more work. Further discussions regarding how the project will work with the retrieval teams and communications with those teams has been suggested and L Armstrong, M Berman, I Currie and G Oniscu will have further discussions regarding how this may best be achieved. **ACTION: L Armstrong, M Berman, I Currie and G Oniscu to discuss**	**L Armstrong / M Berman / I Currie / G Oniscu**
14	**VIDEO HEART AND LUNG PROJECT**	
	There is a great deal of interest from cardiothoracic colleagues concerning the use of video to make better decisions regarding retrieval. The kidney imaging pilot is now in its 2nd stage and a pancreas imaging pilot will start shortly. C Callaghan offered to assist with development of a similar project for heart and lung imaging. It was noted that this can be a complex pathway and it is important to involve SNODS and the Hub at an early stage of any development. It was also suggested that John Richardson may be able to help with using EOS and Donorpath to attach images (although WhatsApp was also suggested as a secure way to send images). **ACTION: M Berman will take this forward and will discuss with J Asher and C Callaghan.**	**M Berman / C Callaghan / J Asher**
15	**NORS GUIDANCE –RAG(19)9**	
	This paper was circulated in response to several incidents reported in relation to incorrect counts, frequently associated with missing raytec swabs and potentially affecting subsequent procedures in theatre. In the event of a miscount local policy must be followed. Any untoward incidents must be reported via the incident reporting tool. https://www.odt.nhs.uk/odt-structures-and-standards/governance-and-quality/tell-us-about-an-incident/ It was agreed that the nature of the retrieval procedure means the cardiothoracic team(s) leave the donor theatre prior to the end of the procedure and so the Abdominal Scrub Practitioner is responsible for the full final check of remaining accountable raytec items. At NRG it was	

	agreed that the abdominal nurse in cardiothoracic retrievals should not be involved in counting swabs as their first duty is to retrieve organs in a timely fashion.	
16	**UTERINE TRANSPLANT**	
	The protocol and ethics approval were agreed in 2018 for this research project involving Oxford and Imperial and contracts have now been signed. It has also been discussed at SMT, RINTAG and NRG previously. NHSBT requested a letter from Oxford Finance confirming that no extra funding will be required to undertake Uterine Retrieval from a NORS perspective and that the NORS service will not be affected. There is funding for 10 transplants and in 2019, one region (London) is to go ahead with the project with Dan Harvey (CLOD) designated as Project Lead assisted by Angie Scales. Training for SNODS and SOP development is now required. NRG was asked if the Oxford team can be ring-fenced to do the uterine retrieval once consent has been achieved. It was agreed that it is important to know how long the Oxford team would be off line for other retrievals as a result in case this affects the workload of the other retrieval teams. **ACTION: Oxford NORS team can be ring fenced for the first consented/suitable uterine donor and case 1 will be reviewed to determine future action.**	**I Quiroga / L Armstrong**
17	**HTA eFORMS**	
	The forms have been rolled out for Pancreas and Kidney retrievals. However, there have been some IT issues at the trusts as well as a funding hiatus at NHSBT which is affecting use of both forms. A paper workaround while these issues are resolved was discussed. However, it was agreed at NRG that continuing development with a paper fix may mean that an electronic solution is not progressed. Use of the forms is to be discussed at PAG in the coming week. NRG noted that it is disappointing that both forms are not yet in full use electronically, but it is good that one of them is now up and running.	
18	**ANY OTHER BUSINESS**	
	There was no additional business raised	
19	**DATE OF NEXT MEETING**	
	The next meeting of National Retrieval Group – now to be called Retrieval Advisory Group (RAG) – will be on **Tuesday 1 October 2019 from 10:30-15:30**. The venue in central London will be confirmed in due course.	