NHS BLOOD AND TRANSPLANT
ORGAN DONATION & TRANSPLANTATION DIRECTORATE

MINUTES OF THE THIRTY SEVENTH MEETING OF THE LIVER ADVISORY GROUP HELD ON WEDNESDAY 20 NOVEMBER 2019 AT 12 BLOOMSBURY SQUARE, LONDON, WC1A 2LP

PRESENT:

Prof Douglas Thorburn	**Chairman**
Mr John Isaac	Deputy Chair, Surgeon, Queen Elizabeth Hospital, Birmingham
Ms Anya Adair	Surgeon, Royal Infirmary of Edinburgh
Dr Varuna Aluvihare,	Physician, King's College Hospital
Mr Mark Aldersley	Physician Co-ordinator Representative
Mr Magdy Attia	Surgeon, St James's University Hospital, Leeds
Prof William Bernal	Liver Critical Care, King's College Hospital
Mr Chris Callaghan	National Clinical Lead for Organ Utilisation (Abdominal)
Mr John Crookenden	Liver Patients' Transplant Consortium
Prof John Forsythe	Medical Director, ODT for NHSBT
Prof Peter Friend	Chair of Multi-Visceral & Composite Tissue Advisory Group & National Retrieval Rep, Oxford
Mr Paul Gibbs	Surgeon, Addenbrooke's Hospital, Cambridge
Dr Tassos Grammaticopoulos	Physician, King's College Hospital, London
Ms Pam Healy	Chief Executive, British Liver Trust
Mr Emir Hoti	Surgeon, St Vincent's University Hospital, Dublin
Dr Diarmaid Houlihan	Physician, St Vincent's University Hospital, Dublin
Dr Mark Hudson	Physician, Freeman Hospital, Newcastle and Chair of the National Liver Offering Scheme Monitoring Committee
Dr Joanna Leithead	Physician, Addenbrooke's Hospital, Cambridge
Ms Wendy Littlejohn	Recipient Co-ordinator Representative
Prof Derek Manas	National Clinical Lead for Governance, The Freeman Hospital, Newcastle upon Tyne
Dr Aileen Marshall	Hepatologist, Royal Free Hospital, London
Mrs Sarah Matthew	Lay Member
Mr Andreas Prachalias	Surgeon, King's College Hospital
Ms Katherine Quist	Recipient Co-Ordinator, Adults
Dr Sanjay Rajwal	Paediatric Hepatologist, Leeds
Mr Gourab Sen	Hepatobiliary and Transplant Surgeon, The Freeman Hospital, Newcastle upon Tyne
Dr Ken Simpson	Physician, Royal Infirmary of Edinburgh
Ms Rhiannon Taylor	Statistics and Clinical Studies, NHSBT
Dr Indra van Mourik	Physician, Birmingham Children's Hospital
Ms Sarah Watson	NHS England Rep
Prof Stephen Wigmore	BTS Rep
Ms Julie Whitney	Head of Referral and Offering, NHSBT

IN ATTENDANCE:

Mrs Kamann Huang	Clinical & Support Services, ODT

ACTION

APOLOGIES & WELCOME

Apologies:
Dr Andrew Holt, Prof Joerg-Matthias Pollok, Dr Tracey Rees,
Ms Susan Richards, Ms Alison Taylor and Mrs Lynne Vernon

1 DECLARATIONS OF INTEREST IN RELATION TO AGENDA - LAG(19)1

1.1 There were no declarations of interest.

2 MINUTES OF THE MEETING HELD ON 8 MAY 2019 - LAG(M)(19)1

2.1 **Accuracy**

2.1.1 The minutes of the previous meeting were agreed as an accurate record.

2.2 **Action points – LAG(AP)(19)2**

2.2.1 All Action points are referred to as agenda items with the exception of the following three:

AP1 – National Liver Offering Scheme
Examine the demographics and aetiology for those patients remaining on the registration list since implementation of the Scheme. This is In Hand by Statistics.

AP2 – Provide data for declined named offers by centre since the implementation date of NLOS This is In Hand by Statistics.

AP11 – Extracorporeal liver perfusion
Look at how the process will work logistically for extracorporeal liver perfusion for patients with acute liver failure with priority given before NHS group 2 patients and research. J Whitney is awaiting feedback regarding final approvals to comply with the required risk assessments and operational changes.

2.3 Matters arising, not separately identified

2.3.1 **LAG Terms of Reference - LAG(19)27**

The Terms of Reference were approved to incorporate the following amendments:

'Liver Patient Support Group' under the category of 'Members' to be revised to *'Liver Patients' Transplant Consortium Group'*.

'Statistics & Clinical Audit' to be revised to '*Statistics & Clinical Studies'* throughout document

2.3.2 **LAG Core Group update**

D Thorburn gave an update on the key issues discussed by Core Group covering updated parameter estimates, centre behaviour for Fast Track, livers turned down and not retrieved and DCD utilisation.

It was highlighted that there are no representatives from Cambridge or Newcastle on Core Group. Following discussions, it was agreed that the Group would continue with its current membership but this will be reviewed.

ACTION

Site visits

D Thorburn thanked all the centres for accommodating his visit to get a better understanding of their working practices as well as to meet the wider clinical teams. Common issues regarding HCC practice variation were raised along with capacity demands on large volume centres.

3 NATIONAL OFFERING SCHEME

3.1 Compliance with sequential data (SDC) submission - LAG(19)28

3.1.1 Members were informed that NHSBT had not received any SDC forms for 35 (10%) of patients who had been active on the transplant list for more than 30 days. Centres were reminded of the need to send regular updates back to NHSBT to ensure accuracy of the TBS score for patients.

3.2 National Liver Offering Scheme (18 months data) - LAG(19)29

3.2.1 Key points from Report:

- There is a lower mortality rate post NLOS. Patients added are more likely to be transplanted. We need to record new registrations and their mortality rate and not just new additions as well as the mortality of all patients and the waiting list outcomes over the same time periods pre and post NLOS.
- All centres saw an increase in donor offers. The previous report included intestinal offers for patients requiring a liver which is now excluded.
- Number of livers accepted and not used – it was commented there are too many categories for reasons not used.
- Currently a full explanation is not required for the decline of an offer for a named patient. The proposal is that in future centres will need to give a detailed reason for the decline.
- A recurring question is the deterioration in DCD outcomes reported in the one-year data. There has been no statistically significant difference for the previous five years.
- Data for the percentage for grafts FT has not yet been examined. The last report showed DBD at 28% and DCD at 40%.
- A key question is how do we fine tune FT going forward and DCDs? Overall, 50% of the livers are transplanted outside the scheme. DCD transplants account for 30% of livers and DBD for 40%.
- It was asked whether long waiters are falling off the waiting list. There is registration outcome data for this. The recommendation is to record the patients' prevalent condition before NLOS.
- We need to continue monitoring the demographics of patients on the waiting list compared to the same time period pre NLOS. 92% first graft compared with 91% prior.

3.3 & 3.4 Feedback from the Monitoring Committee and specific NLOS Issues

3.3.1 Main issues and discussion points were:

- The pattern is very much as before with the primary concern being the inequity of donor liver offers for HCC patients. Evidence has been presented showing that there may be an over estimation of patient survival. We need to understand the cause of the inequity e.g. the time of listing. Data shows there is a wide variation in offers and transplant activity

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between centres and it is difficult to establish whether this is down to centre size or practice. It is not clear whether this is a capacity or resource issue. For the over 60 years age group there has been an increase from 30 - 33% for DBDs.

- King's asked why patients on the waiting list at 20 March 2018 were not getting as many offers as patients joining the new scheme and not knowing the cause is a serious concern. D Manas will look into the question of how many patients were bypassed as a result of local management decisions and not going through the offering system. **D Manas**

- There is a wide variation in offers for variant syndrome patients. Outcomes are good but decline rates are high. One outlier centre has received 62% of offers made. The proposal is to reduce proportional allocation from 10% to 5% for this cohort. P Gibbs commented that a lot of HCC patients are older resulting in the younger age group getting even less offers? so we should not randomly allocate. There is also a higher mortality for patients with regrafts.

- Overall mortality has been lower on the waiting list since NLOS (from 2- 4% post and 3 – 7% prior).

- The use of machine perfusion will be added to the liver donor form and it is hoped that this will be completed by the end of this financial year. This will have an effect on two centres for CIT for Edinburgh and Newcastle.

- Royal Free raised the question of whether the assumption of mortality being better for the 26-39 age group has been tested generally. This has not been looked at as the review point is undertaken at 5 years after registration. Age has a strong impact on TBS. The Monitoring Group is to assess the reduction in the transplant activity for that age group and the effect on the mortality rate. **M Hudson**

- J Crookenden highlighted that the QoL for PSC patients was very poor and priority should be given patients who have waited a long time and were already registered before NLOS. R Taylor to have another look at the PSC numbers in conjunction with HCC patients. We currently do not have data for QoL for any of the patient groups. **R Taylor**

Next Steps:

The view is that we should not wait another six months to view further results but to undertake some modelling to be shared with centres and then to make a decision.

- Look further into two options – revising the TBS using updated parameters or proportional allocation. There is evidence that M1 survival is best for HCC patients. **D Thorburn/ M Hudson/ R Taylor**

- Send a questionnaire round centres to see how they manage HCC patients e.g. if they are delisted or remain on the list? No data has been seen for HCC patients prior to NLOS.

3.5 Donor zones – LAG(19)30

3.5.1 The current liver allocation zones introduced on 8 January 2013 were based on adult DBD donors only and did not take into consideration DCD donors.

A concern has been raised that there are no appropriate donor offers to paediatric centres. Birmingham and King's are reporting that they are

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receiving a smaller proportion of donors compared to Leeds. There are only 25 paediatric donor offers nationally per annum. A donor not from your own zone is currently offered sequentially through your centre.

LAG agreed that the same current liver allocation zones continue to be applied to adult but new zones to be proposed for paediatric donors and adult donors meeting split criteria

3.6 Offering of blood group AB donors – LAG(19)31

3.6.1 A concern has been raised that there is no prioritisation for blood group A donors, blood group AB patients may be offered a blood group A liver before a blood group A patient. AB patients are shown to be waiting less than other blood groups and it was reported that there was an increase in transplants last year using blood group B organs.

LAG agreed to prioritise blood group B patients ahead of blood group AB patients for blood group B donors but not to change the blood group priority for blood group A donors.

3.7 Simultaneous Liver and Kidney waiting list

3.7.1 Following discussion LAG agreed that waiting time for kidney only patients registered on the liver and kidney list with a variant syndrome should start from the earliest of liver registration, kidney registration or dialysis start date. Waiting time for elective liver and kidney patients registered with CLD or \hCC would not change and would start from liver registration. This has been discussed prior to the meeting with the Chair of the Kidney Advisory Group who agreed with the recommendation.

4 UPDATE FROM FTWUs

4.1 Cirrhotic – ACLF – LAG(19)33a & b

4.1.1 The first part of the report remains unchanged when it was reviewed at the last LAG meeting in May.

The second part of the report has been refined and includes consultation looking at the evaluation of cirrhotic patients with patient representation.

The report outlines new ways of classifying patients now with transplantation being shown to be very successful for some patients.

The FTWU have agreed the basic parameters around threshold severity and work is in progress with A Gimson looking at graft allocation within the existing offering scheme.

It is anticipated that the pilot would see 30 - 50 patients within 2 years. It was agreed that once 30 patients have been registered this would serve as the point to review the pilot. Discussion took place regarding where these patients would be offered in the liver offering sequence and it was agreed that they would be offered after the super-urgent, multi-visceral, combined liver and cardiothoracic and paediatric split tiers but before the adult elective tiers. D Thorburn recommended that the decision to register a patient should be made by the clinical surgeon and this is to be made clear in the Guidelines. The clinical surgeon's decision needs to be made with consensus within the unit. **W Bernal**

Approval was given by LAG to undertake the pilot.

R Taylor to communicate to NHSBT ODT Hub to build this into the offering sequence. **R Taylor**

ACTION

4.2 Fast Track - LAG(19)34

4.2.1 The FTWU chaired by D Manas looked at the current five trigger points for FT in NLOS.

It was agreed that *'knife to skin'* in the first option 'The liver is declined for any reasons after retrieval has commenced or is not yet accepted by any centre at or after knife to skin' needs to be amended to *'cross clamp*'. This needs to improve. It was acknowledged that the reason for decline needs to be made clearer. The FTWU has agreed that the offer of a liver will continue until it has been declined 7 times instead of 3 donor or organ reasons. The detailed reasons for decline also needs to be logged.

LAG agreed to the five points for FT made by the FTWU and the suggestion was made to write the criteria as single sentences to avoid confusion. **D Manas**

It was also agreed that the fast-track sequence for CLD patients should be changed to a rota sequence rather than be based on the highest TBS Score.

The FTWU also recommended that if the liver had been offered and declined for all blood group and weight compatible named elective variant syndrome patients, then offering should continue down the named CLD/ HCC pathway.

The agreed criteria will need to be raised at The Retrieval Group (RAG) to ensure retrieval teams and relevant parties are notified. **D Manas**

4.3 Liver Splitting - LAG(19)35

4.3.1 The current splitting criteria are:

- DBD
- Age <40 years
- Weight > 50 kg
- ITU stay is less than 5 days

The proposed revised splitting criteria are:

- Age <45 years
- Weight <90 kg or BMI <30
- latest ALT prior to offering <200 and latest bilirubin to offering <30

It is estimated that 70-80 splits are required annually. The revised criteria are expected to provide an average of 110-120 splits annually and would have a negative impact on travel time.

It was acknowledged that under the new criteria different patients would be selected for splitting? and this change needs to be monitored.

Points raised were:

- make clear that paediatric donors are offered to paediatrics first up to the age of 16 years.
- look at the data again for modelling on <90 kilos AND BMI < 30. **R Taylor**
- BMI is commonly not measured and is always estimated.
- the paediatric centre can determine how much they want to use of the left lobe which will determine how the right lobe is eventually used.

LAG approved the proposed criteria.

ACTION

4.4 Cholangiocarcinoma and MELD exception points (LAG(19)36 changed to verbal report)

4.3.1 The FTWU is chaired by N Heaton. A summary was given by J Isaac. Discussions on liver transplantation for hilar cholangiocarcinoma have taken place and there is a recommendation for tumours less than 3 cm to be classed as an indication for transplantation. The specifics of the protocol is yet to be determined.

Recommendations for hilar cholangiocarcinoma have yet to be decided and there is also a need to discuss proportional allocation. Work is still ongoing with final recommendations yet to be produced.

4.5 Neuroendocrine Tumours (NET) – (LAG(19)37 changed to verbal report)

4.5.1 The FTWU is chaired by T Shah. Work undertaken so far has recommended that NET should be classed as an indication for registration for OLT within a service evaluation. Clinical staging needs to be standardised and the group recommends a 3 and 6 monthly CT scan for patients and biopsies whilst on the waiting list. It is perceived that there are 50 patients eligible over 5 years. Discussions need to take place on the allocation of the liver but it was highlighted that the transplants need to take place within 6 months to have a successful outcome. A further update will be given at the next meeting.

4.6 Centralised explant review, SU listing & HCC – LAG(19)38

4.6.1 The FTWU is chaired by A Suddle. In his absence a summary update was given. The direction of the work originally was to look at standardising operational practice across centres for minimal listing criteria. Work is now being undertaken to look at defining the need for minimal listing criteria and what the criteria should be. An update will be given at the next meeting.

5 ODT HUB UPDATE

5.1 With the acceptance of the transplantation of HCV positive organs into HCV negative recipients the interim offering plan will be for organs to be fast tracked (FT) through the positive virology scheme for all organ groups. As more centres come on board, organs will be FT and offered to the highest ranking.

Contact and Offering Workshop

A Workshop was held in August and 16 themes were raised to improve communication, following complaints from centres getting through to Hub Operations, and operational improvements. The Chairs of the Advisory Groups have agreed to 'a single point of contact' pilot scheme for named patient offers over the coming months in King's and Addenbrookes.

The FT agreement is not to include centres in group or FT offers if they have previously declined for all recipients due to donor related reasons; if previous decline was for logistical reasons the centre will be included in subsequent offers due to circumstances changing over time.

Another issue is that there is no trigger to stop offering following multiple declines for donor related reasons which are offered to all centres. Each Advisory Group Chair is to review the number of organs accepted and transplanted if the organ is declined for the same donor related reason by three or more centres and make recommendations. It was commented that if a retrieval surgeon and accepting surgeon agree that an organ is not transplantable, consideration needs to be given to the fact that to meet organ

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utilisation the maximum opportunity needs to be given for the liver to be used e.g. a fatty organ is a judgement call as opposed to a cancerous liver.

6 ADULT TO ADULT LIVE DONOR TRANSPLANT

6.1 This type of transplant will be part of the post 2020 strategy for liver transplantation and will form part of organ offering. This agenda item can now be removed.

7 LIVER TRANSPLANT COMMISSIONING

7.1 **NHS England**
S Watson reported that no proposals or applications had been received by centres in response to the offering of a franchise model for liver transplantation.

Feedback from King's was that their model would be looking at exploring patients' geography and having full clinical teams in place. S Watson stated that this would need to be submitted as an Aspirant Market entry.

8 OPT OUT LEGISLATION IN ORGAN DONATION – LAG(19)39

8.1 A presentation was circulated to members regarding the anticipated consequences of the change in law around organ donation. NHS England has been updated by NHSBT on the potential increase in transplantation numbers.

It was questioned whether the legislation would affect families favouring DBD over DCD. Hub Operations reported that they have not seen any evidence of this arising and DCD and DBD will continue to be delivered in the same way it is now with no priority given to either.

Post Meeting Note:
The Chair stated that DBD is better than DCD and where possible this would be targeted but will not be built into the 'Opt Out' Scheme. D Thorburn will discuss with R Johnson to include in the NHSBT strategy to use DBD wherever possible to maximise donation.

9 SUSTAINABILITY

9.1 With more donor organs being available this will place a squeeze on resource and with the 'Opt Out' legislation this will create further pressures.

One option already in discussion in London has been the Pan London Transplant Collaboration (PLTC). A meeting is being held in December for this collaboration scheme to be rolled out in other regions of the UK to maximise resource. Another initiative has been the Lung Transplant Summit held in conjunction with BTS. This forum has produced 12 recommendations to improve lung transplantation. This could be a national initiative for Liver.

The British Liver Transplant Group (BLTG) have been holding discussions with commissioning hubs. Each centre will respond with their services for the next five years detailing what extra resource and facilities will be required. It was highlighted that any requests made needs to be backed up by evidence. It was acknowledged that most transplant centres also serve as district hospitals.

ACTION

It was reported that a kidney pilot scheme has been undertaken to inform patients if it is a logistical or capacity issue that has resulted in their transplants being cancelled.

The recommendation is for liver centres to have a Liver Transplant Summit with patient involvement.

10 ORGAN UTILISATION – HIGH QUALITY DONORS – LAG(19)40

10.1 Offer Review Schemes (ORS) are currently operating in the UK deceased donor kidney and pancreas transplantation. This looks at individual organ offer declines or organ discards from 'high quality donors' which are defined by a set of criteria. If an organ is discarded, it will be highlighted to a Clinical Review. If a concern is ongoing a letter will be sent to the centre.

The proposal is to implement ORS for livers. The criteria for 'high quality donors' for livers will require a sub set of quality donors for adult elective patients

This was agreed by LAG.

11 LUNG-LIVER CASES

11.1 This is an uncommon indication with two lung and liver transplant cases arising in the last 10 years; with two additional cases arising in the last year. The two cases were discussed with cardiothoracic surgeons as the two patients did not meet the minimal listing criteria. An informal Lung/Liver Group is in place and if either the lung/liver do not meet minimal listing criteria, it will go through the appropriate Appeals or Adjudication Panel. This has been agreed by both the cardiothoracic groups and liver groups for both heart/liver and lung/liver patients.

12 CLINICAL SERVICE EVALUATIONS/PROPOSALS

12.1 HCC Downstaging – LAG(19)41

12.1.1 Since the introduction of the service evaluation on 2 March 2015 to transplant HCC down-staging patients, 38 patients have been registered with 34 transplants undertaken, three patients dying while on the waiting list and one still active on the waiting list. Of the 34 transplanted patients, 29 were alive and one had died.

A letter has been sent to all centres informing them that the service development will be closing once 40 patients have been listed.

The proposal is to keep the programme open to look at 2 and 5 year survival outcomes. This was approved by LAG.

Centres will be written to asking for further information on any disease recurrence in patients. **R Taylor**

13 COLECTORAL METASTASIS AS A TRANSPLANT INDICATION – LAG(19)42

13.1 This study has previously been raised by P Muiesan looking for all centres to be involved and not just one. This has stalled because the trial does not include the size of lesions and lesions greater than 5.5 cm would incur a high recurrence of transplantation. It was also reported that there was a big

ACTION

problem with post-transplants not included in report. All transplant centres previously agreed with the study but the recommendation was that it needed to go through R&D.

D Thorburn proposed a FTWU to be set up to recommend an indication for discussion or undertake as a pilot study. J Isaac will discuss this with J Forsythe. **J Isaac**

14 MODIFICATION OF THE OFFERNG SEQUENCE TO PRIORITISE LIVERS TO PATIENTS UNDER NEW INDICATIONS

14.1 Listing criteria will need to be established before this can progress.

15 USE OF HEPATITIS C VIRAEMIC DONORS IN TRANSPLANTATION

15.1 Update on Welsh Experience (LAG(19)43 changed to verbal report)
To-date the Cardiff transplant centre leading on the use of hepatitis C viraemic donors in transplantation have undertaken eight kidney transplants between May and October of this year. Livers and cardiothoracic organs are currently not included in Wales.

15.2 Offering of Hep C positive donors
There is now access to DAA drugs for the transplantation of HCV positive donors to HCV negative recipients and there is an agreed national protocol detailing the criteria to be in place at transplant centres to accept these organs.

For a centre to be offered HCV positive organs, approval needs to be given by A Elsharkawy and the required paperwork and consent form is to be returned to D Mutimer.

Approval given to centres so far are:

Edinburgh – liver and kidney
Cardiff – kidney
Belfast – kidney
Birmingham – liver
Royal Free?

16 GOVERNANCE ISSUES

16.1 Non-compliance with allocation

16.1.1 There have been no reports of non-compliance with allocation.

16.2 Governance

16.2.1 Governance Report – LAG(19)44

16.2.1 Issues highlighted were:

- Communication needs to improve between accepting centres when a liver is being split. Miscommunication has led to one case resulting in a poor outcome.

ACTION

- Unexpected and unintended IT changes to the National Liver Offering Scheme were implemented when the updated kidney and pancreas offering schemes went live on 11 September. It was agreed that offering would revert to centre-based offering whilst the issue was investigated and resolved and NLOS was reinstated on the 19 September 2019. The final investigation still ongoing and centres affected have been contacted.
- An incident recently occurred where centres expressed concerns regarding whether a super-urgent registration met the super-urgent criteria. It was agreed that centres with concerns should discuss with the registering centre and should contact Chair of LAG if the concerns remain. The Liver Selection Policy has been updated and communication will be sent to all transplant centres.
- QUOD - The question of whether a recipient should be asked for consent for a biopsy was said to cause a huge logistical challenge. It was highlighted that centres taking a biopsy of a lesion need to know the result before transplantation starts.
- Using the pithio-platform as a national donor pathology platform has not been received well and meetings are taking place with laboratory managers.

16.2.2 New findings at transplant centres requiring histopathology – LAG(19)45a & b

16.2.2.1 Members were informed of the operating procedure and form to be completed for an accepting centre on finding lesions on an organ requiring histopathology assessment.

16.3 CUSUM

16.3.1 Summary of CUSUM monitoring of outcomes following liver Transplantation – LAG(19)46

There has been one CUSUM trigger in June 2019 against the national rate and one trigger at the same centre in July 2019 against the centre specific rate for adult elective liver transplantation. A formal review for the national rate trigger has been held and acted upon.

Overall, there has been about four or five triggers in the last 12 months.

16.3.2 Report on recent triggers

16.3.2.1 There have been no recent triggers.

16.3.3 Lessons learnt template - CUSUM triggers – LAG(19)47

16.3.3.1 Doug, Was this approved?

17 STATISTICS AND CLINICAL STUDIES (SCS) REPORT

17.1 Summary from Statistics and Clinical Studies – LAG(19)48

17.1.1 A paper was provided giving an update.

A key highlight was the new kidney and pancreas offering schemes going live on 11 September 2019.

The first Annual Review has been produced since the implementation of NLOS. J Forsythe and D Thorburn will be writing to each transplant centre to obtain feedback regarding the operation of NLOS for the first 12 months.

ACTION

National infographics have been produced summarizing the annual organ specific reports and members are asked to review the infographics and provide feedback through the survey on the website **All Members**

R Taylor was thanked for her hard work for the statistical support provided for the FTWUs.

18 MULTI-VISCERAL & COMPOSITE TISSUE ADVISORY GROUP (MCTAG)

18.1 Report from the Multi-Visceral & Composite Tissue Advisory Group Meeting - 13 March 2019

18.1.1 There were no significant concerns arising from MCTAG to be reported to LAG.

19 ORGAN OFFERING PROCESS AND CONTACT BETWEEN ODT AND TRANSPLANT CENTRES – LAG(19)49

19.1 Refer to Item 5.1

20 ANY OTHER BUSINESS

20.1 **Review of NICE guidelines for cirrhosis.** Mark Aldersley agreed in his capacity as a hepatologist to represent LAG in the Review. It was highlighted that aetiology needs to be included in the guidelines.

20.2 Issues were raised regarding the type of blood used when organs are on machine perfusion and whether livers from viraemic positive donors should be placed on machine perfusion. It was agreed a FTWU would be established to resolve at these issues **D Thorburn**

20.3 I van Mourik confirmed that a group had been established to review the paediatric indications.

21 Date of next meetings:

- Wednesday 20th May 2020, London.
- Wednesday 18th November 2020, London

22 FOR INFORMATION ONLY

The following papers were attached for information to members:

22.1 **Transplant activity report: September 2019 - LAG(19)50**

22.2 **Group 2 Transplants – LAG(19)51**

22.3 **Outcome of appeals – LAG(19)52**

22.4 **Activity and organ utilisation monitoring (dashboard) – LAG(19)53**

22.5 **Minutes of the Multi-Visceral & Composite Tissue Advisory Group meeting: 13 March 2019 - LAG(19)54**

22.6 **Minutes from the National Retrieval Group: 24 April 2018 - LAG(19)55**

ACTION

22.7 **QUOD statistical reports – October 2019 - LAG(19)56**

Organ Donation & Transplantation Directorate **November 2019**

Administrative Lead: Kamann Huang