NHS BLOOD AND TRANSPLANT
ORGAN AND TISSUE DONATION AND TRANSPLANTATION DIRECTORATE

THE TWENTY FIRST MEETING OF THE MULTI-VISCERAL AND COMPOSITE TISSUE ADVISORY GROUP MEETING AT 11:30 AM ON WEDNESDAY 11 MARCH 2020, AMBASSADORS BLOOMSBURY HOTEL, 12 UPPER WOBURN PLACE, BLOOMSBURY, LONDON, WC1H 0HX

PRESENT:

Prof Peter Friend	**Chairman** (and Rep for National Retrieval and Liver)
Dr Girish Gupte	Deputy Chair & Birmingham Intestinal Transplant Centre Rep
Dr Philip Allan	Oxford Intestinal Transplant Centre
Dr Elisa Allen	Statistics and Clinical Studies
Mr Andrew Butler	Cambridge Intestinal Transplant Centre
Dr Richard Baker	National Clinical Governance Lead, ODT
Ms Samantha Duncan	Recipient Co-Ordinator Rep
Mr Michael Gumn	Information Services Rep
Dr Susan Hill	Paediatric gastroenterologist and BSPGHAN Rep
Ms Heather Howe	Recipient Co-Ordinator
Ms Katie Morley	Recipient Co-Ordinator Lead
Prof Elizabeth Murphy	Lay Member
Ms Angie Scales	SNOD Rep
Dr Lisa Sharkey	Cambridge Intestinal Transplant Centre
Mr Hector Vilca-Melendez	King's Intestinal Transplant Centre
Ms Sarah Watson	NHS England
Ms Julie Whitney	ODT Hub Rep

IN ATTENDANCE:

Mrs Kamann Huang	Secretary, ODT

ACTION

Welcome

Apologies were received from:
Ms Carly Bambridge, Prof John Forsythe, Dr Simon Gabe, Mr Henk Giele, Ms Monika Hackett, Dr Jonathan Hind, Prof Simon Kay, Ms Sarah Peacock, Dr Tracey Rees, and Mr Khalid Sharif.

Mr Craig Jones will no longer be a Lay Member following a change in his job.

1 DECLARATIONS OF INTEREST IN RELATION TO AGENDA - MCTAG(19)16

1.1 There were no declarations of interest in relation to the agenda.

ACTION

2 MINUTES OF THE MCTAG MEETING ON 16 OCTOBER 2019 - MCTAG(M)(19)2

2.1 Accuracy

2.1.1 The minutes of the meeting held on 16 October 2019 were agreed as an accurate record.

2.2 Action Points – MCTAG(AP)(20)1

2.2.1 Liaise with HTA regarding the classification of abdominal fascia in the context of intestinal transplantation and inform J Forsythe to confirm if further action is required (AP2 24.10.18)
A Butler reported there has been no communication from D Manas regarding discussions on the storage of vessels.

The HTA has accepted individual applications for the refrigerated storage of fascia (regarded as tissue and not an organ) beyond the limit of 48 hours. The HTA will not extend fascia storage for 14 days for governmental legal and safety reasons. J Whitney will speak to Vicky Gauden regarding the issue of fascia storage and provide an update. **J Whitney**

Currently, SNODs at King's, Royal Free and Addenbrooke's take consent for fascia as part of the bowel but cannot without the bowel. The question was raised as to whether there should be a blanket consent for fascia. H Vilca-Melendez stated that putting in a general requirement would not resolve the issue of paediatric donors as their fascia may be too small to be usable.

A Butler confirmed that there is published documentation for vessels, taken as tissue and used in intestinal transplants, but not for fascia which also a tissue. A Butler to present documentation/minutes of meetings with HTA at the next MCTAG meeting. **A Butler**

J Whitney, V Gauden, A Butler and H Vilca-Melendez to discuss this further via a teleconference with J Whitney to lead on this. **J Whitney**

2.3 Matters arising, not separately identified

2.3.1 There were no matters arising.

3 ASSOCIATE MEDICAL DIRECTOR'S REPORT

3.1 Governance

3.1.1 Non-compliance with allocation

3.1.1.1 There were no non-compliances reported with respect to allocation.

3.1.2 Detailed analysis of incidents for review – MCTAG(20)2

3.1.2.1 An incident was raised regarding an intestinal transplant centre not being able to provide a NORS team for retrieval of all abdominal organs and requesting the on-call NORS team to retrieve. The matter has been resolved: if the accepting intestinal transplant centre is not on-call for NORS, then a 1 to 2 member team from that centre will join the allocated NORS team to facilitate intestinal/multi-visceral retrieval. This has been formally agreed with RAG.

ACTION

4 Coding of abdominal wall fascia – MCTAG(20)3

4.1.1 M Gumn requested clinical input to enable correct coding of the abdominal wall fascia.

Skin and subcutaneous tissues are left with the donor when retrieving the fascia. The fascia is later dissected from the abdominal muscles at the recipient hospital, and the muscle disposed of.

These criteria will be incorporated into the coding process; M Gumn will check the historical data to clarify in which cases the abdominal wall/fascia was actually transplanted. NHSBT clinical contacts to answer questions related to this item will be A Butler and H Vilca-Melendez.

5 Priority of hepatoblastoma and intestinal recipients in the paediatric setting

5.1 G Gupte raised a concern about the number of paediatric donor livers that have been used for children with hepatoblastomas that might have been suitable for children awaiting multi-visceral transplants. It was agreed that data over the last 4 years would be gathered, relating to the use of donors of less than 30kg.This may lead to a request to review the relative prioritisation of these two groups of patients. It was noted that multi-visceral recipients require a size-matched deceased donor, whereas hepatoblastoma patients may have the option of living donors or split livers from deceased donors.

E Allen to provide G Gupte with the data for presentation to the LAG meeting in May. **E Allen**

6 STATISTICS AND CLINICAL STUDIES REPORT

6.1 **Summary from Statistics and Clinical Studies – MCTAG(20)4**

The question was raised as to whether it was necessary to collect post-transplant DSA data, as occurs at present. This was reported to be time consuming for both H&I labs and the Statistics team, and there appears to be no current plans for analysis.

A Butler expressed the view that it is important to continue the data collection as one of its uses is to inform the management of simultaneous kidney and bowel transplants.

E Allen to confer with S Peacock to establish if the data collection can be simplified, e.g. to collect lab data in the same format as the data collection form. S Peacock will provide guidance on analysis objectives. **E Allen/ S Peacock**

6.2 **POL193 – MCTAG(20)5**

MCTAG responses to queries regarding the policy for the allocation and acceptance of organs to adult and paediatric recipients on the UK national transplant list:

- Section 1.3 Allocation policy (P3). Retain points 1 and 2. Remove point 3.

ACTION

- Section 1.3.1.6 Overseas donors and recipients (P4). It was agreed that the offer of overseas donors should be simultaneously sent to all intestinal centres, a 45 minute response window should be allowed for all transplant centres to respond and then the organ allocated according to the intestinal matching run.
- 'Additional waiting time points' section (P6). The policy currently lists an email address for centres to use to request additional points. As this address is not manned, it was agreed to omit the email address and leave as is to write to the Chair of MCTAG.

The current criteria for bowel donation are: DBD donor; age limit of 56 years; weight limit of 80 kilos. Following discussion MCTAG agreed that as the general population is living longer and getting heavier the age limit should be extended to 60 years and maximum weight to 90 kilos. The Statistics team will provide evidence from the transplant registry of the impact of this change on bowel offers.

The change in criteria will need to go through the Transplant Policy Review Committee and will require an IT change.

E Allen will amend the policy to reflect the responses. **E Allen**

7 NATIONAL BOWEL ALLOCATION

7.1 Performance report of the National Bowel Allocation Scheme (NBAS) – MCTAG(20)6

Discussion took place regarding patients on the waiting list for 2 years. King's stated that they prefer to register patients for multi-visceral transplantation to reduce rejection. It was approved that agreed criteria should be fulfilled before a liver can be included in a multi-visceral transplant, in order to ensure the most appropriate use of the liver and to balance the competing needs. H Vilca-Melendez to discuss with G Gupte and J Hind and present to the next meeting. **H Vilca- Melendez/ J Hind/ G Gupte/ K Huang**

Discussion took place about the possibility of a national audit of intestinal transplant units: essentially this might be similar to a Peer Review, although with a different name. The benefit of internal bench marking was felt to be of potential benefit: this might take the format (e.g.) of a paediatric surgeon visiting an adult transplant centre and vice versa. Alternatively, it might take a more formal approach (e.g. Service Review) with external input to include NHS England. R Baker offered to recommend names and advise on the process. G Gupte, H Vilca-Melendez and A Butler to develop a proposal. **G Gupte/ H Vilca- Melendez/ A Butler**

Members were requested to inform NHSBT Hub Information Services, via ODT online, of any long-waiting patients removed from the waiting list.

8 GROUP 2 BOWEL TRANSPLANTS – MCTAG(20)7

8.1 E Allen to amend the recipient age to 40 years, from 27 years, for the patient at Oxford who received a bowel-only transplant. **E Allen**

H Vilca-Melendez has performed one group 2 (person residing outside the UK not qualifying for NHS treatment) bowel transplant. He will work with N Heaton to put together a case for group 2 transplants to be **H Vilca-Melendez**

undertaken at King's and then raise at MCTAG for approval. There is no formal funding for group 2 transplants. King's is currently undertaking group 2 transplants on a case by case basis: this is deemed to be the best approach as these are uncommon events. ODT are informed of this.

9 PATIENT SURVIVAL AFTER INTESTINAL TRANSPLANTATION – MCTAG(20)8

9.1 A paper was presented showing 16 years of data.

The issue was raised as to how best to display data relating to the causes of death up to 10 years for paediatric cases (Table 6) and adults (Table 7), allowing that deaths are commonly multi-factorial. The recommendation is to have a primary cause (e.g. rejection) and secondary cause (e.g. infection) of death. E Allen will work with P Allan to present the causes of death in the most useful way. **E Allen/ P Allan**

10 PAEDIATRIC DONATION

10.1 **Small donors and reasons for decline – MCTAG(20)9**
Data was shown on the organ donor pathway, from deaths that may be suitable for organ donation through to the point at which to the deceased individual becomes an actual donor. During 2018/19 out of 1,600 organ donors, 4,000 transplants took place. The reasons for not offering or not transplanting the bowels of DBD donors (from whom at least one organ was retrieved) were shown. The main reasons have been a lack of consent for bowel donation and a lack of suitable recipients. The comparable pathway from audited paediatric deaths was also examined. All the data presented are available from the NHSBT ODT Statistics & Clinical Studies website <https://www.odt.nhs.uk/statistics-and-reports/>.

10.2 **Initiatives to increase paediatric donation – MCTAG(20)10**
Summary of points from presentation:

- From 2008/9 to 2017/18 paediatric donation has remained static.
- 36 weeks is the minimum number of weeks before screening and assessment can take place.
- Trialling in April the extension of triggers for adults in End of Life care at a much earlier stage.
- The small pool of donors is not matching the recipients.
- Neo-natal units are currently not audited.

A Scales asked members if the current initiatives to increase paediatric donation were right and if there were any other initiatives to consider.

King's currently use neo-natal grafts (donors under 6 months) for hepatocyte transplantation. Birmingham reported that they are undertaking more detailed investigation into the loss of paediatric donor organs to CRV (community respiratory virus) for liver and bowel transplantation. It was stated that in the absence of conclusive information, transplantation should not be restricted and the decision as to what organs are suitable should rest with the transplant clinician on the day.

ACTION

11 REFERRAL CRITERIA STRATEGY FOR INTESTINAL TRANSPLANT – MCTAG(20)11

11.1 Formal approval is pending from BAPEN for the funding of a scoping exercise to be undertaken with M&F (a communications organisation) to increase awareness of intestinal transplantation as well as other treatments in intestinal failure.

In the interim, S Gabe will meet with M&F. C Bambridge and S Hill have agreed to be part of the team. A request was made for other MCTAG attendees to be involved to include a full and broad representation. Following discussion, an update will be given at the next MCTAG meeting. MCTAG endorsed the initiative. **S Gabe**

12 TRANSFER OF UK INTESTINAL DATA TO THE INTERNATIONAL INTESTINAL TRANSPLANT REGISTRY (ITR)

12.1 There has not been much progress for this. L Sharkey will continue to lead on this on behalf of the UK intestinal transplant units. **L Sharkey**

13 ACCESS TO LIVER-CONTAINING GRAFTS IN THE PRESCENCE OF SUPER-URGENT LIVER WAITS

A concern was raised that waiting times are going up and whether this is related to an increase in the rate of super-urgent listing for liver transplantation.

Approximately 100 super-urgent livers are required annually; on average a new listing remains on the list for 3 days. It was questioned if the criteria should be changed if patients are waiting too long for multi-visceral transplants.

For paediatric DBD organs consented for liver and bowel transplant the order of prioritisation is:

1. Super-urgent liver intestinal patients,
2. Hepatoblastoma liver patients
3. Elective multi-visceral/liver-intestine patients.

A paediatric donor is offered to both paediatric and adult elective intestinal recipients before being offered to a paediatric liver only patient.

14 REVIEW OF INTESTINAL FAILURE DIAGNOSES COLLECTED BY NHSBT

14.1 **Adult patients: Revision of "Intestinal transplantation: patient selection" policy – MCTAG(20)12**

With reference to the Appendix, there was a query regarding three different phrases being used to refer to the process of using a catheter. L Sharkey to discuss with G Gupte and E Allen the definitive phrase to be used. **L Sharkey/ G Gupte/ E Allen**

Section 3. Selection Criteria. MCTAG confirmed that the role of NASIT is not to approve potential adult candidates for transplantation but rather to provide a forum to discuss patients.

ACTION

14.2 **Paediatric patients – MCTAG(20)13**

MCTAG approved the revised list of intestinal failure diagnoses for paediatric patients.

E Allen will work with L Sharkey and G Gupte to implement the changes to intestinal failure diagnoses. **E Allen**

15 UPDATE FROM THE WORKING GROUPS

15.1 **Quality of Life Working Group: data collection**

15.1.1 **Adults**

P Allan reported that progress is being made, particularly with respect to defining the metrics to measure QoL.

15.1.2 **Paediatrics**

G Gupte to ask C Bambridge to write a proposal for the methodology to be used in paediatric patients. This must accommodate the complexities of patients who transition from intestinal failure to transplant and sometimes back to intestinal failure. An update was submitted by C Bambridge in her absence to say that a Working Group is being set up to undertake the work.

15.2 **Update from the Working Group on NHSBT data and post-operative data collection**

15.2.1 An update was submitted by J Hind in his absence stating that once the dataset has been agreed he will start work with NHSBT and IRTA again.

15.3 **Update from the Working Group on a patient information and consent document for intestinal transplantation – MCTAG(20)14**

15.3.1 The document is being trialled internally at Addenbrooke's: an issue has been identified with respect to conveying outcome data to patients. There may be a need to have two documents, one for liver containing grafts and another for non-liver containing grafts. Paediatric transplantation will require another separate document.

H Howe will review the adult document: the aim is to have one national document. The Winton Centre is a specialist organisation which may be able to assist, for example with the graphical information. **H Howe**

16 KING'S CURRENT PRIVATE PATIENT LISTED FOR ISOLATED SMALL BOWEL AND COLON TRANSPLANT

16.1 There has been one transplant undertaken in Oxford and another in Cambridge. A problem arose with the weight restriction in the request for an adult bowel less than 60 kilos, resulting in the patient missing a lot of suitable offers.

J Whitney will investigate whether we are losing potential isolated bowels owing to the agreed need to preserve the donor pancreas for solid organ pancreatic transplantation from these donors. It has been agreed that the pancreas can be removed for islets rather than solid organ (preserving the full length of the superior mesenteric vein), but only in cases where the intestine is allocated to an NHS-eligible patient. **J Whitney**

ACTION

17 APPEALS/PRIORITY

17.1 There were no appeals reported regarding bowel intestinal transplantation.

18 UPDATE ON NASIT

18.1 L Sharkey reported that the monthly face to face meetings had moved to video conferencing meetings in the light of COVID-19. The only difficulty has been a technical issue with non-regular members not being able to connect. The four core groups have been in attendance.

19 BOWEL TRANSPLANTATION – STANDARDISATION OF TESTING AND CROSSMATCH PROTOCOLS IN THE UK – MCTAG(20)15

19.1 Refer to agenda item 6.

20 FEEDBACK FROM THE LIVER ADVISORY GROUP MEETING ON 20TH NOVEMBER 2019

20.1 The draft minutes of the Liver Advisory Group meeting held on the 20 November 2019 had not been reviewed by the Chair at the time of the meeting so no update was available.

21 ANY OTHER BUSINESS

21.1 Official NHSBT guidance was requested for transplant centres and SNODs in the wake of the COVID-19 virus. P Friend stated that until guidance was given, any patients returning to the UK from a designated red area should not be considered for transplant. Currently, testing is only undertaken if patients show any symptoms. Results will take 24 hours. J Whitney will ask O McGowan for official NHSBT guidance. **J Whitney**

21.2 Members thanked P Friend's work as Chair of MCTAG for two terms. The process of interviewing for a new Chair is in hand.

22 DATE OF NEXT MEETING:

- Wednesday 21 October 2020 via MS Teams video conferencing

23 FOR INFORMATION ONLY:

Papers attached for information were:

23.1 ICT Progress Report **– MCTAG(20)16**
23.2 Transplant activity report for January 2020 **– MCTAG(20)17**
23.3 Minutes of LAG meeting: 8 May 2019 **– MCTAG(20)18**

March 2020

Administrative Lead: Kamann Huang