NHS BLOOD AND TRANSPLANT
ORGAN AND TISSUE DONATION & TRANSPLANTATION DIRECTORATE

MINUTES OF THE THIRTY EIGHTH MEETING OF THE LIVER ADVISORY GROUP HELD ON WEDNESDAY 20 MAY 2020 AT 11 AM VIA SKYPE

PRESENT:

Prof Douglas Thorburn	**Chairman**
Prof John Forsythe	Medical Director, ODT for NHSBT
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
Mr Chris Callaghan	National Clinical Lead for Organ Utilisation (Abdominal)
Ms Becky Clarke	Regional Manager, Specialist Nurse, Organ Donation Representative
Mr John Crookenden	Liver Patients' Transplant Consortium
Ian Currie	Chair of Retrieval Advisory Group
Lewis Downward	Statistics and Clinical Studies, 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 Grammatikopoulos	Physician, King's College Hospital, London
Ms Pam Healy	Chief Executive, British Liver Trust
Dr Andrew Holt	Physician, Queen Elizabeth Hospital, Birmingham
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, King's College Hospital
Prof Derek Manas	National Clinical Lead for Governance, The Freeman Hospital, Newcastle upon Tyne
Dr Aileen Marshall	Hepatologist, Royal Free Hospital, London
Dr Steve Masson	Physician, The Freeman Hospital, Newcastle upon Tyne
Mrs Sarah Matthews	Lay Member
Prof Jörg-Matthias Pollok	Surgeon, Royal Free Hospital
Mr Krishna Menon	Surgeon, King's College Hospital
Mr Thamara Perera	Surgeon, Birmingham Children's Hospital
Mr Andreas Prachialis	Surgeon, King's College Hospital
Ms Katherine Quist	Recipient Co-Ordinator, Royal Free
Dr Sanjay Rajwal	Paediatric Hepatologist, Leeds
Dr Tracey Rees	Scientific Advisory, ODT
Mr Peter Robinson-Smith	Recipient Co-ordinator Representative
Dr Ken Simpson	Physician, Royal Infirmary of Edinburgh
Ms Alison Taylor	Liver Patient Group Co-Chair
Ms Rhiannon Taylor	Statistics and Clinical Studies, NHSBT
Ms Lynne Vernon	Lay Member
Ms Sarah Watson	NHS England Rep
Dr Steven White	Surgeon, Newcastle upon Tyne
Prof Chris Watson	Surgeon, University of Cambridge Department of Surgery
Ms Julie Whitney	Head of Referral and Offering, NHSBT
Prof Stephen Wigmore	Vice President of BTS

IN ATTENDANCE:
Mrs Kamann Huang Clinical & Support Services, ODT

ACTION

APOLOGIES & WELCOME

Welcome:
Ms Becky Clarke, Regional Manager, Specialist Nurse - Organ Donation replacing Ms Susan Richards (Midlands and S Central regions).
Mr Krishna Menon, Surgeon, replaces Prof Nigel Heaton, King's College Hospital.
Mr Thamara Perera, Surgeon, replacing Dr Indra van Mourik, Birmingham Children's Hospital.
Mr Peter Robinson-Smith, Recipient Co-Ordinator Representative replacing Wendy Littlejohn, King's College Hospital.
Dr Steven White, Surgeon, replacing Prof Derek Manas as the Newcastle upon Tyne representative; Prof Derek Manas will remain as the governance representative.

Apologies:
Mr Emir Hoti and Dr Diarmaid Houlihan

1 DECLARATIONS OF INTEREST IN RELATION TO AGENDA - LAG(20)1

1.1 There were no declarations of interest.

2 MINUTES OF THE MEETING HELD ON 20 NOVEMBER 2019 - LAG(M)(19)2

2.1 **Accuracy**

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

2.2 **Action points – LAG(AP)(20)1**

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

AP 9 - ODT Hub update – maximum opportunity to be given for the liver to meet organ utilisation
Owing to COVID-19 this work has yet to be undertaken and will be reported at the next LAG meeting. **J Whitney/ J Isaac**

AP 11 - Colectoral Metastasis as a transplant indication
This work will be progressed via a Research Group. There is representation from all centres and funding will be sought. The clinical trial will go ahead once funding is secured and will be brought back to LAG for further discussion and approval.

2.3 Matters arising, not separately identified

There were no matters arising.

3 Update on Opt Out and Organ Donation

3.1 Max and Keira's Law – the Organ Donation (Deemed Consent) Act went live today, 20 May 2020, and is a significant landmark for organ donation. Following many discussions, it was agreed with the Secretary of State and Parliament that despite the prevalence of COVID-19, it was the right decision

ACTION

to assist in the completion of the Act through the parliamentary process, though the major benefit will not be seen until things return to normal.

A huge amount of work with all the faith groups has been undertaken in the background and during the COVID-19 pandemic to reach the passing of the Law. J Forsythe paid tribute to the people within NHSBT and patient groups for their contributions.

4 COVID-19 in Liver Transplantation – LAG(20)2

J Forsythe thanked the support from Advisory Groups for solid organ transplantation in working with NHSBT to deal with COVID-19; especially to D Thorburn and D Manas for their time and effort in keeping the transplantation process operational. Communications have been in the form of a regular weekly bulletin update outlining actions taken alongside two regular Clinical team meetings per week and frequent meetings with commissioners from all over the UK to provide a comprehensive unified approach to organ transplantation across the UK. The Clinical Team comprises the Medical Team and Chairs of Advisory Groups, as well as key managers from senior level in ODT, to make organ offering and donor criteria changes to support transplant centres to sustain the transplantation process. Meetings have also been held with NHS England and Clinical Leads of units to develop a national consensus for any changes in organ offering, as well as the management of the risks and safety issues.

A registry has been set up linked to PHE, ONS, NHS Digital data and PHS data for Scotland. These linkages will provide the best data in the world for comparing outcomes for waiting list and transplanted patients. It will also help inform the process for patient consent during COVID-19.

With regards to the question of 'Is there any evidence how COVID-19 has affected recently transplanted patients?'. J Forsythe reported that our data suggests that if patients contracts COVID-19 in the early period of post-transplant, about 85% have contracted it in the community and only a small percentage within the hospital. For liver transplantation to-date, it was reported that there were 64 COVID-19 positive transplant recipients and 10 became COVID-19 positive on the waiting list with one patient mortality. A regular report on the website provides more information.

It was stated that some transplant centres may not be aware of COVID-19 patients in the early stages, as they may have presented to outlying centres. D Thorburn reported that centres will be informed of COVID-19 positive patients that have come from their own centres and requested centres to complete two forms at the time of diagnosis and follow up to assist the process of data gathering.

4.1 There have been changes implemented for liver transplantation during COVID-19 with super-urgent and clinical urgent patients prioritised. Since the beginning of April, livers not accepted by higher tiers in the offering scheme have been offered to the centre with the highest named clinically urgent patient, who can accept the liver for any clinically urgent patient. Livers not accepted for any clinically urgent patients may then be considered for an elective patient using the same centre sequence as that for clinically urgent patients

Summary of data provided for the period 4 February – 11 May 2020:

- for the week 5-11 May, 10 livers were offered, 8 were retrieved and 7 were transplanted; 6 were DBD transplants.

ACTION

- 67% of transplants were SU deceased donor liver transplants, the majority have been adult transplants. For the week from 5 – 11 May there were 5 adult transplants and 1 paediatric transplant.
- as at the end of April 2020 the active elective transplant list had 476 patients, all centres were asked to suspend non high urgent cases resulting in the number active dropping to 104 (75 adult and 29 paediatrics) clinically urgent patients nationally as at 14 May 2020.
- the number of clinically urgent patients ranged from 3 to 21 by transplant centre and from 24 to 129 for suspended patients per centre.
- there has been no increase in deaths or removals from the waiting list by month since 1 January 2019.
- there has been a reduction in the number of assessments. During the Recovery Phase, centres will be ramping up assessment activity to catch up.
- during recovery some of the restricted donor criteria established early in the pandemic have been changed i.e. DBD has increased from 60 to 75 years of age and DCD from 50 to 60 years of age to increase transplants.

It was acknowledged that owing to the reduction in donation during COVID-19 fewer organs are getting past the clinically urgent stage, which suggests inequity of access with a subset of active patients and a subset of suspended patients. This was stated to be the optimum option until things return to normal.

5 NATIONAL OFFERING SCHEME

5.1 Compliance with sequential data (SDC) submission - LAG(20)3

5.1.1 Since March 2018 transplant centres now only send sequential updates for chronic liver disease (CLD) or hepatocellular carcinoma (HCC) patients and not for VS patients. This was to prevent VS patients whose UKELD oscillated around 49 transitioning to the chronic liver disease pool inappropriately.

NHSBT have received 5525 SDC forms from all the seven UK liver transplant centres between 14 December 2017 and 10 May 2020. Of the 85 clinically urgent patients on the elective CLD/HCC transplant list on 10 May 2020, 25 (29%) had not returned a SDC form to NHSBT within the last 2 months. NHSBT have not received any SDC forms for 16 patients who were on the transplant list for more than one month.

Transplant centres were reminded to return their forms within the required time period.

5.2 National Liver Offering Scheme (24 months data) - LAG(20)4

5.2.1 Summary discussion points raised at LAG Core Group from the Report:

- Fig 12b: the overall acceptance rate of DBD's seems low and is improving. It was questioned whether the acceptance rate has improved with time and was not due potentially to organs coming back round the offering system for named offers. Table 13 shows a 47% acceptance rate and a 29% transplant rate. Further work is yet to be undertaken on this.

- Table 11: although all centres have received increased offers, it was asked what the demographics were for two centres receiving significantly more. It was commented they are the two largest centres so with more patients on the waiting list they will get more offers.

- It was commented that Birmingham were transplanting more DBD's and for the two years post scheme. Consequently, their utilisation of DCD's has

ACTION

reduced by 15%. DCD utilisation is to be considered by the Monitoring Group when non utilised livers are reviewed.

- R Taylor to examine the outcome of prevalent and incident patients on the list since the inception of NLOS. The mortality of these patients added to the list have fallen since implementation of the scheme but has overall mortality on the waiting list for the two years prior and post changed? This was presented in **LAG(20)6** and showed that the mortality rate during the first two years of NLOS had decreased compared with during the two years prior.

- It was proposed to look at the active and/or suspended patients on the list for more than two years as at 19 March 2018 to see if they have had offers and what were the demographics for the 41 patients who died and had they received any offers. This was examined in **LAG(20)6**.

- The IT changes required to support e.g. the change in fast-track criteria will need to be looked at in order of priority but not whilst COVID-19 is prevalent. The triggers for fast-track would not require an IT change but the rota for centres will. J Whitney will raise with D Thorburn when the time is appropriate.

- Work on updating the parameters for the TBS is still ongoing.

- Final wording for the fast-track trigger points is still required from D Manas.

5.3 Feedback from the Monitoring Committee and specific NLOS Issues - LAG(20)5 changed to Verbal Report

5.3.1 Main issues and discussion points were:

- the past patterns and trends are consistent and similar for the last year. There remains concern about HCC patients receiving fewer DBD's which is believed to be due to overestimation of M1 in this group. Work is in progress looking at updating parameters for all chronic liver disease and HCC patients to establish what happens to other groups of patients as a result of this.

- a rise from 36% to 43% in HCC patients receiving DCD livers. For these livers there have been a reduction in survival at 90 days. The Monitoring Group will investigate this further. **Monitoring Group**

- there is concern around the 418 adult elective patients on the waiting list prior to the introduction of NLOS, receiving fewer transplants and there is a higher mortality rate from 6 – 10% post scheme.

- Monitoring Group would like to have more information on named patients who are FT and how many DCD, HCC patients are FT and transplanted. **R Taylor**

- it is recognised DCD livers are not being retrieved; from 1306 to 1487 DCD transplants. A review of DCD utilisation is to be undertaken by P Gibbs once COVID-19 settles down.

- outcomes on the list of prevalent and incident patients on the list remain different. We do not know why patients, listed as at 19 March 2018 have received less grafts than the new registrations. The likelihood of transplantation seems higher on entry to the waiting list but decreases the longer patients waits. Looking at M1 from the time of registration may provide an explanation though this is low priority.

- Monitoring Group to look at the demographics of those patients on the waiting list (M1 of those who have died/removed, the number of offers they **Monitoring Group**

ACTION

have received and how many times they appear on the matching run and in what position, and what also happens at 3 and 6 months post registration).

- Liver utilisation has gone down. This was steady in the 21 months pre-scheme but then declined. Some centres are using more DBD's which may result in the reduction of DCD utilisation particularly where centres are near capacity. We do not want to lose useable organs and this is a real concern.

- Analysis is required to look at why there were fewer re-transplants in the 24 months post. **R Taylor**

- NLOS shows a trend observed over the two years that the 60+ have benefited from the system and there is a big shift towards DCD transplantation.

- A request was made to de-anonymise names for transplant centres for external transparency which was agreed. R Taylor to inform each centre of their data for the 24 months report. **R Taylor**

Future meetings will be every six months.

Issues/comments raised from the data presented were:

- Outcome for HCC patients remain poor as indicated from previous reports.

- Need more detail regarding the reduction in the number of offers for DBD named patients and for HCC patients.

- Good to see a significant improvement in survival for CLD patients since inception of the scheme.

- Older patients with ALD are being transplanted quicker.

5.3.1 Patients on the list since inception of NLOS – LAG(20)6

5.3.1.1 There were 2387 patients active or suspended during the first two years of the National Liver Offering Scheme. The mortality rate for patients on the list in the first two years of NLOS was lower than for patients on the list in the two years prior to NLOS (7% and 10% respectively).

The survival from listing was higher in CLD patients registered in the 18 months post NLOS compared with patients registered in the 18 months prior to NLOS.

It was commented that patients post NLOS were transplanted quicker and what the reason was for the 50 patients on the waiting list for end stage liver disease, prior to NLOS, still remaining on the list. It is difficult to quantify surgical risks as some conditions e.g. vascular thrombosis is not recorded on the database.

It was acknowledged that once the situation regarding COVID-19 settles down it may be possible to look at the reasons and detail for these 50 patients, and one patient on the list since 2009.

Future transplantation data requirements are very different to that collected originally and we need to review data collection. This is also being reviewed within the NHSBT 5 years strategy work streams.

5.3.2 Livers turned down and not retrieved

5.3.2.1 This area of work will be looked at by P Gibbs under DCD utilisation.

ACTION

5.3.3 DCD Utilisation

5.3.3.1 One centre has increased DCD utilisation, one has remained the same and the other four have noted reductions. P Gibbs has been unable to visit Stoke Gifford and undertake the work looking at DCD utilisation and to look at livers turned down and not retrieved. It is hoped that once COVID-19 settles down a report will be available at the next meeting in November. **P Gibbs**

5.3.4 Update on TBS parameters – LAG(20)7

5.3.4.1 A working group has been set up to look at the over prediction of M1 survival for named DBD patients with HCC.

The work undertaken to update the TBS for the CLD cohort of patients has not been simple. The results from the simulation models, two cancer and two non-cancer models, have been unpredictable and more work is required. This work needs to be completed before IT changes can be made for Fast Track and Liver Splitting changes.

It was stated that the updating of the TBS parameters is not to fix the HCC issue but to improve the prediction of the whole model for all patients although this issue has been highlighted by the HCC issue. The work will include extending the cohort to the earliest possible patient group with a complete dataset.

5.3.5 New liver allocation scheme flight cost impact – LAG(20)8

5.3.5.1 Data was presented on behalf of SMT and Commissioning Group to make members aware of the increase in flight costs from June 2019 to 1 March 2020. The increase in travel was foreseen as an impact of NLOS but the cost implications had not been quantified and this data is to make members aware. The average flight cost (excluding handling) per transplanted liver has risen from £1,410 pre NLOS to £2,336 post NLOS; though there was a reduction in costs to just over £9,000 for the quarter Jan to Mar 2020 compared to just over £12,000 for the quarter 18 Jan to 19 Mar 2019 pre NLOS. J Whitney will ask the LAG Core Group to analyse flight costs and look at factors such as the use of flights by centre, where livers have flown from and whether there have been benefits in terms of time savings. **J Whitney**

It would be beneficial for to include analysis of the following two points raised at the meeting. Which centre incurred the highest cost and to know the length of the flight rather than just the cost of the flight and the distance covered. **LAG Core Group**

D Thorburn acknowledged that there needs to be a better understanding of these costs, e.g. whether journeys previously undertaken by road are now being moved to flights or whether it is due to the increased rate of fast track offers.

6 UPDATE FROM FTWUs

6.1 Cirrhotic – ACLF

6.1.1 Will Bernal has been leading this and has produced a protocol with minor modifications made after the last LAG meeting. This was approved. There is one final step to create a tier in the offering scheme to allow priority for patients below offering for splitting but above the elective pathway. This will require an IT change.

6.2 Fast Track – LAG(20)9

6.2.1 There have been three meetings with representation from all units and the Hub. The six changes are outlined in the paper. It has been agreed 'knife to

ACTION

skin' will be changed to 'cross clamp'. For SU patients, after cross clamp, the donation will go to FT if unsuitable for the super-urgent patient. The FT trigger will move up from 3 to 7 named patient offers declined. The changes were agreed at LAG and the paper is the written agreement.

Remove the word 'at' towards the end of the following sentence: "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". **D Manas**

Point 6 in the Summary Section – the rota basis is based on the least overall activity.

6.3 Liver Splitting

6.3.1 Work was undertaken by the FTWU looking at modelling based on factors such as age, weight, bilirubin and ALT.

The approved recommendation is for donors less than 45 years of age, weight less than 90 kg or BMI less than 30, bilirubin less than 30 and ALT less than 20. It is anticipated this will generate 120 split whole livers from these criteria.

6.4 HCV positive transplants into HCV negative recipients – LAG(20)10

6.4.1 From 1 March 2019 to 29 February 2020, there were 45 HCV positive donors offered, of these there were 13 solid organ donors leading to 23 transplants. All liver centres are now approved to use positive donors into negative recipients, except for Kings College. Any centre wishing to undertake this type of transplant for all solid organ programmes will require approval and consent from David Mutimer. It was confirmed that it was King's intention to join the programme. No livers have yet been transplanted from an HCV positive donor into an HCV negative patient. The Monitoring Group chaired by D Mutimer will be looking at the outcomes of HCV positive kidney recipients next month.

The first 8 kidney positive recipients have been treated for Hep C.

Currently all the offers are done by FT. How these organs will be offered in the offering scheme are to be discussed in future meetings.

6.5 Neuroendocrine Tumours (NET) – LAG(20)11a & b

6.5.1 This FTWU has been co-chaired by T Shah and P Gibbs to examine NET tumours as an indication for transplantation. The advice is based on the Milan programme. It will be undertaken as a service evaluation initially. Evaluation of 50 patients will take place over 6 years. After 10 patients, there will be an assessment of outcome. The Milan programme indicated an 88% survival for those patients undergoing the transplant.

As this is a new indication, the proposal is to run the programme with national oversight, protocol and follow up. The programme will be administered via a programme monitoring group with some members from the Advisory Group. If the programme is accepted, the issue is to work out how organ allocation and prioritisation will operate and how the national follow up and protocol will deal with a recurrence after transplant. It was highlighted that a Gallium scan is mandatory as part of the programme. It is anticipated that the first patient will be transplanted in a year's time.

ACTION

There will be a separate piece of work to look at how CCa, ACLF and NET patients, where TBS may not be appropriate, will be transplanted within a timely window.

P Gibbs will include into the document: **P Gibbs**
- Time frame for offers will be within 6 months from going on the waiting list.
- Management of tumour recurrence. It was stated that a patient can survive for a long time even with tumour recurrence.

Success of the programme will be defined as one-year survival greater than 60%.

The next stage of work is to set up clear Terms of Reference for which patients to transplant. It is proposed that all centres will undertake the new indication for transplantation provided they meet the protocol and specification to do so. The issue of immuno-suppression can be discussed and agreed with all centres.

6.6 Protocol and dataset for machine perfusion – LAG(20)12

6.6.1 A small group with representation from each centre looked at issues such as use of virally infected donors and cross matching blood against the recipient or donor. A draft document was produced with the local lead haematologist, who has unfortunately gone down with COVID-19.

The document fell outside the remit of the National Blood Transfusion Committee. It was submitted to the joint professional Advisory Committee of NHSBT, also out of action from COVID-19, so it is now with the British Society of Haematology Guidelines Committee to clarify if it is to be good guidance or protocol.

The second issue looked at was registry and data to be recorded. Metrics for liver outcome is crude and not sensitive to anything in the middle so allograft function metrics was looked at. The ideal would be the allograft score based on over 7 days data collection.

The optimum method of moving the livers around the country would be Centre B fetches, taking their machine to centre A, and bringing back A's machine with the liver on it.

All centres were keen to take part in the trial period for machine perfusion for six months but it will be a new burden on NHSBT for data collection and require an IT change to change the dataset on the form which can be undertaken. Retrieval forms have been updated to include NRP. The data to be gathered relates to what happens once the organ being transferred to the implanting centre. Ideally the form would be undertaken as an electric download form.

D Manas will include the recommendation into the Governance Policy. A ramp and inverter will be required to load the machine onto the vehicle for transfer to other centres and will be written as a national requirement. **D Manas**

J Whitney will discuss this further with C Watson outside the meeting. It was confirmed that the information regarding the offering of the livers for this process would be undertaken between the centres involved and not go through Hub Operations. **J Whitney**

Another issue for centres to think about is whether they would be prepared to place an infected liver on the perfusion machine.

ACTION

6.7 Cholangiocarcinoma – LAG(20)28

6.7.1 N Heaton and J Isaac have been collaborating on this. A recommendation has been made for a service development to offer transplantation for cholangiocarcinoma in two settings: perihilar cholangiocarcinoma for patients with tumours less than 3 cm in size and the second, for patients with intra-hepatic cholangiocarcinoma for liver disease with tumours of 2 cm or smaller. The survival rate is anticipated to be 60-65% over 5 years for both groups.

The proposal is to set up an implementation group look at unresolved issues e.g. where the neo-adjuvant would be delivered, looking at appropriate donors (anticipated to be DBD's outside the splitting criteria) and develop a tumour allocation algorithm which will be time sensitive; the transplants would need to be undertaken within a three month window. It was confirmed that chemo radiation would be mandatory in the form of a proton beam.

NHS England stated that the use of proton beam is restricted to certain criteria in this country. D Manas stated that Maria Hawkins would take this back and report back on how this will be undertaken. **D Manas**

The finer details will need to be agreed but LAG approved the principles for CCA as an indication for transplant.

7 LIVER TRANSPLANT COMMISSIONING

7.1 **NHS England**

S Watson thanked D Thorburn and the collaboration from the centres over the last eight weeks in supporting communications regarding COVID-19 back to NHS England.

NHS England has received an application, third week of March, from the SW Peninsula to deliver liver transplant services out of Plymouth hospital in conjunction with King's College hospital. It would be the King's team and local services operating at Plymouth. There have been meetings on clinical governance and access on this. The response will likely be delayed by the pandemic. NHS England would seek advice from LAG on this and a range of responses are possible which includes undertaking a national review of access to liver transplantation.

8 Revision of indications for LT in paediatric population – LAG(20)13

8.1 The out of date indications have been updated with a lot more conditions and have been discussed and agreed between the three liver paediatric centres. The plan is to update the indications every 2-3 years in view of new cases.

LAG approved the updated indications and NHSBT will update the liver selection policy. **R Taylor**

9 GOVERNANCE ISSUES

9.1 Non-compliance with allocation

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

9.2 Governance

9.2.1 **Governance Report – LAG(19)14**

9.2.1.1 There have been no major governance issues to report on. Governance around machine perfusion has been mentioned in item 6.6. It was stated that

ACTION

the only way to manage governance is for people to highlight them so that they can be dealt with in a timely manner.

9.3 CUSUM

9.3.1 **Summary of CUSUM monitoring of outcomes following liver Transplantation – LAG(20)15**

Two signals (one adult, one paediatric) were triggered in March 2020 by two centres who have yet to respond by the end of May. The two centres were reminded to respond by the required timeframe.

9.3.2 Report on recent triggers

9.3.2.1 All preceding triggers have now been closed.

10 STATISTICS AND CLINICAL STUDIES (SCS) REPORT

10.1 Summary from Statistics and Clinical Studies – LAG(20)16

10.1.1 A presentation summarising the first 18 months of the National Liver Offering Scheme was given to the British Transplantation Society Conference on the 4-6th March 2020.

There are currently three clinical fellows working with the Statistics team in in abdominal organ utilisation, malignancy in transplantation and in cardiothoracic transplantation.

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

11.1 Report from the Multi-Visceral & Composite Tissue Advisory Group Meeting - 11 March 2020

11.1.1 There are two main issues to report on. One being the ongoing discussions with the HTA regarding the abdominal wall fascia for abdominal wall reconstruction. The problem is that if the fascia is removed from the abdominal wall for transplant, it is regarded by the HTA as tissue and not an organ (i.e. fascia being transplanted as part of the abdominal wall). The HTA will not extend fascia storage for more than 14 days for legal and safety reasons. The second issue is a conflicting demand for organs from small donors for patients with hepatoblastoma versus small patients requiring multi-visceral transplants. No data has been seen for the second issue so this will need to be discussed further and brought back to the next LAG meeting. **P Friend/ K Huang**

Post Meeting Note:
This has been examined and will be presented at the next MCTAG meeting.

King's reported that they have such patients on the waiting list and wondered if there was a time frame for resolution. P Friend will contact A Butler for progress and report to T Grammatikopoulos. **P Friend**

The use of fascia in transplanted patients if they have been immuno-suppressed has not been looked at by MCTAG. Raise with A Butler. **P Friend**

12 ANY OTHER BUSINESS

12.1 On behalf of I Currie, Chair or Retrieval Advisory Group, D Thorburn outlined that there have been situations where the SU liver accepted for a SU patient, has required the donor's heart or lungs to be considered for cardiothoracic transplantation (CT), causing a substantial delay in the length of the offering process, which is a problem for SU patients where time is critical. It was

ACTION

therefore agreed with the CT Advisory Group that in situations where the liver is accepted for a SU liver recipient, there will be a group offering of CT organs to all CT centres simultaneously, rather than sequentially, and some modification in the timing of retrievals for the CT team to be there one hour before retrieval starts. A Monitoring Group will be established in three month's time for the process to start.

12.2 Following discussion, LAG agreed that the organ utilisation dashboard would be de-anonymised. It was acknowledged that that this would aid learning. As there was no representation from Dublin at the meeting, R Taylor will check with the Dublin representatives. **R Taylor**
It was stated that it would be beneficial to provide a dashboard for paediatrics as well, which can be discussed outside of the meeting. **R Taylor**

13 Date of next meetings:

- Wednesday 18th November 2020 - MS Teams Video Conferencing.

14 FOR INFORMATION ONLY

The following papers were attached for information to members:

14.1 **COVID-19 Reports:**
14.1.1 Transplant Recovery Programme – LAG(20)17
Post meeting:
https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/19002/pol296.pdf
14.1.2 Refinements in Liver Offering – LAG(20)18
14.1.3 COVID positive registrations

14.2 **FTWUs deferred to the next meeting:**
14.2.1 Minimal listing criteria for HCC
14.2.2 Hepatopulmonary syndrome patients

14.3 **Transplant activity report: March 2020 - LAG(20)19**

14.4 **Group 2 Transplants – LAG(20)20**

14.5 **Outcome of appeals – LAG(20)21**

14.6 **Activity and organ utilisation monitoring (dashboard) – LAG(20)22**

14.7 **Combined listing of cardiothoracic and liver patients – LAG(20)23**

14.8 **Clinical service evaluation – HCC downstaging – LAG(20)24**

14.9 **Minutes of the Multi-Visceral & Composite Tissue Advisory Group meeting: 16 October 2019 - LAG(20)25**

14.10 **Minutes from the National Retrieval Group: 1 October 2019 - LAG(20)26**

14.11 **QUOD statistical reports – April 2020 - LAG(20)27**

May 2020

Administrative Lead: Kamann Huang