NHS BLOOD AND TRANSPLANT
ORGAN AND TISSUE DONATION AND TRANSPLANTATION DIRECTORATE
THE FIFTEENTH MEETING OF THE NHSBT CTAG(H) HEARTS ADVISORY GROUP
ON MONDAY 23 MARCH, 11:00-14:00
TELECOM

Present:

Jayan Parameshwar (Chair)	CTAG Hearts and Lungs Chair, Royal Papworth Hospital
Lyn Ayton	Transplant Managers Forum Representative
Ian Currie	National Clinical Lead for Organ Retrieval, NHSBT
Jonathan Dalzell	Chair, Golden Jubilee Foundation
Melissa D'Mello	CTAG Lay Member Representative
John Forsythe	Medical Director, OTDT, NHSBT
Rob Graham	Chair, CTAG Hearts and Lungs Patient Group
Gill Hardman	CTAG Audit Fellow
Margaret Harrison	CTAG Lay Member Representative
Clive Lewis	Cardiologist, Royal Papworth Hospital
Debbie Macklam	Senior Commissioning Manager, NHSBT
Derek Manas	Joint Clinical Governance Lead, NHSBT
Katie Morley	Lead Nurse Recipient Co-Ordinator
Lisa Mumford	Head of ODT Studies, NHSBT
Nicky Ramsay	Recipient Transplant Co-ordinator, Harefield Hospital
Aaron Ranasinghe	Cardiologist, Birmingham
Marian Ryan	Specialist Nurse Organ Donation
Philip Seeley	Recipient Transplant Co-ordinator, Freeman Hospital
Steven Shaw	Cardiologist, Wythenshawe Hospital
Andre Simon	Centre Director, Harefield Hospital
Fred Smith	Senior Statistician, NHSBT
Nicola Steedman	Medical Director, Procurement, Commissioning and Facilities, NHS National Services Scotland
Sarah Watson	Highly Specialised Services, NHS England
Julie Whitney	Head of Service Delivery (ODT Hub), NHSBT

In attendance:

Lauren Caddick	Assistant Manager of Service Delivery
Caroline Robinson (Minutes)	Clinical and Support Services Manager

Item	Apologies and Welcome	ACTION
	Apologies were received from Nawwar Al Attar, Marius Berman, Pedro Catarino, Jorge Mascaro, Fernando Riesgo Gil, Jeanette Foley, Liz Armstrong, Guy Macgowan, Olive McGowan The Chair welcomed everyone who was able to attend the meeting on this occasion which was changed to a telecom in the light of the COVID-19 issue and acknowledged the additional very demanding commitments and pressures being placed on NHS clinicians currently.	
1.	**Declarations of Interest**	
	No declarations of interest were declared at the meeting	
2.	**Minutes and Action Points of the CTAGH Meeting on 26/09/19**	
2.1	The Minutes of the previous CTAG Hearts meeting held on 26 September 2019 were accepted as a true record	
2.2	Action Points from the previous meeting were raised at the meeting by the Chair. A revised list of outstanding actions along with actions from this	

	meeting will be circulated with these Minutes.	
3.	**Medical Director's Report**	
3.1	Developments in NHSBT J Forsythe thanked everyone for the work being done during the current COVID-19 crisis and provided the following update: • The senior management team of OTDT at NHSBT is meeting daily for an early morning call lasting up to an hour to discuss latest developments and updates and the Medical Team (including Advisory Group Chairs) is meeting for a twice weekly call. • The Specialist Nurse network and NORS teams are checking their resilience to cope with the current demands on the service. • We have a strong network of transplant units and a good indication of which of these are open or closed. A register is being developed of any transplant recipients who have contracted COVID-19 and it is important to contribute data to this. Demographic details should be recorded initially, and clinical information can be included subsequently. • The AMD news bulletin is being sent out more frequently at present to ensure that all have relevant and timely information. Anyone not currently receiving this who needs to be included should contact caroline.wills@nhsbt.nhs.uk. • From today (23 March 2020) donor criteria for offering are being tightened in response to the current environment. • The length of donation process which was to be discussed in this meeting will not now move forward until the current crisis has passed. However, the process will include: o One method of communication with each centre only o A mandatory data set to be provided at offering. o Centres will be offered organs for the Super-urgent/Urgent patients but will be asked to consider whether the organ will be acceptable for non-urgent patients on their list. Time limits for centres to accept offers will be strictly enforced. o A 'red button' will speed up the process particularly if a donor family is likely to withdraw consent because of delays. It was noted that the updates are extremely helpful in the current climate. M D'Mello asked whether, despite the measures being put in place, when COVID-19 poses such an increased risk to patients, clinicians and the public, it is right to continue with retrieval and transplantation and that these decisions are made at a local rather than national NHS level. She also asked about the opportunity cost of all the resources being used for transplant (ie, pre transplant, during and post-transplant), including allied services. J Forsythe stated that there is a very careful review conducted daily across the country to check ICU and other resources. At present, this is being managed well with some specific exceptions, particularly in the London area. Local centres are conducting risk analyses and where a life-saving transplant is required and ICU resource is not needed for surgery elsewhere, transplantation will go ahead. It was also noted that many patients waiting for a heart transplant are using an ICU bed and a transplant is sometimes the best way to move them out of critical care. In addition, the risk for kidney patients on the waiting list may be reduced by going ahead with a transplant rather than remaining on haemodialysis in the present climate.	
3.2	New Appointments No new appointments were discussed at this meeting.	
4.	**ODT Hub Update**	
4.1	Length of Donation Pathway J Whitney reiterated the points made in the Medical Director's Report	

	above. Retrieval times will be moved forward for cardiothoracic organs. As the paper planned for presentation at this meeting to explain the length of donation pathway was not available, it was agreed that any questions would be considered when this has been circulated. There will be one point of contact at each centre. **ACTION: Length of Donation Pathway paper to be circulated to CTAGH members when ready.** It was noted that there are still offers made without key data like an ECG or x ray result which are important in making decisions about whether an organ can be used. It was agreed that it would be emphasised to SN-ODs that an offer cannot be made without inclusion of a mandatory data set. **ACTION: M Berman to report back on the mandatory data set that is required in order to offer an organ.**	**J Whitney** **M Berman**
4.2	<u>Proposal for Heart Fast Track Scheme</u> The current heart fast track offering scheme is initiated in two scenarios: • When a heart is available at short notice from a UK donor, ie: o Aortic cross-clamp is expected within 90 minutes of the referral to NHSBT, or o The heart has already been removed or is in the process of removal, and o All UK centres have not already had an opportunity to decline the heart • A heart is available from Europe The paper presented showed the number of offers of a DBD donor heart before offering stops where the heart was used for transplantation or declined/accepted/not used for donor or organ related reasons. In over 90% of cases heart offering stopped by the 5th offer. In cases where the heart was accepted and ultimately used for transplantation, 94% were accepted by the 2nd offer. Given this information, the following criteria for entry into the fast track scheme are proposed for DBD donor hearts: a. Three heart transplant centres decline the heart for a donor or organ quality related reason. The reason given may differ between centres but must relate specifically to donor or organ quality. b. When a heart is available at short notice from a UK DBD donor, i.e: • Aortic cross-clamp is expected within 90 minutes of the referral to NHSBT, or • The heart has already been removed or is in the process of removal, and • All UK centres have not already had an opportunity to decline the heart c. A heart is available from Europe Offers of hearts meeting the Fast Track offer scheme criteria will be made to all centres simultaneously by Hub Operations by either simultaneous text message to pager/mobile phone or facsimile transmission of donor information. Centres must respond by telephone to a Fast Track offer to Hub Operations within 45 minutes of the offer if they wish to accept. Hub Operations will not follow-up those centres that do not respond within this time. Centres not responding will be deemed to have declined the offer. The fast-tracked heart will then be allocated to the first accepting centre and may be used for a super-urgent, urgent or non-urgent patient. However, if more than one centre wishes to accept the Fast Track Offer, negotiation can be made between centres. Group 1 patients will be allocated organs before Group 2 patients. Centres accepting for Group 2 patients must wait until the 45 minutes have lapsed to ensure no centre is accepting for a Group 1 patient.	

	It was noted that all centres agreed to the proposal.	
4.3	Potential Changes in the Donor Pathway - Super Urgent Liver Recipient Recipients listed for super urgent liver transplant are at risk of rapid and fatal deterioration during the time between offering and transplantation. The deterioration may occur over hours, such that the patient may become un-transplantable. Experience suggests that potentially avoidable retrieval delay contributes to poor outcome in these patients. If the super urgent liver offer is accepted, it becomes a priority to establish if heart or lungs will also be accepted. Heart and Lungs will be 'group offered' simultaneously to all centres for all recipient types. The highest-ranking patients/centres will be allocated the organs in accordance with current allocation rules. Once the CT organs have been accepted or declined by all within the time frame allowed for group offers, the Hub will mobilise NORS teams. During this time the SN-OD will make preliminary enquiries about theatre times in the donor hospital, assuming the nearest available teams would be attending the donor. The SN-OD will inform the donor hospital theatre team that a super urgent liver patient was awaiting the donor liver and that avoidable delays must be kept to a minimum. A major trauma call would receive appropriate priority in the donor hospital. The process is outlined in the paper circulated prior to the meeting. It was noted that it can be difficult to predict what will happen, particularly to VAD patients and can be challenging as it can take up to 3 hours for explantation of the LVAD and recipient heart. However, the process will enable the liver transplantation to go ahead. It was suggested that the process would be trialled for 6 months once all centres had the opportunity to comment on the proposal.	
4.4	Update on Heart/Lung Offering Scheme Changes L Mumford explained that these are not yet released. While all the IT changes have been completed, testing was due to commence in the coming week and it is not yet known how COVID-19 will affect any IT release. A date is needed before any further update can be given.	
5.	**Governance Issues**	
5.1	Non-compliance with Heart Allocation D Manas gave a verbal report on non-compliance with heart allocation policy. There have been a few of incidents and these are detailed in the Clinical Governance Report circulated prior to the meeting.	
5.2	Clinical Governance Report The report was circulated prior to the meeting for information and members were asked to consider the following: • INC 3840 – *Consider if it would be beneficial to 'back up' hearts where there is a significant distance between donor hospital and accepting centre.* It was agreed that a few scenarios would need testing by Hub Ops before this could be actioned as this is not feasible in many instances. • INC 4225 – *Consider if there should be a national agreement of cardioplegia used when OCS machine is being used in DBD donation to prevent last minute request and standardise process.* It was noted that Edinburgh now produces a mandatory prescription form signed by the surgeon each time for the donor indicating the drugs and fluid required and theatre teams then set up accordingly. In this way, the organ is not lost and the recipient receives the transplant. This will be discussed further at the forthcoming Retrieval Advisory Group meeting.	
5.3	CUSUM Monitoring of 30-day outcomes following heart transplantation	

	No CUSUM signals have been reported in the last 6 months for heart transplantation.	
5.4	Group 2 Transplants There were no Group 2 transplants during the period.	
5.5	Harefield Review: Learning Points The Chair thanked all those involved in this review. An internal review by the Harefield team had analysed five years of heart transplantation data and The Chair thanked the management, clinicians and clinical governance team at Harefield for engaging with the process and cooperating fully with the external reviewers. The main learning points from the review are: • Overall, one-year survival was slightly below the UK average (but not statistically significant). The outcome in patients transplanted while supported with durable LVADs was high. Harefield has a high percentage of LVAD patients on their heart transplant waiting list. • It was agreed that the MDT assessing patients for transplant and LVAD should work better; all members of the group should be encouraged to voice their opinion. Senior members of the Intensive care team plan to attend the MDT more frequently in the future. • Succession Planning: The loss of an experienced member of the transplant cardiology team may have contributed to the lack of a strong cardiology voice at the MDT. The problem with succession planning (particularly with transplant surgeons) is an issue that every unit in the UK will have to deal with. • Management of complicated patients in the ICU: The intensive care team had concluded that they need to have more senior input for complicated patients (particularly at night). • The Review Panel also felt that a sharing of the burden between members of the team e.g. double consulting/vetting of donors and double scrubbing for complicated patients may help. This was not accepted as useful by all members of the surgical team but has been successful at other centres in improving outcome. A Simon commented that while the recommendations made were accepted it was difficult to implement everything suggested (eg, having two different surgeons available when the rota was already stretched). The patients are also frequently complex. In conclusion, J Forsythe noted that he had been impressed by both Harefield's reaction and co-operation in the process and he was grateful to both sides in ensuring a successful review. It is important to foster a culture in which a CUSUM trigger is not viewed with trepidation but as an opportunity to review practice and improve outcome.	
6.	**Heart Utilisation**	
6.1	Centre Specific Activity Report The report presented to the meeting shows there have been 1% fewer DBD donors and 6% more DCD donors than in the same period for the previous financial year. At the same time, there have been 8% fewer heart transplants and 1% fewer lung transplants. For the first 11 months of 2019/20, heart transplant numbers are down 4% on the same period 2018/19. Lung and heart-lung transplant activity has increased slightly in the first 11 months, with an increase of 2% on the same period last year. The number of transplants for the coming year are hard to predict at present.	
7.	**Heart Allocation**	
7.1	Summary of Adjudication Panel Appeals The paper presented reports on Heart Adjudication Panel referrals between 26 October 2016 (the date of the introduction of the super-	

	urgent heart allocation scheme) and 29 February 2020 as well as urgent heart-lung adjudication panel referrals which are referred to the Lung Adjudication Panel but sometimes also the Heart Adjudication Panel, if standard urgent heart listing criteria are not met for the same period. Referrals for Total Artificial Heart (TAH) implantation were not included. Statistics and Clinical Studies at NHSBT have kept records of all Adjudication Panel referrals since Oct 2016. There were 90 adult referrals and 19 paediatric referrals to the Heart Adjudication Panel for urgent or super-urgent listing. Of the 74 urgent adult appeals, 58 (78%) of the recipients had a long-term VAD implanted at time of application. Harefield had the highest number of urgent adult appeals and the highest number of urgent registrations. For the super-urgent adult appeals, 8 (50%) of the 16 cases had a long-term VAD implanted at time of application and again Harefield had the most registrations over this period. Two of the paediatric heart patients had a long-term VAD at time of appeal; one from each of the paediatric centres. M D'Mello raised the question whether given the Statistics and Clinical Studies paper presented generally showing a high percentage of acceptance of appeals, do these meetings work well and are they a good use of time. It was agreed that the appeal process was valuable and was an opportunity to review new criteria as they arose.	
7.2	<u>DCD Hearts for paediatric patients</u> The governance team has indicated that there are issues concerning movement of perfusion devices around the country currently, particularly with only two centres in the UK. It was felt that by using the current matching run for DCD hearts for paediatric patients we may see challenges between the two centres and so NHSBT would look to see if it was possible to allocate DCD hearts for paediatric patients on a geographical basis. **ACTION: L Mumford to discuss this with Hub Operations**	**L Mumford**
7.3	<u>Cardiothoracic and liver registrations</u> The paper circulated showed activity on combined cardiothoracic and liver registrations and outcomes from 1 January 2018 to 29 February 2020. Since 1 January 2018, there have been 8 patients registered for a cardiothoracic and liver transplant (4 heart and liver, 4 lung and liver). As at 3 March 2020, 5 of these patients are currently active on the list, 2 have received transplants and 1 died on the list. Seven of the 8 patients were registered on the urgent heart/lung list whilst 1 is registered as non-urgent, as at 3 March 2020. The 4 heart-liver patients generated offers from 140 donors up to 29 February 2020, with one acceptance. Of the 4 heart-liver patients, all were registered onto the urgent heart scheme, with one registered with a category requiring panel approval. None of the lung-liver patients required panel approval.	
8.	**Statistics and Clinical Studies reports**	
8.1	<u>Summary from Statistics and Clinical Studies: Spring 2020</u> L Mumford stated that the interim cardiothoracic transplant report and mechanical circulation report are now both available online.	
8.2	<u>Registry Form Returns</u> L Mumford stated that these will be requested soon. All were thanked for keeping return rates high, though Harefield and Papworth had lower return rates for long term forms. Poor performance from GOSH was noted yet again and the centre has been asked to review its process.	
9.	**Reports and Discussion Points from the Chair**	
9.1	<u>CTAG Work Plan</u> The CTAG workplan was circulated prior to the meeting. It was suggested the lead for each action point be named next to the item. **ACTION: CTAG Chair to consider this proposal.**	**J Parameshwar**

9.2	CT Centre Directors Telecon: Minutes The Minutes were circulated prior to the meeting. A question was raised concerning the transplantation tariff due to be introduced in April. It was noted the effect of the COVID 19 outbreak on all tariffs would be considered by NHSE.	
9.3	RAG (NRG) Update I Currie gave an update from the last Retrieval Advisory Group meeting held in the autumn last year. The next RAG meeting will be held on 31 March.	
9.4	Joint Innovation Fund Bid Update This start date for the plan has been postponed because of the COVID 19 outbreak Current arrangements for reimbursement will continue for the present.	
9.4.1	Heart Allocation Policy - POL228_11 This policy document was circulated for information	
9.4.2	Allocation of DCD Hearts Dr Matthew Fenton had raised this issue but was not at the teleconference. Organs will be offered as per the DBD non-urgent rules, but we may have to consider the effect of geography and avoid transporting the OCS machine and organ long-distances. **ACTION: Julie Whitney to consider this with Marius Berman**	**J Whitney / M Berman**
9.5	QUOD Update There was no verbal update at the meeting and this has been paused currently due to COVID-19	
9.6	HCV Positive Donor Organ update Papworth and Birmingham are signed off to accept these organs; other centres are still fulfilling the requirements.	
9.7	Real Time Retrieval Imaging Ian Currie reported that M Berman has negotiated a preferential rate with a commercial company to allow a surgeon to send real time retrieval imaging via mobile phone or pc back to base. This will be trialled over 6 months at Papworth and Edinburgh. It was agreed that having access to this kind of imaging was good for governance.	
10.	**Reports from sub-groups**	
10.1	CTAG Clinical Audit Group (CAG) Chair's Report and Minutes The Chair's Report and Minutes were circulated prior to the meeting for information.	
10.2	CTAG Patient Group The Minutes from the Patient Group meeting were circulated. R Graham stated that this was an extremely difficult time for patients with high levels of uncertainty, particularly regarding self-isolation, availability of key workers and possible re-deployment of transplantation staff. The question was raised about whether a transplant patient would be treated in a local hospital rather than the transplant centre. J Parameshwar confirmed that this was likely to be the case and that transplant activity is likely to fall markedly with non-urgent lung transplantation unlikely to take place. It was important to maintain phone contact with patients who are well. D Manas also stated that patients contracting COVID-19 post-transplant seem to be doing well at present.	
11.	**For Information**	
11.1	Transplant Activity Report This report indicates that activity is largely the same as in the previous year.	
11.2	NHSBT ICT Update for Advisory Groups The ICT report was circulated for information	
12.	**Any other business**	
12.1	Travel/accommodation booked for Advisory Group meetings The Chair asked all members to consider booking any future travel to or accommodation for meetings through the Clinical and Support Services	

	Team at OTDT in order to try and reduce costs for meetings once COVID-19 issues have passed.	
12.2	Dates of Future meetings: **CTAG Patient Group** – Wednesday 13th May 2020 12:00 to 16:30 - TBA **CTAG Lungs Meeting** – Thursday 17 September 2020, Mary Ward House, Tavistock Place, WC1H 9SN – 11:00 to 16:00 **CTAG Hearts Meeting** – Monday 28 September 2020, Mary Ward House, Tavistock Place, WC1H 9SN – 11:00 to 16:00 **CTAG Patient Group** – Wednesday 18 November 2020, 12:00 to 16:30 - Fine Room 1&2, Asia House, 63 New Cavendish Street, London, W1G 7LP **HOLD THE DATE 2021 – Proposed dates of Future Meetings 2021** **CTAG Hearts Meeting** – Monday 22 March 2021 - 11:00-16:00 – TBA **CTAG Lungs Meeting** – Wednesday 31 March 2021 – 11:00-16:00 - TBA	