NHS BLOOD AND TRANSPLANT
ORGAN DONATION AND TRANSPLANTATION DIRECTORATE

THE TWENTY-FOURTH MEETING OF THE RETRIEVAL ADVISORY GROUP (FORMERLY NATIONAL RETRIEVAL GROUP) ON TUESDAY 31 MARCH 2020 FROM 10:30 UNTIL 1:00PM VIA MICROSOFT TEAMS

MINUTES

Present:

Ian Currie	National Clinical Lead for Organ Retrieval **(Chair)**
Marius Berman	Associate Clinical Lead for Organ Retrieval
Richard Quigley	Cardiothoracic Recipient Coordinator Representative
Victoria Gauden	National Quality Manager, ODT, NHSBT
Olive McGowan	Clinical Governance
Cecilia McIntyre	Retrieval and Transplant Project Lead Specialist
Debbie Macklam	Senior Commissioning Manager, NHSBT
Derek Manas	Clinical Governance Lead, NHSBT
John Hammond	NORS lead, Abdominal, Newcastle
Majid Mukadam	Representing NORS lead, CT Birmingham
Bart Zych	Harefield Hospital, attending on behalf of Andre Simon, NORS lead
Afshin Tavakoli	NORS lead, Abdominal, Manchester
Elijah Ablorsu	NORS lead, Abdominal, Cardiff
Hynek Mergental	NORS lead, Abdominal, Birmingham
Hector Vilca-Melendez	NORS lead, Abdominal, King's Hospital
John Stirling	NORS Workforce Transformation Lead, NHSBT
Gavin Pettigrew	NORS lead, Abdominal, Addenbrookes
Chris Watson	Joint Chair, Novel Technology Implementation Group
Andrew Butler	MCTAG representative
Michael Hope	Abdominal Recipient Coordinator Representative
Bimbi Fernando	BTS rep
Julie Whitney	Head of Service Delivery, ODT Hub, NHSBT
Dale Gardiner	National CLOD, NHSBT
Hester Ward	Scotland rep
Rebecca Curtis	Statistics and Clinical Studies, NHSBT
John Forsythe	Associate Medical Director, ODT, NHSBT
John Asher	Clinical Lead – Medical Informatics, ODT. NHSBT
John Isaac	Deputy Chair, Liver Advisory Group
Melissa D'Mello	Lay representative
Liz Armstrong	Head of Transplant Development, NHSBT
Peter Friend	Chair, MCTAG

In Attendance:

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

		ACTION
2.	**WELCOME, INTRODUCTION & APOLOGIES**	
	Apologies were received from Ayesha Ali, Chris Callaghan, Gabriel Oniscu, Doug Thorburn, Victoria Fox, Catherine Coyle,	
2.1	**ACCURACY AND FOLLOW UP OF PREVIOUS MINUTES AND ACTION POINTS OF THE RETRIEVAL ADVISORY GROUP**	
2.1	Minutes - The Minutes of the last RAG meeting on 1/10/2019 were approved with no amendments.	

2.2	Action Points - The Action Points from the previous meeting were updated as follows:	
	AP1: Advisory Group Priorities – Pancreas: JJC and PF confirm that pancreas is not offered for solid organ transplant when small bowel is retrieved. As no vessels are required, it was agreed to close the item.	**CLOSED**
	AP2: Training J Stirling and R Ploeg have been liaising with colleagues to refresh the abdominal electronic module. C Wilson has informed IC that planned changes are in hand but may be delayed given current situation. **Ian Currie to follow up with Colin Wilson and discuss at next RAG meeting.**	**Ongoing** **IC**
	AP11: Training and Registration: The issue of competence for retrieval of tissue was raised as HTA are likely to check NHSBT records to ensure this is recorded on a yearly basis. I Currie and V Gauden have agreed that surgeons should have annual updates on HTA modules – reminder to go out from NHSBT. However, surgeons and NORS leads remain responsible for own updates. T&R has been updated to reflect this. **IC/VG to ensure reminder email goes out annually to NORS Leads.**	**Ongoing** **IC/VG**
	AP13: Video Heart and Lung Project: This has been replaced with an alternative (Remote Imaging Project; MB) Thanks were extended to John Asher, Chris Callaghan and Marius Berman.	**CLOSED**
	AP14: Uterine Transplant: This is currently suspended due to covid-19 situation.	**Ongoing**
	Bile Sampling in Organ Donors: an update will be considered on the agenda for this meeting.	**Ongoing**
	Any Other Business: Cardiothoracic boxes after consideration from M Berman and other units as NHSBT do not purchase the boxes this item has now been closed.	**CLOSED**
2.3	Matters Arising – there were no matters arising.	
3	**TERMS OF REFERENCE RETRIEVAL ADVISORY GROUP (RAG)** The terms of reference were ratified further to one amendment of adding John Asher, National Clinical Lead, Medical Informatics NHSBT, to the group.	
4	**INITIATIVES SINCE THE LAST RAG MEETING**	
4.1	**REMOTE ORGAN IMAGING** MB and IC advised that due to time constraints in this particular meeting that it won't be demonstrated. However, a six-month trial has been agreed and will be jointly funded by Papworth and Edinburgh – and will report back at the next RAG meeting in September if appropriate experience has been gathered, given the current situation.	
4.2	**SUPER URGENT LIVER GROUP** Recipients listed for super urgent liver transplant are at risk of rapid and fatal deterioration during the time between listing and transplantation. Experience suggests that avoidable retrieval delay is common in such patients. The purpose of this document is to examine the pathway for organ retrieval when the liver has been allocated to a super urgent recipient. The document identifies avoidable delays, avoidable mortality, and proposes a better pathway to	**IC to re-convene S-ULG**

	minimise the time interval between allocation of a liver to a SU recipient and arrival of the liver at the recipient hospital. It was agreed that this is an important development. It has been approved by CTAG and all relevant parties. Once the COVID-19 situation retreats, expedited offerings will be implemented by the HUB when livers are allocated to Super Urgent Recipients. The development group will meet in the first instance to assess any further details required prior to implementation.	
5	**ASSOCIATE MEDICAL DIRECTOR'S UPDATE** JF reported that the covid-19 bulletins have been reaching wide audiences and increasing the audience every day. Feedback has said that this is useful in these ever-changing times. He said that there is a medical meeting to include the chairs of the Advisory Groups each week and these are useful information gathering meetings. Registry set up and encourages each centre to use and it will inform patients for the future. Concern was shown for patients that might have covid-19 and are still considered as a potential recipient of a donation as the risk would be higher if the operation does not go ahead.	
6	**CLINICAL UPDATE – COVID 19**	
7	**Update from Advisory Group Chairs** • Multi-visceral • Cardiothoracic • Kidney • Liver • Pancreas None of the above groups had specific updates for RAG with their programs of work at the present time.	
8	**NOVEL TECHNOLOGY IMPLEMENTATION GROUP (NTIG)**	
8.1	**JIF/DCD HEARTS PROJECT** MB reported that the JIF/DCD programme was supposed to start on 1 April but due to current situation has been put on hold. All the clinical protocols, HUB operations and all units are all set up and ready to go when needed.	**MB to update on JIF/DCD hearts at the next RAG meeting**
8.2	**NRP FUNDING BID** DM advised that the business case for funding was put forward some time ago to support the NRP roll out and all is on hold at the moment, waiting to hear back from DHSC. No response from the English health department but there is clear and positive support from Scotland and Wales. The sustainable funding group has asked for further information on project-wide risks and increased costs for hospitals. Thanks were extended to DM for continuing to follow this up.	**DM to update at next RAG meeting as to DHSC opinion**
9	**RESEARCH AND CLINICAL DEVELOPMENTS**	
9.1	**RINTAG –** no update at this meeting.	
9.2	**INOAR –** no report given at this meeting.	
9.3	**QUOD –** IC reported that this is on hold at the moment due to current situation.	
9.4	**BILE SAMPLING** The paper describes the techniques in bile in DBD donors and was recommended at the last RAG meeting. Looks	**HW to put on agenda for next RAG meeting.**

	straightforward without any risk to the liver. Mr Shahid was not in attendance. Given current situation, defer to Autumn meeting.	
9.5	**UTERINE TRANSPLANT PROGRAM**	
9.6	**PITHIA –** IC reported that this is on hold at the moment due to current situation.	
10.	**PERI-MORTEM INTERVENTIONS PROJECT –** DG reported that this is currently on hold due to the current situation and will report back at a later meeting.	
11.	**CLINICAL GOVERNANCE –** DM described movement of OrganOx machines between some centres and how to do this safely. As the use of machine perfusion has increased it has been suggested that a national agreement is required around the sharing of organs whilst on machine perfusion, such as OrganOx. DM has agreed to take this work forward with centres. It will also be raised at LAG to increase awareness. Incident –A graft was lost during OrganOx transport. The device had been connected to a 12V supply (cigarette lighter) which provided inadequate power. **Organox should not be connected to a transport cigarette lighter and requires an adequately rated power supply.** For awareness. Hep C case – shared learning amongst the retrieval community. Donor surgery was delayed when an anticoagulated HCV+ donor was deemed to require clotting products and blood tests prior to starting surgery. **DM agreed to circulate documentation.**	**DM to follow up with each centre on OrganOX**
12.	**ORGAN DAMAGE**	
12.1	**ORGAN DAMAGE REPORT** RC highlighted the main points from the organ damage report and stated that each of the retrieval teams would have received information each month on damage and this would have been discussed at the NORS contract review meetings. It was noted that the summary Figure on the first page of the report refers to retrievals '1st January 2017 – 31st March 2018'; this is an error, the data refer to 1st January 2018 to 31st December 2019. NORS teams are encouraged to feedback any inaccuracies in the monthly damage reports. Otherwise, the data are assumed correct. It was suggested that pancreas damage is still too high and that it could be put on the agenda for the masterclass. After discussion this was considered not to be feasible. IC had previously discussed at PAG supported learning for pancreas retrieval.	**IC/JC to discuss supported learning for pancreas retrieval**
12.2	**RETRIEVAL INJURY FTWU** PROPOSED CHANGES TO ORGAN DAMAGE RECORDING/DAMAGE SCALE/CUSUM MONITORING RC and IC introduced the proposed changes to the RTI and HTA B forms. The objective is to make the damage scale more useful and informative, and to reflect the clinical consequences of organ injury rather than the injury per se.	**I C/DM/RC to clarify final details for damage scale and CUSUM reporting.**

	It is possible to make some edits to the HTA-B fairly promptly with IT and various departments but the RTI form is a further project. IC and DM to discuss the damage wording further before implementation as there needs to be additional detail regarding cold ischaemia time and fatty pancreases – to prevent these being described as 'damage'.	
13.	**TRAINING AND REGISTRATION** IC stated that the training and registration document had been updated and asked NORS leads to familiarise themselves with the document and to ask their teams to keep their HTA training updated on a yearly basis.	**HW to send out updated T&R form to all NORS leads.**
14.	**NORS STANDARDS** The Chair introduced the existing NORS Guidelines Policy (MPD1043) which has been under review for the last 12 months. Proposed changes are highlighted in yellow in the document that has been circulated. Those at the meeting discussed all the changes and the Chair also welcomed further verbal or written feedback. • *Paragraph 1.7 - If the donor is found to be pregnant at the time of retrieval, the retrieval team should stand down immediately.* It was noted that while all women who could be potentially pregnant are tested there could be a need to stand down if such a case arose. The meeting agreed that it is important to have a plan in place should such a scenario occur. **ACTION; IC to look into a structured plan for this scenario** • *Paragraph 2.10 –delays where cardiothoracic patient proves to be a complex case.* It is proposed that the recipient should be ready for anaesthesia when knife goes to skin in the donor, and the heart is judged to be safe for transplant. In such instances, it is suggested that the maximum delay should be 2 hours. This has been discussed with some cardiothoracic surgeons who are supportive. It was agreed that there are probably ways to cut down aspects of the retrieval process and pathway. The meeting also agreed to go ahead and see what feedback is received. D Manas stated that a change of recipient at a late stage of the process is not covered in this and it may be prudent to add a line to say that if different circumstances arise, such as a different recipient or fast track offer, then it is reasonable for the delay to be increased. **ACTION: IC to amend this.** • The comment was also made that for multi-visceral retrievals, 2 hours is sometimes not long enough, eg an explant can be complicated and the delay may need to be longer. This should be reflected in the paragraph concerned. **ACTION: IC and AB to put suitable text together to reflect this.**	

	• *Paragraph 3.4 - Use of NRP in abdomen in the retrieval of lungs* – There are circumstances where lungs are retrieved with no bleeding and other occasions when there is considerable bleeding in chest. It was felt that it was important to reflect that meticulous surgery in the chest is required when NRP in use. The 2nd paragraph also refers to when more than 4 units of blood are required for the NRP circuit or NRP is terminated prematurely or when organs are lost due to bleeding in the chest, such events should be reported to clinical governance and considered a serious adverse event. This is strongly worded but there is concern for potential organ loss. MB commented that training sessions are planned to minimise this happening. At present, there is no solid data to confirm how often this happens re ANRP and it would be useful to know how frequently this happens. **ACTION: IC to amend the paragraph and will also look into how data may be collected when NRP is used.** • *Paragraph 3.5 - DCD donor – heart starts beating again when donor in theatre.* If this occurred, the lead surgeon and team stands down and the ICU team are summoned. DG commented that a further problem can be a sense of double tragedy for the family, probably not only with the heart re-starting, but also that organs are not used as planned, but there was agreement with the sentiment that no-one in the surgical team should be compelled to continue. It was noted that this could be a very challenging situation. PF stated that explicit guidelines are preferable to avoid a PR problem. **ACTION: DG to circulate national guidelines agreed at NODC with members of RAG** It was also agreed that there was enough momentum to write something further to clarify the situation and what should happen (eg distinguishing between ventricle fibrillation that arises from an NRP procedure and an unrelated incident where the heart re-starts while in surgery) • **ACTION: IC to develop document** • *Paragraph 3.25 - Signing of HTA forms* – It is agreed that the lead surgeon is legally responsible for content and accuracy of HTA forms and that a phone number and centre is needed regardless of whether s/he signs the form. However, there are instances when s/he may still be operating when the organ needs to leave the building. The meeting felt that it was inappropriate for the surgeon to sign the form in advance to avoid a delay in organ departure, nor that the SN-OD should be expected to sign the form instead. It was agreed	

	that the surgeon should check the contents and delegate responsibility for signature and that the person signing the form should print their name, including the date and time of signature for governance purposes. The surgeon's name MUST appear on the document in the usual place, plus their contact number. Overall, paperwork should not stand in way of organs leaving the building simply because it is awaiting a signature from a lead surgeon who may still be in surgery. • **ACTION: IC and Melissa D'Mello to take forward and pass to O McGowan, D Manas and H Vilca-Melendez** • *3.42 - Flushing bile duct for DCD liver.* It appears that there are different methods in place including using saline as well as UW alone. Agreed that UW is the preferred method although 2 centres do use saline. It was also agreed that this should be in situ and not on the back table. The wording will stand as amended • *Paragraph 3.5 – Vessels* - The wording that one set of iliac vessels should go with the liver and one with the kidney pancreas was agreed. • *Paragraph 3.56 Late decline 3.56 – after withdrawal of life sustaining treatment in DCD surgery or during surgery for DBD.* It was felt that the current situation about whether the operation will proceed until it's confirmed all organs have been declined for life saving surgery or research is not clear at present and the surgeon could be accused of continuing with a retrieval even when a specific organ has been declined in a particular place. It was agreed that there should be a clear pathway that protects the surgeon but that the word research is removed. **ACTION: IC to remove the word 'research' and to clarify wording.** • *Paragraph 3.68 Retrieval team must not be delayed.* If the team needs to leave, it was agreed that SNODS should not delay departure until all organs are placed. It was noted that an update is currently in process with the specialist nurses. • **AB and IC to liaise further on the text on section 2.6 and will add to the document as regards multi-visceral transplant**	
15.	**EQUIPMENT AND TECHNICAL** New procedure packs. JS advised that the document has been circulated to all NORS leads and that 11 teams out of the 16 have been	

	trained. JS and CM will be in touch with the remaining centres and will complete the training remotely.	
16.	**WORKFORCE AND SUSTAINABILITY** IC advised that the surveys will be discussed in more detail at the next RAG meeting as the data needs to be shared and lessons learnt. He encouraged RAG members to read the surveys.	
17.	**AOB** **BLUE LIGHT GROUP** – D Macklam advised that M Parry from DfT has asked for more detailed analysis which the team are gathering and once completed will have a further meeting with M Parry once able. **SURGICAL CARE PRACTIONER ROLE** – JS advised that this role has been shared with all NORS leads and will also circulate to perioperative teams. **TANRP** – MB reported he is working with DG, Alex Manara and others to develop this, and will bring to a further meeting.	**HW to put on agenda for next RAG meeting**
18.	**Date of Next Meeting:** Tuesday 29 September 2020, 1030-1300.	**HW to put on agenda for next RAG.**