

Study Re-Ranking and Survey Feedback

May 2021 RINTAG Meeting

One of RINTAG's first tasks in 2017 was to design a ranking and allocation system for studies to receive organs for research. Before this, organs for research were allocated on a geographical basis. The system that was designed by RINTAG considers several factors to calculate a score:

- Whether a study can transplant the organs it receives
- Whether the study has been peer-reviewed
- How many organs the study requires (the feasibility)
- Whether the study is basic science, clinical, or is unrelated to transplant (this replaced a category that assessed how quickly the study would increase the number of organs available for transplant, but used the study's end date)

The following secondary categories are used as tiebreakers, and don't have any corresponding numerical value:

- Collaboration with other institutions
- Use of novel technology
- Alignment to ODT strategy

Whilst no doubt an improvement on the previous system, researchers have identified issues and provided feedback on the system. Some of the main areas of concern are:

Little movement up/down the ranks

The factors that are considered in the ranking process stay relatively static through a study's lifetime, so many studies stay at either the top or the bottom of the list. If a study has wide acceptance criteria and is placed near the top, it prevents studies lower down the list from receiving much tissue, if it all.

Rare organ types

Studies that wish to receive rare organ types are often separated by very small margins (often a single point), but this results in the first-ranked study receiving all of the tissue and other studies not receiving any. In the past this has been settled by coming up with alternative arrangements (i.e. the studies take it in turns to be ranked first each month).

Survey Results

A survey was circulated to all active researchers in early 2021 to gather their feedback (please see the Appendix for the questions). There were 13 respondents.

Most of the respondents were positive or neutral about the understandability and fairness of the current system (Fig. 1). Respondents were more negative about the visibility of the system. The most disagreement was around whether research that is not directly related to ODT should be lower ranked. One suggestion was that donor families, members of the public, and transplant recipients should be consulted and asked to help define research priorities. A James Lind Alliance priority setting exercise could be carried out to achieve this, or the new ODT strategy – with research as a key theme – could be used to redefine ODT research priorities.

Other suggestions included incorporating:

- Upcoming grant deadlines
- Geography
- Specific organ requirements (e.g. fatty livers)
- Whether the project can improve (in the long term) the quality of life of potential recipients
- Study progress (in terms of meeting their protocol)

Suggestions for a definition of novel technology included cell therapies, machine perfusion, and emerging technologies such as artificial intelligence, bioprinting and nanotechnology. However several respondents also found this hard to define, and RINTAG should consider developing a list or criteria.

Responses were evenly split about whether there was often competition from other studies when calling into the Hub. Respondents noted that the competition is dependent on the organ type, time of offer, and location of the offer. However, later on in the survey, the most common reason for not being able to accept an organ was because other studies called in and were higher-ranked (Fig. 2). The second most common reason was the condition of the organ making it unsuitable for research as well as transplant.

Most studies had accepted fewer organs as a result of the COVID-19 pandemic, but 1 stated that they had received more. The decrease in donation and transplant activity was subsequently felt in the research community as well, with fewer offers. Social distancing within labs also meant it was harder to accept organs, particularly if several were offered in a short time period. One study responded to say that they could not use their perfusion machine as the oxygenators it needed were also used by ECMO machines, and therefore the company would not sell them any for research purposes.

Suggestions for increasing acceptance overall were as follows:

- Helping with transport costs
- Mandating that the NORS team will take organs for research if there is appropriate consent/authorisation
- Earlier notice in order to minimise the cold ischaemic time
- Putting details of machine perfusion status in the offer message

4. Please indicate if you agree or disagree with the following statements:

[More Details](#)

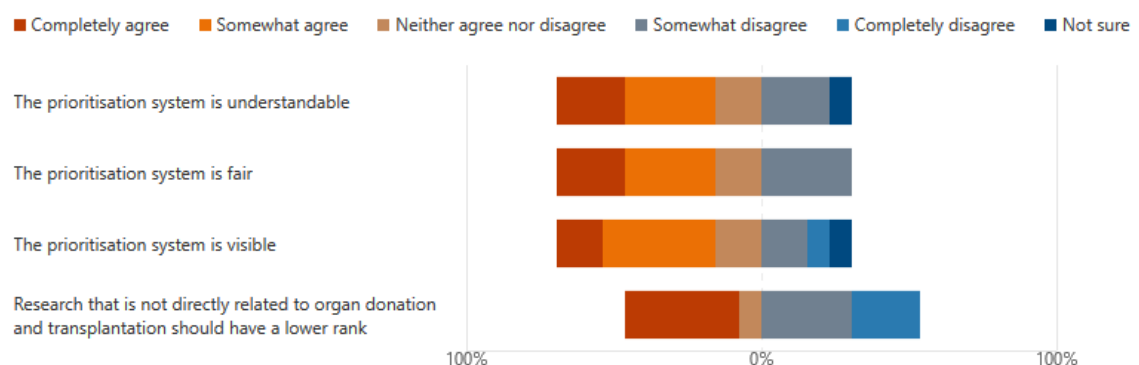


Figure 1: Views on the prioritisation system from the 13 survey respondents.

11. The most common reason(s) that we can't accept organs are because:

[More Details](#)

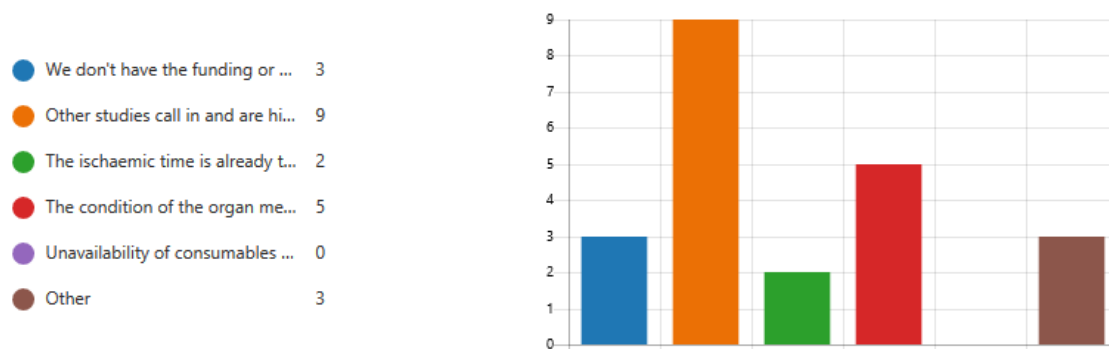


Figure 2: The most common reasons for not being able to accept an organ for research.

Quick fixes include increasing the visibility of the current ranking by making it available on the ODT Clinical website.

A priority-setting partnership (i.e. carried out with the James Lind Alliance) with lay members, donor families and other members of the public would be valuable. A working group within RINTAG could be set up to address the other issues raised here.

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Appendix 1: Survey Questions

1. What is your ODT Study Number?
2. Which type(s) of organs do you receive through the scheme?
3. What is your current rank, if you know it?

Our current system gives studies a numerical score based on:

- whether a study can transplant the organs it receives
- how many organs the study requires, and in what timeframe (the feasibility)
- whether a study is basic science or clinical in nature, or if it is unrelated to transplantation
- whether the study has been peer-reviewed, and if so, by whom

Secondary categories help to distinguish between studies that have the same score. These are:

- collaboration with other universities/institutions
- use of novel technologies
- alignment to the NHSBT Organ Donation and Transplantation strategy

Studies are assigned a provisional rank when they first apply to RINTAG, and then re-ranked approximately every six months in line with the face-to-face RINTAG meeting cycle.

4. Please indicate if you agree or disagree with the following statements:
 - a. The prioritisation system is understandable
 - b. The prioritisation system is fair
 - c. The prioritisation system is visible
 - d. Research that is not directly related to organ donation and transplantation should have a lower rank
5. What is a 'novel technology' to you?
6. Please suggest any improvements to the prioritisation system, or additional factors that the prioritisation system should consider here:
7. Do you find there is much competition from other studies when you call into the Hub?
8. Space for further detail here
9. Have you been able to accept more or less organs as a result of COVID-19?
10. Space for further detail here
11. The most common reason(s) that we can't accept organs are because:
 - a. We don't have the funding or personnel to have a 24/7 rota
 - b. Other studies call in and are higher ranked than we are
 - c. The ischaemic time is already too long by the time the organ is offered
 - d. The condition of the organ means that it's unsuitable for our research
 - e. Unavailability of consumables
 - f. Other
12. Space for further detail here and/or suggestions for how NHSBT could help to increase acceptance
13. Please indicate whether you agree or disagree with the following statements:
 - a. I receive all of the emails from the ODT Research address
 - b. I read all of the emails from the ODT Research address
 - c. I would like a monthly overview of the number of organs offered and accepted to be sent to me
14. Extra space for feedback about our communications, if required.

