NHS BLOOD AND TRANSPLANT
ORGAN DONATION AND TRANSPLANTATION DIRECTORATE
CTAG CENTRE DIRECTORS TELECON
MONDAY 21 JUNE 2021

MINUTES

PRESENT

Rajamiyer Venkateswaran (RV)	Chair (CTAG Hearts); Wythenshawe Hospital
Stephen Clark (SC)	Freeman Hospital, Newcastle
Jonathan Dalzell (JD)	Golden Jubilee National Hospital
Matthew Fenton (MF)	Great Ormond Street Hospital
Jorge Mascaro (JM)	QEH, Birmingham
Stephen Pettit (SP)	Royal Papworth Hospital
Sally Rushton (SR)	Principal Statistician, NHSBT
Steven Shaw (SS)	Wythenshawe Hospital
Ulrich Stock (US)	Harefield Hospital
Sarah Watson (SW)	NHS England
Julie Whitney (JW)	Head of Service Delivery - OTDT Hub

IN ATTENDANCE

Caroline Robinson (CR) - (Minutes)	Clinical and Support Services, NHSBT

Item	Discussion	Action
1.	**Welcome**	
	RV welcomed everyone to the meeting which sought final approval on some issues that came out of the recent CTAG meeting and before the autumn meeting. An increase in COVID cases may also affect future developments as well as current capacity.	
2.	**6-Tier allocation system for urgent heart transplantation and work towards a model of national waiting list for all urgent patients**	
	Due to issues around the IT system requirements within NHSBT, it was proposed that as it has not been possible to introduce the 6-tier allocation system for urgent heart transplantation agreed many years ago under Stephen Tsui's chairmanship of CTAG, this should be either put on hold or rejected in favour of accepting the status quo. The meeting agreed that if this is to happen, decisions need to be made to ensure all patients get the right treatment at the appropriate time. After discussion the meeting agreed the following points: • A lot of thought went into the 6-tier system reflecting that the current system was less than perfect and so it would be unwise to shelve it altogether. • There is a lack of granularity in the status quo compared with elsewhere in the world. It is therefore important to upgrade it so that the sickest patients do not have to wait too long and the most benefit is derived from transplantation. • A national urgent system is a preferred option. However, in creating this, it will be important to decide on the ranking of the patients. It was noted that for liver, scores are used to rank patients to determine the most benefit there will be from a transplant. If this option is agreed for CT, a scoring system will be needed, and the group will need to decide what data is needed. • The ramifications of any decisions made need to be considered alongside the national system itself, (eg increased ischaemic times, more short-term mechanical times, costs of transporting hearts around the country). **AGREED:** • **The 6-tier allocation system will be put on hold** • **RV to create a sub-group to discuss the development of a national urgent list** • **RV to discuss this issue with J Parmar (Chair of CTAG Lungs) to see if any of these issues relate to lungs as well.**	

	• **JW will inform RV of appropriate NHSBT people to be members of this group.**	
3.	**Proposal to ignore April 20-March-21 data for changes to zonal allocation review**	
	Changes to the heart and lung allocation zones are made if there is a statistically significant difference (at the 5% level) between the percentage share of registrations and the percentage share of donors for any centre following a review each autumn. At the CTAG Hearts meeting in March it was agreed that the Bonferroni correction will be removed in future. COVID has had a significant effect on transplantation this year and it is clear there have been fewer registrations and fewer donors during the pandemic. In the last analysis, the period for review for registrations was August 2018 to July 2020. The proposal is to discount the first 3 months of this financial year. If the usual review was repeated this autumn without these 3 months, there would be no significant differences and so the plan is not to re-run the data this year, but to go forward next autumn with a review that does not include the financial year 2020-21. This was agreed at this meeting.	
3	**Changes to heart CUSUM**	
	Every 2-3 years the baseline period is updated to reflect current clinical practice. Previously this period was Jan 2013-Dec 2016 for adult and paediatric transplants. This is now being updated to 2015 to 2018. At CTAG Hearts in March changing the Heart CUSUM from 30 days to 90 days was discussed. The 30-day mortality rate is 8.7% and would change to 12.9% if the CUSUM was changed to 90 days. The Centre Directors' meeting discussed whether 90-day outcomes would better reflect the "success" of a transplant, whether DCD hearts should be included in the baseline (leading to a potential for more sensitive charts and more signals) and whether graft failure should be included as an event in CUSUM. **AGREED:** • **<u>90 days</u> - 30 days is not meaningful in terms of a successful outcome. It is easier to keep patients alive for longer and some patients may die just after the 30-day period and so while not triggering CUSUM, would not be considered a success by the centres. It was agreed that 90 days is a better option.** • **<u>DCD Hearts</u> should be included in CUSUM even if it lowers the morbidity threshold as it is now an established part of the transplantation programme. The philosophy of CUSUM should be about identifying learning and improving practice and not seen as a punishment or a penalty. It was however, noted that it would be helpful to look at data prospectively going forward rather than retrospectively and it was confirmed that where monitoring periods overlap with periods that have already been measured, only new time periods will be considered.** • **<u>Re-transplant</u> – the meeting agreed that this should not be included for the time being. This is a complicated issue as it could result in two procedures being included for 1 patient. If the patient survives, the graft procedure should not be included as an adverse outcome. Re-transplants are a rare occurrence and so it was agreed that it would be useful to collect data on this area for the next 2 years before deciding whether to include it in CUSUM.**	
4	**Sherpa-Pak**	
	At the March meeting this year, CTAG Hearts were asked to support an application to RINTAG to trial Sherpa-Pak, a temperature-controlled pack that could replace the current system of transporting organs in an ordinary icebox that has been in existence for many years. All units have used Sherpa-pak, but this initiative is currently being supported by charitable funding and it is not possible to share the service if you are not a retrieving centre. Currently a surgeon is required to attend to travel with the organ to the recipient centre which can extend travel time and incur additional costs and there is no approval for unaccompanied transport. RINTAG are supportive in principle of a bid for funding and although it is noted that NHSBT cannot fund this, they will provide	

	support and assistance to find funding. In order to move towards more widespread use of Sherpa-pak, the meeting was asked to consider: • Approval of a driver to accompany the organ rather than a surgeon. • Work towards a sharing agreement where units share boxes, returning unused boxes to a driver to return to the hospital. . **AGREED:** • **Sherpa-pak will be asked to contribute 50-60 boxes for free to centres to demonstrate the benefits of its use compared with ice boxes and to give centres the potential to share Sherpa-pak boxes.** • **Centres will provide data on donor numbers where Sherpa-pak has been used and RV will send this through to SR.** • **The group will need to decide on what a good control group is and what checklists need to be put in place to do a good comparative study with controlled data.** • **RV will continue to meet with Liz Armstrong and Debbie Macklam at NHSBT to discuss a potential business case to get approval for funding.**	
6	**De-escalation plan individual units – Unit Directors' verbal report**	
	The de-escalation plan at each unit was discussed and SW attended from NHS England. Initially it appeared that things were going well throughout the UK, but it now appears that some issues have emerged at some centres: • Glasgow – The service has resumed to pre-COVID levels and is functioning well, although there are some issues regarding social distancing and allowing visitors into the ward. • Newcastle – The centre is reporting considerable difficulties at present that are not due to COVID. The programme appeared to be back on track, but due to issues within the hospital, there are considerable shortages of staff, particularly with surgeons on the transplant rota; there are only 3 maximum at present each day and likely to be only 2 over the holidays and the summer months. This is compounded by a shortage of recipient co-ordinators. Transplant surgeons stepping back from the non-transplant rota is being explored. The assistance of other centres to help with its 10 urgent patients is also being considered. It has been agreed that the centre's ability to accept new referrals also needs to be discussed. • Manchester – The centre has been open for both heart and lung transplants since April and has completed 6 x heart and 4 x lung procedures. Assessments are running on the Mon-Weds pathway, but the Weds-Friday pathway is not yet running. It is hoped that from the end of August this will improve but there has been a significant increase in case numbers since last week. Intubated and ventilated COVID patients also mean the hospital is almost at capacity and it is hoped that the vaccination programme will improve this situation. • Birmingham – The situation is critical here. For urgent and super urgent patients who are in hospital, there is access to heart transplantation. Lung transplantation, however, is more problematic and one third of patients (about 10 people) have been moved to other units. The main issue is ITU where there is a severe shortage of staff. Every offer needs to be considered carefully on a single case basis. Lung transplantation will be re-assessed in 4 weeks' time. It has been agreed that if there is a risk of not being able to go through with a procedure at short notice, backing up of offers going to Birmingham will be considered to avoid late declines. • Papworth – The service is running as normal, albeit with a backlog of assessments and post transplantation work to get through. Papworth would be happy to talk to their co-ordinators about a backup of offers. • GOS – The service is back to normal and any pressures are more to do with withdrawal of hardware. This issue will be discussed out of the meeting.	
7	**Any Other Business**	
	• RV stated that the ECMO bridge to lung transplantation is now to be funded.	

	• JW reminded those present of the importance of sending back follow up forms and HTA-B forms in good time. • JW told the group that the definition of damage is changing in the next couple of weeks and she will be sending out a letter with further details.	