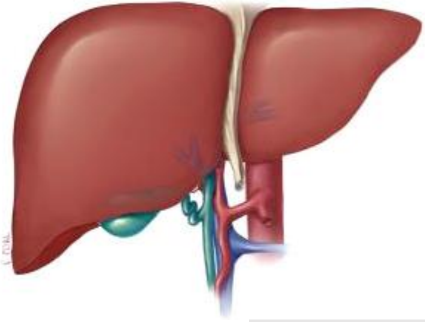


NHS
Blood and Transplant

LDLT Project Recommendations

Lisa Burnapp

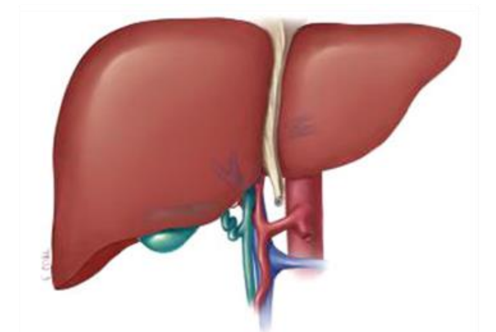
Associate Medical Director

Living Donation and Transplantation, NHSBT

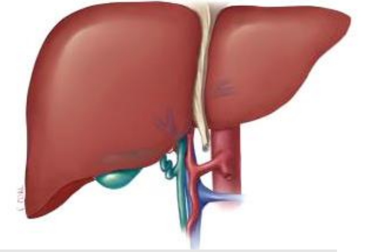
LDLT Stakeholder Engagement Event, 10th February 2023

Project & Plan

From April 2022

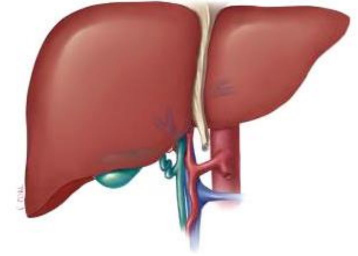


LDLT Project



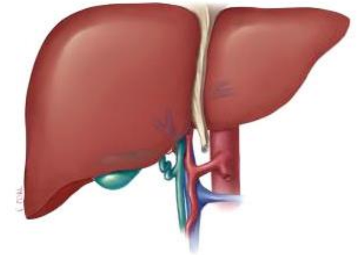
1. National initiative to provide UK-wide programme - commenced April 2022
2. Project Board and workstreams established
3. Terms of Reference agreed
4. Work in progress

Project Board



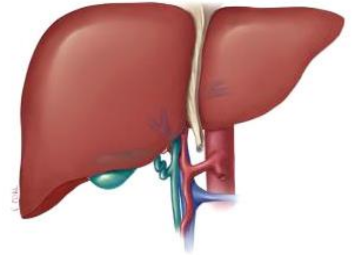
Lisa Burnapp (Chair)	Associate Medical Director, Living Donation and Transplantation
Derek Manas	Medical Director, OTDT NHSBT
Varuna Aluvihare	Consultant Hepatologist, King’s College Hospital
Joshua Bell	Consultant Radiologist, Leeds
Sarah Matthew	Lay Representative
Katie McGoohan	Advanced Nurse Practitioner, Liver Transplant Services, Leeds
Raj Prasad	Consultant HPB Surgeon, Leeds
Karen Quinn/Emma Billingham	UK Commissioning and Service Development, NHSBT
Douglas Thorburn	Consultant Hepatologist, Chair of LAG, Royal Free Hospital
Sarah Watson	Specialised Commissioning, NHSE
Julie Whitney	Head of Service Delivery - ODT Hub

Workstreams



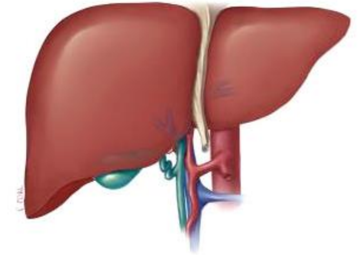
1. Operational model, workforce resilience and sustainability
   - Adult and paediatric LDLT
2. Indications for LDLT, assessment and follow-up
   - Recipient and donor
3. Educational resources
   - Recipient, donor, professional
4. Commissioning
   - Service specification to be drafted once workstreams 1 & 2 report

Project Plan 2022-2024



2022/23	- Develop recommendations for operational and clinical requirements - Achieve endorsement from clinical community and key stakeholders - Present agreed recommendations to commissioners to incorporate in service specifications and embed in professional guidelines
2023/24	- Embed approved recommendations in commissioning arrangements in all 4 nations and update professional guidelines - Develop operational model, referral pathways, clinical network and educational resources and start roll-out of adult to adult (A-A) LDLT programme - Identify requirements to support/develop existing paediatric LDLT

Project Plan 2024-2026



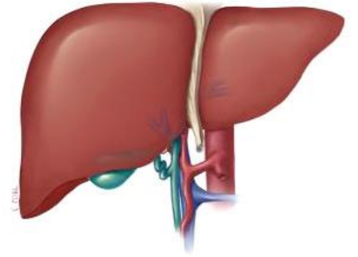
2024/25

- Continue roll-out of A-A LDLT to centres that wish to participate and ensure infrastructure for paediatric LDLT is embedded
- Address residual inequities in access to LDLT (e.g. geography; referral practice)
- Evaluate success of A-A LDLT roll-out (on-going)

2025/26

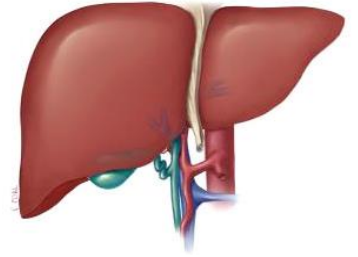
- Complete roll-out of A-A
- Ensure capacity and capability supports equity of access to LDLT for adults and children (directed and non-directed (altruistic) LDLT)
- Continue to evaluate outcomes of LDLT

Recommendations (A-A LDLT)



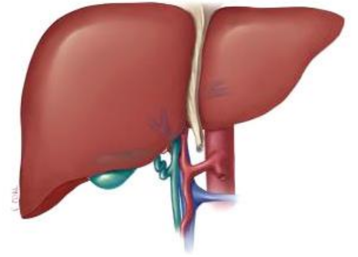
- Provide a **high-level operational and clinical framework** to embed in **Commissioning Service Specifications** and professional **UK LDLT Guidelines**
- **Developed** with clinical engagement via the workstreams
- **Approved** and adapted by the LDLT Project Board
- **Consultation** with patient representatives
- Require **endorsement** from the clinical community and key stakeholders

Critical to Success



Endorsement from the clinical community and key stakeholders

Patient Engagement

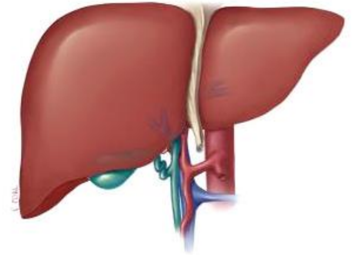


With thanks to

- British Liver Trust and UK Liver Patient Alliance
- **On-line Survey:** 201 responses *
- **Patient Support Focus Groups**
  - Patients waiting for a transplant
  - Transplant recipients

*https://britishlivertrust.org.uk/nhs-blood-and-transplant-are-seeking-the-views-of-patients-on-living-donor-liver-transplantation/

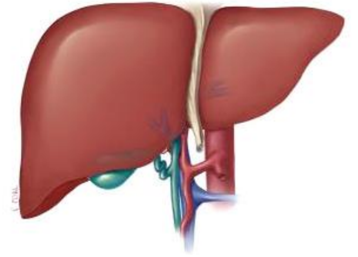
Patient Engagement: Survey (n=201)*



1. Do you support the development of a living donor living transplant programme in the UK?
   - 99% Yes
2. Would the option of receiving a living donor liver transplant be something that you personally would want to consider if you needed a transplant?
   - 95% Yes
3. If you were to think about the option of living donor liver transplant what would be the most important considerations for you?
   - Outcomes- donor, recipient and transplant
   - Education, opportunity to discuss
4. Any other comments you wish to make?

*https://britishlivertrust.org.uk/nhs-blood-and-transplant-are-seeking-the-views-of-patients-on-living-donor-liver-transplantation/

Patient Engagement: Focus Groups **

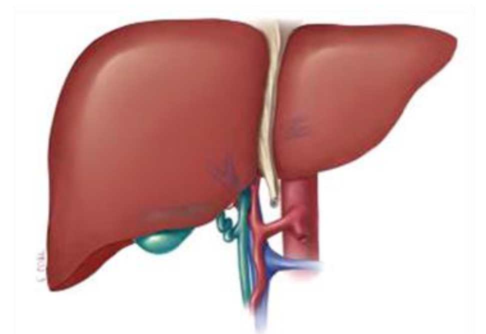


- ***All patients*** *and* ***family members*** *were* ***pro living donation***
- ***All patients*** *had considered or* ***would consider living donation***
  - ***None willing to allow*** *their family member to donate to them*
  - ***Easier to go through*** *the operation knowing it was* ***a stranger, already deceased***
  - ***Biggest barrier*** *was concern over the* ***risks to the donor***
- *One person assessed for LDLT but withdrew at a late stage*
  - ***'Couldn't live with themselves post-transplant if their family member didn't make it'***
- ***Everyone: if their child needed a transplant****, they would* ***donate in a heartbeat***

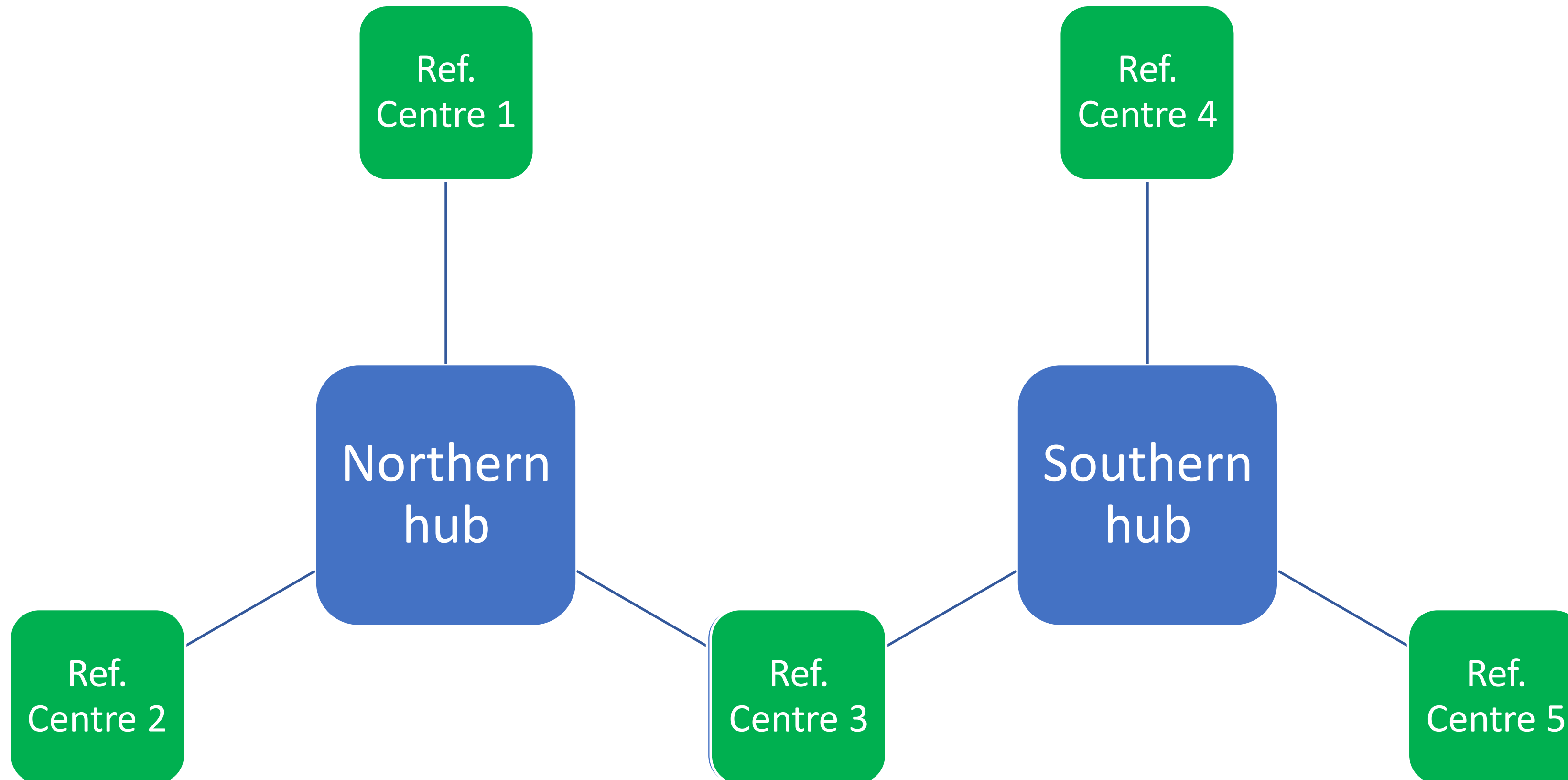
**Focus Group Insights

Proposed Operational Model for Adult to Adult LDLT (WS1)

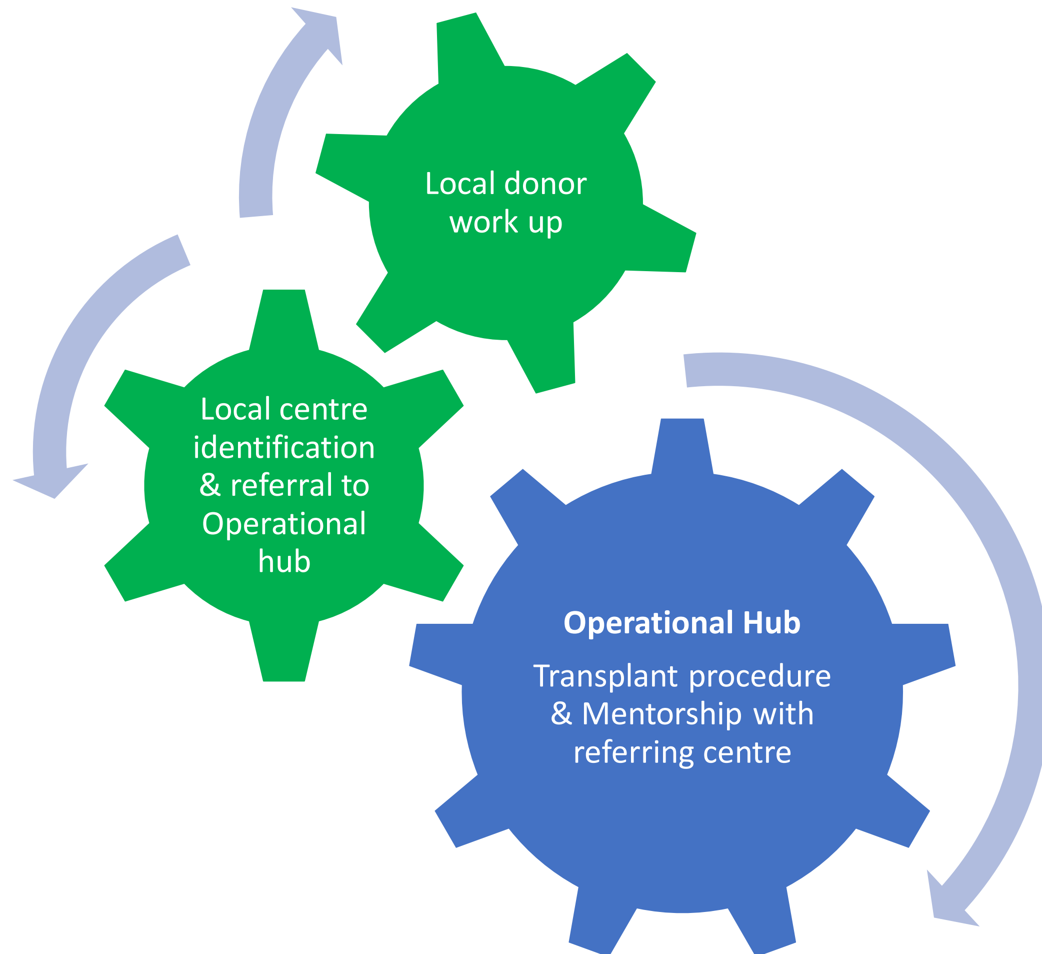
For Approval

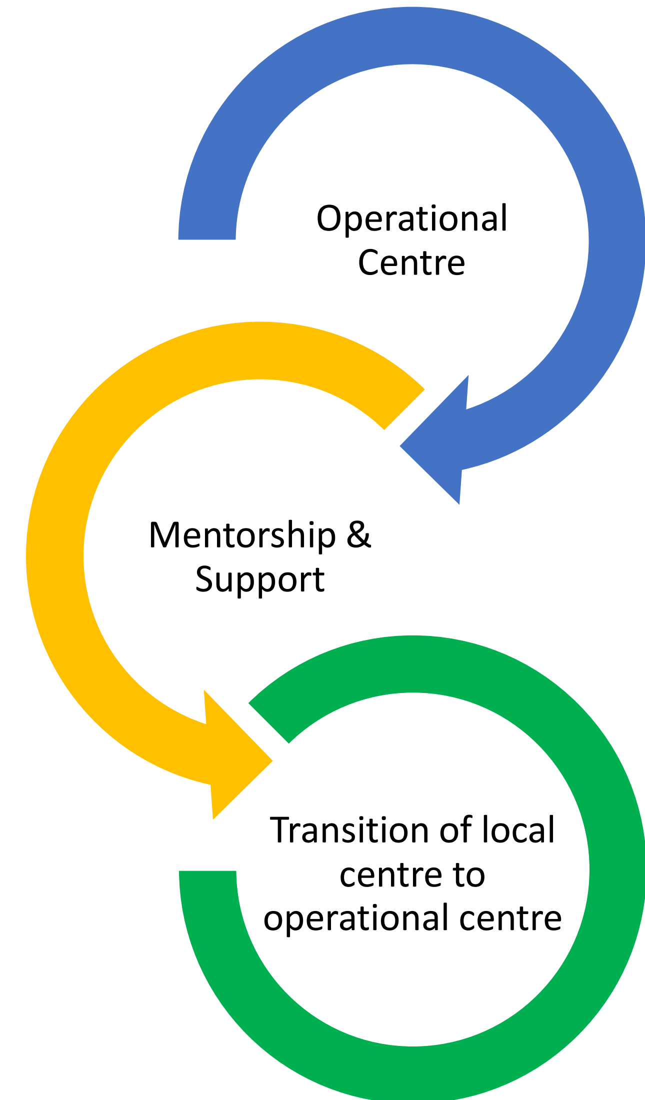


Plan A– Geographical 'hub and spoke' Model



Plan A- Relationships – referring centres and operational hubs





Plan B- Proctoring Scheme

Tx. Centre 6

Tx. Centre 1

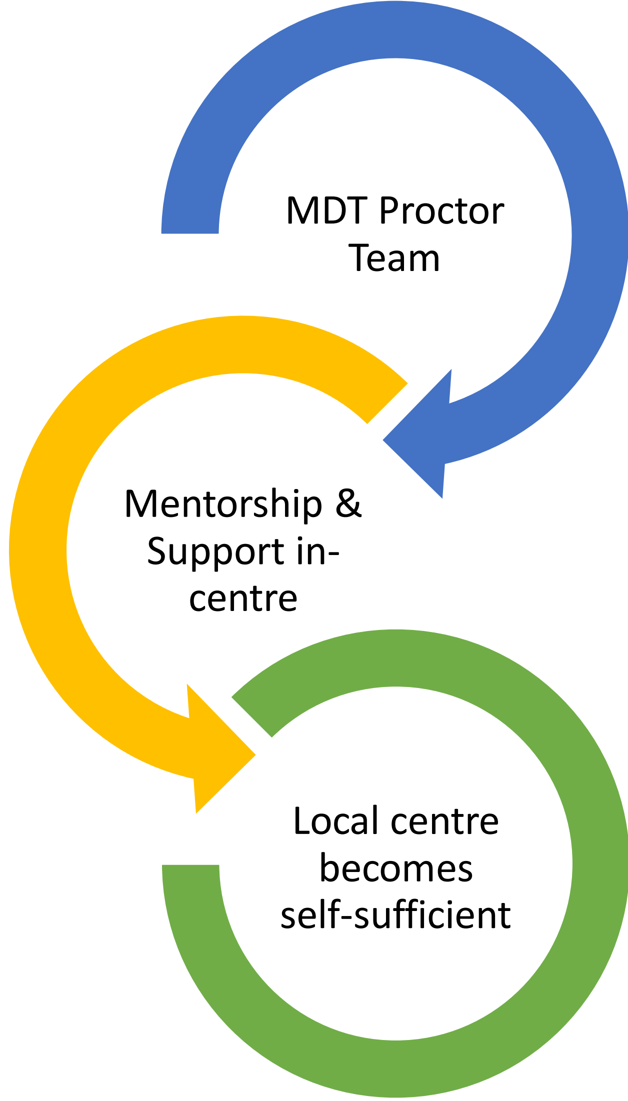
Tx. Centre 2

MDT Proctor Team

Tx. Centre 5

Tx. Centre 4

Tx. Centre 3



MDT Proctor Team

WHO?

- Senior donor surgeon
- Senior recipient surgeon
- Donor advocate physician
- Living donor coordinator
- Consultant radiologist
- Consultant anaesthetist
- Alternates for flexibility

WHAT?

- Oversight for donor and recipient clinical pathways
- Mentor donor and recipient surgery
- Share best practice/transfer knowledge and expertise to create local Tx. Centre self-sufficiency
- Has ‘go/no go’ responsibility

MDT Proctor Team

HOW?

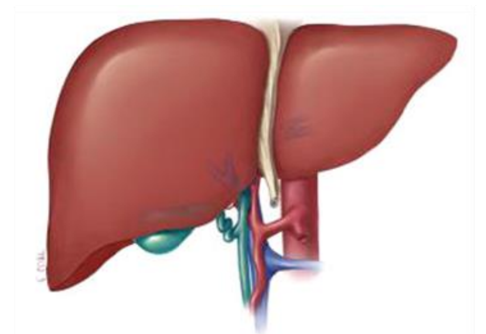
- Work to standard protocols (WS2)
- Work with centres who want to engage to identify and meet their needs
- Perform surgery in-centre with local surgeons

CONSIDERATIONS

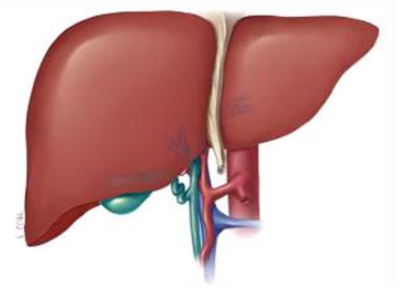
- **Expected engagement** from all centres
- **Staffing and remuneration** for proctor team and back fill
- **Timeframes for delivery** in all centres that wish to engage and have the infrastructure
- **Clinical Governance** Monitoring outcomes and experience i.e.; donors, recipients, clinical teams, proctoring team)

Proposed Indications and Clinical Pathways for Adult to Adult LDLT (WS2)

For Approval



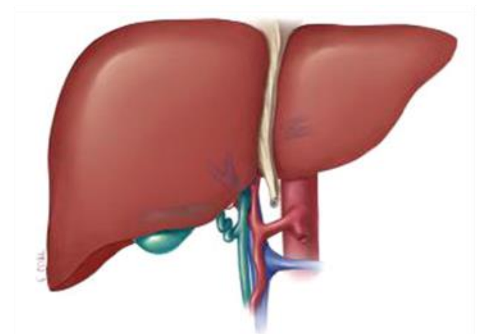
Clinical Recommendations



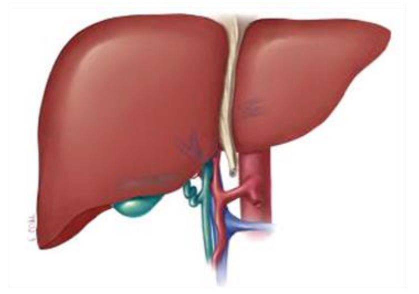
- **Donor selection**
  - Increase donor age for consideration- up to 60 years, case-by-case
  - Right lobe for non-directed altruistic donors
  - Exclude extended criteria donors (e.g.; size of graft GRWR<0.8, BMI > 30, anatomical complexity)
  - Access to radiology is key; volumetry has a learning curve
- **Recipient selection**
  - Start with chronic liver disease (CLD)
  - Include new cancer indications (but clear that they are service evaluations) and re-transplantation
  - Exclude acute liver failure and acute on chronic liver failure (ACLF) initially
- **Education**
  - Patients and families informed that the A-A LDLT programme is essential to bridge the gap between supply and demand

Supporting Actions

For Approval



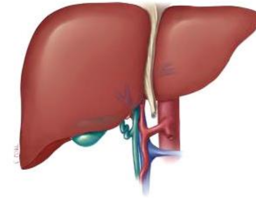
Supporting Actions

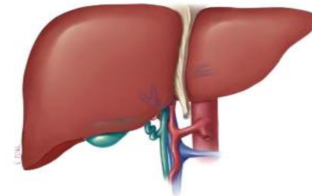


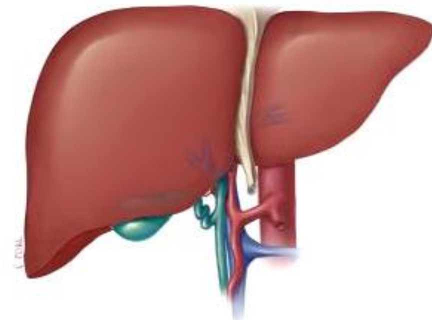
- **Commissioning (WS4)**
  - Service specifications - centre requirements (capacity and capability); clinical pathways
  - Business Case to support reimbursement of Proctor Team
- **Clinical Best Practice**
  - Update UK BTS/BASL Guidelines for LDLT
  - Direct access image sharing for all participating centres
  - Development of a UK LDLT Network - similar to LKD Network; local MDT champions/leads
  - UK MDT
  - Educational resources
- **Education (WS3)**
  - Resources for donors, recipients and healthcare professionals

Acknowledgements

- Project Board and workstream leads
- Working group members
- Liver Advisory Group
- Professional societies
- Patient organisations
  - British Liver Trust; UK Liver Patient Alliance
- NHSBT Clinical, Commissioning and Hub Ops.
- NHS England
  - Sarah Watson







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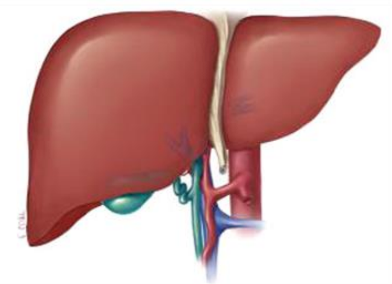
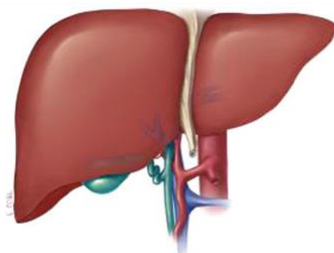


Discussion Points – Breakout Session

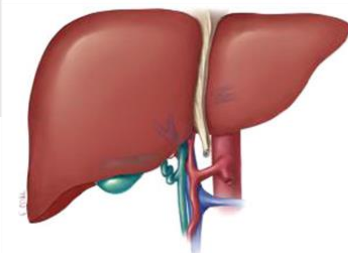
1. Is this the right model?
2. Is this the right time?
3. Will this improve equity of access to LDLT?
4. Will this help meet the shortfall in donor numbers?
5. Will it support or detract from the overall LT programme?
6. Is this feasible in your local team?
7. Is there appetite to do this in your local team?
8. Should the minimal listing criteria be the same for DD and LD?



Discussion Points - Response

1. Is this the right model? Yes

- Considerations
  - Flexibility
  - Standardisation and credentialling through NHSBT (GMC registration)
  - Add anaesthetists
  - Pick ‘n’ mix team- building relationships between centre and PT
  - Governance
    - Ownership of the outcome
    - ‘go/no go’- emerging teams; agree ‘go/no go’ status for mature programmes
  - Activity per centre- remain under review

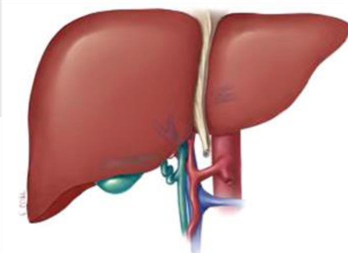


Discussion Points - Response

2. Is this the right time? **Yes**

3. Will this improve equity of access to LDLT? **Yes**
   - Maybe some challenges around centre-specific criteria
   - Benefit for long-waiting and low TBS score patients
   - Change rules of engagement ?consider referring patients elsewhere

4. Will this help meet the shortfall in donor numbers? **Yes**
   - Will help; long-term plan; significance difficult to assess



Discussion Points - Response

5. Will it support or detract from the overall LT programme? **No**
   - May upskill surgical team

6. Is this feasible in your local team? **Yes**
   - Workforce considerations
   - In-centre capacity

7. Is there appetite to do this in your local team? **Yes**

8. Should the minimal listing criteria be the same for DD and LD? **Yes**
   - Keep criteria under review