NHS BLOOD AND TRANSPLANT

CTAG CLINICAL AUDIT GROUP

FINAL MEETING OF UKCTA STEERING GROUP
TUESDAY 17 SEPTEMBER 2013 – 10:30

ASSOCIATION OF ANAESTHETISTS, 21 PORTLAND PLACE, LONDON W1B 1PY

MINUTES

Present:

Mr Nawwar Al-Attar	(NA)
Dr Nicholas Banner	(NRB) **Chairman**
Dr Mike Burch	(MB)
Mr Steven Clark	(SC)
Prof John Dark	(JD)
Mr John Dunning	(JDu)
Dr Edmund Jessop	(EJ)
Mrs Rachel Johnson	(RJ)
Dr Jennifer Lannon	(JL)
Mr Christopher Myers	(CM)
Mr Jorge Mascaro	(JM)
Dr Jayan Parameshwar	(JP)
Dr Chris Rogers	(CR)
Mrs Helen Thomas	(HT)
Mr Steve Tsui	(ST)
Prof Nizar Yonan`	(NY)

Apologies:

Mr Peter Braidley	(PB)
Dr David Cromwell	(DCr)
Mr Andre Simon	(AS)

1. **Welcome**

NRB welcomed everyone to the meeting.

2. **Minutes from the last meeting and matters arising**

The minutes of the last meeting were accepted.

CF study with Johns Hopkins University – a manuscript is being prepared; authorship is still to be agreed. Those not included as authors will be acknowledged.

3. **Chairman's report**

NRB reported that HT will be moving to a new role in NHSBT and that her audit role will be taken over by JL. NRB thanked HT for her significant contribution to the UKTCA and welcomed JL to the team. He also reported that going forward the UKTCA has become the CTAG Clinical Audit Group.

There were four UKTCA-related presentations at ISHLT: Donation after circulatory death (DCD) lung activity in the UK – 100 transplants and counting; Non-

transplantation of hearts when there is consent for donation: A UK national study; Current status of donor echocardiography in UK and Primary graft dysfunction following heart transplantation; validity of a pragmatic self-reporting definition.

The manuscript describing VAD trends has been published in the European Journal of Heart Failure. Work is beginning further VAD studies which will focus on survival and renal outcomes. Invitations to join the working groups for these studies will be circulated.

Results from the heart study are expected in 2014.

4. **Future format of UKCTA audit**

NRB summarised the current situation and the future structure of the audit was then discussed. The contract with NHS England is still to be agreed. In the interim a pragmatic approach is being taken; several aspects of the strategy discussed at the last meeting will be taken forward, particularly the proposal to recruit three additional members with expertise in lung transplants, paediatric transplants and organ retrieval to the CTAG Audit Group (successor to the UKTCA Project Group). Elections will be arranged, nominations will be invited for the lung and retrieval specialists; paediatric representation will be decided jointly by Great Ormond Street and Newcastle, subject to agreement from the wider group. It was suggested that the retrieval member should be a surgeon. The expectation will be for group to function in a similar way to other NHSBT working groups. The group will report to CTAG and so after discussion it was agreed that we will no longer hold Steering Group meetings as the functions of the Steering Group will be covered by CTAG. The project/working group will identify priorities and it is intended that a further clinical fellow will be appointed once the enlarged Group has been established.

5. **Annual report**

The 2013 annual report has been prepared and circulated for comment (deadline 30 September). There was one signal for 90-day outcome in the last year.

5. **Quality of Life (QoL) study**

A draft manuscript is being prepared.

6. **VAD database project**

The paediatric centres have received training and are starting to add data to the VAD database. Discussions with the IMACS registry continue, they have requested information on the regulatory system in the UK. It is expected that data will be submitted very soon. The mapping between the UK and IMACs database will be done by IMACs. It appears the UK will be one of the first national registries to submit data to IMACs. The EuroMACs registry has also been in touch, it was agreed that EuroMACs should be supported so long as the burden of work for NHSBT is limited and that European data from the registry can be provided to the UK for benchmarking. It was also suggested that it would be useful to explore whether IMACs could forward UK data to EuroMACs, so as to avoid duplicate work by NHSBT.

7 **CUSUM outcome monitoring – 30 or 90 days?**

Currently NHSBT continuous monitoring focuses on 30-day outcomes. However, this year's annual report identified a signal at 90-days that was not identified at 30-days. Although moving to 90-days would delay the notification of a signal it was agreed that a move to continuous monitoring of 90-day rather 30-day outcomes

should be discussed at CTAG recognising the final decision will be made at CTAG with agreement from NHS England (The Service Commissioner). NHSBT are also working to include risk adjustment in the routine CUSUM monitoring.

9. **Update on study of primary graft dysfunction (PGD)**

CR presented an updated analysis which included additional information on ischemia times. It was suggested that centres should aim for implant times of < 1 hour and a total ischemia time < 4 hours. It was also agreed that centres should be asked to check excessively long times including implant times > 90 minutes, and that histograms for all components of ischemia time would be helpful. Members commented that centres need to be mindful of transport times as well as the implant times.

10. **Audits from point of referral**

JD reported that commissioners need a picture of the total service from referral, not just from listing. Referral for transplantation is documented in the heart referral database (NICOR) and work is beginning to look at geographical variation in referral rates.

11. **Study of the impact of ischemia time on the outcome of lung transplantation – update**

The proposal was circulated previously. NY indicated that he is interested in joining the group. Currently JL is seeking information on bypass times and the use of EVLP. JD reported that if others wish to be actively involved they should contact NHSBT. It was agreed that JD should re-circulate the invitation.

12. **Any other business**

NA suggested it would be interesting to investigate the role of remote preconditioning in donor heart transplantation. NRB explained that the late Professor Bonser had considered this previously but the study had appeared not to be feasible due to the limited number of transplants performed and number of clinical events. There was discussion about whether remote preconditioning could be effective in brain-dead donors. Nevertheless it was agreed that a new proposal should be developed and discussed again.

Contract and collaboration with the RCS. NRB suggested that while the new arrangements shift the “balance” of the audit group it would be advantageous to have a continuing role for the RCS, particularly with respect to new initiatives such as exploring the value of HES data and that further discussion between NHS England, NHSBT, RCS and the project group would be beneficial.