**CT Centre Director Telecon**
**24th March 2016**

**The following people dialled in to this telecom:**

**Steven Tsui (Chair)**
**Phil Curry (Deputising for Nawwar Al-Attar)**
**John Dark**
**Matthew Fenton**
**Jorge Mascaro**
**Jenny Mehew**
**Jayan Parameshwar**
**Andre Simon**
**Mike Stokes**
**Rajamiyer Venkateswaran**
**Rachel Hogg**

| | Item | Action |
|---|---|---|
| **1** | **CTAG (BTS/RCS) Clinical Trials Meeting**<br><br>• This meeting took place on 02.11.15 – it was instigated by Peter Friend who outlined the RCS initiative to facilitate discussions to increase clinical trials in the transplant field.<br>• All units are supportive. It was agreed that this was a good forum for clinicians to discuss potential projects as opposed to the CTAG Wider Group meeting.<br>• Attendees to circulate research proposals to colleagues with the aim to follow up on ideas, funding applications, expressions of interest.<br>• All agreed these meetings should be held every 6 months to update proposals with colleagues and for new proposals to be put forwards.<br>• S Tsui to look at dates and contact PF to see whether RCS could offer venue<br>• This is in addition to other CTAG meetings.<br>• No impact on CTAG budget<br>• June better than May due to other meetings in May. | **S Tsui** |
| **2** | **EUROMACS**<br><br>• Following agreement by CTAG, NHSBT send a UK VAD data extract to IMACS on an annual basis.<br>• CTAG agreed a couple of years ago that IMACS could share UK VAD data with EUROMACS. However, due to recent restructuring within the IMACS committee and a lack of communication, this has not been actioned.<br>• The CTAG Clinical Audit Group recently suggested that the data sharing agreement is re-communicated with both EUROMACS and IMACS, if agreed by CTAG, however Stephan Scheuler (SS) has written to express concern over providing UK data to EUROMACS.<br>• SS does not feel that CTAG is the right forum to make an appropriate decision over VAD data sharing | |

| | | |
|---|---|---|
| | • Centre Directors on this call agreed to support the data sharing proposal given that NHSBT has already performed the appropriate information governance checks, and that IMACS would not have agreed to data sharing unless appropriate checks had been carried out.<br>• This decision was made by all centre directors as clinical representatives of their respective units. Hence the group felt that this was an appropriate forum to make a decision.<br>• Conclusion that UK VAD units are happy to share data with IMACS and EUROMACS<br>• J Mehew to respond to Stephan on behalf of the group of Clinical Directors confirming their previous decision and ask him to inform ST of any specific concerns about sharing data with EuroMACS.<br>• ST to write to EUROMACS and IMACS to inform them of this data agreement<br>• If any unit decides at a later date to stop sharing data, they can do so – changes to the agreement could be made. If so, NHSBT should send two sets of data to IMACS – one with all centre data for IMACS and one without the particular centre for IMACS to forward to EuroMACS. | **J Mehew**<br><br>**S Tsui** |
| **3** | **NORS KPI for heart and lung retrievals (Chris Callaghan Paper)**<br>• Paper from Chris Callaghan – chair of NORS ReviewWorking Group 3– looking at training, staffing, standards, governance etc.<br>• Chris has put together a paper regarding standards (KPIs) proposed for retrieval teams – for comment. There are 4 key areas to focus on.<br>• Needs some reflection on timelines and what data should be collected<br>• Would be good to come up with an initial benchmark for each KPI. Timeliness of retrieval could be easily quantified but all unit directors need to be part of this agreement.<br>• These KPIs are not supposed to be punitive.<br>• 4 domains proposed:<br><br>1) Damage<br><br>• Current reporting on organ damage is not particularly useful - gradings for damage are not clear and more detailed scoring of organ quality would be useful HTA A form not fit for purpose for heart and lung – ok for kidney. .<br>• S Tsui to draft a new grading system for organ quality and circulate . However, WG3 will not be able to implement a new grading system at the present time.<br>• Will this be completed by retrieval and recipient team? Both teams should grade organ retrieved.<br><br>2) Communication<br><br>• no need if retrieved organs are fine, but a call is needed if there are any injuries or concerns (anatomy, perfusion, damage, mass, etc) or delays or if specific requests have been made by the implanting team. | **S Tsui** |

| | | |
|---|---|---|
| | 3) Outcomes<br><br>• no clear consensus, but there was a preference for primary graft dysfunction or non function (defined as requiring a VAD or ECMO), and 30-day heart survival, and 90-day lung graft survival.<br><br>• J Mehew to provide data on last 3 years in terms of;<br>o Death within the hospital admission<br>o death or MCS use within 30 days of heart transplant<br>o death or MCS use within 90 days of lung transplant<br><br>4) Timeliness<br><br>• time from cross-clamp to organ in box (heart and lungs)<br>• time from organ in box to organ out-of-theatre (heart and lungs)<br><br>• NB.exclude those organs put in an OCS device (heart and lungs<br><br>ACTION: ST to feedback discussion to Chris Callaghan | **J Mehew**<br><br>**S Tsui** |
| **4** | **Offering times proposal ( M Stokes paper)**<br><br>• Changes as part of the NHSBT Hub initiative mean that all offering will be carried out by the Duty Office (as opposed to SNODs) . With so many patients on the urgent heart list, the Duty Office has been in discussion with CTAG for a while over how the total amount of time spent offering can be reduced. Proposal is to change to the time of each offer to 45 Minutes, and to make individual offers to 3 centres before simultaneous offers to all the other centres.<br>• The benefits will be reduced call times, faster responses etc.<br>• Who would accept the organ would be known by 3 hours at the latest but final allocation will be based on offering sequence:-<br>**ü** Change the offer time to 45 mins<br>**ü** Offer to three centres in sequence<br>If all are declined then simultaneous firm offer to centre 4 first urgent patient and provisional off to all patients/centres<br><br>• S Tsui stated that 'Fast track' should be avoided as a term as this could be confused with the established 'Fast track' system.<br>• Allocation of the organ could be one of two processes: -<br>**ü** Centre highest on the rota who accepts gets the heart<br>**ü** First responding centre<br>• This needs to be drafted out clearly to check feasibility<br>• S Tsui to draft a new draft to take to CTAG on 13 April | **S Tsui** |
| | | |

| | | |
|---|---|---|
| **5** | **Ischaemic time component audit – lungs (spread sheet from Mo Al-Aloul)**<br><br>• The proposed data fields are appropriate – but some important time points are missing<br>• There is a similar template, agreed by CTAG in 2015, for heart.<br>• As it stands, quite difficult to read.<br>• S Tsui will change the format, rewrite and take to CTAG on 13 April for sign-off. | **S Tsui** |
| **6** | **Lung retrieval in DCD donor undergoing NRP**<br><br>• Discussed at length at Organ Perfusion Protocol Meeting but, after circulation of minutes, some concerns.<br>• 2 alternatives – outside of heart DCD retrievals in East Anglia – NRP of whole body, perfusion of lung – reliant on bronchial arteries.<br>• Extraction of lung immediately whilst NRP continues – haemostassi must be effective.<br>• However, there have been repeated incidences of haemorrhage.<br>• Alternative is to leae lungs in situ until NRP complete (2 hours) and abdominal surgeons are ready.<br>• Not everyone is in favour of option 2.<br>• Conclusion that technique will not be changed – i.e. immediate lung removal but retrieval surgeon must ensure effective haemostasis and must confirm that abdominal team is happy before CT NORS team depart.<br>• S Tsui will take this back to NRG. | **S Tsui** |
| | | |