CT Centre Director Telecon
20th April 2015, 16:00 to 17:00

The following people dialled in to this telecon:

Steven Tsui (Chair)
Nawwar Al-Attar
Mike Burch
Jorge Mascaro (Items 1 – 3 only)
Rajamiyer Venkateswaran

Apologies:
Steve Clark, Jenny Lannon, Jayan Parameshwar, Andre Simon

In attendance: Kathy Zalewska

		Action
1	**Proposed changes to offering sequence (from Duty Office)**	
	There have been recent incidents where offering of cardiothoracic organs took over 6 – 8 hours, resulting in donors being compromised and risking withdrawal of family consent. As a result S Tsui was asked to consider ways to expedite the offering sequence, particularly for urgent hearts. A proposal was circulated resulting in a maximum sequence of 2.5 hours if all centres are contacted. Centre A would receive a firm offer and Centre B a provisional offer for 45 minutes. In the event of Centre A not responding or declining within the timeframe Centre B would be given a further 20 minutes firm offer and Centre C would receive 20 minutes for a provisional offer. This sequence would be repeated with each centre having a maximum of 40 minutes (20 min provisional offer and 20 firm offer) until the organ was accepted. When received, offers should be considered for all urgent and elective patients, not just one individual. S Tsui stressed the importance of centres making a quick decision and not 'sitting on the fence'. If there is insufficient information initially to make a robust decision, additional information can be obtained once the offer has been accepted and, if necessary, the organ can be declined in light of additional information. The Duty Office response to the proposal expressed concern around the time it would take making calls every 20 minutes and keeping track of these calls. The Duty Office counter-proposal is an initial firm offer to Centre A, and a provisional offer to Centre B. After 45 minutes Centre A loses the offer which then moves to Centre B. If the first three centres don't accept the organ then the proposal is to fast-track it to the remaining centres to avoid the Duty Office continuing with the staggered sequence. Following discussion S Tsui agreed to feedback to NHSBT the view of the meeting which was that the counter-proposal was not appropriate and that centres would prefer to adopt the process outlined by S Tsui above using a staggered offering sequence and not fast-tracking the organ. Members were also asked to comment on proposed changes to the fast track arrangements. Currently if more than one centre responds to a fast track offer within 45 minutes, the organ is offered to the patient at the top of the offering sequence rather than to the patient whose centre responds the quickest. The proposal is to change this to offer on a 'first come, first served' basis. In principle all members agreed to the proposal to change to fast track offering on a 'first come, first served' basis.	**S Tsui**

		ACTION
2	**CTAG Audit/Research Fellow**	
	S Tsui explained that NHS England had agreed to provide 3 year funding for a CTAG Audit/Research fellow, which was subsequently awarded to Golden Jubilee National Hospital in Scotland. It was then highlighted that as this post was being funded by NHS England, the award should have been made to a centre in England. Agreement was reached whereby the NSD in Scotland would fund a fellow at GJNH and NHS England would fund a fellow at Papworth Hospital.	
2.1	**GJNH:** Nawwar Al-Attar advised that Sanjeet Singh was appointed to the post in Scotland. He has visited ODT in Bristol and is working on a project looking at primary graft dysfunction after heart transplantation as well as a pilot study on remote ischaemia conditioning. He is planning to visit all the UK cardiothoracic transplant centres in order to collect data on patients for modelling for primary graft dysfunction. A named point of contact at each centre would be helpful.	
2.2	**Papworth Hospital:** S Tsui reported that Aravinder Page was appointed to the post at Papworth. Aravinder is currently an NTN ST4 in the training programme at Papworth and has to give three months' notice to take OOPR from his training. However, he will take one day off per week to work on the Scout II from April 2015 and will be visiting centres in order to capture some of the outstanding scout data. Ideally the Scout II data forms should be returned to Jenny Lannon within five working days of the scout event but if not a reminder is sent otherwise there is a risk that the data will be lost. S Tsui agreed to ask Aravinder to touch base with all centre directors to be put in touch with retrieval team members who are going out to do the scouting.	**S Tsui**
3	**The future of EVLP**	
	At the NTOT sub-group meeting it was noted that formal commissioning of ex- vivo perfusion of cardiothoracic organs would not yet take place. Subsequently a process was agreed for NHSBT to fund an exploration of the utility of ex-vivo lung perfusion at Newcastle and Birmingham. S Tsui asked whether this is technology that should be used in every centre and whether it is efficient, affordable and there is enough volume to develop the expertise. This should be considered as part of a future strategy for all centres and members were asked to consider what initiatives the UK should pursue and which of these each centre would wish to be involved in. The establishment of OCS hubs for DCD heart transplants would also be something to consider as a future initiative. These ideas would then be submitted to CTAG for endorsement.	**All**
4	**Lung DCD protocol with Abdominal NRP**	
	There have been reports of severe haemorrhage following the retrieval of lungs in DCD donors undergoing NRP, resulting in loss of perfusion. Although there is a protocol in place for the appropriate surgical technique for lung retrieval in DCD/NRP, this problem has occurred on more than one occasion with loss of abdominal organs. S Tsui was therefore asked to raise this issue and ask that retrieval surgeons either adhere to the agreed technique for immediate lung retrieval in DCD/NRP, or leave the lungs in situ until NRP is complete. For the latter, the aortic arch vessels should be clamped so that the bronchial vessels are perfused.	

	Members were asked whether they would prefer to remain with the original protocol and remove the lungs with complete haemostasis or to leave the lungs in situ and wait until NRP is complete before removal of the lungs. The consensus of opinion was to adopt the requested method of leaving the lungs in situ whilst NRP takes place. However, the lungs would need to be ventilated during this time.	
5	**Hand Transplant – left carotid artery line?**	
	S Tsui reported that for hand transplantation, the hand retrieval surgeon will plan to carry out a rapid retrieval of the arm either above or below the elbow before cardiothoracic and abdominal dissection takes place. This would take between 8 and 10 minutes including the requirement to tie off blood vessels. If the donor is a hand donor then scouts will need to find an alternative to the normal venous or arterial cannulae. Members agreed that in the case of hand donors then a left carotid artery line should be used.	
6	**Sign off of retrieval surgeon by another team**	
	S Tsui referred to a letter from R Ploeg re the sign off of trainee retrieval surgeons by another team. In addition to having to carry out ten heart/lung retrieval trainees have to be signed off by a competent retrieval surgeon from a retrieval team within another centre. This is proving logistically difficult compared to the current process and may result in delays in signing off trainees. It was highlighted that for other surgical procedures this is not the practice and consultants sign off trainees from their own centre. S Tsui agreed to respond to R Ploeg.	**S Tsui**
7	**AOB**	
7.1	S Tsui reported on applications for national fellowships in transplantation. There were eight applicants for two posts at Newcastle and Papworth. Four applicants were shortlisted for interview. The highest scoring candidate completed his CCT in the Scottish rotation and his first choice was the Papworth post. The second ranked candidate came from Manchester. He has passed his written exam but is due to take his clinical exam in May and to complete his CCT in July. Although this candidate only applied for Papworth, the panel decided to provisionally offer him the Newcastle post on condition that he passes his clinical exam in May. If he fails to pass the exam, this offer will be withdrawn automatically. If he passes but decides not to take the Newcastle offer then it will be offered to the third placed candidate from Birmingham.	
7.2	M Burch reported that GOSH currently has a long routine paediatric transplant list whilst the Newcastle routine paediatric list is relatively short. The offering sequence for routine paediatric patients alternates between Newcastle and GOSH. M Burch asked if a proposal could be put to the next CTAG to request that offering to routine paediatric patients be prioritised using time of listing rather than the current alternate process, ie a national transplant waiting list for routine paediatric patients. M Burch would contact Jenny Lannon at NHSBT to put together a one-page proposal for this for CTAG.	**M Burch**