NHS BLOOD AND TRANSPLANT

MINUTES OF THE CLINICAL RETRIEVAL GROUP MEETING
FRIDAY 18TH OCTOBER, 2013; 10.00AM AT THE FOREST HOTEL, DORRIDGE

PRESENT:	Rutger Ploeg	National Clinical Lead for Organ Retrieval (Chair)
	Roberto Cacciola	Associate National Clinical Lead for Organ Retrieval
	John Dark	National Clinical Lead for Governance and Organ Utilisation
	Peter Friend	Pancreas Advisory Group Representative
	Derek Manas	British Transplantation Society Representative
	Gerlinde Mandersloot	National Clinical Lead – Donor Optimisation
	Darius Mirza	Bowel Advisory Group Representative
	Cara Murphy	Statistician, Statistics & Clinical Audit, NHSBT
	Fidelma Murphy	National Quality Manager, ODT
	Paul Murphy	National Clinical Lead for Organ Donation
	James Neuberger	Associate Medical Director, ODT
	Karen Quinn	Assistant Director – UK Commissioning, ODT
	Steven Tsui	Cardiothoracic Advisory Group Representative

IN ATTENDANCE:

Janice Bayliss	Specialist Nurse, Midlands
Andrew Bradley	Deputy for C Watson, Kidney Advisory Group Rep.
Laura Fenn	Clinical & Support Services, ODT
Susan Richards	Deputy for F Wellington, Regional Manager, ODS
Claire Williment	Head of Transplant Development, ODT
Kathy Zalewska	Clinical & Support Services Manager, ODT

ACTION

WELCOME & APOLOGIES

Apologies were received from:
Emma Billingham, Senior Commissioning Manager
Rachel Johnson, Head of Organ Donation & Transplantation Studies, NHSBT
Dave Metcalf, Divisional Finance Director, ODT
Dinesh Sharma, Liver Advisory Group Representative
Chris Watson, Kidney Advisory Group Representative
Fiona Wellington, Regional Manager, Organ Donation Services

1 DECLARATIONS OF INTEREST

1.1 There were no declarations of interest.

2 MINUTES OF THE CLINICAL RETRIEVAL GROUP MEETING HELD ON 21ST JUNE, 2013 – CRG(M)(13)2

2.1 The minutes of the previous meeting were agreed as a correct record.

2.2 **Action Points - CRG(AP)(13)3**

AP1: Completed
AP2: Completed
AP3: Delays in responses on clinical investigations
A more defined timescale for responses is being considered together with a review of the letters used on clinical investigations.
AP4: Refer to minute 3 below.
AP5: Completed
AP6: Completed
AP7: DCD heart study: R Ploeg to ask S Large for a copy of the final protocol including the technical aspects of retrieval and how they impact on other retrieval protocols for consideration by CRG. **R Ploeg**
AP8: Refer to minute 5 below
AP9: Refer to minute 6.1 below
AP10: As no contract existed between NHSBT and Eurotransplant, no breach

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of agreement had taken place. K Quinn and J Neuberger agreed to investigate the possibility of initiating a contract with Eurotransplant via Axel Rahmel. **K Quinn/ J Neuberger**

AP11: Work on producing NHSBT/BTS guidance on the use of organs was reported as in hand. **J Neuberger/ D Manas**

AP12: Refer to minute 6.3 below
AP13: Refer to minute 7.1 below
AP14: Completed
AP15: Refer to minute 8.1 below
AP16: Completed
AP17: Refer to minute 9 below
AP18: Completed
AP19: Completed

Reasons why organs not retrieved – CRG(13)21

Following a request at the last meeting, C Murphy reported on risk-adjusted analysis of organ retrieval and the reasons for not retrieving. Current data collection is inconsistent between the Duty Office and the attending retrieval team with a large number of 'other' reasons reported. It was recommended that an audit take place to capture additional data over a six month period, on a temporary new form alongside the current RTI form.

Concern was expressed about adding an additional form to the process. It was suggested that data collection improvements could be captured as part of the review of the damage data collection or at the time of the NORS evaluation. **C Murphy**

Cardiothoracic retrievals – CRG(13)22a&b

Members noted the concerns of CTAG re the decision made by CRG to discontinue the practice of cardiothoracic retrieval teams retrieving out of zone unless for a paediatric recipient (<30kg donor) or for a complex adult congenital recipient. K Quinn and R Ploeg confirmed that cost was not a factor in the decision to revert back to in-zone retrieval but the principle of NORS. In addition David Metcalf had calculated that a scenario of out of-zone retrieval would add a significant extra cost to NHSBT that has not been budgeted. Members agreed that a possible system was for the closest team to retrieve wherever possible and if the local team is unable to attend, then the implanting team should retrieve. This concept could be considered as part of the review of the NORS scheme due to take place in the next year. There was a suggestion that the use of a Transmedics device could be added as a valid reason for the accepting team to perform the retrieval. However, concerns were raised around the integration of devices such as Transmedics machines into the retrieval process. There is little or no data on which to build a business case currently. Members were sympathetic to the introduction of new technology but a formal protocol would be required together with data on the use of these devices. S Tsui agreed to liaise with A Simon at Harefield to take this forward. K Quinn agreed to circulate the procedure for this type of service development. This will also be discussed at the Horizon Scanning Workshop on 25th October, 2013. **S Tsui / K Quinn**

2.3 **Matters arising, not separately identified**

There were no further matters arising.

3 DEVELOPMENT OF WORKPLAN FOR CRG

3.1 **Advisory Group Priorities**

Advisory Group representatives were asked to present three retrieval related issues or priorities for their Advisory Group for consideration by CRG.

Bowel Advisory Group (BAG) – D Mirza

1) Paediatric Donors/Recipients
   - Improved access to paediatric donors. The system is not automated and more emphasis is required on paediatric bowel donation.
   - Arrangements for transition of bowel patients from paediatric to adult centres.
2) Access to donors via Eurotransplant under a reciprocal agreement. It is important that teams are not penalised for retrieving from Europe if a zonal donor arises.
3) Flexible arrangements in providing a competent retrieval surgeon or team to retrieve intestinal-containing grafts in the UK.

Cardiothoracic Advisory Group (CTAG) – S Tsui

1) Kick-starting the Scout Pilot has been a priority for CTAG to ensure it is a sustainable process. An indication prior to the end of the pilot year would help as CTAG will require a lead in time.
2) CTAG will look at ways of using extended criteria hearts or grafts with marginal function well as the use of improved preservation and new technology.
3) Consideration of whether, in donors with poor heart function, particularly young donors, a process of assessment soon after the initial storm would allow the heart to recover and therefore improve quality. There is good published data from both the US and Europe on this and a project is underway at NHSBT to obtain UK data.

Kidney Advisory Group (KAG) – A Bradley

1) Work on a national histopathology service for biopsies.
2) Perfusion techniques – horizon scanning workshop.
3) Better adherence to the agreed stand down time.

Liver Advisory Group (LAG) – D Manas/D Mirza

1) Use of a national histopathology service to undertake an echo on cirrhotic livers.
2) Improved adherence to liver splitting rules based on donor criteria and not recipient criteria.
3) The referral of inappropriate donors who would never produce a liver for transplant. These should be reported as clinical governance incidents so that they can be followed up.

Pancreas Advisory Group (PAG) – P Friend

1) Unnecessary pancreas damage and quality during retrievals, particularly when retrieved by another team. Focus should be on maintaining high standards of retrieval and continued reporting on retrieval damage.
2) Concerns over the number of pancreases being discarded or not retrieved. A review similar to that undertaken by Cambridge for kidneys would be useful.
3) Reassessment of the donor criteria to improve assessment, retrieval, and acceptance of pancreases; plus the acceptance of more pancreases by islet teams.

4 NHSBT UPDATE

4.1 **Update on TOT2020 – CRG(13)23**

The NHSBT strategy is broken down into several actions some of which are to be implemented by NHSBT. The key action involving the Clinical Retrieval Group is to develop and implement a training and accreditation programme for all retrieval surgeons, which will be led by R Ploeg.

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4.2 **Workshop on Horizon Scanning in Organ Perfusion – 25th October 2013**
This workshop will review the current situation in organ perfusion and discuss the future needs. This will not be a scientific workshop but will cover implementation, practicalities, governance and commissioning.

4.3 **Organ Donation & Transplantation Congress – September 2013**
The Congress, held on 3rd & 4th September, was an opportunity for professionals within transplantation to meet and share ideas outside of their normal working environment. The Congress received positive feedback from attendees and it is hoped that this will become a bi-annual event, running alongside other events such as the BTS congress.

4.4 **Supporting Research:**

- Dorsal Root Ganglia – CRG(13)24
  A report on the impact of this study to date was received. From the Scottish experience it was concluded that the risk of a donor family withdrawing consent for organ donation as a result of being approached about a specific research study such as the DRG study is very low.

- Abdominal wall and skin donation – CRG(13)25
  P Friend presented a protocol on abdominal wall and skin transplantation, seven of which have been successfully undertaken to date. P Friend agreed to send the protocol to members for comment and, once agreed this would need to be circulated to all interested parties and incorporated within existing NHSBT policies. **P Friend**

4.5 **New appointments**
J Neuberger notified the group of new appointments within NHSBT.

- Aaron Powell has been appointed as Assistant Director of Transplantation Support Services and will be looking to implement a number of improvements to IT projects.
- Claire Williment has been appointed as Head of Transplant Development and will be working with clinicians on aspects of implementing the strategy.

5 UPDATE ON HISTOPATHOLOGY AUDIT

5.1 R Cacciola reported on progress to date with the audit. Thirty champions are involved in data collection over several different centres. The audit is planned to run for three months and will focus on malignancy rather than damage. There are two forms for completion, one for the retrieval team and the other for the implanting team. In mid-November there will be interim data to circulate and a decision can then be made on whether to extend the audit beyond 3 months. **R Cacciola**

6 CLINICAL GOVERNANCE

6.1 **Review of organ damage rates: 1st April 2012 – 31st July 2013 – CRG(13)26**
C Murphy presented data on organ damage rates which showed no significant changes over the first four years of NORS. The Commissioning Team will discuss with the relevant teams the reasons for significantly high exported damage rates.

6.2 **Change to 'Response to signals' policy – CRG(13)27**
J Neuberger reported on changes to this policy to include monitoring of damage rates. Any investigations relating to signals triggered as a result of retrieval damage would be carried out by NHSBT as Commissioner of the

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National Retrieval Service.

6.3 **Damage reporting and quality assurance in organ retrieval – CRG(13)28**

R Ploeg introduced a proposal for damage reporting to the HTA in order to comply with the EUODD. Recently, the same proposal had been supported by the Advisory Group Chairs. Members were asked to support this proposal as a priority project in terms of IT resource. Members unanimously agreed to the proposal which had already been approved by ODT CARE and would now be submitted as a priority for the forthcoming meeting to decide on IT projects.

6.4 **Review of relevant individual incidents**

6.4.1 Clinical Governance Incident ODT

Incidents were raised for discussion and these included:

- Inc 136 – Arising from this incident, it was discussed and confirmed by members that, in the case of organs to be allocated outside the UK, the regional NORS team will retrieve the respective organ(s). Foreign recipient centres may send a surgeon to observe and assist if they desire so, but at their own cost. This will be added to the NORS standards and should be communicated by J Neuberger to A Rahmel as Medical Director of Eurotransplant. C Murphy was asked to look at how many European teams retrieved within the UK and circulate to R Cacciola and R Ploeg **J Neuberger C Murphy**

- Inc 172 – Members discussed this incident re a staple misfiring and were asked to remind retrieval teams to inspect and gently test staple lines on pancreases before packing. It was agreed that it was not necessary to add this to the NORS standards.

6.5 **Intestinal/MV retrieval**

S Richards reported on a recent incident where a retrieval team accepted two commitments to retrieve; the first being a standard retrieval within their zone, the second a multivisceral donor for their own recipient. Following discussion, it was agreed that a common sense approach should be taken to ensure all commitments are followed through and no organs are lost.

7 COMMISSIONING

7.1 **NORS evaluation – CRG(13)29**

K Quinn advised that an evaluation of the NORS scheme will take place to benchmark current service provision, identify any gaps or short falls and make recommendations. A paper outlining the rationale for undertaking the evaluation was received for information. An external independent chair of the Project Board for this evaluation is due to be appointed.

R Ploeg stressed that this evaluation would not only look into financial and operational aspects form a NHSBT perspective but should also reflect input of all stakeholders and especially NORS teams. Retrieval team leads will be contacted for their input into the evaluation.

7.2 **Monitoring of NORS: 4 months: 1st April 2013 – 31st July 2013 – CRG(13)30**

C Murphy outlined a paper on activity of the NORS service from 1st April – 31st July 2013. Members discussed the key issues which were:

- Adherence to stand down times
- Creation of a central 'air traffic control' system for retrieval teams - it is hoped to implement this by early 2014.
- Transport costs – these will be considered as part of the evaluation.

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- Redefinition of the donor hospital allocation system.

The high percentage of retrievals performed by Oxford/Royal Free where they are not first on call was noted. C Murphy and K Quinn were asked to investigate amending the hospital allocations to improve upon this. **C Murphy/ K Quinn**

7.3 **Monitoring of NORS: addition to clinical microsite – CRG(13)31**
C Murphy presented a report on data on NORS activity which could be considered for inclusion on the ODT Clinical website. Following minor amendments to the data re the SORT team and the dual abdominal teams, this report was endorsed for inclusion on the website. **C Murphy**

7.4 **Clinical research and NORS contracts**
Refer to minute 2.2 above.

7.5 **Organ box update**
An evaluation is due to take place in October/November, 2013.

8 DONOR MANAGEMENT PROCEDURES

8.1 **Cardiothoracic NORS Scout pilot programme: update – CRG(13)32**
G Mandersloot updated the group on the status of the pilot. The number of hearts retrieved for 2013/14 has increased whilst the number of lungs retrieved has remained static. There is no evidence to suggest that this increase is a result of the scout pilot.

A meeting has been arranged to review the project in early November, following which G Mandersloot will then email members by the end of November to be advised on the direction of the study. G Mandersloot also agreed to clarify to regional managers where the feedback forms should be returned. **G Mandersloot**

8.2 **Coroner's report: update – CRG(13)33**
It was reported that stakeholders had been identified and invited to join a working group.

9 TRAINING AND COMPETENCIES

9.1 **Retrieval Surgery**
Discussions are taking place with the Royal College of Surgeons (RCS) on a formal training programme for retrieval surgery with competency based certification using an integrated system with the intercollegiate surgical programme. It is hoped that some components will be ready for early next year.

9.2 **Organ retrieval master class (17th-18th December, 2013)**
R Ploeg updated the group on progress with the organ retrieval master class scheduled for 17th-18th December, 2013.

10 UPDATE ON CLINICAL RETRIEVAL FORUM – CRG(13)34
R Cacciola updated members on arrangements for the forthcoming Clinical Retrieval Forum in Newcastle. Representation from all centres has been established and notes from the meeting will be reported back to CRG. A further meeting of CRF is planned to take place at the BTS congress in Spring 2014.

11 FOR INFORMATION

11.1 **Stand down times – CRG(13)35**
C Murphy summarised the paper regarding stand down times. Following a discussion it was agreed that the stand down time for abdominal teams

ACTION

should remain at three hours. It was agreed that a paper on stand down times should be submitted to the next KAG meeting for discussion on why offers are sometimes turned down after just one hour. **CSS**

11.2 **Retrieval KPI summary - CRG(13)36**
Members noted a summary of retrieval KPI for information.

11.3 **NORS standards and perfusion protocol – CRG(13)37a & b**
Members noted the addition to the NORS standards of the National Abdominal Perfusion Protocol

12 ANY OTHER BUSINESS

- J Neuberger reported that since the 50% increase in donors reported in April, numbers have continued to increase, impacting on work loads of, amongst others SNODs and ICU staff. NHSBT acknowledged the work of those involved in delivering these results.
- J Neuberger reported from the first meeting of the Vascular Composite Allograft group which had met to consider how these allografts may develop over the next 5+ yrs and how to ensure such developments are brought in effectively and safely.

13 DATES OF MEETINGS FOR 2014 (to be agreed)
Dates for 2014 will be scheduled for February, June and October. **CSS**

October, 2013