NHS BLOOD AND TRANSPLANT
ORGAN AND TISSUE DONATION AND TRANSPLANTATION DIRECTORATE

THE TWENTY-SEVENTH MEETING OF THE MULTI-VISCERAL AND COMPOSITE TISSUE ADVISORY GROUP MEETING
AT 10:30 AM ON WEDNESDAY 8 NOVEMBER 2023
VIA MICROSOFT TEAMS

Present

Andrew Butler	**Chair MCTAG /** Cambridge University Hospitals
Philip Allan	Oxford Intestinal Transplant Centre
Irum Amin	Cambridge University Hospitals
Richard Baker	Associate Medical Director – Governance, NHSBT
Carly Bambridge	Recipient Co-Ordinator Rep
Gemma Brewin	BSHI Rep
Chloe Brown	Statistics and Clinical Research, NHSBT
Suzi Browne	Corporate Communications Manager, Public Affairs, NHSBT
Emilio Canovai	Oxford Transplant Centre
Kim Corbey	Recipient Co-ordinator
Gordon Crowe	Regional Manager, SNOD
Samantha Duncan	Recipient Co-ordinator Rep
Henk Giele	Consultant, Plastic Reconstruction and Hand Surgery, Oxford
Girish Gupte	Consultant Paediatric Hepatologist, Birmingham
Susan Hill	Paediatric Gastroenterologist and BSPGHAN Rep
Jonathan Hind	King's College Hospital
Isabel Quiroga	Oxford Intestinal Transplant Centre
Lisa Sharkey	(formerly) Cambridge Intestinal Transplant Centre
Pedro Simas	Oxford Transplant Centre
Douglas Thorburn	Chair – Liver Advisory Group; Royal Free Hospital
Julie Whitney	Head of Service Delivery, OTDT Hub, NHSBT

In attendance

Cherrelle Francis Smith	Advisory Group Support, NHSBT
Caroline Robinson	Advisory Group Support, NHSBT (Minutes)

	Item	Action
1	**Welcome and Apologies**	
	• A Butler welcomed all to the meeting. • Apologies were received from Ayesha Ali, Chris Callaghan, Peter Friend, Simon Gabe, Simon Kay, Sian Lewis, Derek Manas, John Richardson, Michael Stokes, Hector Vilca Melendez, Sarah Watson, Craig Wheelans, Anthony Wrigley	
2.	**Declaration of interest in relation to the agenda – MCTAG(23)01**	
	• There were no declarations of interest at the meeting. • The agenda, Minutes and papers from this meeting will be added to www.odt.nhs.uk Authors of any papers that should not go on this website should identify these as soon as possible.	
3.	**Minutes and Action Points of the MCTAG meeting held on 31 May 2023**	

3.1	Accuracy - **MCTAG(M)(23)01** – The Minutes of the last meeting on 31 May 2023 were approved with the following amendments: • Item 5.1 – DCE heart funding is changed to DCD • Item 6 – HDK is changed to HTK • Item 21.2 - AB to confirm wording	
3.2	Action Points - **MCTAG(AP)(23)02**	
3.2.1a AP1	The issue of MV patients coming below hepablastoma in liver only grafts when it would be possible to use split livers was taken to LAG. D Thorburn stated: • In this financial year there have been more DCD donors than DBD. Currently, only 25% of livers are split. Splitting criteria was reviewed pre-COVID, but it has not been possible to implement anything due to the reviewed criteria being in the IT changes queue for 4 years. • Prioritization of IT changes is now needed as the delay is having an impact on offering and which organs are offered for splitting. • During COVID, the paediatric list waiting list did not change markedly. However, in the last 6M there has been an increase in the waiting list, leading to a need for an updated paediatric liver offering analysis. This is likely to be due to the reduced number of DBD donors and increase in DCD donors. A meeting of paediatric centres, plus Leeds will be arranged to decide on preferential allocation of the sized match donors for MV patients rather than to hepatoblastoma patients while considering demands currently on the elective liver transplant waiting list to ensure there is no disadvantage to this group. **ACTIONS: a) C Bambridge will ensure J Whitney is informed of this and other meetings b) A Butler, J Whitney & D Thorburn to discuss offline prioritization of implementation of age, BMI criteria and LFTs to expand the pool of organs in the list of IT changes currently planned c) this Issue will be taken to the new paediatric subgroup for LAG when it meets.**	**A) C Bambridge / J Whitney** **B) A Butler / J Whitney / D Thorburn** **C) A Butler**
3.2.1b AP1	D Manas previously agreed to discuss a potential manual process to highlight small donors who would benefit from a split liver with J Whitney. It was acknowledged that this is not easy to implement alongside other processes in place.	**ONGOING (with 3.2.1a above)**
3.2.2 AP2	Review of Cytomegalovirus (CMV) and Epstein Barr virus (EBV) infections in Intestinal transplantation UK wide experience – (17.3.21) - incidence, outcome and strategies - There is a substantial risk for MV recipients if EBV is not reported and this can determine whether organs are utilized. R Baker stated that he has not yet heard from I Ushiro-Lumb regarding inclusion of this issue in a service specification and he will follow this up.	**ONGOING** **R Baker**
3.2.3 AP3	Governance	*See Item 22.2*
3.2.4 AP4	Patient survival after intestinal transplantation – It is agreed that 3 months is the point at which PN becomes irreversible post-transplant, and this should be the criteria for data collection from all centres.	**COMPLETE**
3.2.5 AP5	M&F Proposal – Potential funding for film – D Manas stated that a proposal has been put forward to make films with Transplant TV using charitable NHS funds (costing around £6K for a 7-minute film). There is no further information at present on what and who should be included. **ACTION: R Baker and I Amin to take forward**	**ONGOING** **D Manas / R Baker / I Amin / P Allan / S Gabe / S Watson**

	set up of a working group and to involve P Allan, S Gabe, S Watson	
3.2.6 AP6	Web information on intestinal and multi-visceral transplantation on the new NHSBT website for patients - **https://www.nhsbt.nhs.uk/organ-transplantation/**	**ONGOING** *See Item 4*
3.2.7 AP7	Disproportionate waiting time for liver and bowel patients compared to a liver patient only	*See Item 22.4*
3.2.8 AP9	Clinical Governance - A survey of 5 MV retrievals showed rectus fascia is not routinely documented on the HTA A form which prevents clear traceability. It was agreed that there is currently ambiguity about where this should be documented and clarification re the nomenclature is needed on the form. There has been no response to R Baker from I Currie / M Berman regarding this issue. **ACTION: I Amin / S Duncan to create a flowchart to show how the information is being recorded. To be discussed at next MCTAG meeting.**	**ONGOING I Amin / S Duncan**
3.2.9 AP10	Summary from Statistics and Clinical Research – **ACTION: R Baker to contact Rebeka Jenkins Rebeka.jenkins@nhsbt.nhs.uk regarding BTRU work she is doing on PREMS and QoL data for MV adult and paediatric transplantation.**	**ONGOING R Baker**
3.2.10 AP11	Patient survival after intestinal transplantation – potential further subdivisions in future reports (malignancy v. non malignancy) - L Sharkey previously agreed to re-circulate the proposed interim data collection spreadsheet for comment and suggestions on capturing transplant indication	**ONGOING** *See Item 8.1*
3.2.11 AP12	Patient survival after intestinal transplantation – potential further subdivisions in future reports (malignancy v. non malignancy) - **MCTAG(23)04** A query was raised about the labelling within the report relating to patient survival from first transplant. The title on Table 1 in the circulated report has been amended to reflect patient survival from time of first transplant.	**COMPLETE**
3.2.12 AP13	Aligning definition of tx type with International Registry data - It was agreed it would be useful to continue getting the report aligned with international registry data and to include the pancreas as an adjunct organ for isolated small bowel only to ensure complete data capture. Removal of the pancreas as a mandatory organ from the liver / small bowel would allow capture of any living donor liver small bowel. C Brown to move the pancreas from a mandatory to an optional organ for the small bowel and liver / small bowel transplant types. **ACTION: To be discussed further at Spring MCTAG meeting.**	**ONGOING C Brown**
3.2.13 AP14	Performance report of the National Bowel Allocation Scheme (NBAS)– **MCTAG(23)06** - C Brown to split Table 2 into adult and paediatric data in future reports. Data on long waiting times (eg the proportion transplanted within <1 year, 1-2 years, >2 years) will be included in future reports.	**COMPLETE** *See Item 13.1*
3.2.14 AP15	Performance report of the National Bowel Allocation Scheme (NBAS)– **MCTAG(23)06** - The issue of patients previously referred from EU countries that do not do small bowel transplantation was raised with specific relevance to a paediatric bowel patient from Serbia (non-EU currently). R Baker to discuss with D Manas whether these patients still qualify as Group One patients now the UK is out o the EU. A live donor transplant was performed but the graft failed and an enterectomy was performed. The plan would be to relist the patier	**ONGOING R Baker / D Manas / C Bambridge**

	and to do a deceased donor transplant (possibly an adult donor) but i is unclear what the status of the child is in the UK for this and whethe they qualify as a Group 1 or 2 patient. **ACTION: R Baker to check this with NHSBT and to liaise with C Bambridge**	
3.2.15 AP16	Discussion re: potential changes to allocation policy	*See Item 13.2*
3.2.16 AP17	Update on Uterine Transplantation	*See Item 9*
3.2.17 AP18	Quality of Life Working Group: data collection	*See Item 18.1*
3.2.18 AP19	Multi-centre collaborative studies and research -	*See Item 22.1*
3.3	Matters Arising – NAD	
4.	**Web information on intestinal and multi-visceral transplantation on the new NHSBT website for patients - https://www.nhsbt.nhs.uk/organ-transplantation/**	
	• L Sharkey is passing this project onto C Rutter who will work alongside C Callaghan. • Work is ongoing to ensure that the language/terminology used is both patient and public friendly and consistent with information included for other organs on the NHSBT website. **ACTION: a) R Baker to ensure there is lay member and patient involvement/review prior to publication b) S Browne to help from a Comms perspective**	**C Callaghan / C Rutter / R Baker / A Wrigley / S Browne**
5.	**Medical Director's Report**	
	R Baker gave the Medical Director's report: • CLODs and Donor Recognition funding are currently under consideration but there is no funding for NRP and ARCs • CLUs are funded for this financial year. • DCD funding is secured for the next two years. Concern was expressed at the meeting that donors are often reported too quickly leading to a DCD drift (which incurs higher costs and lower organ procurement per donor). More evidence on this is needed. • Histopathology – interim solution for this funding will start in March next year. • OUP / IOUS – there is now a steering group looking at implementation of organ utilisation recommendations chaired by John Forsythe. The key areas highlighted are putting patients at the heart of the service and re-doing the operational infrastructure to maximise transplant potential (to include CLUs, innovation, CT review funded by NHSE).	
5.2	Appointments – • The new Lead Liver CLU is Anya Adair • Varuna Aluvihare becomes the new Chair of the Liver Advisory Group (replacing Doug Thorburn). Steve Masson will be the deputy chair for the group. • Lisa Burnapp will be doing 'retire and return'. A new Project worker and Living Donor Support Nurse will be appointed to support her work.	
6.	**Clinical Governance Report for MCTAG – MCTAG(23)08**	

	This report was circulated prior to the meeting. There are about 60 incidents per month (700 pa). R Baker highlighted an issue regarding contamination from gastric staples. This was addressed during this year's Retrieval Masterclass and learning is included in the report circulated.	
7.	**OTDT Hub Update**	
	J Whitney highlighted the SCORE (Sustainability and Certainty in Organ Retrieval) programme which will look at retrieval taking place overnight with implanting during the day. The impact of this on offering and allocation are to be investigated, but it is hoped offering will become a daytime activity. There will be an impact on recipient co-ordinators and workshops are being arranged across all organ groups to assess how these changes may improve activity and utilisation.	
8.	**Summary from Statistics and Clinical Research – MCTAG(23)09 – circulated for information.**	
	The report circulated prior to the meeting provides an update from Statistics and Clinical Research and includes up-to-date contact details for the Statistical leads. The 2022-23 annual report for intestinal transplantation is published on the NHSBT website and the link is shown in the report. • There are fewer patients on the active waiting list compared with the previous financial year. • There were 25 intestinal transplants. This is slightly lower than the previous year (27 transplants) but the results are still good.	
8.1	Patient survival after intestinal transplantation – potential further subdivisions in future reports (malignancy v. non malignancy) - The proposed interim data collection spreadsheet has been sent to C Brown prior to circulation. Each centre will collect data and then decide on whether additional columns are needed. **ACTION: P Allan will take over the oversight of this work from L Sharkey.**	
8.2	Potential infographics for bowel transplants to see on website – A one page summary infographics for different organs representing the key metrics agreed in the advisory groups are published on the OTDT clinical site. An example of the lung infographics was shown in the MCTAG meeting to indicate the kind of information that can be summarized to be used by clinicians with their patients. This does not exist currently for MCTAG., and members agreed that it would be useful for discussion with patients. **ACTION:A Butler, E Canovai, P Allan, J Hind/G Gupte will meet with C Brown to decide on metrics to present at the Spring MCTAG meeting.**	**A Butler / C Brown / E Canovai / P Allan / J Hind / G Gupte**
9.	**Ethical Issues Relevant to Uterine Transplantation**	
	I Quiroga gave an update for uterine transplantation: The programme is a collaboration between Oxford Transplant Centre and Imperial College for which there was a lot of publicity and media interest with very little negative feedback. • There are two programmes running; the living donor programme is not research as there have now been several successful transplants across the world. The second programme is related to disease which is research.	

	• The first living donor transplant (sister to sister) was done on 12 February and the patient is doing well. This was a CMV positive to CMV negative transfer and unexpectedly, the patient converted to CMV which is now being treated. There will be no embryo transfer until CMV levels are undetected. • It was not intended to make the transplant public until the embryo transfer had taken place. However, this became an ethical issue. NHSBT Comms were involved with all interested parties and the media release was timed to coincide with publication of the case report on 23 August in the British Journal of Gynaecology. • There is now the possibility of another living donor. • The DBD programme is research and is now live. South Central team has been trained. The first donation was in December last year but there was no transplant. • It is now hoped to increase the recruitment regions. The Midlands team is being trained currently. • The first DBD transplant took place in September and the patient is doing well. There is no publicity for this yet, so MCTAG members are asked not to discuss this case at present as Comms need to be handled carefully.	
10.	**Scarcity of organs for small child recipients. Discussion on what to change to avoid waiting list deaths**	
	Due to the small numbers of donors available and lack of split livers, patients are dying while on the waiting list. J Hind stated he is now having to tell families that there is very little chance of an organ transplant. Isolated liver transplants are being performed just to save lives leaving patients on a palliative care pathway. Pressure is now needed urgently on to change prioritisation of IT changes to increase the range of organs available for splitting and to reverse this situation	
11.	**Moving forward with NRP in DCD donors. Developing a strategy and actions.**	
11.1	Following the presentation given by the Spanish guests at the last MCTAG meeting, S Browne, Corporate Communications Manager at NHSBT stated it would be useful to know whether paediatric centres are able to move forward with NRP and how NHSBT can help with this. To progress it is important to know: • The appropriateness of this for paediatric patients • The skills of staff doing perfusion • The equipment that is needed • The ethical and governance issues associated with this. It is proposed: • As Birmingham is the venue for the next international symposium, this issue is discussed there and NRP experts are asked to come and talk to enable a national agreement to be put in place. • Input from NHSBT on ethics and governance will also be needed at this event. • There is no offering for DCD MV grafts currently. It was agreed that consensus on the pathway is needed which needs support from D Manas and OTDT SMT.	**a) Kings / Birmingham reps, I Currie/C Watson** **b) G Gupte**

	A fixed term working group with key individuals will be set up to agree the pathway and an action plan that can be taken through governance re offering and allocation. **ACTION: a) Small term working group to be created to report to the symposium to include representation from Kings, Birmingham, NHSBT, I Currie/C Watson b) G Gupte to contact J Whitney after the meeting.**	
12.	**Potential Bowel Donors – MCTAG(23)12**	
	This paper examining the pathway from identification of potential bowel donors to transplantation and the points at which donors are 'lost' was circulated prior to the meeting. Before 1 November 2021 potential DBD donors aged <56 weighing <80 kg were considered for bowel donation. Since 1 November 2021 potential DBD donors aged <60 and weighing <90kg have been considered for bowel donation. • In 2022-23 there were 772 UK DBD donors. • 381 donors met the criteria for bowel donation. • Consent was given in 337 donors. • 234 bowels were offered of which 24 were accepted for transplantation. Full details are given in the paper circulated. **ACTION: a) J Whitney agreed to identify cases where a paediatric graft has been used for an adult recipient. b) C Brown to forward the core donor data form and the sequence of offers to A Butler c) at the next meeting MCTAG members will look at survival data of ABO compatible versus identical transplant and the implications of this.**	**A) J Whitney** **B) C Brown** **C) ALL**
12.1	Update from Birmingham / Kings re: NRP – This issue will be taken to the National Forum in January.	
12.2	Update on publicity campaign re: paediatric transplants - Suzi Browne, Corporate Communications Manager at NHSBT described work to raise awareness of multi-organ bowel transplants. • NHSBT has been approached by Kings and GOSH regarding a potential pro bono campaign to raise awareness of paediatric donation backed by advertising company, Wunderman Thompson • The mum of a patient (and an employee at the company) recorded a radio appeal broadcast at the end of the school holidays to say that while children are waiting to return to school, others are waiting for a transplant. • As a result, a doll has been created to represent every child awaiting transplant to be hosted in hospitals and other settings and the campaign was launched on 21 September featuring 15-16 children and their families. • 13-14 hospitals have agreed to host dolls. • The campaign includes a TV advert and is focused on registration as this has been shown to be the most effective predictor of donation. This will be launched on 21 November featuring several stories and will hopefully run through Christmas. All of this work has only been possible because of the support of the agency who have also done a review of NHSBT's website and registration pages.	
13.	**National Bowel Allocation**	

13.1	Performance report of the National Bowel Allocation Scheme – **MCTAG(23)10 –** This paper detailing patients active on the transplant list between 1 January 2023 and 30 June 2023, a comparison of 1 year post-registration outcomes over time, median time to transplant, and prolonged registrations was circulated prior to the meeting. MCTAG members are also reminded to notify NHSBT (via ODT Online) of any data amendments (eg. deaths, removals). • There were 28 patients on the active intestinal list at any time (ie 28 registrations) • 19 were adults • 9 were paediatric patients • There were 9 transplants by October • Of the 15 remaining on the list, 9 are active and 6 are blood group O, 1 has sensitisation points and 2 have hospital urgency points. Full details are in the report circulated. It was noted that splitting waiting times between paediatric and adult has helped to highlight paediatric issues which were previously obscured. It is felt that adult patients are waiting longer so breaking down time periods from 2015 into separate cohorts would be helpful.	
13.2	Discussion re: potential changes to allocation policy - It is agreed patients being considered for transplant are not included in the currer allocation policy, particularly those transplanted for malignancy. **ACTION: a) A subgroup will meet to look at how allocation points can help improve access to specific patient groups b) C Brown to provide data on malignant v. non-malignant patients on waiting list.**	**A) J Whitney / I Amin / P Allan / E Canovai** **C Brown**
14.	**Group 2 Bowel Transplants**	
	Data of the period 1 March to 30 September 2023 shows there have been no Group 2 transplants since the last meeting.	
15.	**Update re: Limb Transplantation**	
	In S Kay's absence, there was no update at the meeting.	
16.	**Potential Routine Inclusion of contrast enhanced CT scan in Donor Characterisation**	
	• This was instigated in the bowel transplantation cohort and has been adopted by CT teams to reduce unnecessary call outs to DCD donors. Information has been transferred to DonorPath. It is likely that CT scans will be taken for DBD donors. • One of the main themes of SCORE is to predict certainty of retrievals through imaging taken pre-operatively and to manage the pathway at certain times. • Multi-phase CTs are likely to get an idea of arterial anatomy to reduce the potential of retrieval call outs where this would reveal a modified MV would never be feasible.	
17.	**Discussion relating to data set for UK reporting**	*See Item 18 below*
18.	**Update from Working Groups**	
18.1	Quality of Life Working Group: data collection – P Allan stated that C Rutter has taken over this work from L Sharkey and some	

	preliminary data is being collected to make sure the PNIQ works for adult patients on the transplant journey and not just for patients with IF. EQ-5D will continue and the data will be administered from NHSBT with a single spreadsheet to be uploaded from both units so there is a single data set used as a measure. Two tools – one disease specific and one generic – will be used to see how they perform both pre-and post-transplant. Patients must be an outpatient at the time of inclusion. **ACTION: A Butler to take this to LAG**	
19.	**Feedback from Liver Advisory Group Meeting LAG(23)(M)01 - MCTAG(23)11**	
	The Minutes circulated from the last LAG meeting on 24 May prior to the meeting. The next LAG meeting is scheduled for 29 November and will take place in London. V Aluvihare takes over from D Thorburn as Chair of LAG and S Masson will be Deputy.	
20.	**Adequacy of psychological support for patients undergoing MV transplantation**	
	Following a meeting with psychologists from different centres, patients' psychological need post-transplant was highlighted as it is currently affecting morbidity and mortality. Data is needed for patients whose transplant journey has been relatively problem free v. those who have ended up with problems psychologically. It was noted that centres' psychological support for patients varies: • Cambridge – a psychologist will see the patient once but does not have access to a psychology team for ongoing care and intervention. • Oxford – psychology support is available pre-transplant and is also available post-transplant for new issues that develop. • Birmingham – Pre-transplant the psychologist talks to the family and identifies what support is needed. A team of 2 psychologists is available post-transplant. It was noted that local support is needed that is ongoing. However, this is difficult to access once a patient is discharged. The frequency of adverse effects of partial psychological support will be discussed at the next MCTAG meeting. It was agreed that there will also be a presentation at the national forum when commissioners are present as clarity about where funding is allocated for this in trusts is needed.	
21.	**Threshold for kidney allocation**	
	A Butler asked the group whether a threshold of 45 ml per minute is still appropriate when transplanting a kidney as part of the graft. It was agreed that input from nephrologists was important in making a decision on any update. **ACTION: a) E Canovai and P Allan will discuss this with nephrologists b) all centres will audit pre and post-transplant patients at 1, 3 and 5 years. c) a group consisting of C Rutter, I Arum, K Corbey, P Allan and E Canovai will work on this issue and report back to the next MCTAG meeting.**	**A) E Canovai / P Allan** **B) ALL** **C) C Rutter / I Amin / K Corbey / P Allan / E Canovai**
22.	**Any Other Business**	
22.1	Multi-centre collaborative studies and research -	**G Gupte**

	ACTION: G Gupte to devise a simple spreadsheet to collect information/data for indications for transplantation and cause of death to circulate at the next meeting.	
22.2	Verbal Update on: Study to evaluate the accuracy of two weight estimation calculations for donor characterization - D Harvey is proposing a study re estimation tools to compare weights estimated by tools and actual weights to see if a solution can be found to the problem of getting critical accurate weights for intestinal patients. G Crowe stated London and Midland teams use an estimation weight tool and after a slight delay over summer, a service evaluation can now go ahead. **ACTION: a) G Crowe to discuss with C Brown regarding the number of patients and tolerance that should be included in this and the number of patients b) G Gupte agreed to discuss the appropriate weight tolerance with surgical colleagues (potentially +/-5 Kilos)**	**A) G Crowe / C Brown** **G Gupte**
22.3	Biotest medical affairs: Quarterly meeting of intestinal transplants – G Gupte will provide information post meeting.	
22.4	Potential need for access to liver grafts post-intestinal transplantation when there is acute liver failure post intestinal transplantation - How cases where patients go into acute liver failure following an isolated intestinal transplant should be managed was raised. This is either due to a vascular catastrophe or because of pre-existing liver disease that does not merit the need for a liver included graft but would progress to an isolated bowel and then develop liver failure. • D Thorburn stated that a futility of >50% 5-year outcomes after transplantation is used for liver transplants. This translates into 1 year survival of 60%. It was suggested MCTAG should decide whether patients meet this futility and what the outcome is likely to be for patients and the thresholds for small bowel alone versus MV transplant. • It was noted that the criteria for doing a full MV is different from liver with 5-year survival previously at 28% and lower both in the UK and worldwide. Although this has improved it does not reach liver futility. • For access to a liver post small bowel transplant, centres need to look at the initial indications for the small bowel transplant. Given the unmet need for liver transplants, it is likely decisions will need to be made on a case-by- case basis to ensure livers that can't be used go back for potential use for liver transplants. • For patients who develop acute liver failure, MCTAG needs to determine if they are appropriate for the ACLF pathway (ie there is some chronic liver disease or decompensation) • For patients who meet the threshold a decision is needed on what level of priority should be given and the likely outcome based on these thresholds. A final decision needs to be made through LAG. • The initiative should be brought forward by MCTAG rather than as part of the ACLF programme.	
22.5	Retrieval issues affecting transplantations going ahead – I Amin raised the issue that MV retrievals and transplants have been affected by delays caused by logistical issues in-house or distances involved. It was noted that is often flexibility if CT retrievals are delayed but this is not the case for MV retrievals. All centres are reminded to complete incident forms should this occur so there is evidence of how frequently delayed MV retrievals happen.	

23.	**Key points from today's meeting for cascade to centres**	
	• The meeting focused on delays and problems associated with paediatric patients on the waiting list and particularly how access to split livers for non-bowel containing grafts could be accessed. • Use of NRP will be discussed at the National Forum in January for further discussion at the next MCTAG meeting. • The potential need for allocation policies to include actions regarding malignancy and liver containing grafts was discussed and whether patients transplanted with malignancies are disadvantaged. A subgroup will be set up to discuss this with data input from Oxford. • Access to acute liver transplantation in context of decompensation post-intestinal transplant was discussed. The Liver Advisory Group will be approached to find a mechanism to gain timely access to liver grafts for appropriate patients. • A subgroup will look at what Infographics can be included on the NHSBT website for a one-page information sheet for bowel transplantation. • The group will start to look at the outcome of paediatric grafts into adults and the safety profile of ABO compatible versus identical grafts. • The psychological impact of bowel transplantation was discussed and data will be produced to discuss at the national forum. • Changes to renal function post-intestinal transplant to include paediatric input were discussed and a subgroup will report back to the next MCTAG meeting.	
24.	**Date of next meeting**	
	The next meeting will be face to face on ***Weds 5 June 2024.*** There will be no hybrid option. MCTAG members are asked to nominate a representative to attend if they are unable to do so themselves. Further information to follow.	