NATIONAL FRAMEWORK

Organ Decline Meetings

Rod Figueiredo
Anya Adair
Vicky Gerovasili
Espeed Khoshbin

Introduction

Aim to standardise structure of meetings nationally

- Collaborative effort
- Abdominal and thoracic involvement
- For further discussion

OUG Recommendation 3

Standardised patient pathways must be developed and made available for each organ type, with well-defined timescales for each stage of the pathway. Data available for each stage of the pathway informs monitoring against best practice. Clinical Leads for Utilisation support the review of the data to identify and drive local improvement initiatives

- Decline meetings in transplant units must be established as a mandatory requirement along with a Nationally agreed profile and template

Overview

Meetings should be collaborative, educational, aiming to provide a forum for supportive discussion with a no-blame culture to promote shared learning

Education

Collaboration

Shared decision-making

15 Recommendations

Recommendations

1. Each organ group in each transplant centre should meet at least once per month, with target best practice of weekly meetings

2. Title of meetings is ‘*Organ* Utilisation Meeting’, with title reflecting organ to be discussed (e.g. Liver Utilisation Meeting)

Recommendations

3. Attendance at each meeting is logged and invitees include:

   a. Consultant Transplant Surgeons
   b. Consultant Transplant Physicians relevant to the organ type
   c. Consultant Transplant Anaesthetists / intensivists
   d. Recipient Transplant Co-ordinators
   e. Trainees (medical and surgical)
   f. Theatre Co-ordinators
   g. Local clinical lead for organ donation
   h. Kidney meetings are welcome to invite local referring centres if they are involved in organ acceptance decision-making

Recommendations

4. For a meeting to be quorate, a minimum of 2 consultant transplant surgeons and 2 consultant transplant physicians, and 1 recipient transplant co-ordinator is required. The meeting should be chaired by the local CLU or a nominated deputy
5. An additional monthly or quarterly analysis should be performed to present overall data such as the total number of offers, number of deceased donor transplants, declines that were transplanted successfully elsewhere, organs declined by all centres, and implant rate referenced to national average if available for the time period being presented such that trends can be identified.

Recommendations

6. All organs declined by each centre that are subsequently transplanted elsewhere should be discussed in detail.
   a. Named offers to be discussed in the context of suitability for recipient
   b. Short term outcome of those transplanted organs should be determined and discussed

Recommendations

7. The basic minimum dataset required for discussion of each case to be tailored to each organ by national CLU teams. As a guide, this should include:

a. Donor demographics (age, sex, location, BMI, blood group)
b. Donor type (DBD/DCD)
c. Donor social factors (e.g. alcohol history, other drug history) and past medical history (relevant to organ)
d. Organ function in donor and/or inspection/radiological imaging (tailored to organ type)
e. Recorded reason for decline
f. Organ outcome
g. Specific identification during the discussion of any organs that meet definition of 'higher quality donors'
h. Relevant recipient factors (background disease, waiting time, risk factors tailored to organ type)

Recommendations

8. Centre recipient transplant co-ordinators and local CLUs are encouraged to communicate nationally with counterparts in other centres to facilitate meaningful discussion of cases by sharing outcome data when requested.

9. Any deaths on the waiting list should be discussed (although the setting of this discussion does not necessarily need to be in utilisation meetings). Discussions regarding any deaths on waiting list should include a review of any suitable offers the recipient had whilst listed.

Recommendations

10. An annual review meeting is held to analyse unit and national utilisation trends over time and discussed appropriately (e.g., utilisation rate, waiting list mortality).

11. Surgeons and physicians involved in utilisation decisions should be informed ahead of the meeting that their case will be discussed, to allow an opportunity to add further information and value to the discussion.

12. Meetings should be minuted and individualised feedback provided where discussion concluded that a different decision regarding organ utilisation should have been made. Minutes should be stored locally in accordance with local protocols.

Recommendations

13. Individual Trusts/Boards provide administrative time and support to allow for meaningful data collection and presentation. Individuals involved in attending utilisation meetings should be job planned appropriately.

14. Decisions on whether to anonymise clinicians' utilisation decisions should be discussed locally, to ensure accountability of decisions without compromising open discussion.

15. Trainees should be encouraged to play an active role in the utilisation discussion process.

Thank you

Discussion