Sustainability and Certainty in Organ Retrieval (SCORE)

Frequently asked questions

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1. General Questions about the SCORE programme

1.1. What is SCORE?

- Following a period of analysis and engagement, NHSBT has launched the SCORE Programme which aims to bring increased certainty to the Organ Donation, Retrieval and Transplantation Pathway with a view to supporting sustainability into the future. This is a key change from the current culture which focusses on donation, retrieval and transplant occurring as fast as possible.
- The Programme is a multi-year initiative with the initial focus over the next few years on laying the foundations for stability across the pathway.
- The first phase of the programme involved seven workstreams with colleagues from donation, retrieval and transplantation communities to contribute to the scoping and definition of the changes that are required to achieve the objectives. These workstreams worked on the following areas:
    - To increase pathway certainty through a National Organ Retrieval Service (NORS) planned arrival window, while accommodating an accelerated pathway for specific cases, providing benefits across the donation and transplantation pathway
    - To increase the probability of donation, improving certainty through a reduction of non-proceeding activity
    - Improving outcomes for recipients by moving complex transplant surgery from a night time activity to the day time.
    - To develop a future model for NORS delivery which modernises our operations and improves resilience and sustainability.
    - To enable a sustainable NORS workforce to improve attractiveness and talent retention.
    - To provide an efficient service in order to ensure financial sustainability.
    - To scale organ retrieval perfusion capabilities for ANRP and DCD Hearts to increase organ utilisation (subject to external investment)
    - The second phase of the programme will be focussed on building towards implementation. This will focus on working with stakeholders affected by the change to help them prepare. Contracts with providers will be updated to reflect the change to help provide the certainty required.

1.2. What services will be impacted by this Programme?

- The shift from ‘as fast as possible’ to ‘with sustainability and certainty’ requires engagement across the donation and transplantation pathway. The following changes are being considered and will be discussed with the wider community:

- NORS service model: specifically exploring whether a planned arrival window for retrieval teams can be established and the impact this will have on the rest of the donation and transplantation pathway.
- NORS workforce: supporting trusts and health boards to establish and maintain a sustainable NORS workforce.
- The donation pathway: specifically, donor assessment, optimisation, length of time for which organs are offered and the time of day that occurs.
- Support services: Specifically ensuring those specialities we rely upon (e.g., transport, laboratory services) to support donation and transplantation are involved in the design of how we access their services.
- Commissioning: Ensuring that any changes to the delivery of donation and transplantation are accurately and appropriately reflected in the contracts for services we commission.
- Communication and Engagement; Ensuring a programme-wide message is conveyed to all stakeholders along the donation and transplantation pathway, in a consistent and timely manner.

1.3. What is the Planned Arrival Window?

- The Planned Arrival Window (PAW) is the time proposed for NORS teams to arrive at donor hospitals to conduct the retrieval. This time has been based on a decade of retrieval data analysed by the Pathway Intelligence Group and combined with recommendations from stakeholders across the pathway. The Planned Arrival Window has been established to be 20:00-03:00.
- Through the implementation of the planned arrival window, the majority donors will need to be registered with the hub by 08:00 hours (which is consistent with current practice), offers made by organ groups between 0800 to 1500 hours and NORS teams allocated by 1600 hours.
- Some case will need to be placed on an accelerated pathway such as super urgent livers or paediatric cases and will proceed as per current practice aligned to the principle of ‘as fast as possible’.

1.4. What is the Planned Arrival Window Plus?

- Donors registered with the Hub after 08:00 and before 1600 could be considered in the PAW that same night if organs are accepted and a NORS team is available.

1.5. Who will be responsible for co-ordinating all of this activity?

- The aspiration is to create a new role based in the Hub, which we are referring to as the clinical decision maker. Among their responsibilities will be supporting offering, allocation and mobilising of NORS teams for arrival at specific times in donor hospitals.
- At the time of writing this FAQ, the clinical decision maker has not yet been formally approved or funded. However, they are referred to throughout this document.

1.6. Which services will not be impacted by SCORE?

- The discovery phase of the SCORE program has revealed that nearly all services related to donation, retrieval, and transplantation will be affected by the changes introduced by SCORE.

1.7. How will you measure success of the SCORE programme?

- We are developing a set of success criteria across the pathway that can be measured to demonstrate successful achievement. The criteria will be finalised on submission of the Programme business case.

- As soon as success measures are confirmed, they will be shared widely with all stakeholders involved.

1.8. How will these proposed changes be rolled out? Trial, phased or big bang?

- The method for rolling out changes is contingent on the specific area of change. Some aspects will be better implemented through a trial, pilot or phased approach while others will necessitate a 'big bang' approach.
- Regardless of the approach, each change is being co-ordinated with colleagues with experience and expertise in the area, and will be thoroughly managed, stress tested, and risk assessed.

1.9. When will SCORE be implemented?

- The scale of the SCORE programme depends on the outcome of the DHSC spending review, which is expected to conclude by the end of quarter 4 of 2024/25.
- The spending review will help determine which parts of the SCORE programme will proceed and establish the associated delivery timeline.
- Implementation plans will be developed in collaboration with stakeholders, ensuring timeframes are communicated and sufficient time is provided to be change-ready.
- If everything proceeds as planned, we aim to achieve an initial roll-out in April 2026.

1.10. Is this a cost saving exercise?

- The main objective of the SCORE programme is to provide a donation and transplantation service which is safe and sustainable for all those involved. This includes the donor families, our commissioned providers, including NORS centres and laboratories, colleagues at donor hospitals and transplant centres, and those employed by NHSBT at the hub and as SNODs. The programme must enable this within existing resource and financial envelopes.

1.11. How can I be involved?

- This programme will involve several working groups/ workstreams with representation from the donation, retrieval, and transplantation pathway.
- Email SCORE@nhsbt.nhs.uk if you would like to contact us.

2. Donation

Impact on donor families

2.1. What are the benefits for the donor families as a result of PAW?

- Donor families will have increased certainty around the time of donation enabling them to rest or/and plan their last hours with their loved one.

2.2. Will donor families be consulted about any changes?

- Yes. SCORE has set up a Public and Patient Sub-Group, comprised of Donor Families, Recipients, people on the transplant waiting list and members of the public interested in NHS improvement initiatives. We have also engaged specifically with the Donor Family Advisory Group to garner their feedback about overnight retrieval. The feedback has been positive in respect of certainty about timings being a strength and will benefit future donor families.

2.3. Do you anticipate this will increase the length of the donation process?

- As part of this project, extensive modelling has been carried out on real time donation activity to enable as accurate as possible predictions on the anticipated pathway once the PAW is implemented. This modelling has shown an increase in the overall length

of process; however, it has also shown an increased ability to provide certainty to the donor families and the donating hospital staff regarding the anticipated timings of each part of the process.

- This change is necessary to ensure better coordination, improve the success of organ retrieval, and enhance the overall safety and efficiency of the process. While this will extend the time frame, it will give predictability on time frames to all involved.

2.4. Do you anticipate a negative impact on consent rates as a result of the increased length of process?

- No. Based on data from St Georges Hospital, who already prioritise overnight retrieval, demonstrates no difference in family decline rates based on length of process.

2.5. Some donor families cannot wait extended periods of time for retrieval, how do you propose we manage that?

- Donor families will have more 'certainty' of when retrieval will take place. This allows families to plan their time with their loved ones. Specialist Nurse are experts in managing family expectations and supporting them through extended periods.
- The Donor Family Advisory Group emphasised the importance of initiatives that help families make the most of their time at the bedside, ensuring those final hours are as meaningful and special as possible.

2.6. Will there be any flexibility in practice to allow for those families who feel they can't wait an extended period of time to be 'prioritised' in the allocation of a NORS team?

- We believe that giving donor families more certainty of when the retrieval takes place will help manage their expectations. There will always be exceptional cases which will require some clinical decision making at that time. There will be teams available throughout the day to ensure no delay to retrievals for specifically accelerated cases. The clinical decision maker in the hub will have oversight of activity across the country and will be in a position to determine if cases can enter the accelerated pathway.
- The current process elicits many declines or withdrawn consent/authorisation based on the length of the donation process. The contributing factors are manifold however, we do have evidence that moving plans and incorporating delays adds to the stress and contributes to the consent issue. It is anticipated that more certainty will give confidence that expectations are met.

2.7. How will PAW fit with faith-based end-of-life requests?

- As per current practice, the SN will liaise and support each family through their donation journey and discuss with them how donation can take place in line with their faith.

2.8. Will DCD donors take precedent over DBD donors.

- No. There's no intention or requirement to prioritise one type of donor over another. Discussions will be required to plan where in the PAW the retrieval is best performed and will take into account the national donation activity alongside the specific needs in each scenario. The clinical decision maker in the hub will be central to all these discussions and make the best choices based on the information available.

Impact on SNODs

2.9. How will the implementation of SCORE benefit the SNODs?

- SNODs will not have to adopt significant changes in their work patterns or changes or changes to the donation process.
- The introduction of PAW will enable them to provide greater certainty to their families and provide them with opportunities to rest or/and plan their last moments with their loved one.
- There will be increased certainty of NORS team arrival times with a reduction in delays of NORS team arrivals as the planning and allocation of teams for a PAW will allow longer planning times and likely reduced travel for teams.
- The NORS teams will not be expected to carry out more than one retrieval in the nighttime retrieval period. This will mean SNs will be greeting NORS teams who are fresh on duty and who will not be rushed to leave the donor to get another retrieval providing a less time/travel pressured NORS team.

2.10. SNs and CLODS need to feel listened to. How will you be making sure we feel part of the discussion?

- Engagement activities have taken place and will continue throughout the duration of the SCORE programme to ensure any implementation is as balanced as possible.
- Some changes to accommodate the PAW will be based on regional team needs. As such, it is for the teams themselves to understand the required changes and should feel empowered to implement them.
- As per point 1.11, SNs and CLODs are welcome to join the programme to add their voice to specific workstreams.
- All operational workstreams have included SNOD and/or CLOD representation.

Impact on donor hospitals

2.11. How will the implementation of SCORE benefit donor hospitals?

- The shift of retrieval to a predominantly nighttime activity will ensure that disruption to theatre lists and routine surgery is kept to a minimum.
- ICUs will be more certain about when beds become available.

2.12. What impact will these proposed changes have on bed occupancy?

- It has been calculated for a 20 bedded ICU, with 15 donors per annum the bed occupancy under the Planned Arrival Window will increase by less than 0.1%.
- To work this out for your own ICU, change the **bold** numbers as needed:

    - For a **20** bedded ICU
    - **20** beds x 24hrs x 365 days = **175,200** bed hours per year
    - **15** donors per annum with extra 10hrs per case (**15**x10) = 150hrs
    - 150/175,200 x 100 = 0.08%
    - This is assuming NORS teams will arrive at 24:00 (middle of PAW)

2.13. CT Organ acceptance would be higher if an echo was available every time. Can we direct finances to a service or to hospitals to ensure this can happen?

- No. It is not part of the remit of SCORE to mandate availability of echo in all donating hospitals.

2.14. Can you start offering heart before 8am pending formal ECHO in the morning so you can meet the next night retrieval window?

- There will be no change from current model where offering cannot begin until an ECHO is available. Practice generally dictates that centres may accept an organ 'pending an ECHO' which in reality puts the offering in a holding pattern until the ECHO is available. The emphasis will be not registering until all information is available.

2.15. Will transplant centres be able to request a 'delay' to the following PAW e.g another 24 hours?

- It is expected that the new process and timescales will provide sufficient time for transplant centres to request all the information needed and prepare their recipient without requesting delays. The clinical decision maker in the hub will be central to all these discussions and make the best choices based on the information available.

3. Offering

3.1. How will offering change under the proposed changes?

- The offering pathway will need to change to support the Planned Arrival Window. We anticipate that the majority of offering will need to move to daytime activity – there are 2 key reasons for this:
  1. To remove anticipated bottlenecks of activity overnight through parallel offering and retrieval activity for Hub Operations and Recipient Coordinators.
  2. To enable daytime decision making to include Multi-Disciplinary Teams and reduce late declines through clinician changes.
- The offering will be done in groups by organ type – cardiothoracic organs offered between 0800 and 1000 hours, liver and bowel offers between 1030 and 1230. Renal offering will be undertaken in two parts. First (between 0800-1300) 'Tier A recipients, and 'D1 donors' and then all other offers to renal centres simultaneously in groups of 3.

3.2. Will multi organ offers allow 'cherry picking' of the best organs. Will this impact marginal organs being accepted?

- No, we expect the opposite will happen. Transplant centres will be able to see all organs available to them and indicate which organs they're prepared to accept. They will be allocated organs based on where their recipient is on the list.

3.3. Is there plans to accept back up offers for routine recipients? Especially when centres have accepted pending virtual cross match.

- The notion of a 'back up offer' will be removed in the new process. Each Transplant centre will be asked to indicate ALL organs they will be willing to accept and understand where in the allocation order they are. From there, should a centre decline an organ having already accepted it, the Hub will be able to contact centres previously indicating a willingness to accept.

Impact on the Hub

3.4. How will the Hub manage with an influx of registrations, offers and logistical arrangements at the same time?

- PAW introduces a cut-off time for the registrations for the day but SNs are encouraged to register their donors when they are ready. Thus, it is not anticipated that the Hub will be overwhelmed by registrations at the same time.
- Registrations as donors are ready will also ensure patients on the super urgent liver list are not negatively impacted.

- Daytime offering will allow for organs to be offered in specific windows, meaning offers will arrive at a predictable time. There will also be more time created for the Hub to allocate organs and plan for the next offering window.
- All proposed changes will be thoroughly tested to assess the pressure points and propose the ideal times.

3.5. Will the HUB require more staff to accommodate the changes to offering?

- The Hub intends to increase headcount with the introduction of the clinical decision maker, but the current staffing model is expected to accommodate the new offering model.

Impact on transplant centres

3.6. If most offers are received in the morning, this will impact clinics. What actions are there to mitigate this disruption?

- We are engaging with the transplant centres to understand the impact that they will face. Many centres have started to consider different ways of working that may support the new approach to offering.
- Each centre should feel empowered to make the local changes necessary to accommodate the new offering model.

3.7. In the current system I would be more likely to accept 2 livers in a 24-hour period. In the proposed system I think I would be less likely as all the offers will arrive at the same time. How will this be mitigated to avoid an increase in declines as an unintended consequence?

- The Planned Arrival Window is a flexible period of time between 20:00 and 03:00. If a centre accepts 2 organs in a 24-hour period, planning retrievals that are spaced out in the window will be possible. The clinical decision maker in the hub will be central to these discussions and support the opportunities to maximise transplants.
- Centres currently decline organs based on logistics; the organs are accepted by a different centre. We expect this will continue.

3.8. If all the offers come in at the same time, will RCPoCs be allocated more time to respond?

- The offering model for cardiothoracic and liver/bowel offers will allow for 2 hours before a decision is required.
- For renal, sequential offering will be carried out in the morning from 08:00 until 13:00 and centres will be allowed 45 mins. Simultaneous offering will be in rounds of 3 centres per round and will also be 45 mins.

Impact on laboratory services

3.9. What impact will there be on laboratory services?

- It is anticipated that there will be no impact from the PAW on the timing of donor samples sent to laboratories for donor characterisation purposes.
- The support services workstream is currently working with colleagues within laboratory services and analysing historic data on service usage to understand any potential impact of the new organ offering and allocation process on laboratory work, specifically H&I laboratories that support donor/recipient crossmatching prior to transplantation.

Accelerated Pathway - offering outside PAW

3.10. What happens with those donors matched to super urgent recipients?

- The new working model for NORS will ensure there is capacity to retrieve at any time for super urgent liver recipients or other cases which may require to be on the accelerated pathway e.g., paediatrics.
- These cases will be undertaken as they are now, under the 'fast as possible' model.

3.11. Multi-visceral offers take much longer than average, will those cases be treated any different under the proposed model?

- It is anticipated the new offering model will remove the delays that can be seen with the current pathway.
- There may be reasons some cases need to be considered outside of the planned arrival window, multi-visceral cases may be one.

3.12. How are paediatric cases incorporated into the proposed changes?

- It is anticipated that these cases will be considered outside of the planned arrival window. They will be facilitated as is current practice to ensure access to multi-disciplinary support services are available for the family, as needed.

4. Retrieval

4.1 What does Planned Arrival Window for retrieval mean?

- The Planned Arrival Window (PAW) is the time proposed for NORS teams to arrive at donor hospitals to conduct the retrieval. This time has been based on a decade of retrieval data analysed by the Pathway Intelligence Group and combined with recommendations from stakeholders across the pathway. The Planned Arrival Window has been established to be 20:00-03:00.
- Through the implementation of the planned arrival window, the NORS teams will be allocated their donors by 1600 hours, providing them with certainty and opportunity to plan their time.
- The aspiration is for a NORS team to conduct only one retrieval per night.
- Some cases such as super urgent livers, paediatric cases will proceed as per current practice aligned to the principle of 'as fast as possible'.

4.2 Are you planning to move to nighttime retrieval?

- SCORE proposes that 20:00-03:00 would be the optimal Planned Arrival Window for NORS teams, in order to ensure the majority of organ implant surgery is within daytime hours to give recipients the best chance of a good outcome.
- This time has been identified for the majority of retrievals based on historic data analysis and recommendations from colleagues across the donation and transplantation pathway, especially NORS teams.
- There is capacity built into the modelling for teams to be available during the day, and cases on the accelerated pathway e.g. super-urgent livers, will be undertaken as fast as possible.

4.3 What is the evidence for surgical outcomes being worse at night?

- UK Guidance strongly discourages overnight elective surgery[1]. There is a rich pool of literature focused on the risks associated with 'out-of-hours' surgery with the largest

[1] A report by the National Confidential Enquiry into Perioperative Deaths (1995/6). "Who Operates When?".

studies demonstrating consistently worse outcomes and revealing preventable causes of mortality[23].

- Surgery conducted overnight presents barriers to accessing the wider MDT, specifically senior support in a timely manner to assist in complex cases and delayed access to services such as blood bank which raises the risk level especially when difficulties are encountered.

Impact on NORS teams

4.4 How does SCORE benefit the NORS teams?

- NORS teams will be allocated their donors to travel to by 16:00 and know when they are required to leave base.
- The benefits will be in knowing in advance and being able to plan your time accordingly, including being able to undertake/complete professional or personal responsibilities.

4.5 Is NORS allocation going to change to 'nearest' team to attend? Does that mean the Northern teams are likely to attend fewer retrievals?

- There is no plan to change to a 'nearest' allocation for NORS. With more planning time, NORS teams will be allocated based on the most efficient use of resources.
- SCORE is undertaking alignment modelling to ensure equity across NORS teams, this is not yet complete.

4.6 A 9th On-Call abdominal team would provide extra resilience. Is it possible to increase NORS capacity?

- SCORE NORS Service Model workstream is reviewing the capacity to address demand and variation in NORS team activity.
- The workstream considered capacity of NORS at current number of attendances, and an additional 250 attendances per year, with 8,9 and 10 abdominal teams, 3 and 4 cardiothoracic teams.
- The workstream recommended at current number of attendances, 8 abdominal, 3 cardiothoracic teams.
- Under the PAW modelling, this allows 98% of all donors to have NORS attendance within the first PAW, including 76% of those donors registered after 08:00 in the PAW that evening. This is based on 2023 data and would have meant that only 32 donors would not have NORS attended in the first PAW.
- It has been recognised that there is a need to have a trigger to review if the number of attendances increases.
- The SCORE programme will need to affect changes within the existing financial envelope.

4.7 It's been said that there will no longer be back-to-back retrievals or no more than 1 in 24 hours per team. Is this a hard rule or is the scope for flexibility?

- There is always scope for flexibility. We recognise that donation, retrieval and transplantation are dynamic pathways and there will always be exceptions.
- An example of an exception could involve two simultaneous donors at the same hospital. In such cases, discussions among the NORS teams, transplant teams, SNs, and the clinical decision-maker will help determine the best course of action based on the specific priorities at that time.

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[2] Althoff FC, et al (2021). Effects of night surgery on postoperative mortality and morbidity: a multicentre cohort study. *BMJ Qual Saf* 2021;30:678–688. doi:10.1136/bmjqs-2020-01168,

[3] Cortegiani et al (2020). Association between night/after-hours surgery and mortality: a systematic review and meta-analysis. *British Journal of Anaesthesia*, 124 (5): 623e637 (2020) doi: 10.1016/j.bja.2020.01.019

4.8 If there are no NORS teams out and there is theatre availability (i.e., at weekends) can NORS be mobilised outside of the PAW window?

- Some cases will be required to enter the accelerated pathway (e.g., super urgent liver cases) which would be facilitated outside the Planned Arrival Window.
- NORS teams will be staffed to meet contractual requirements for the Planned Arrival Window and the accelerated pathway, therefore there may not be capacity.

4.9 What impact will these proposed changes have on travel time for the NORS teams?

- With more time for logistical planning in the Hub, NORS teams will be mobilised to donors in the most efficient way.
- Early modelling indicates there will be a reduction in travel time for both abdominal and cardiothoracic NORS teams. More work will be undertaken to confirm this.

4.10 With more time to plan, will the NORS teams be given more time to muster?

- The mobilisation period was extended to 90 minutes in recognition of the additional equipment required to support developments such as NRP and DCD Hearts.
- It is not anticipated that NORS teams will require more time to muster under Planned Arrival Window, due to the ability to plan in advance.

4.11 How do you plan to raise the profile of the NORS workforce in their local hospitals? Much of their work is undervalued or not recognised.

- The SCORE programme has made recommendations for Trusts and Health boards to implement. One of which is the establishment of a Local NORS collaborative forum to provide a focus on NORS related priorities and recognise the support needed to provide a robust sustainable service.

4.12 How can we make working in a NORS team more attractive / a career choice?

- One of SCORE's recommendations is to make NORS a career of choice, by promoting and advocating the roles.
- We have developed a NORS recruitment and retention toolkit to assist Trusts and Health boards in attracting staff.
- It is anticipated that under the Planned Arrival Window there will be more certainty in working patterns, making the role more attractive.

4.13 The modelling (on a busy week) demonstrates challenges for the Cardio-thoracic team. Will there be scope for increasing the number of On-Call NORS teams?

- The SCORE programme will need to affect changes within the existing financial envelope, as such an additional cardiothoracic NORS team is not in scope for the SCORE programme.

4.14 What happens when there are more than 3 donors who need cardiothoracic attendance in a 24hr period? Will that incur a 24hour delay?

- The same will happen under the new model as it does today. 1 donor will be required to wait until the next retrieval opportunity. This does not necessarily mean a 24-hour delay as there will be capacity to retrieve in the day time as well. The clinical decision maker in the hub will be central to these discussions and make the best possible decisions in the circumstances at the time.

4.15 Would it be better if there was a standardisation in NORS working patterns? Currently each team is free to choose their start/finish time.

- NORS is a commissioned service for availability rather than defined shift patterns. As such, we cannot impose what shift patterns are worked or what time teams start or finish.
- The final decision as to the most appropriate model will be taken within NORS Centres as employers of the NORS Teams.

4.16 In the modelling for travelling, did you account for teams requesting ANRP or requesting to go out of zone? How will this impact the proposed changes?

- ANRP is not currently a commissioned service so was not included in the initial modelling. Further modelling will be undertaken by the SCORE programme and will include this.

4.17 Do our transport providers have capacity to deal with most travel being concentrated at certain times of the day?

- The SCORE programme has a 'Support Services' workstream whose responsibility includes working with transport providers to ensure service provision aligns with the new changes introduced by the planned arrival window.
- The certainty of requirements as a result of PAW provides NHSBT and our transport provider greater opportunity to plan an efficient use of transport. Thus, our transport provider has welcomed the change.

4.18. If organs are flying, we will need the airports to be open for them to fly out.

- Decisions about where in the PAW a retrieval takes places will have to include factors relating to travel / transport as well as all other factors. SCORE programme is working with transport providers and airports to understand the full extent of changes on process.

4.19. Retention of surgeons in the UK is an issue. Can NHSBT instruct trusts / health boards to use the money provided in a specific way to address this issue?

- No. NHSBT's contractual obligations are strictly limited to the disbursement of funds to the Provider (Trust/Health Board) for all Services that the Provider delivers in accordance with the NORS Contract, i.e., NHSBT's obligations do not extend to and/or include how the NORS funding is to be disbursed by the Provider.
- It would be considered unreasonable and inappropriate for NHSBT to mandate how the Provider's HR/Finance Directorates operate their internal processes and/or for NHSBT to control/govern this operationally for the Provider.
- The Provider remains fully responsible for the disbursement of NORS funding upon receipt from NHSBT. NHSBT is not accountable in relation to how the NORS funding is disbursed by the Provider.

4.20. When will NORS and Donor Characterisation contracts change?

- Shadow contracts will be issued in advance of any new arrangements being implemented.

4.21. When will we be informed about changes to the contracts?

- Any contractual changes will be communicated as per our usual processes to all for teams to make any operational changes required.

Impact on donor hospitals

4.22. Access to operating theatres in some hospitals can be challenging, how will the SCORE programme affect this?

- Data tells us that the majority of delays in the donation process are resultant from waiting for theatre availability (45% between 0800-1800). The creates pressures in the donating hospitals and disrupts planned theatre lists.
- SCORE proposes a 'nighttime' retrieval window to alleviate these pressures.

4.23. There are already issues at times for staffing or theatre access overnight in hospitals - especially when the staff are busy with emergencies - is there messaging going out from NHSBT to Trusts and health boards?

- It is expected that with more planning time, solutions to staffing issues may be resolved in time for NORS arrival.
- Messaging to trusts and health boards about upcoming changes will need to be decided regionally given the local relationships and the impact PAW will likely have on each hospital. The SCORE programme can provide assets to support local messaging.

Use of technologies

4.24. Has SCORE included the use of organ perfusion technologies?

- SCORE is modelling the inclusion of ANRP and DCD hearts, although this is not yet part of the commissioned NORS service.
- We await the outcome of the 2024 DHSC spending review and will revisit the decisions regarding alignment of ANRP and DCD heart services with the SCORE programme once the outcome is announced.

5. <u>Transplant</u>

5.1 Do transplant centres have theatre capacity to transplant with offers/organs arriving at around the same time?

- We will be working with Transplant commissioners to ensure that implant theatre capacity does not become a new limiting factor. Greater clarity around timings should allow for better planning processes.

5.2 What impact will this have on the workload or ways of working for recipient co-ordinators?

- The SCORE programme has identified implementing the PAW may change working patterns for Recipient coordinators. As each centre works slightly differently, this needs to be addressed locally once the proposals have been finalised.
- Laura Stamp (Lead Nurse – Recipient coordinators) has organised some initial engagement sessions with each organ groups recipient coordinators.

5.3 Will there be a dedicated Consultant to take offers during the day as often they can be in theatre or in a clinic and RCPoc cannot speak to them?

- Transplant centres will have to review their current service provision against the proposed offering model. It will be for each individual transplant centre to decide how to accommodate offering alongside their routine work in the hospital.

5.4. Will the new offering model mean that a centre that accepts more than one organ will likely receive all organs at the same time?

- The Planned Arrival Window is a flexible period of time between 20:00 and 03:00. If a centre accepts 2 organs in a 24-hour period, planning retrievals that are spaced out in the window will be possible. The clinical decision maker in the hub will be central to this discussion and support the opportunities to maximise transplants.

- Centres currently decline organs based on logistics; the organs are accepted by a different centre. We expect this will continue.

5.5. Is this new model not going to have an impact on cold ischaemia times and resource requirements especially for implanting teams that accept more than one organ type?

- Cold ischaemic times (CIT) have been taken into account for all organs in the modelling of the planned arrival window. For example, if CT organs have been accepted, the teams would be asked to attend later rather than earlier in the PAW to accommodate the shorter tolerance of CIT.
- Modelling on the 2023 data shows that under the PAW centres would be receiving almost identical number of organs per day as happened in 2023, the majority being 1 organ per centre. For those multi organ transplant centres more likely to accept more than 1 organ, the data is again reflective of actual events in 2023. With a clinical decision-making role in the Hub there will be the ability to plan organs arriving at different times to those centres who accept more than 1. This is something we are highlighting as part of the latest round of engagement with liver centres.

5.6. How will a potential future ARC model fit with SCORE timings?

- The SCORE programme and the introduction of the Planned Arrival Window are seen as laying the foundations for ARCs. For ARCs to be a success, we still need a robust and sustainable retrieval service, which is the primary objective of the SCORE programme.

5.7. I'm concerned that the offering times now coincide with the implantation times. In our hospital, it is the surgeon that accepts the offers.

- We are engaging with the transplant centres to understand the impact that they will face. Many centres have started to consider different ways of working that may support the new approach to offering.
- Each centre should feel empowered to make the local changes necessary to accommodate the new offering model.

6. Glossary

Term	Definition
ANRP / NRP - Abdominal Normothermic Regional Perfusion	ANRP is a technology that has potential to increase the quality and number of transplantable organs. ANRP involves using a machine to pass blood through organs in a person's body after the heart has irreversibly stopped beating
CLOD – Clinical Lead for Organ Donation	A doctor, usually a consultant who provides clinical leadership within the hospital, to champion and promote the value of deceased organ donation.
CT – Cardio-thoracic	Collective term for the donation, retrieval or transplantation of heart and/or lungs.
DBD – Donation after Brain Death	Donation after Brain Death (DBD) refers to patients/donors whose death has been confirmed using neurological criteria (also known as brain-stem death or brain death).
DCD – Donation after Circulatory Death	Donation after Circulatory Death (DCD), previously referred to as donation after cardiac death or non-heart beating organ donation, refers to the retrieval of organs for the purpose of

	transplantation from patients whose death is diagnosed and confirmed using cardio-respiratory criteria.
Multi-visceral	A multivisceral transplant means that the liver, small intestine, and other abdominal organs (for example, the stomach and pancreas) are transplanted at the same time.
NORS – National Organ Retrieval Service	A surgical team whose responsibility it is to attend a donor hospital to undertake the organ retrieval operation.
PAW – Planned Arrival Window	A proposed time in which NORS team will arrive at donor hospitals to undertake organ retrieval operations – see 1.3
RCPoC – Recipient Centre Point of Contact (or recipient coordinator)	The role of the Recipient Transplant Co-ordinator is to support and guide the recipient through their transplant pathway.
SCORE – Sustainability and Certainty in Organ Retrieval	The change programme set up to deliver improvements in donation, retrieval, and transplantation pathways – see 1.1
SN – Specialist Nurse	Specialist Nurses support potential donor families and the operational processes of organ donation.