NHS BLOOD AND TRANSPLANT
ORGAN DONATION AND TRANSPLANTATION DIRECTORATE

THE SIXTEENTH MEETING OF THE NATIONAL RETRIEVAL GROUP (NRG) WEDNESDAY 9th NOVEMBER 2016 FROM 10:30 UNTIL 15:30

CORAM, 41 BRUNSWICK STREET, LONDON WC1N 1AZ

Present:

Prof Rutger Ploeg	National Clinical Lead for Organ Retrieval **(Chair)**
Ms Liz Armstrong	Head of Service Development, ODT
Mr John Asher	Clinical Lead, Medical Informatics, ODT
Ms Emma Billingham	Senior Commissioning Manager, ODT
Mr Roberto Cacciola	Associate National Clinical Lead for Organ Retrieval, ODT
Mr Chris Callaghan	National Clinical Lead for Abdominal Organ Utilisation, ODT
Prof John Dark	National Clinical Lead for Governance, ODT
Ms Melissa D'Mello	Lay Member Representative
Prof John Forsythe	Associate Medical Director, ODT, NHSBT
Mrs Victoria Fox	Lay Member representative
Ms Victoria Gauden	National Quality Manager, ODT, NHSBT
Ms Sally Johnson	Director of Organ Donation & Transplantation, NHSBT
Prof Derek Manas	Liver Advisory Group Representative
Ms Kate Martin	Statistics and Clinical Studies - NHSBT
Mr Gabriel Oniscu	RINTAG Representative
Mr Gavin Pettigrew	NORS Retrieval Teams Representative
Ms Anne Sheldon	Head of Referral & Offering, ODT, NHSBT
Ms Amanda Small	Head of Operations for Organ Donation (for J Whitney – mat. leave)
Mr John Stirling	Perioperative Clinical Lead
Mr Steven Tsui	Cardiothoracic Advisory Group Representative
Prof Chris Watson	Kidney Advisory Group Representative
Mrs Claire Williment	Head of Transplant Development, ODT, NHSBT

In Attendance:

Mrs Kathy Zalewska	Clinical and Support Services, ODT

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	Apologies: Mr John Casey, Prof Peter Friend, Mr Ben Hume, Mrs Rachel Johnson, Ms Debbie McGuckin, Mr David Metcalf, Dr Paul Murphy, Ms Karen Quinn, Mr Andre Simon, Mr Anthony Snape, Mr Mick Stokes, Ms Helen Tincknell, Ms Fiona Wellington, Ms Julie Whitney, Dr Mike Winter, Ms Belinda Wright	
1	**DECLARATIONS OF INTEREST IN RELATION TO THE AGENDA**	
	There were no declarations of interest in relation to the agenda.	
2	**MINUTES OF THE NATIONAL RETRIEVAL GROUP MEETING HELD ON WEDNESDAY 6TH JULY 2016**	
2.1	**Accuracy** The minutes of the meeting were agreed as a correct record subject to removal of the wording '*and no less than 40kg*' in relation to the revised description for small cardiothoracic donors. The corrected final bullet point for paediatric cardiac donor size on page 2 to read: • This means that the new limit would be 145 cm.	

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2.2	**Action Points – NRG(AP)(16)3** **AP1 Minutes:** Corrections to previous minutes have been completed. **AP2 Advisory Group priorities:** The cardiothoracic perfusion protocol will be included within the next revision of the NORS standards. Diagrams/videos in relation to novel technologies will be included within the cardiothoracic e-learning module and the Organ Retrieval Masterclass. It was confirmed that instructions re ceasing the use of T3 have been circulated. A Simon will confirm if and when a trial at Harefield takes place. Manchester now has the go ahead to perform DCD heart retrievals although none have yet taken place. D Manas is to reconvene the liver splitting group in order to address concerns on who undertakes the splitting and the fact that this may disadvantage adult recipients. A possible solution would be to combine the work on developing a national team of mentors for living donation with work on splitting. G Oniscu confirmed that work is ongoing on changing the forms for the donor pathway. The wording re division of the accessory right hepatic artery arising from the SMA has been clarified for the NORS standards. **AP3 Data on Coroner Refusals:** Work is ongoing on adjustments to the report on coroner refusals. **AP4 ODT Hub:** Workshops continue on developments to the system with the involvement of transplant surgeons. **AP5 NORS teams dispatch function:** The use of a flag system to flag the urgency and risk of the donor in order to improve prioritisation is under consideration. J Asher is liaising with the ODT Duty Office on identifying clinicians able to help with work improving the dispatch function. **AP6 NORS Standards Review:** Work is taking place on identifying a core group to begin the review of the NORS Standards. **AP7 Electronic Quality Form Pilot:** Amendment completed. **AP8 Priming of NRP devices with RBC:** On agenda at item 4.3. **AP9 DCD Human Hearts:** On agenda at item 7.1. **AP10 Retrieval of tissues:** Discussions are ongoing with regard to retrieval of new types of tissues during organ retrieval. **AP11 NORS review implementation:** On agenda at item 9.1. **AP12 Annual report on NORS 2015/16:** The quality matrix is to be included in future reports. **AP13 Commissioning performance report:** On agenda at item 9.4. **AP14 Feedback from contract review meetings:** On agenda at item 6.7.	**R Ploeg**
2.3	**Matters Arising – not separately identified**	
	There were no other matters arising.	

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3	**ADVISORY GROUP PRIORITIES** **<u>Bowel</u>** Bowel Advisory Group representative not in attendance. **<u>Cardiothoracic</u>** DCD Hearts: Refer to minute 7.1 below. Scout project: Refer to minute 7.2 below. **<u>Kidney</u>** Neonatal kidney allocation working group: This group, chaired by a KAG lay member, will meet following KAG in December to agree on which centres should transplant kidneys from neonatal donors. Discussion will then take place on who should retrieve these kidneys, ie the lead surgeons from those transplanting centres. J Forsythe highlighted a recent incident where a neonatal block was accepted and subsequently turned down by a centre, was then offered on, transplanted and failed. **<u>Liver</u>** Work on the issue of utilisation is being remodelled as this is too much for a short term working group to take on. There is a need to remind NORS teams with regard to the liver perfusion protocol included in the NORS standards as some teams have developed their own protocol in-house. Other work includes the ways in which data are recorded; and liver splitting protocols. **<u>Pancreas</u>** There is concern that the retrieval of pancreases for islets is seen as less important than for whole pancreas transplant. Accurate assessment of pancreases must be carried out on the back table therefore it is important that retrieval teams follow the policy to remove the pancreas if it has been accepted for transplant. It should be passed to the pancreas implanting team to make the decision on whether the organ is viable. Following notification of an incident involving local deviation from the agreed perfusion policy, R Ploeg agreed to write to NORS Retrieval Teams to remind them of the importance of adhering to the agreed perfusion policies, both abdominal and cardiothoracic. It was recommended that, following a full investigation of the incident, the NORS team involved should be written to separately.	**R Ploeg**

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4	**NHSBT UPDATE**	
4.1	**General Update & New Appointments**	
	Donor characterisation review: The donor characterisation project is continuing, looking at aspects of H & I, microbiology, virology and pathology. **Digital Pathology workforce project:** This is being taken forward with a research proposal by R Cacciola and G Pettigrew. **Donation and retrieval process:** The data is now available to indicate that the pathway for donors, particularly DCD donors, is becoming longer. **Review of ODT website:** NHSBT is looking to upgrade the ODT website, possibly with a password protected area for learning from incidents, including damage at the time of retrieval. Consideration would need to be given on how to ensure centres access this regularly. J Asher highlighted the advantage of a password protected area for the consent process video for families.	
4.2	**Update on RINTAG**	
	G Oniscu reported on key points from RINTAG: A draft policy for organ allocation for research will be implemented based on objective criteria which may need refining. This will be reviewed monthly to check it does not impact on the number of organs being sent for research. A short term working group will be established to look at ways of streamlining the application process for requesting access to organs for research. Consideration is being given to recovering organs not transplanted but which have been consented for research. As QUOD facilitates NHSBT research it has been agreed that proposals tabled at RINTAG should be discussed to see if QUOD can help and support sample collection. QUOD has been awarded sustainable funding until 2020. The plan is to market QUOD to enable more monies to be recouped. In response to concerns expressed by some centres, it has been agreed that recipients should be advised that a biopsy may have taken place on an organ they receive. Any incidents related to QUOD are being monitored and an independent external audit was carried out last year. Any consequences have been reported to the relevant Advisory Groups.	
4.3	**The Use of Bank Blood and Donor Blood for Novel Technologies - NRG(16)21**	.
	G Oniscu reported on a proposal for blood utilisation for ex situ perfusion and preservation technologies at the time of retrieval. Devise strategy for pot risk of clashing. This was designed to prevent any potential competing interests for access to donor blood and establish the need for banked blood products availability at the donor hospital. Members discussed the requirements for the various organs for either bank blood or donor blood in varying situations. G Oniscu agreed to amend the paper to reflect the discussion and forward this to S Tsui to confirm with colleagues the requirements in relation to cardiothoracic organs. This work should also take place in parallel with the NRP protocol currently being developed. The documenting of the use of blood given during NRP or ex-vivo procedures should be included in the NRP protocol	**G Oniscu/ S Tsui**

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	which would need to be approved by MHRA. V Gauden agreed to liaise with G Oniscu, J Dark, S Tsui and N Watkins to take this forward with MHRA. Good communication around the use of NRP or ex-vivo perfusion was highlighted as an essential requirement in the process in order to ensure the correct blood requirement during the retrieval process.	**V Gauden**
4.4	**Paediatric and Multi-visceral Retrieval**	
	A paper is to be submitted to the next meeting of the Senior Management Team, followed by a more detailed paper to Commissioners in January 2017. This will be submitted to the next meeting of NRG in March 2017.	**K Quinn**
4.5	**Data on Coroner's Refusals – NRG(16)22**	
	K Martin presented a paper summarising Coroner/Procurator Fiscal data from April 2013 to 30 September 2016. Induction courses for new coroners now have input from ODT and there is regular liaison between ODT and the Chief Coroner. It was acknowledged that good relationships had been established but there remain pockets of areas with high refusal rates. Within Europe refusal rates are less than 2%; a significant difference between the UK and Europe being that within Europe most coroners have a clinical background whilst within the UK they have a legal background. It was suggested that it would be more appropriate to submit this data to the National Organ Donation Committee rather than NRG in the future. J Forsythe, in his talks with the new Chief Coroner, agreed to ask how NHSBT can help in strengthening their links with organ donation.	**J Forsythe**
4.6	**ODT Hub Update**	
	The new urgent and super-urgent heart allocation schemes went live on 26th October 2016. The ODT Duty Office is now able to register all urgent heart patients on-line and 20 manual steps have been removed from the process. The next priority is to make revisions to the lung allocation scheme, introducing safety parameters within the Duty Office. In addition, work is taking place on first functionality registering on the transplant list for liver transplantation.	
5	**DIGITAL PATHOLOGY WORKFORCE**	
5.1	**Progress Towards Service and Research – NRG(16)23**	
	Since the last NRG meeting the bid for funding to support a digital histopathology project was submitted to NIHR and a decision is awaited. It is hoped to start the project on both kidneys and livers. A protocol for livers is awaited from D Mirza and D Manas agreed to take this up on behalf of LAG. Once approval has been obtained an operational group will be established to agree the processes and protocols required. If the bid is unsuccessful an application will be submitted to the Health Foundation.	**D Manas**
6	**CLINICAL GOVERNANCE**	
6.1	**NORS Standards Review**	
	A review of the NORS standards is due to take place to eradicate duplication and to re-format the document to make it more user-friendly. A core group telecon will take place on 30th November to agree how to structure the process.	

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6.2	**Electronic Quality Form Pilot – Working Group Results**	
	J Asher reported from the working group looking at the collection of improved data without any additional burden for the surgeon. The pilot of the new interface will run side by side with existing paperwork for HTA purposes. Following refinement of the content, consideration will be given as to whether to build the electronic form into the donor path or whether to run this separately, in addition to looking at what paperwork needs to accompany the organ as per HTA requirements.	**J Asher**
6.3	**Proposed Pilot Re Attaching Organ Images to Selected Kidney Offers – NRG(16)24**	
	C Callaghan reported details of a proposed pilot for imaging organs at retrieval (or at decline by implanting centres) and an approach to determine if this could reduce unnecessary organ discard. Due to the fact that imaging all deceased donor organs would be resource intensive the proposal was to target the subset of kidneys first. Draft criteria for imaging deceased donor kidneys had been agreed and this proposal would now be submitted to the Kidney Advisory Group meeting in December for endorsement. Members approved the proposal subject to a check of the Duty Office MPD/SOP on images in relation to MPD1100/2 to ensure that they are consistent and the undertaking of a risk assessment process. Following these checks, and endorsement from KAG, the proposal will be taken forward and a start date agreed.	**E Billingham/ A Sheldon**
6.4	**Pancreas Discard Assessment Project**	
	The project commenced in July for 3 months. Twenty three pancreases have been assessed and an extension to the project has been applied for. All organs assessed are sent to research centres according to priority.	
6.5	**Service Development of NRP/EVLP**	
	G Oniscu reported on slow progress on EVLP and a technical issue with the supplier for NRP. There have been 62 donors in total since NRP started, resulting in 180 organs, 18 of which were hearts, 60% liver utilisation, and 0% ischaemic colangiopathy rate. Included in the service development or at the time of the NRG meeting N=11.	
6.6	**Clinical Governance Report – NRG(16)25**	
	Members noted the retrieval governance report summarising incidents relating to retrieval. A number of the incidents were not strictly surgical as they were either organisational or related to forms or mobilisation. From 1st January 2016 there were 30 incidents related to mobilisation of NORS teams; three donors were lost due to delays/logistical reasons (consent withdrawal) and there was one incident where donor abdominal organs were lost due to no abdominal team being available. Contract review meetings have almost been completed and teams have indicated that the monthly report on organs utilised is highly appreciated. Medical Team members are prepared to support the Duty Office in trying to co-ordinate mobilisation of NORS teams.	
6.7	**Organ Damage Report – NRG(16)26** K Martin reported on a summary of organ damage rates from 1st April 2015 to 30 September 2016. These rates of damage are determined according to organs reported with moderate or severe damage on the HTA-B form by receiving surgeons.	

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	There was unease around considering publishing this data on online due to concerns re validation of the data being reported. It was suggested that NORS teams be asked to give NHSBT, on a monthly basis, summary feedback on their monthly report in order to help validate the data. This could be carried out prospectively over a six month period. This suggestion would be discussed at the next meeting of the Clinical Retrieval Forum together with the proposal to change the description 'severe' to apply only to those organs not transplanted. Members agreed to a suggestion to record damage as part of rebuilding functionality for the electronic quality form and to add an automatic email to the retrieval surgeon or Centre Director to allow investigation in real time. It was acknowledged, however, that this suggestion could not yet be implemented due to IT restrictions. Grading of the organ by both the retrieval and the implanting team would enable early identification of any problem and allow better evaluation of the service each NORS team is providing. The use of imaging would only enhance this service. It was agreed that the above issues should be raised at the next meeting of the Clinical Retrieval Forum. The issue of who should report any damage identified and how this should be acted upon should also be taken up with NORS teams at their regular meetings. S Tsui agreed to respond to K Martin outside the meeting on the question of reporting of lung pairs.	**R Cacciola** **R Cacciola** **S Tsui**
7	**UPDATE ON CLINICAL DEVELOPMENTS**	
7.1	**DCD Human Hearts**	
7.1.1	**Clinical Progress**	
	Twenty eight transplants of hearts from DCD donors have taken place in the UK (23 at Papworth and 5 at Harefield). Twenty seven recipients survived beyond 30 days and 26 survived beyond 90 days.	
7.2	**Update from External Scout Review**	
	Scout project: An external review of the project was convened on 12th/13th September with most stakeholders involved. The final report of the review is awaited pending the recommendations by the external reviewers and will be circulated when received.	
8	**WORKFORCE TRANSFORMATION AND TRAINING**	
8.1	**Perioperative Training Progress**	
	Introduction of the joint scrub nurse role as part of the NORS Workforce Transformation project has been delayed by up to 18 months in order to identify ways in which this could be introduced safely. A simulation exercise was undertaken in June in Edinburgh with one scrub nurse supporting both the abdominal and cardiothoracic teams working together with one set of instruments. The simulation focussed on standardisation of instrumentation and principles and there were serious concerns regarding the safety of the role for DCD donation. A further simulation to test practical approaches for DBD and DCD retrievals using the joint scrub nurse will take place imminently at Cambridge. There is, as yet, no evidence as to how this would work if new or novel technologies are involved. The next step will be to use evidence generated from the simulations as the basis for a practical SOP for two vanguard teams (Northern & Eastern) which will test the shared scrub nurse role in real life situations roles and collect data to evaluate after 6 months.	

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	A competency framework has been developed to support all peri-operative staff and has been circulated to all NORS teams. Training includes the development of an e-learning programme, attendance at the Organ Retrieval Masterclass in December; and a training pack to support delivery of training at a local level There are concerns from NORS teams on the value of this move on two points: - there is a perception within abdominal teams that this is a role within their team and within some cardiothoracic teams the scrub nurse acts as the assistant surgeon as they struggle to recruit to this role. - Peri-operative team members have concerns that this would make the role less attractive and create issues with recruitment and retention.	
8.2	**Instrument and Consumables Core Set – NRG(16)27**	
	Following feedback from NORS teams a standard instrument kit for abdominal and cardiothoracic retrieval has been identified. It is anticipated that, subject to a satisfactory trial, the costs of the instruments will be met by NHSBT via a tendering exercise. NRG members endorsed the proposed list which will be trialled via the vanguard teams. A similar exercise to that for the instrumentation list is planned in order to establish a standard set of consumables.	
8.3	**Organ Retrieval Masterclass 2016**	
	For the first time this year peri-operative staff will take part in the Organ Retrieval Masterclass which will take place on 12th & 13th December in Bristol. Members were asked to encourage applications from NORS team members. This would also be highlighted at the forthcoming Clinical Retrieval Forum.	
8.4	**French and Belgian Interest in Training**	
	R Ploeg reported on growing interest from overseas, including from ROI, in the UK Organ Retrieval Masterclass. The event is subsidised by NHSBT and priority is given to members of UK NORS Retrieval Teams. Due to the cancellation of the ESOT Masterclass held in Leiden it was agreed that up to 5 overseas attendees could be accommodated at the UK event.	
8.5	**Update on E-Learning Training Tools**	
	The cardiothoracic e-learning tool is now in place. Surgical representatives from the UK will need to meet with representatives from the Netherlands to review the different e-learning components to ensure they are self-sustaining and self-supporting going forward. The development of an e-learning module for peri-operative staff is also underway.	
9	**COMMISSIONING**	
9.1	**NORS Demand and Capacity – NRG(16)28**	
	A paper proposing methods of monitoring NORS teams' activity, key principles that will trigger a review and an outline process of addressing capacity was received for consideration. It was agreed that the activity data for part-time teams should be shown as independent centres. Members considered the principles for triggering a review and the review process itself. Recommendations: • NORS teams that are busy, or alternatively inactive, for at least 70% of	

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	their time on call for three successive quarters will trigger a review. • Geographical location of donors will inform where the increases/ decreases in capacity will occur. • Cost/benefit analysis will be undertaken before changing capacity. • Loss of donor due to insufficient NORS capacity will trigger a review. Following discussion it was agreed that E Billingham, R Cacciola and K Martin would liaise to decide on what information is required to agree the key principles for NORS review criteria. If required, further representation would be sought via the Clinical Retrieval Forum. D Manas agreed to work with J Gilbert to produce a position paper on future transplant posts.	**R Cacciola/ E Billingham/ K Martin** **D Manas**
9.2	**Delays at Donor Hospitals – NRG(16)29**	
	In response to concerns at contract meetings about delays at donor hospitals, the Commissioning Team's monthly performance reports now include a quarterly breakdown of delays incurred by abdominal and cardiothoracic teams at both DBD and DCD donors. A report giving more information on the reasons for the delays was shared with NRG but due to the small numbers involved it was difficult to draw any conclusions. Following a Rapid Improvement Event changes are to be made to the process of co-ordinating and mobilising NORS teams which it is hoped will have a positive impact on delays. The Commissioning Team will continue to monitor performance via the monthly performance reports,	
9.3	**Feedback from Rapid Intervention Event Despatching NORS Teams – NRG(16)30**	
	A Rapid Improvement Event was held in October to review the ODT flight sourcing and booking process. The event looked at the most efficient and effective way to organise flights for the transport of teams and of organs. A mixture of short and longer term actions arose from the meeting which should provide an improvement to the flight booking process. Members agreed on the need for a new algorithm in order to help the Duty Office to have the oversight which was agreed. Input from NORS leads, both abdominal and cardiothoracic, is needed in order to work with NHSBT to identify triggers and help develop the algorithm. NRG agreed to provide details of a small group of individuals to help develop the algorithm.	**E Billingham/ K Quinn/ R Cacciola/ R Ploeg**
9.4	**Commissioning Performance Report – NRG(16)31**	
	Members noted for information the Commissioning Performance Report for the reporting period August 2016.	
9.5	**Progress on Commissioning Contract**	
	This contract is with the contracts team and the aim is to get this to centres for consultation within the next few weeks with a view to being formally signed off in December 2016.	
9.6	**Update on Republic of Ireland**	
	J Forsythe reported that a retrieval team from the Republic of Ireland was now the first on-call team for abdominal retrievals in Northern Ireland. This process is entirely disassociated from allocation except where organs from ROI cannot be placed in the Republic and are offered to the UK.	

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10	**ANY OTHER BUSINESS**	
	Discussions are taking place with the Human Tissue Authority on the licensing requirements in relation to the possibility of NORS teams retrieving windpipes. Further details will be reported to NRG in due course.	
11	**Dates for 2017 Meetings:** Wednesday, 29th March – Chartered Institute of Arbitrators, London Wednesday, 12th July – Association of Anaesthetists, London Wednesday, 8th November – London venue tbc	

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