Approved 26/04/17 **CTAG L(M)(16)2**

NHS BLOOD AND TRANSPLANT
ORGAN DONATION AND TRANSPLANTATION DIRECTORATE

THE EIGHTH MEETING OF THE NHSBT CTAG LUNG ADVISORY GROUP ON FRIDAY 14TH OCTOBER 2016, 15:00 – 17:00 AT THE ROYAL COLLEGE OF ANAESTHETISTS, CHURCHILL HOUSE, 35 RED LION SQUARE, LONDON, WC1R 4SG

PRESENT: Mr S Tsui, **Chair**
Dr M Al-Aloul, Cardiologist, Wythenshawe Hospital, Manchester
Mr N Al-Attar, Surgeon, Golden Jubilee Hospital, Glasgow
Ms T Baker, Transplant and Divisional Support Manager, Harefield Hospital
Dr M Carby, Chest Physician, Harefield Hospital
Dr V Carter, BSHI Representative, Newcastle
Mr S Clark, Surgeon, Freeman Hospital, Newcastle
Prof J Dark, National Clinical Lead for Governance, ODT
Mrs J Nuttall, Recipient Co-ordinator Lead, Wythenshawe Hospital, Manchester
Dr J Parmar, Chest Physician, Papworth Hospital, Cambridge
Mrs K Quinn, Assistant Director, UK Commissioning (part meeting)
Miss S Rushton, Statistician, Statistics and Clinical Studies, NHSBT
Dr R Thomson, Cardiologist, Queen Elizabeth Hospital, Birmingham
Mr R Venkateswaran, Surgeon, Wythenshawe Hospital, Manchester
Ms L Waite, Deputy for Ms L Logan, Regional Manager, Organ Donation Services, ODT
Ms S Watson, Commissioner, NHS England
Miss E Wong, Statistician, Statistics and Clinical Studies, NHSBT

IN ATTENDANCE:
Miss L Newman, Clinical & Support Services, ODT
Mrs K Zalewska, Clinical & Support Services, ODT

APOLOGIES: Mr J Asher, Clinical Lead – Medical Informatics (ODT)
Dr N Banner, Cardiologist, Harefield Hospital, Middlesex
Dr M Burch, Cardiologist, Great Ormond Street Hospital, London
Prof J Forsythe, Associate Medical Director, ODT
Prof S Fuggle, Scientific Advisor, ODT
Mr B Hume, Assistant Director TSS, ODT
Dr E Jessop, Medical Adviser, NHS England
Ms S Johnson, Director of Organ Donation and Transplantation
Mr M Knight, Lay Member Representative
Dr C Lewis, Cardiologist, Papworth Hospital
Dr S Lewis, Acting Medical Director, Welsh Health Specialised Services
Ms L Logan, Regional Manager, Organ Donation Services, ODT
Dr P Mangat, Acting Medical Director, Welsh Health Specialised Services
Mr J Mascaro, Surgeon, Queen Elizabeth Hospital, Birmingham
Mr J McGuinness, Surgeon, Mater Misercordiae University Hospital, Dublin
Dame J McVittie, Lay Member Representative
Mr N Muthialu, Surgeon, Great Ormond Street Hospital (Deputy for Dr H Spencer)
Ms K Redmond, Surgeon, Mater Misercordiae University Hospital, Dublin
Dr Z Reinhardt, Freeman Hospital, Observer
Mrs C Riotto, Recipient Transplant Co-ordinator Representative, Papworth Hospital
Ms D Russell, General Manager, Harefield Hospital, Observer
Ms A Sheldon, Head of Referral & Offering, ODT
Mr A Simon, Clinical Lead for Organ Utililsation, Harefield
Dr H Spencer, Surgeon, Great Ormond Street Hospital
Mr M Stokes, Duty Office Services Manager, NHSBT
Ms H Tincknell, Lead Nurse, Recipient Co-ordination

Dr J Townend, Cardiologist, Queen Elizabeth Hospital, Birmingham
Dr C Wheelans, NSD Scotland (Deputy for Dr M Winter)
Dr M Winter, (NSD) National Services Division - Scotland

	Apologies and welcome	**Action**
1	**DECLARATIONS OF INTEREST IN RELATION TO THE AGENDA – CTAG(16)L9** There were no declarations of interest in relation to the agenda	
2	**MINUTES OF THE MEETING HELD ON WEDNESDAY 13TH APRIL 2016 - CTAG L(M)(16)1**	
2.1	**Accuracy** The minutes were approved as a correct record	
2.2	**Action points – CTAG L(AP)(16)1** **AP1 – Collection of data on the use of EVLP** There were no further comments so the dataset agreed last time will be used. **AP2- Clinical Governance report** A further incident occurred recently when, based on the retrieval surgeon's interpretation of an x-ray en route to the retrieval, a decision was made to recall the retrieval team. The decision should not have been made on the x-ray alone. Having images available should be a standard of care. DBD donors can be scouted, but for DCD donors, echo and bronchoscopy are undertaken by agreement with the ICU. It was suggested that NODC be asked to consider making x-ray and bronchoscopy part of the minimum dataset on EOS. **AP3- Clinical Evaluation of EVLP Pilot** Refer to minute 5 below. **AP4- Statistics and Clinical Studies report – prolonged lung registrations** Recommendation was made during the Heart meeting that S Rushton would look at how best to do this once the urgent allocation schemes have been implemented. **AP5- Updated post-lung transplant survival models** S Rushton will look at how to take these models forward. **AP6- Lung selection and allocation policies – review of current policies** J Forsythe updated the group on UK/ROI discussions during the Shared section. **AP7- Paediatric lung allocation issues** The group convened and agreed a single national paediatric lung waiting list. S Tsui to clarify what was agreed and then liaise with J Dark to submit a proposal to TPRC. **AP8- Audit of components of ischemia in lung transplantation** S Tsui has liaised with E Billingham and C Callaghan regarding this. **AP9- Any other business – zipped files to be avoided when sending papers to members** Completed	**S Tsui** **J Dark**
2.3	**Matters arising, not separately identified** There were no matters arising that were not separately identified	

3	**GOVERNANCE ISSUES**	
3.1	**Non-compliance with lung allocation** There were no instances of non-compliance to report.	
3.2	**Lung incidents for review** There were issues identified and raised by the tissue bank around some pulmonary valve homograft as they have found a suture on the pulmonary trunk where it has been cannulated for the delivery of Perfadex. This is necessary when donor lungs are being retrieved for transplantation. J Dark will write to A Chandrasekar to clarify these details. An item to be raised at CRF will be that when the abdominal teams are retrieving cardiothoracic organs, they must leave a long pulmonary artery. The instruction sheet will be sent out again as a reminder. J Dark reported on an incident involving a patient who had received previous cardiac surgery and who was considered as a potential DCD donor. Both the retrieving and implanting surgeons felt that in this case, additional warm ischemia time would rule out use of the lungs. However, senior surgeons reassessed and felt that a 60 minute ischemia time would have been acceptable and the lungs should have been used. This is the type of information which could be disseminated in a 6 monthly newsletter, as discussed in the heart section. S Tsui proposed establishing a sub-group of CTAG to consider all aspects of the pathway. S Tsui agreed to consider the suggestion that the CTAG meetings should be split over two days to allow more time to consider items.	**J Dark** **S Tsui**
3.2.1	**Clinical Governance report – CTAG(16)L10**	
3.3	**Summary of CUSUM monitoring of outcomes following lung transplantation – CTAG(16)L11** There were no signals in the last 6 months.	
3.4	**QUOD Specimen Report** The QUOD paper will be circulated after the meeting as per the heart QUOD paper. The proposal is that research BAL is undertaken in every donor attended by a cardiothoracic NORS team. Even when the lungs are turned down, retrieval teams should always take the bronchoscope with them. For DBD donors the BAL can be undertaken by the Scout and for DCD, this can be carried out at the point of lung re-inflation. Samples will be sent to the QUOD centre for processing. A recipient information sheet will be produced to give information to the recipients. Following discussion, there was unanimous support for this. Reimbursement for disposables for cardiothoracic retrievals is the same for the heart and the lungs, which includes re-sterilisation of the bronchoscopes. Comments should be returned to J Dark by the 31st October in order for him to summarise to take to QUOD on 21st November.	**Clinical Reps**
4	**Report from Chair – CTAG(16)L13** There were no specific lung issues to report.	
5	**Clinical Evaluation of EVLP Pilot** There have been no EVLP since April in Newcastle or Birmingham. Funding is	

	available from NHSBT for any completed before April 2017	
6	**Update on Super Urgent Lung IT Project** The update was given during the Shared section of the meeting. The urgent and super urgent lung allocation schemes will be implemented in early 2017. Clear information will be given on the registration process for patients when the changes are introduced and the registration forms will be issued to centres three weeks prior to the go-live date. There was discussion around the lack of funding for bridging to lung transplant. The super urgent system needs to be in place prior to any request for BTT commissioning. J Parmar raised this question when the Transplant Service Specification was out for public consultation. S Watson clarified that this comment was removed as BTT would be service developments and the service specifications document what is currently commissioned. The exercise to refresh the service specifications in 2016 was to split the single cardiothoracic transplant service specification into two separate documents. M Al-Aloul commented that a scoping exercise to assess how many patients across each of the five centres would be referred as super urgent or urgent patients (19 of 120) as these patients may be eligible for mechanical support as a bridge to transplant. In 2014 centres were advised that there was no plan to commission ECMO as a bridging procedure. Centres are commissioned to complete salvage respiratory ECMO with a view to having these patients repatriated to their own hospitals and not as a bridge to transplant.	
7	**Submission of UK DCD Lung Data to ISHLT** Work is in progress to bridge the gap between the data collected by NHSBT and that collected by ISHLT.	**J Dark**
8	**STATISTICS AND CLINICAL STUDIES REPORT**	
8.1	**UK Fast Track Scheme: Lungs – CTAG(16)L14** The Fast track scheme is not used excessively, with only 6% of retrieved lungs fast tracked during the past two financial years; however it does yield extra lungs that were transplanted. In contrast to hearts, many of these were in poor condition or from donors with poor health. This underlines the fact that different centres may decline organs for differing reasons, but this should be easier to monitor moving forward with the new Grading of Retrieved Donor Lungs document.	
9	**Any Other Business** J Dark reiterated his request to consider splitting the CTAG meeting over 2 days.	
10	**Dates of 2017 meetings:** Wednesday 26th April 2017 – 10am-12 noon, London Venue TBC Wednesday 13th September 2017 – 3pm-5pm, London TBC	