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

NHS BLOOD AND TRANSPLANT
ORGAN DONATION AND TRANSPLANTATION DIRECTORATE

THE SEVENTH MEETING OF THE NHSBT CTAG SHARED ISSUES MEETING ON FRIDAY 14TH OCTOBER 2016, 12:30 – 14:45 AT THE ROYAL COLLEGE OF ANAESTHETISTS, CHURCHILL HOUSE, 35 RED LION SQUARE, LONDON, W1CR 4SG

PRESENT: Mr S Tsui, **Chair**
Dr M Al-Aloul, Cardiologist, Wythenshawe Hospital, Manchester
Mr N Al-Attar, Surgeon, Golden Jubilee Hospital, Glasgow
Dr N Banner, Cardiologist, Harefield Hospital, Middlesex
Ms T Baker, Transplant and Divisional Support Manager, Harefield Hospital
Dr M Burch, Cardiologist, Great Ormond Street Hospital, London
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
Prof J Forsythe, Associate Medical Director, ODT
Mr B Hume, Assistant Director TSS, ODT
Ms S Johnson, Director of Organ Donation and Transplantation (Part meeting)
Mr M Knight, Lay Member Representative (Part meeting)
Dr C Lewis, Cardiologist, Papworth Hospital
Mr J Mascaro, Surgeon, Queen Elizabeth Hospital, Birmingham
Mr J McGuinness, Surgeon, Mater Misercordiae University Hospital, Dublin
Mrs J Nuttall, Recipient Co-ordinator Lead, Wythenshawe Hospital, Manchester
Dr J Parmar, Chest Physician, Papworth Hospital, Cambridge
Ms K Quinn, Assistant Director, UK Commissioning, ODT
Miss S Rushton, Statistician, Statistics and Clinical Studies, NHSBT
Dr R Thomson, Lung Physician, 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
Dr C Wheelans, NSD Scotland (Deputy for Dr M Winter)
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 A Reed, Harefield Hospital
Prof S Fuggle, Scientific Advisor, ODT

Dr E Jessop, Medical Adviser, NHS England
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
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 Utilisation, 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 M Winter, (NSD) National Services Division - Scotland

	Apologies and welcome	**Action**
1	**DECLARATIONS OF INTEREST IN RELATION TO THE AGENDA – CTAG(16)S18** There were no declarations of interest in relation to the agenda	
2	**MINUTES OF THE MEETING HELD ON WEDNESDAY 13TH APRIL 2016 - CTAG S(M)(16)1**	
2.1	**Accuracy** The minutes of the last meeting were agreed as a correct record subject to the following change: Section 3.3: '*The proposal arose from investigation of an incident which highlighted the differences between Health Boards in Scotland resulting in the parties involved blaming others rather than learning from the experience' to be changed to reflect the conversation more accurately*' to be amended to read: '*The proposal arose from investigation of an incident which highlighted the differences between Health Boards in Scotland resulting in the parties involved being unable to determine where responsibility or the governance around the issue lies*'	**L Newman**
2.2	**Action points** – **CTAG S(AP)(16)1** **AP1 –** There are concerns over the percentage of data points from retrieval services that are missing. S Tsui proposed that this issue be shelved for the time being to be reviewed again at a later date. **AP2 – ODT Hub Update** The HUB update will follow later in the meeting at item 4.1 (CTAG(16)S20). **AP3 – Service Specifications** S Watson spoke to clinical reps re the public consultation. This work has been completed and is in the process of being published separately. **AP4 – Summary of heart/lung transplants** No feedback or additional comments received. **AP5 – Update by Clinical Lead on Organ Utilisation** The panel of reasons for declining organs has been revised to create a more concise list and will be attached with the Centre Directors Core Telecon Minutes Item 9.2 CTAG(16)S30. (L Newman to circulate) **AP6 – Changes to the Fast Track Scheme** For clarity, the Fast Track Scheme operates on a first come first served basis **AP7 – Offering times** Changes to the offering times will be monitored following implementation of	**L Newman**

	the urgent and super urgent policies.	
2.3	**Matters arising, not separately identified** There were no matters arising that were not separately identified.	
3	**ASSOCIATE MEDICAL DIRECTORS REPORT**	
3.1	**Developments in NHSBT**	
3.1.1	**New appointments** J Forsythe congratulated Dr N Banner and Prof S Clark on their reappointments as deputy chairs of CTAG (Hearts) and CTAG (Lungs) respectively.	
3.2	**Governance issues** Governance issues will be reported during individual Heart and Lung Sections and removed from the Shared agenda.	**L Newman**
3.2.1	**Peer Review** J Dark raised centres' concerns about the prospect of Peer Review being able to tackle the problems faced by centres due to the inability to link pressure on services at local level with any increase in funding. Although this has been flagged at a national level, there appear to be no means to resolve this. S Watson agreed to feed back the comment to the Peer Review team.	**S Watson**
4	**ICT Update – CTAG(16)S19** B Hume reported on work taking place to rebuild the National Transplant Database, looking at specific organs in turn. Good progress has been made with heart allocation and the software was developed by the end of September to go into its final testing phase. All centres need to revalidate their waiting lists. The Duty Office will receive one week of intensive training on the new system before it goes live to all centres on 26/10/16. Recently the Donor Pathway was implemented which enables the SNOD to assess donor suitability at the front end and removes about 20-40 steps in the process which were completed by the Duty Office or the SNOD. The combination of new software will improve and centralise the offering of hearts. The new system for lungs should go live between January and March 2017.	**Centre Directors**
4.1	**ODT Hub Update – CTAG(16)S20** See minute 4 above for the full ICT update.	
4.2	**Cardiopulmonary allocation policies implementation plan** See minute 4 above for the full ICT update.	
5	**External Review of Scout Project** Phase One of the Scout Project took place in 2013/2014 and Phase Two during 2015/2016. There were some difficulties with interpreting the results and External Review took place in London four weeks ago. Two external reviewers were involved and all the service providers were involved together with other stake holders. A draft report is in progress and will be shared as soon as it is available.	

6	**NORS Review implementation – CTAG(16)S22** The NORS review has been implemented and is working well to date. Three on call teams are active at any given time. In addition, there have been two occasions when a fourth team was deployed; one of those occasions was today for Harefield. This is an example of good practice, as Harefield wanted to implant as well as retrieve. The on call team that should have gone were the Glasgow team. By utilising the local team who were available at the time, the scheme saved on flight cost. Teams are busy, but as yet no team has triggered the 70% activity rate so there has been no need for additional capacity. E Billingham has been working extensively on this project with the Duty Office, looking at smarter utilisation of the teams to reduce costs. One outstanding action from the NORS Review is to look at the shared Scrub Nurse function. S Tsui reported that in the first quarter there were no donors lost from withdrawal of consent due to delays in either process or travel. Going forwards, NRG will monitor this data every 6 months R Venkateswaren commented that cardiothoracic transplants used to be carried out during the early hours to prevent disruption to theatres; however, delays within the whole process are starting to impact on the usual business for the donor and recipient hospitals. S Tsui is aware that day time retrievals and transplants has been increasing over the past two years. J Forsythe added that a review of timings throughout the whole process is taking place to establish why the intervals between donation and retrieval have increased. M Burch thanked NORS for the paediatric element agreed following the review, commenting that it has transformed the service. It had been suggested that this was only confirmed until 31/03/17. K Quinn said that this is likely to continue if working well. Since the NORS Review, there have only been four incidents reported in this quarter where the team was mobilised too early and spent between four and seven hours in hospital. One example was the Duty Office not knowing which teams were available and three cases where a SNOD made the call too early. K Quinn discussed this with the ODT Commissioning Team yesterday and E Billingham will submit a paper to NRG to review the order in which teams are mobilised. The new allocation of donor hearts, going live on 26th October, should also help reduce potential delays in future.	**E Billingham**
6.1	**Potential Cardiothoracic Retrieval KPI Outcome Variables – CTAG(16)S23** S Tsui introduced the Cardiothoracic Retrieval KPIs which will measure quality across the National Organ Retrieval Service using outcomes such as primary graft failure or poor function when a recipient requires mechanical support within 30 days after transplantation and short-term patient survival. J Mascaro asked how to differentiate between the NORS and the implanting team affecting outcomes as the measurements here show only how the retrieval team is performing. Surgeons commented that they would like to	

	know whether the organs they retrieve are accepted. C Wheelans also thought that survival following transplant has more to do with the recipient team than the quality of NORS. J Dark reported on behalf of Working Group 3 that C Callaghan and E Billingham worked on the key performance indicators for all retrieved organs. There was a strong view that it would be wrong not to know the outcomes of organs retrieved by individual NORS teams. The 30 day funnel plot is already risk adjusted. S Rushton will look at risk adjusted outcomes. S Tsui confirmed that whichever monitoring tool is used, there will be flaws. Organ and recipient outcomes only form part of the KPIs. Other measures will include dispatch times for organs. J Forsythe suggested obtaining the crude data and then refining it. This would need to be monitored and data gathered should be submitted to NRG and CTAG. Complete recipient data is available but not complete donor data, risk adjustment can take place on recipient survival.	**S Rushton** **S Rushton**
7	**Applications for data – approval process – CTAG(16)S24, CTAG(16)S24.1, CTAG(16)S24.2** At present, the CTAG Clinical Audit group monitors all requests for data from the NHSBT Transplant database. J Dark submitted a proposal to enable a pre-prepared dataset to be made available without having to apply to the CTAG Clinical Audit group. . This process is in place for liver data and is being established for kidney data. N Banner chairs the CTAG Clinical Audit Group and provides a report on its activities every 6 months. This includes any requests for data and the Group's decision. It serves to avoid duplication of requests. Usually, the turn round time for requests is not protracted and many CTAG Audit Group members spoke out against a change in the system. S Tsui asked S Rushton to establish whether there has been a surge in requests for these data. N Banner will monitor requests for access to CTAG datasets over the next six months and report how many requests were received and the duration from the data application being received to a decision being finalised. If there are significant delays which are impacting on research or a project then the situation can be reviewed. At this point the group felt that the proposal should be put on hold pending review at a later date.	**S Rushton** **N Banner**
8	**STATISTICS AND CLINICAL STUDIES REPORT**	
8.1	**Summary from Statistics and Clinical Studies – CTAG(16)S25** Refer to paper – CTAG(16)S25	
8.2	**Summary of heart/lung transplants – CTAG(16)S26** E Wong explained that the overall average waiting time from registration on the waiting list to transplantation is two years. Papworth carried out 14 heart lung transplant (HLT), all but one of whom survived. Eight HLT were carried out elsewhere, three of those recipients sadly died. Members were asked if they felt it was appropriate for centres carrying out	

	infrequent heart-lung transplants to continue to undertake them. R Venkateswaran confirmed that Manchester had carried out three HLT in the past 18 months; all three recipients survived. S Tsui congratulated Manchester on their successes. Each centre will review their own approach to heart lung transplantation.	
8.3	**Zonal Activity – CTAG(16)S27** Refer to item 8.4.	
8.4	**Allocation zonal boundary changes – CTAG(16)S28** Two papers were presented on zonal activity, one showing differences in within/out of allocation zone activity across centres and one showing that the proportion of registrations and donors across zones is significantly different, for both hearts and lungs. However, since separate allocation zones for hearts and lungs are being implemented shortly, boundaries for the current heart/lung allocation zone will not be adjusted this year to avoid confusion Within the zonal allocations the system is set up to try to ensure that centres registering higher numbers of patients are offered a higher percentage of donor organs. Zones will be used for all tiers of heart offering but not for urgent and super-urgent lung offering because ischemia time for the heart is much more detrimental compared with that for the lungs. The new NORS rota will have no effect on ischaemia times as it does not alter donor organ allocation.	
9	**REPORT FROM CHAIR**	
9.1	**CTAG/BTS Clinical Trials meeting – CTAG(16)S29** The second CTAG Clinical Trials meeting took place on 30 June 2016, represented by all but one centre. Minutes to be circulated by L Newman. These meetings will continue on a 6-monthly basis.	**L Newman**
9.2	**Report from CTAG Core Group teleconference – CTAG(16)S30** There have been three Centre Directors' telecons since the last CTAG meeting and minutes have been circulated. L Newman to circulate to the rest of the CTAG Wider Group. The proposed new Grading System for Donor Organs was accepted by all centre directors. R Johnson is updating the forms. This is a better way of assessing organ quality than the damage report, and could be used as a KPI once established. Working Group 3 were keen to adopt a similar grading system for abdominal organs too. J Asher is developing an electronic system to allow the recording of grading of organs. M Al-Aloul advised that training would need to be standardised otherwise less experienced surgeons may grade organs differently. This will be covered at the Organ retrieval Masterclass, and also during the training and accreditation process. M Carby raised that there will still be variable grading from surgeons which will need to be monitored for quality. If any donor organ is less than perfect, the retrieval surgeon will be expected to call the recipient team to report Implanting surgeons will also need to record the quality of the information	**L Newman** **R Johnson**

	provided by the retrieval surgeons in addition to the quality of the organ. N Banner commented that when there are problems, an organ will be turned down. S Clark explained that this is why eLearning is included in the training and accreditation process, but communication will also need to be included in the quality assurance process. S Tsui requested that the draft feedback form is circulated for comment about quality of information and communication. Reasons for declining organs are now listed as four categories, each with six to eight reasons for decline. These also need to be circulated.	**L Newman**
9.3	**CTAG Advisory Group Workplan – CTAG(16)S31** There have been no changes, please let S Tsui know of items to be raised at future meetings.	**Clinical Reps**
9.4	**Justification for allocating cardiothoracic organs by age/Use of age of height weight criteria in policies** Age is used as a cut off criterion for the allocation of hearts and lungs, which contravenes the overarching transplantation policy for NHSBT. If CTAG wishes to continue using age as a cut-off criterion then this needs to be justified using clinical reasons. Some other organ policies do include age, but not as a cut-off criteria. It was commented that size matching should be done by height and or weight. S Tsui asked J Dark and M Burch to take this discussion back to their teams before a decision is made as to whether age is retained as a factor or a consideration. Any changes will need to be reviewed by TPRC , so development of the new SUHAS and revised UHAS should continue as planned. Comments from Newcastle and GOSH to be submitted to S Tsui by 30th November 2016 prior to initiating the review process.	**J Dark** **M Burch**
9.5	**National Cardiothoracic Transplant Fellowship** A third fellowship has been funded and appointed in Manchester. The Papworth fellow will complete training by November and has been appointed to a locum consultant post in Glasgow. Funding has already been granted to re-appoint another national fellow to Papworth. The Cardiothoracic Lead Dean Professor Simon Plint is retiring. S Clark will continue to highlight to the SAC and the new Dean the importance of maintaining the national fellowship scheme. Cardio Solutions has kindly donated £12K to support the 3 national post-holders for education related to mechanical circulatory support. S Tsui thanked Professor Clark for his efforts in securing this valuable resource.	**S Clark** **R Venkateswaran**
10	**Update by Clinical Lead on Organ Utilisation** Item deferred in the absence of A Simon.	
11	**UPDATES FROM OTHER MEETINGS**	
11.1	**Cardiothoracic Patient Group Update – CTAG(16)S32** The last CTAG Patient Group meeting was held on 9th May and was attended by patients from all centres as well as patient charities. The next Patient Group Meeting is scheduled on 17th November 2016 in London and	**All CTAG**

	all members of the CTAG wider group are welcome. Members were asked to contact Lucy Newman for venue and timings if they would like to attend.	**Members**
11.2	**CTAG Clinical Audit Group Chairs Report – CTAG(16)S33** N Banner summarised items from the report	
11.3	**QUOD Update** R Venkateswaran reported that Manchester University had requested donor heart samples and confirmation was awaited as to whether they were seeking biopsies or another type of sample. Once a response has been received R Venkateswaran will confirm the exact requirements to J Dark.	**R Venkateswaran**
12	**TRAINING**	
12.1	**Cardiopulmonary retrieval training/certification** S Clark reported that new EMS approval is being sought for use of the UK training and accreditation scheme throughout Europe. There was further discussion about whether to include the control of bleeding with NRP as part of eLearning. This is at the initial enquiry stage at present, and additional costs are being looked at. The aim in the future is to include other members of the team in the training to improve their experience.	
13	**FOR INFORMATION ONLY**	
13.1	**Transplant Activity Report: February 2016 – CTAG(16)S34** The report was noted for information purposes.	
14.2	**Update on Patient Consent Scheme – CTAG(16)S35** The report was noted for information purposes.	
14	**ANY OTHER BUSINESS** N Al-Attar will be hosting the next CQUIN meeting in Glasgow; the proposed date is Friday 15th September 2017. T Baker confirmed that the CQUIN Meeting will now be known as The Annual Clinical Meeting as no CQUIN payment will be linked to future meetings.	
15	**Dates of 2017 meetings:** Wednesday 26th April 2017 – 12.30pm-2.45pm, London Venue TBC Wednesday 13th September 2017 – 12.30pm-2.45pm, London TBC	