NHS BLOOD AND TRANSPLANT
ORGAN DONATION AND TRANSPLANTATION DIRECTORATE
THE THIRTEENTH MEETING OF THE NATIONAL RETRIEVAL GROUP (NRG)
HELD ON WEDNESDAY 1ST JULY 2015, FROM 10:30 UNTIL 15:00 AT
MSE MEETING ROOMS, OXFORD STREET, LONDON

PRESENT:
Rutger Ploeg National Clinical Lead for Organ Retrieval (Chair)
Karen Quinn Assistant Director – UK Commissioning, NHSBT (Co-Chair)
Emma Billingham Senior Commissioning Manager, NHSBT
Roberto Cacciola Associate National Clinical Lead for Organ Retrieval, NHSBT
John Dark National Clinical Lead for Governance, NHSBT
Ben Hume Transplantation Support Services Representative (Part meeting via telecon)
Paul Murphy National Clinical Lead for Organ Donation, NHSBT
Derek Manas Liver Advisory Group Surgical representative
Dave Metcalf Finance Directorate, NHSBT
Sally Rushton Statistics & Clinical Studies, NHSBT
Catherine Slater Quality Assurance Manager, NHSBT
Steven Tsui Cardiothoracic Advisory Group Chair
Chris Watson Kidney Advisory Group Chair
Fiona Wellington Head of Operations for Organ Donation, NHSBT
Julie Whitney SNOD Representative, NHSBT
Claire Williment Head of Transplant Development, NHSBT
Chris Callaghan National Clinical Lead for Abdominal Organ Utilisation, NHSBT

IN ATTENDANCE:
Christopher Bowles Harefield Hospital
Stephen Large Papworth Hospital
Simon Messer Papworth Hospital
Linda Hall Clinical & Support Services, ODT

<table>
<thead>
<tr>
<th>Item</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WELCOME AND APOLOGIES</strong></td>
<td></td>
</tr>
<tr>
<td>Representatives from Harefield and Papworth were welcomed to today’s meeting.</td>
<td></td>
</tr>
<tr>
<td>Apologies were received from:</td>
<td></td>
</tr>
<tr>
<td>• Rachel Johnson, Head of ODT Studies, NHSBT</td>
<td></td>
</tr>
<tr>
<td>• Ian Currie, NORS Retrieval Teams Representative</td>
<td></td>
</tr>
<tr>
<td>• Peter Friend, Pancreas Advisory Group Representative</td>
<td></td>
</tr>
<tr>
<td>• Darius Mirza, Bowel Advisory Group Representative</td>
<td></td>
</tr>
<tr>
<td>• Ella Poppitt, SNOD Representative (Fiona Wellington attending in her place)</td>
<td></td>
</tr>
<tr>
<td><strong>1 DECLARATIONS OF INTEREST – NRG(15)14</strong></td>
<td></td>
</tr>
<tr>
<td>1.1 There were no declarations of interest.</td>
<td></td>
</tr>
</tbody>
</table>
## 2 MINUTES OF THE NATIONAL RETRIEVAL GROUP MEETING HELD ON 13th FEBRUARY 2015 – NRG(M)(15)1

### 2.1 Accuracy

The minutes of the previous meeting were agreed as an accurate record. The following was noted:

- **Action Point 9:**
  
  Signing of HTA A Forms – this issue still needed further clarity regarding the responsibility for HTA A forms sign-off. The issue was raised due to livers having to wait until the form is signed. There appeared to be a misconception that R Ploeg tried to clarify. Fidelma Murphy had been consulted and asked to enquire whether the HTA required the actual signature of the lead surgeon (requiring him to unscrub, sign and rescrub to retrieve other abdominal organs) or a signature on behalf of the surgeon by another health care professional would suffice. The answer we understood came back that another health care professional signing the HTA A form preventing further delay was admissible. This (completed) action point has been mixed up with the impression that the request was whether SNODS can fill out the HTA A form. This has never been the issue. Current policy for most abdominal teams is that the theatre practitioner who comes with the NORS team prepares the form and the surgeon signs. In those few teams were there is no theatre practitioner, the surgeon has to complete the form. Despite this explanation there remained some lack of clarity, so R Ploeg suggested he would further discuss with F Wellington.

- **Item 8.5:**
  
  The spelling of ‘en block’ is incorrect and should be spelt ‘en bloc’.

### 2.2 Action points – NRG(AP)(15)2

Action points were either completed or would be raised on the agenda.

### 2.3 Matters arising, not separately identified

No matters arising.

## 3 NRG WORK PLAN – NRG(15)15

### 3.1 R Ploeg noted that the intention of the NRG Work Plan was to oversee the priorities being undertaken by the group and completed by the key stakeholders responsible for respective tasks. Progress is being made and most items will come back on the agenda.

This will become a running document. Details still have to be completed for items 5 and 6 and this will be undertaken by R Cacciola. E Billingham requested an additional column be added to the workplan for any updates.

## 4 Advisory Group issues in retrieval

### 4.1 Bowel

There were no issues.

It was noted that P Friend had been liaising with the NHS England CRG which was due to launch a consultation relating to bowel transplantation. This would be circulated to NRG members.

### 4.2 Cardiothoracic

S Tsui stated the only issue is uncertainty as to who retrieves paediatric CT organs in Europe. It was discussed and agreed that all the NORS team will be part of a rotation for European adult size cardiothoracic retrieval. Over 30kg is...
Item | Action
--- | ---
no longer paediatric size. If the continental partner is not able to retrieve then the NORS team will go out on a rotational basis. There is a system and reimbursement system in place.

This rota is being maintained and E Billingham will be meeting with the manager and duty office regarding how this will be maintained.

**ACTION:** Place information on the Standards document site and circulate link to stakeholders, to ensure everyone always has access to the same information.

**ACTION:** E Billingham to liaise with duty office to confirm who would manage the rota and then confirm details to Duty Office, SN-ODs, CTAG etc.

**ACTION:** E Billingham to contact S Tsui if there are any arbitration issues.

4.3 • **Kidney**

No issues to report.

4.4 • **Liver**

D Manas reported as follows:

(i) Utilisation - J Neuberger had issued advice regarding the 2 hour delay – utilisation may be improved by implementing changes.

National allocations work is ongoing and will impact on utilisation; however, it does not take into account distance – this appears to be a flaw in the system. J Neuberger noted it was up to LAG to recommend the allocation system they want.

C Watson stated that within the LAG Clinical Governance Report there was confusion.

**ACTION:** J Dark to update Clinical Governance Report once the information is available.

(ii) A working group, Chaired by Ian Currie, had been established to look at utilisation rates.

**ACTION:** C Callaghan and a lay member to be invited to join this group.

4.5 • **Pancreas**

P Friend will stand down as Chair in October. John Casey has been appointed as the new Chair.

**ACTION:** John Casey to be invited to join the NRG.

D Manas noted the level of pancreas ‘non-use’ is higher than any other organ.

5 **NHSBT UPDATE**

5.1 **New appointments**

- Chris Callaghan – Abdominal Clinical Lead for Organ Utilisation – focussing on acceptance/ utilisation, rather than retrieval issues. He will be talking to AG Chairs to seek their advice.

- Andre Simon – CT Clinical Lead for Organ Utilisation - developing a strategy to maximise CT utilisation and provide a draft report to the NRG.

- John Casey – Chair of PAG

- Peter Friend - moving to Chair BAG
<table>
<thead>
<tr>
<th>Item</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Gabriel Oniscu – Chair of new Research, Innovation and Novel Technologies Advisory Group (RINTAG)</td>
<td></td>
</tr>
<tr>
<td>• Linda Hall and Amanda McEvoy – Joined Clinical and Support Services Team under K Zalewska. Still in process of appointing one more person to the team.</td>
<td>ACTION: Invite new Chairs and Clinical Leads for Organ Utilisation to join NRG</td>
</tr>
<tr>
<td>5.2 Update on Novel Technologies in Organ Transplantation (NTOT)</td>
<td>L Hall</td>
</tr>
<tr>
<td>C Williment reported the establishment of a new Research, Innovation and Novel Technologies Advisory Group (RINTAG) which will be chaired by Gabriel Oniscu. Work was underway to appoint members. Membership included BTS, BTRU, QUOD and AG Chairs. It will function slightly differently to other AGs due to its large remit and focus on research/ innovation.</td>
<td></td>
</tr>
<tr>
<td>5.3 ODT Workforce Project developments</td>
<td></td>
</tr>
<tr>
<td>F Wellington reported on behalf of E Poppitt. This is a project to look at the workforce, structure and processes to ensure they are fit for practice and to deliver the aspirations of the 2020 strategy and that the service is responsive to the needs of transplant centres. E Poppitt is the Business Lead.</td>
<td></td>
</tr>
<tr>
<td>There are several projects:</td>
<td></td>
</tr>
<tr>
<td>1. Dedicated requestor: reviewing the impact of splitting the SN-OD role to explore the impact of having SN-ODs who only focus on family approach. There are five SNODs in the North West and Yorkshire regions dedicated to approaching families and obtaining consent. If consent is obtained they will mobilise the normal SN-OD. They are working 12 hour shifts (Mon-Fri) – not covering 100% of consent but the vast majority. Initial feedback has been positive from the North West Team. This is a 9 month pilot running from April to December 2015.</td>
<td></td>
</tr>
<tr>
<td>2. Regional Boundaries: Reviewing whether the 12 regional boundaries are still the most appropriate.</td>
<td></td>
</tr>
<tr>
<td>3. Management and administration: Whether the current structures could be improved and streamlined.</td>
<td></td>
</tr>
<tr>
<td>4. DBD triage: Whether paper-based triage is effective. (9\textsuperscript{th} March to 9\textsuperscript{th} July 2016).</td>
<td></td>
</tr>
<tr>
<td>The plan is to present an updated business case to the September Change Programme Board at SMT and then look at options and recommendations for taking forward.</td>
<td></td>
</tr>
<tr>
<td>It was noted that there were currently issues in Belfast regarding retrieval teams having to wait for long periods to get to theatre. F Wellington agreed to explore the issues in Belfast.</td>
<td>F Wellington</td>
</tr>
<tr>
<td>5.4 Scottish IGA Consultation Response – NRG(15)16</td>
<td></td>
</tr>
<tr>
<td>K Quinn reported that Scotland had undertaken an independent review of commissioned organ donation and retrieval services, primarily to decide whether the current arrangements are value for money and fit for purpose. There were two recommendations relating to:</td>
<td></td>
</tr>
<tr>
<td>(i) Scottish Organ Retrieval Team (SORT) moving the commissioning arrangements in order to align the commissioning of organ retrieval and transplantation services within Scotland, and</td>
<td></td>
</tr>
<tr>
<td>(ii) The operational management and professional development of the SNODs.</td>
<td></td>
</tr>
</tbody>
</table>
The report was high level and low in detail, so the potential implications were unclear.

A Consultation was under way regarding the draft recommendations. K Quinn has written to all Transplant Centres and Heads of Retrieval Teams seeking views on what NHSBT should include in the response from Ian Trenholm.

**ACTION:** Members to contact K Quinn with any comments by the close of play on 10 July 2015. It was recommended that any members with opinions on the document respond themselves.

The Group made the following comments:

- There was no clarity regarding issues such as equality of access to organs. For example, Scotland is a net importer, so how would implementation work across borders? Who would pay for organs retrieved in England, but transplanted in Scotland and vice-versa?
- If it saves money and the system stays the same, then may be in favour. However it was unclear if this would actually be possible.
- Conversations with SORT team members indicate they want to stay part of NORS, so it is not clear if there is clinical backing for the report.
- There was the potential for inequality in the retrieval service across the UK.
- Governance would be difficult and NHSBT systems/processes would not apply to Scotland.
- Concern regarding the potential splitting of teams may lead to variation in approach, training, policies etc.
- Concerns that this may lead to problems with consistent messages
- Scotland already has difficulties in lung retrieval, training etc. A split from national commissioning would make this even harder.
- At best, this will not enhance the current successful system. At worst, will be disruptive.

**ACTION:** NRG should request sight of Ian Trenholms’ response to ensure it reflects accurately the views he has sought.  

**ACTION:** D Manas indicated that BTS will send a response for K Quinn to forward with NHSBT response,  

**ACTION:** R Ploeg and K Quinn to review individual comments from the group.

6 BUSINESS CASE – HISTOPATHOLOGY (WP)

6.1 Draft proposal of business case – NRG(15)17

The analysis of the National Histopathology Audit had been completed and was available on the ODT Microsite. The report concludes that there is correlation between the availability of histopathology services and organ utilisation.

**ACTION:** Circulate full report to NRG

After informal conversations with the National Lead for Pathology in NHS England, Prof. Sir Bruce Keogh had supported the suggestion that NHSE work in collaboration with NHSBT to develop proposals for a national digital histopathology pilot project.

A project group would be established, including Edmund Jessop (NHSE specialist commissioner), Desley Neal (Pathologist, Birmingham), Dan Gosling (NHSE Pathology Policy Lead) and Gavin Pettigrew. The aim of the group would
be to develop a business case for a pilot project, NOT the system itself (which will need funding etc).

**ACTION:** Invite C Callaghan to the project group.

In essence, this project will be used as a guinea pig for other services – the concept is that there could be 4 or 5 centres in the UK where a sample is sent.

### 6.2 QUOD/NHSBT Project Proposal – NRG(15)18

It was proposed that QUOD biopsies of kidney and liver should be scored by 3 independent expert pathologists for kidney and liver followed by an evaluation of correlation between scores and immediate and 1 year function. After this validation with UK data the next step is to see if it is possible to enhance clinical decision making to accept or decline using the biopsy information in addition to the EOS data. A Steering Committee was convened to support this work and advise on parameters for assessment.

R Cacciola noted that with kidneys, the score helps the clinician in decision making. D Manas noted that with the liver this is more difficult.

There was general agreement that using the QUOD facility to evaluate the clinical impact of a biopsy on predicting outcomes or utilisation was a good idea and helpful for ODT to answer a relevant and timely question.

### 7 CLINICAL GOVERNANCE

#### 7.1 Review of organ damage rates: 1 April 2013 to 31 March 2015 – NRG(15)19

S Rushton summarised a paper circulated to members prior to the meeting.

There were concerns about the accuracy of reported damage data and lack of validation. E Billingham noted that validation will be performed and separate discussions continue with the teams.

Members felt that the report could be misleading and there were concerns about the wording. It was agreed that the report should not be published online.

It was suggested for future analyses to focus on organs that were unsuitable for transplantation due to damage, or where organs were implanted and harm came to the recipient, or where the graft had to be subsequently removed. S Rushton to consider these suggestions and advise on timelines for implementation.

There is also concern regarding the level of onward reporting within centres, with data that is not being used/ acted on. Data is provided and published by NHSBT, showing retrieval and outcome rates, noting some outliers. However, this is raw data and there is concern that the data may be misleading, meaning that problems and issues are not correctly identified and addressed. From a governance point of view, the system of surveillance and retrieval should be improved and reports circulated to centres.

There is also a quality/ professional issue regarding responding to queries and investigations regarding incidents.

**ACTION:** E Billingham/ R Cacciola, S Rushton and R Ploeg to discuss.

#### 7.2 Damage reporting and quality assurance in organ retrieval (WP)

A business case was being developed to improve the amount and timeliness of information that is provided and shared by organ retrieval and transplant teams. The proposal is to develop a new electronic form, which would include HTA A & B form data, alongside increased amounts of real-time data and pictures regarding organ physiology, with the aim of supporting clinical decisions and addressing issues regarding inconsistency of data sought/ provided. The
database would be a ‘satellite’ system, accessed through (but not interfacing with) EOS. It would be accessed by retrieval teams and transplanting surgeons.

The electronic capture will replace the paper trail of HTA A and B forms. The database would be an interim measure, until The Hub could provide this functionality.

All clinicians present express their support for this project that will enhance quality and safety as well as support better decision making whether to accept an organ for a particular recipient. It will also create an immediate feedback option per mail from transplant team to retrieval team in case any discrepancies are noted. This information is important for the NORS team to discuss and improve its procedures.

A detailed business case is to be provided to NHSBT Change Portfolio Board in mid-July.

7.3 Trends and organ utilisation – NRG(15)20

The following was noted:

- It has become apparent that retrieval damage featured highly among the trends. AGs not necessarily the best place to report and discuss damage. In the lung section of CTAG there were only two surgeons in the room.
- Include damage as a performance indicator.
- Damage that results in organ loss has to be reported.
- Prime duty of governance team is to report things of a mandatory nature.
- Incidences have to be reported by a proper audit and data. Incidences only giving a very distorted picture of the problem.
- Paper going to Change Portfolio Board will encapsulate all the problems.
- Communication, quality of perfusion also needs to be captured.

**ACTION: J Dark to attend Clinical Retrieval Forum**

J Dark

7.4 Follow-up from the issues around lung retrieval at the same time as abdominal NRP in DCD donors

There has been a problem when DCD lungs were retrieved from donors with abdominal NRP, due to the requirements for warm perfusion of the abdomen and cold perfusion of the lungs. On some occasions, lungs had been lost as a result of attempts to undertake simultaneous cold and warm perfusion, due to major haemorrhage.

CTAG had reviewed the 2013 protocols, but the issue remained unresolved.

There was a need for a technique that teams feel comfortable to execute. It was suggested that the priority should be for surgeons and teams to use an approach that they feel comfortable with and if necessary, leave the lungs in until after the NRP process. It has to be the retrieval team making the decision.

It was noted that NRP has been undertaken with lungs intact for 30 minutes. This had a good outcome and was preferred as a controlled process.

The receiving transplant service has to be aware of the technique being used and decide if the lungs are acceptable. There should be no reduction in the number of lungs able to be used.

Whilst there is support for NRP, it is important to take this one step at a time.

There were concerns about adopting the technique from 2 years ago and also on
insisting that people adopt a technique in which they have received no training.

**ACTION:** S Tsui, through CTAG, to revise protocols for DCD donation. To be shared with CTAG over the summer and finalised at the latest in September CTAG meeting.  

**S Tsui**

**ACTION:** J Dark and S Tsui to liaise with Gabriel Oniscu regarding this issue.  

**S Tsui/ J Dark**

There is also a general nervousness regarding potentially re-starting the heart for DCD donors. If the EVLP technique re-starts the heart, then this would cause further consternation. The intensive care community would need reassurance if this was a risk.

**7.5 Data collection for organ perfusion**

Following proposals from J Dark and C Watson regarding capturing data on organ perfusion technologies and the need to clarify implications of ischaemic times, work is progressing within NHSBT regarding organ perfusion activity. There is the potential for this to link in with the work to improve the HTA A & B forms.

**8 DCD HUMAN HEART**

**8.1 DCD Human Heart Project, Papworth**

S Messer provided a presentation on Papworth’s DCD Heart Project. There have been 6 successful DCD transplants in the last 3 months. Discussion took place around why the lungs in some of these patients were declined.

**8.2 Proposal DCD Human Heart Transplant – Harefield Hospital**

C Bowles provided a presentation. There have been 7 offer events (one not formal). The following was noted:

- Committed to using organs to best advantage.
- SNOD experience has been really positive.
- One concern is long term and having sustained personnel to run this kind of programme.
- Congratulations to both teams from Papworth and Harefield. Currently have proof of concept and identified some of the issues, e.g. impact on other organs, finances, resources, training, manpower. Looking to see how to move to a service evaluation and look at the impact on the heart, lungs and abdominal organs.
- Paper for continuation of the DCD Heart pilot has been to ODT Senior Management Team and the Executive Team, who were supportive in principle. It will go to the sustainable funding team at the end of July.
- There will need to be some economies of scale.
- There may come a time when there will need to be some wider support in the media, there should be caution about media handling.
- Harefield use a supplementary consent form. In Papworth, consent is person to person. From the donor point of view this is very much led by SNODs.
- It is important not to lose the information. At Papworth a database will be produced and should link in with NHSBT.
- Two practical issues were to be addressed: (i) the need to agree who is going to get the donor blood and additional blood, and (ii) the need to agree who is going to retrieve the heart.
<table>
<thead>
<tr>
<th>Item</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>9</strong> COMMISSIONING</td>
<td></td>
</tr>
<tr>
<td>9.1 NORS Review (WP) (Ben Hume dialling in)</td>
<td><strong>ACTION:</strong> B Hume to discuss with relevant parties with regard to practical implementation and impact on results in the Duty Office.</td>
</tr>
</tbody>
</table>

At the last NRG discussion took place about the basic principles around timings and the impact of the NORS Review on the Duty Office. A workshop took place in March with the Duty Office to work through examples and test principles. The Duty Office is building on this feedback to develop more detailed proposals for implementation.

The aim is to get something in place before summer but is more likely to be after the 1st October deadline.

**ACTION:** B Hume to discuss with relevant parties with regard to practical implementation and impact on results in the Duty Office.  

The dispatch function is a priority - drivers can be tracked under the new arrangements.

K Quinn noted the Review led to 15 recommendations, which would be overseen by an Implementation Board tasked to implement by the end of March 2016 (for majority).

First Implementation Board chaired by R Ploeg at which four working groups were developed:

1. Capacity and Rota - S Tsui/Elijah Ablorsu
2. Training and Quality – Ian Currie/Stephen Clark
3. Operational Issues, including dispatch – Chris Callaghan/Emma Billingham
4. Commissioning – Mike Winter/Karen Quinn

These working groups need to be efficient and effective. A template would be used for implementation planning and reporting.

**9.2 Monitoring of NORS: 1 April 2014 to 31 March 2015 – NRG(15)21**

S Rushton spoke to her paper circulated prior to the meeting which presents NORS activity data from the last financial year. The key messages were that activity had decreased slightly for most teams compared with the previous financial year, abdominal teams were busy roughly half of days in the year compared with roughly a quarter for cardiothoracic teams and there were statistically significant differences in the mean number of organs retrieved and transplanted per DBD donor across retrieval teams.

R Ploeg noted that changes will need to be made to the focus of the report as NORS moves away from first on call zones.

J Neuberger requested that the report be in a similar format to the organ specific reports and published on the website.

**ACTION:** S Rushton to action these suggestions.  

**9.3 Procurement update**

Kidney box validation was underway and a preferred supplier would be identified shortly. Evaluated 8L and 18L boxes – 8L was too small to meet requirements. 18L slightly larger than current boxes, but similar to those used for Liver and CT organs. These could also be used for pancreas.

**9.4 Update on Clinical Reference Groups**

K Quinn attended Renal Transplant CRG. Ongoing restructuring within NHS England with regional hubs had led to slow progress in getting a living donor tariff
established. Now looking at 2017/18 to get the tariff in place.

The number of Clinical Reference Groups may be reduced, which may lead to increased difficulty for NHSBT to liaise effectively with NHSE.

D Manas advised he has been asked to regroup as a Liver Group CRG. It was agreed that setting a liver transplant tariff across the board is a good thing to do and D Manas will invite K Quinn to attend the meeting.

A tariff has its risks as well as its benefits but would be a good leader for organ utilisation.

9.5 Process and rationale for agreeing Out-of-Zone retrievals

There was a need to further streamline the retrieval of multiple organ transplants when recipient centres travel out of zone attend to retrieve. There is agreement that, in general, there is no need at all for the recipient team to be involved in the retrieval. However, there are rare occurrences where this is essential in order to meet some specific specialist skills. This applies to CT/abdominal transplant patients and should be rare occurrences (up to 3 a year).

It was agreed that the recipient team could retrieve if there was specific expertise needed to meet the recipient requirements. In general, if a recipient team is retrieving, then they should retrieve all appropriate organs, with the organ being sent on ahead of the recipient team if necessary (noting that this may lead to additional transport requirements).

There should be discussion between retrieval teams and SN-ODs regarding approach and roles before retrieval commences.

9.6 Cardiothoracic Perfusion Protocol Proposal

It was agreed that there should be a CT Perfusion Protocol in place, similar to that used for abdominal perfusion.

**ACTION:** S Tsui to confirm if there is a CT perfusion protocol already in place

**ACTION:** If there is no current protocol, R Ploeg to convene a workshop to develop a protocol.

10 DONOR MANAGEMENT/PROCEDURES

10.1 Cardiothoracic NORS Scout pilot programme: Update(WP)

This project launched on 1st April – this was the second phase of the Scout project (1st phase was a feasibility study).

Analysis of first two months of data provided. It is progressing largely as anticipated but with some issues:

(i) Still some incorrect versions of the form are being submitted.

(ii) Some forms are being sent in hard copy, rather than electronic.

(iii) Data is incomplete or incorrect

(iv) Some forms were not returned. Not all relevant fields have been completed on the forms – where possible the forms have been designed with required fields.

The Steering Group, Chaired by K Quinn and S Tsui, is working to address these issues.

There will be on-going training for Scouts and SN-ODs to manage staff turnover.

**ACTION:** Members advised the forms should be revised to increase the mandatory fields and provide threshold limits where applicable.
There was also concern regarding the risk that some centres might cease their involvement, which would have severe implications on timescales for the delivery of the project. If a centre did drop-out, then the Steering Group would consider implications and make recommendations to NHSBT regarding next steps.

**ACTION:** S Tsui to contact Birmingham to ascertain if they are still involved in the pilot programme.

**10.2 Coroner’s report update**

The audit of all referrals has been completed and a review of the data so far has been undertaken. This led to some recommendations for next steps, i.e. 28 cases where the Coroner gave full refusal or partial permission to proceed, but no post mortem was then performed. This led to a significant loss of organs.

The analysis has been discussed with a representative of the Chief Coroner and RCLOD and some initial recommendations on next steps developed, which will be discussed by a wider group of stakeholders.

J Neuberger will be talking at the coroner’s conference in November. A number of regions have agreements with the coroners in place but it is unclear whether it is making a difference in refusal rates.

There were some cases of good practices and these successes need to be celebrated.

**ACTION:** The Group advised that the analysis should be written for inclusion in a peer-reviewed journal

**10.3 Editing of the NORS Standards**

R Ploeg, E Billingham, K Zalewska have been updating the standards and policies. Next release is due in October 2015.

**10.4 Update on neurological criteria for brain-stem death (BSD)**

There was inconsistency between the protocols and forms used for recording BSD, which had led to some issues for retrieval teams. Ideally, work would be undertaken to create a consistent approach across the UK. As an interim measure, NHSBT had developed a new form which could be signed by the consultant to confirm death by neurological criteria. This proposal had been widely circulated and well received. One Retrieval Lead had questioned the authority of NHSBT to change. Proposals were put to an external/internal lawyer who confirmed it fulfils both statutory and professional responsibilities. When asked the HTA confirmed that a form to confirm death is part of NHSBT’s remit and custodianship to organise. NHSBT will be writing to the four Health Departments to inform them of the change prior to implementation.

**11 Training and certification (WP)**

The new programme for certification of retrieval surgeons was in place. Work to develop an e-learning course for CT retrieval was nearly complete. Work was also progressing well with the RCS to seek accreditation for the programme.

A Steering Group for the Training and Certification process has been established which will consider the whole process. This needs to keep up to date with developments and remain relevant. R Ploeg discussed the curriculum with all the retrieval teams and people have been very positive. A Training Advisory Committee to help with relevant educational issues and certification decision has been named. Candidates asked have kindly accepted; B Fernando (Surgical Chapter BTS/ abdominal), I Currie (NORS team lead representative/abdominal), S Clark (CT e-learning lead/cardiothoracic), A Simon (cardiothoracic expert).
<table>
<thead>
<tr>
<th>Item</th>
<th>Action</th>
</tr>
</thead>
</table>
| 12   | **Update on Clinical Retrieval Forum**  
The meeting with the BTS went well. Planning for the next meeting is underway |
| 13   | **Retrieval Team Dispatch Process update (WP)**  
Nothing to report. |
| 14   | **For information** |
| 14.1 | **Terms of Reference – NRG(15)22** *(NORS standards depending on above response)*  
Any comments to be submitted to R Ploeg. |
| 15   | **Any other business**  
There was no other business. |
| 16   | **Dates of next meeting**  
The next meeting will take place on Wednesday 14\textsuperscript{th} October at 10.30am. The venue for the meeting will be the MSE Meeting Rooms, 103a Oxford Street, London, W1D 2HG. |