

bulletin

The newsletter for everyone involved in organ donation and transplantation

Autumn 2009

Secretary of State joins Wall of Life

Triple liver transplant survivor Janet Atherton has signed up the newly appointed Secretary of State for Health, Leigh MP Andy Burnham to join the Wall of Life. Also in support of the Campaign were Leigh Centurions Head Coach and Club Captain, Paul Rowley and Stuart Donlan.

Glen Berry, Assistant Director of Health Development at NHS Ashton, Leigh and Wigan PCT commented: "We are delighted

and grateful that Andy Burnham has given his personal support for this campaign."

The Wall of Life was launched in June as part of a nationwide campaign that aims to promote awareness of, and support for, organ donation to boost the 16.4 million people on the NHS Organ Donor Register (ODR).

The Wall of Life is an online mosaic created from people's photos posted on the site to



Pictured is Paul Rowley, Stuart Donlan, Glenn Berry, Andy Burnham and Janet Atherton

show their support for organ donation. These photos come together to make up the image of two-year old Louisa

McGregor-Smith whose life was saved by a heart transplant in 2007 at just five months old. (Cont page 2)

Organ allocation to non-UK EU residents

In recent years the media have periodically covered stories about organs from deceased UK donors being transplanted into non-UK resident EU nationals.

In March the former Secretary of State for Health, Alan Johnson commissioned a report by Elisabeth Buggins, Chair of the former Organ Donation Taskforce, to address public concern about organ allocation.

The report's recommendations, which have been broadly accepted by the Department of Health (DH)

are to:

- seek agreement from devolved health administrations to ban all private clinical practice in the UK involving solid organs donated after death within the NHS, from 1 October 2009
- establish an implementation group to work with NHS Blood and Transplant (NHSBT) and commissioners of transplantation to monitor referrals from overseas
- support the development of

a new liver allocation scheme to build greater transparency into the allocation process

- develop DH guidance for transplant centres to provide clarification on the eligibility criteria for people from abroad
- raise with colleagues across the EU the need to build capacity or expertise in developing transplant programmes in Member States or the building of reciprocal agreements between neighbouring countries

In response to the publication of the report, Lynda Hamlyn, Chief Executive NHSBT said: "In a situation where there are not enough organs to treat



Lynda Hamlyn

the citizens of the very country donating them, the priority must be to ensure a fair and open system of allocation and treatment and the necessary level of public reassurance that this is the case."

Lung transplant recipient wins a place on Fourth Plinth

Lung transplant recipient Clare Lauwerys has won a place on the Fourth Plinth in London's Trafalgar Square to raise awareness of organ donation.

Clare (pictured), will spend one hour from 11pm to 12 midnight on 11 October

celebrating her 39th birthday on top of the 22-foot column.

The mother of two from Colchester in Essex underwent a single lung transplant at Harefield Hospital on 15 November 2008.

She is keen to get as much publicity as possible for her stint on the plinth to highlight the need for more organ donors.

While standing on the plinth, she will also publicise



Clare Lauwerys

the charity, LAM Action, which supports women with lymphangioliomatosis (also known as LAM).

Clare is one of around 120 women in the UK with the incurable condition, which causes the lungs to waste away.

She said: "I applied on a whim and was lucky enough to be accepted.

"I am always looking for ways (Cont page 4)

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Copy date for next issue
1 November

Please email
henny.fordham@nhsbt.nhs.uk
with ideas for submissions

global news

German Corpse Tissue Trade A Bavarian company specialising in human tissue implants is being investigated by state prosecutors for illegally trading in body parts from Ukrainian corpses.



China to Cut Use of Executed Inmates' Organs China has launched a national organ donation system to try to reduce its dependence on body parts taken from executed prisoners, who make up the

majority of donors. Apple Boss thanks Donor Steve Jobs tells audience "I have the liver of a mid-20s person who died in a car crash. I wouldn't be here without such generosity." Opt out campaign The Observer

newspaper continued its support for presumed consent in September with an appeal for donors by TV scriptwriter Frank Deasy, who urgently needed a liver. Sadly, he has since died.

Transplant stories from around the world

Donation Promotion at the Anglesey Show

Medics involved in organ donation and transplantation joined forces to manage a stand at the Anglesey Agricultural Show this summer. Over 50,000 people attended the event which proved a great opportunity to connect with the general public and highlight the need for more organ and tissue donors.

Regional Transplant Co-ordinators and Tissue Donation Practitioners together with the Clinical Lead for Organ Donation and the Bereavement and Donation Specialist Nurse from the local Ysbyty Gwynedd worked together to hold the event.

Free sweets, pens and helium balloons caught the attention of the passing public and helped open discussion about organ donation and many people signed up to the organ donor register on the day. Currently 27% of the population in Wales are on the NHS Organ Donor Register.



Blood and Organ display at the Welsh Show. Note, organ donation branding will be getting a new look following the national Autumn TV campaign

The team answered questions and helped clear up common misconceptions such as there being no age limit to being an organ donor and how having a donor card doesn't automatically mean you are on the organ donor register.

Further awareness raising events are planned in the region with the Blood Service Team, in order to collate resources and ensure a multidisciplinary approach to promotion.

Secretary of State joins Wall of Life cont.

More than 2,728 people have now joined the WoL as word spreads via social networking websites. At least 60,000 people need to upload their photos on to the Wall to build Louisa's image.

The Wall of Life is also being promoted on social networking sites, such as Facebook, Bebo, MySpace and Twitter. The official Twitter RSS feed to the Wall of Life has attracted over 325 followers and there are 415 members on our Facebook profile.

People joining the Wall of Life can pass details to their friends and families to download a personalised widget on their social profiles and websites, spreading the message across social networks.

More information

For more information about organ donation or to sign up to the NHS Organ Donor Register, please call the Donor Line on 0300 123 23 23 or visit www.walloflife.org.uk.

uk news round

Wales



In September 2008 the Minister for Health and Social Services, Edwina Hart, appointed Dr George Findlay, Consultant Intensivist at Cardiff and Vale NHS Trust, as Chair of a Wales Organ Donation Implementation Group. This Group was established to take forward the implementation and monitoring of the UK-wide Organ Donation Taskforce Recommendations, specifically to ensure Wales' specific measures are taken forward and that the UK wide implementation encompasses the needs of the service and stakeholders in Wales. The group meets quarterly and includes in its membership representation from



Edwina Hart

the Organ Donation and Transplantation Directorate of NHSBT along with a wide range of other stakeholders. Also in Wales, the Local Health Boards are making good progress in appointing Clinical Leads for Organ Donation and establishing Organ Donation Committees.

The Welsh Assembly Government's formal public consultation on options for changes to organ donation consent, including an opt-out system, closed on 3 August. Assembly Government officials are now analysing the consultation responses which will be published shortly.

Peter Carr, Organ Donation Policy Lead



July and August have been busy months for the team in Scotland. The appointment process for clinical leads for organ donation continues and we now have 19 clinical leads for organ donation in post. They have established a communication network and have met collectively on two occasions. Eight of the eleven mainland Health Boards have established Donation Committees and their Chairs have also established a communications network and have held their first meeting with another one planned for October.

The Scottish Government has completed its tendering exercise to secure PR/Direct Marketing and

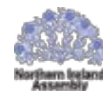
Advertising Agencies to work with us over the next three years and a very successful meeting was held with the agencies with a view to developing our organ donation advertising strategy. A design agency has also been appointed to help update the highly regarded Organ Donation Teaching Resource pack for use across the whole of secondary school education in Scotland. A DVD, for use with the pack, has been filmed and footage includes contributions from donor and recipient families, an ICU consultant, a donor transplant co-ordinator and a transplant surgeon.

Ongoing discussions are being held with NHS Education Scotland, with a view to adding organ donation modules onto existing educational programmes for all new nursing, midwifery and AHP registrants and to critical care nursing educational frameworks.

We are also in the planning stages for a series of focus groups to identify how we might identify and take forward an effective method of promoting organ donation and the "gift of life" to the BME population in Scotland.

Pam Niven

Northern Ireland



In Northern Ireland work has been moving ahead on the implementation of the ODTF recommendations. The new Donor Transplant Co-ordinators have been appointed and will be in post shortly and our local implementation

team is moving forward with plans for a local road show event, now expected to take place in early November.

Earlier this year Northern Ireland took the opportunity to carry out a local advertising campaign aimed at encouraging people here to sign up to the Organ Donor Register. The campaign was carried out through local radio stations, supported by poster displays across the region and ran for three weeks. During this period the Northern Ireland ODR registrations, by telephone and website, ran at about twice the usual level, indicating the campaign's immediate success in raising public awareness. This, together with other news stories which included our Health Minister Michael McGimpsey joining the Wall of Life, has ensured that the need for donor organs has remained in people's minds.

Our DTC team is currently in the process of planning our regular Service of Remembrance and Thanksgiving for Organ Donation. This service, which is for patients, family, friends and staff involved in organ donation and transplantation, is held at the Spires Conference Centre in Belfast and has proved very popular in the past, with an attendance of close to 1000. The service includes an Act of Remembrance which involves transplant recipients giving small floral tributes which are then received by representatives from donor families.

Siobhán McKelvey

Working with the HTA



Vicki Chapman HTA Head of Policy and Strategy

The HTA hit the headlines at the end of June when we announced there had been an increase in the number of altruistic kidney donations, where a person donates an organ to someone they do not know. In this time of financial insecurity and concerns about the spread of swine flu, this was a rare good news story.

When the HTA began approving living kidney donations in 2006, we expected to see very few altruistic donations, no more than a couple a year. Remarkably, we have seen many more. So far we have approved 25 altruistic kidney donations and 22 have gone ahead. Donating to someone you do not know is truly an altruistic act. The medical tests take time and the procedure is not without risk. It is the role of the HTA to ensure that those giving so generously fully understand the risks involved. It is not clear whether

we will see a further increase in years to come, but the publicity has already sparked calls from people expressing an interest in becoming an altruistic donor.

Role of the HTA in living donation

However, the vast majority of living donations are to someone genetically or emotionally related. The role of the HTA is to ensure that all transplants involving living people follow an independent assessment process. Although most organs for transplants are donated from people who have died, every year, more and more people receive organs from living donors. In 2008/09 the HTA approved 1,023 living donations compared to 971 in 2007/08. Living-donor kidney transplants now represent more than one in three of all kidney transplants.

The independent assessment process

During the independent assessment process, all donors and recipients see a local Independent Assessor (IA) who acts on behalf of the HTA. The IA interviews the donor and recipient together and separately, and writes a report. They make sure that the donor and recipient have been thoroughly assessed and understand what is involved in giving and receiving an organ, and that the risks have been properly explained. The HTA must be satisfied that the donor is not under any pressure to donate and has given their consent freely and voluntarily. The Human Tissue Act (HT Act) covers England, Wales and Northern Ireland. Scotland has its own law, the Human Tissue (Scotland) Act 2006, but the HTA was asked by the Scottish

“
The vast majority of living donations are to someone genetically or emotionally related.”

Government to approve the donation of organs from living donors on its behalf.

Other types of living kidney donation

The HT Act has provided a clear regulatory framework for living donations, and also enabled a more flexible approach to who can donate to whom, so that more people can benefit from a living-donor transplant. As well as altruistic donations, there is another new kind of transplant called paired or pooled transplant. A paired transplant is when a donor and recipient whose blood groups or tissue types are incompatible can be paired with another donor and recipient in the same situation. Pooled transplants enable more than two donors and two recipients to be involved in the swap. If all goes to plan, each recipient will benefit from a transplant that they would otherwise not have had.

Bone marrow donation

As well as approving organ donations, the HTA is responsible for approving all donations of bone marrow or peripheral blood stem cells (these are cells found in the bloodstream which are able to develop into all of the different cell types in blood) from children and adults who are unable to make an informed decision.

The donor, or a person acting on the donor's behalf, must be interviewed by a local Accredited Assessor (AA) who writes a report. The HTA will then consider the report and give approval before the donation can go ahead. The HTA must be satisfied that the donor is not under any pressure to donate and that consent is freely given.

Conclusions

Living donation is on the increase. The role of the HTA is to safeguard the interests of the donor, ensure they fully understand the risks involved, that consent is freely given and that there is no evidence of reward.

Vicki Chapman is the new Head of Policy and Strategy at the Human Tissue Authority

More information

HTA website
www.hta.gov.uk

The HTA leaflet 'Information about living donor-transplants'
www.hta.gov.uk/about_hta/publications/leaflets.cfm

The HTA leaflet 'Information about donating bone marrow and peripheral blood stem cells'
www.hta.gov.uk/donations/bonemarrowandstemcelldonations.cfm

Chiefly



Sally Johnson Director Organ Donation and Transplantation

It seems extraordinary that I have now been in post for a year. A huge amount has happened during that time with over 150 Donor Transplant Co-ordinators joining NHSBT,

the Electronic Ordering System being rolled out (and winning an award!), the first contracts being signed for organ retrieval and 132 Clinical Leads for Organ Donation being appointed across the UK.

We always knew that making organ donation 'usual rather than unusual' required the engagement of staff throughout the NHS and this really feels as though it is gathering momentum now. More than half of the clinical leads are now in place, several Organ Donation Committees are meeting and non-clinical champions are being appointed. After a successful Donation Conference in Scotland, there have been road shows in five Strategic Health Authorities. These are bringing together Clinical Leads, non clinical Champions, Donor Transplant Co-ordinators, Intensive Care and Emergency Medicine doctors and nurses, managers and even transplant recipients and donor families at some. The events provide a forum for everyone to learn about organ donation, discuss the barriers and how these can be overcome and make a commitment to improving organ donation in their hospitals. It has been really encouraging to see the enthusiasm that everyone brings to the event and to leave knowing that we have made real progress.

A huge amount of work is now going into preparing for the organ donor campaign, with adverts being filmed and photographed, a new thank you pack and donor card being designed and the website and organ donor line prepared to cope with the large numbers of people we expect will contact us to join the NHS Organ Donor Register. The campaign will launch in the autumn (providing we are not all engulfed with swine flu) and we hope that everyone with an interest in organ donation and transplantation will watch out for it and encourage everyone they know to join. If you don't want to wait for the campaign then why not ask everyone you know to join the Wall of Life (www.walloflife.co.uk) and show their support for organ donation now!



As universities across the country welcome their first-year students, the NHS Blood and Transplant (NHSBT) team is donning its swimwear to find a new generation of lifesavers!

NHSBT's 'Baywatch' themed roadshow is visiting 19 freshers' fairs across the country to encourage students arriving at university for the first time to become a 'lifesaver for life' by signing up to be donors of blood and organs.

At the NHSBT stand, which will include a beach backdrop and lifeguards, students will be able to find out more about

Promoting donation at Freshers' fairs

donating blood and signing up to help save a life after their death by joining the NHS Organ Donor Register (ODR).

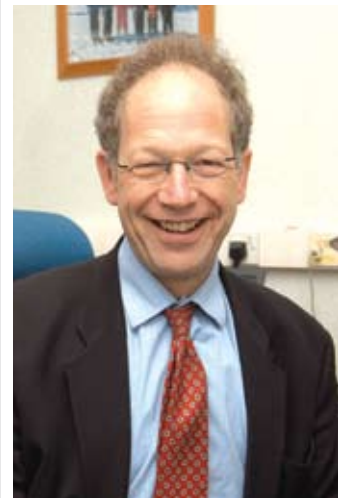
Lynda Hamlyn, Chief Executive of NHS Blood and Transplant, said: "We know that young people are very committed to helping other people less fortunate than themselves and are great supporters of donation. Freshers' week is a time when many are already making big decisions about their life and their future. We want every student starting university to think seriously about joining the Organ Donor Register and becoming a regular blood donor - as part of the important decisions they will make this year about who they are and what sort of a society they want to live in - and take that step towards becoming a lifesaver."

Jack Davidson, 20, a pharmacy student at Keele University is undergoing treatment for acute lymphoblastic

leukaemia. Jack has received around 30 units of blood and five units of platelets. Ironically, his illness was discovered during an appointment to give blood at his local donor centre, something he had committed to doing from the age of 17. He said: "My treatment is underway and I'm sure I'll require more lifesaving blood transfusions. By making the commitment to give blood on a regular basis, students make treatment such as mine possible."

Gemma Pickett, 25, from Grimsby had a kidney transplant at the age of seven and recently graduated in nursing at Edge Hill, Lancashire. Gemma, who is about to get married, said: "Without the help of my donor I would not be here today and achieved what I have. I will be forever grateful."

No age limit to donation



Professor James Neuberger

More than half of the over 55s in the UK have written themselves off as potential organ donors, according to research commissioned by NHSBT, as they believe they are either too old or too ill for their organs to be of use.

In a study looking at the reasons why people aren't signed up to the NHS Organ Donor Register, the over 55s were twice as likely as the rest of the population to say they didn't think they would qualify as suitable donors.

Professor James Neuberger, Associate Medical Director at NHS Blood and Transplant, said: "The belief that there is some sort of age limit on becoming an organ donor is a complete myth. Organs are successfully transplanted from people in their 70s and 80s and the oldest cornea donor recorded was 104 years old. There are also very few illnesses that prevent someone from donating their organs after death - that's why we would encourage anyone who wants to sign up to the NHS Organ Donor Register to do so and ensure those close to them are aware of their wishes.

"Many people joke that we wouldn't want their organs, but with 10,000 people currently in need of a transplant, we really do."

The research has been carried out to understand the barriers to signing up as an organ donor, and to inform a major public awareness campaign, due to launch later this year. The UK has one of the lowest rates of organ donation in Western Europe at 13 donors per million of population. Spain has the highest rate of organ donation in Europe at 35 donors per million of population.

Lung transplant recipient wins a place on Fourth Plinth cont.

to promote LAM Action and lung transplantation. This seemed like a huge stage to get the message across about both things.

"It will be in complete contrast to how I spent my 38th birthday last year. I was in Harefield Hospital on one of 10 false alarms before I had my transplant. "A year ago, I would not have been able to stand up for 10 minutes let alone an hour."

Sculptor Anthony Gormley called for volunteers for his 'One and Other' Fourth Plinth Project earlier this year.

Since Monday, 6 July volunteers have been allowed to occupy the plinth 24 hours a day, for 100 days without a break.

For every hour, a different person will make the plinth their own, creating an uninterrupted succession of 2,400 volunteers and a unique portrait of the UK in the 21st century.

Three other volunteers have also helped to publicise blood and organ donation while standing on the plinth.

Blood donor, Jan Symes, 48 occupied it for an hour on 4 August. Kidney transplant recipient Elizabeth Oliver, 62, stood on the plinth on 10 August to highlight the need for more organ donors as did Tim Gerrard, aged 43 on 17 August, six months to the day after receiving a heart transplant.



Top left and bottom right Elizabeth Oliver, a kidney recipient, atop the Fourth Plinth in Trafalgar Square as part of Anthony Gormley's living monument. The plinth, usually reserved for Kings and Generals, was occupied every hour for 100 days over the summer. Elizabeth's slot was 10 August between 10 and 11pm. Bottom left Tim Gerrard.

Eye Retrieval at the time of Organ Retrieval

After a downward trend over many years we are now starting to see an increase in the number of multi-organ donors donating eyes. Organ donors tend to be younger than eye only donors and the fact that the donor is tissue typed means that the corneas are always in demand.

The historical practice for this type of combined donations is to retrieve the organs in the operating theatre and the eyes later, as a separate process (usually the following morning) in the hospital mortuary. This practice is now being considered more closely to try and optimise the eye donation process. The Royal College of Ophthalmologists Guidance on Eye Retrieval states

that eyes should be removed from a donor as soon as possible after death. The quality and safety of corneas is compromised with increasing post-mortem time for two main reasons:

1. With the passing of time there is an increasing microbial load on the ocular surface, due to lack of blinking and protective tear film. This leads to increased likelihood of bacterial and/or fungal contamination during storage rendering corneas unsuitable for transplantation.

2. With cessation of aqueous flow, there will be loss of nutrients for the corneal endothelium and build up of harmful metabolic waste products in

the aqueous humour, leading to greater endothelial cell loss with increasing post-mortem time.

Several donation teams are now facilitating eye retrieval in theatre following the organ retrieval which not only reduces the time to retrieval but reduces the risk of contamination as the retrieval is performed in controlled clean environment.

Eye retrieval is a fairly uncomplicated procedure that can be performed by trained Health Care Professionals and many of these professionals are comfortable with undertaking the eye retrieval in the operating theatre environment. Recently Bolton Eye

Retrieval Centre undertook eye retrieval as part of the organ retrieval process and both the enucleation and the reconstruction went smoothly with no complications. After the procedure was successfully completed the donation team were very impressed by how well combining both procedures fitted together.

The consensus was that combining both procedures is more dignified for the donor, it allows the multi-disciplinary donation teams to work together and optimises the eye donation process to provide the highest possible tissue for recipient patients.

Why I trained to retrieve eyes



Helen Williams

Helen Williams is an Ophthalmic Sister at the Royal Preston Hospital

Over the many years I have worked as a registered nurse in Ophthalmology I have seen the steady increase in the

number of patients requiring a corneal transplant. I have also seen the great benefits these transplants give to patients. Realising the importance of this operation to patients and recognising the generous gift made by donors and their families spurred me on to review the eye donation service within the hospital I work.

One of the main issues getting in the way of effective retrieval was the lack of availability of qualified ophthalmologists to do the retrieval due to other work commitments. After serious consideration I decided to undertake the eye retrieval course myself which was facilitated by the Manchester Eye Bank. I had assisted the ophthalmologists in the retrieval process several times so I had a very good idea about what was involved.

The training provided me with the practical knowledge and theoretical aspect of the retrieval. Once back in the hospital I started to retrieve under the

supervision of an ophthalmologist until I was competent. As with all nursing practice, gaining competency was not about how many eyes I retrieved but about when I felt competent to carry out the task on my own. I also kept a personal diary at the beginning to reflect on my practice which was very useful.

I believe in the holistic approach to patient care and this care should not stop when a patient dies. In undertaking eye retrieval I am often the last health care professional to provide care for the patient and I take great pride in undertaking it to the best of my ability. I also gain satisfaction from being able to carry out a person's last wishes so that they can help someone following their death.

Taking on this role has given me more confidence, job satisfaction and a greater insight into the important of this wonderful gift one person can give to another.

Eye retrieval manual

As a core reference and training document, the Eye Retrieval Manual is designed to help and guide users through the donation process, as well as give additional information and advice about issues they may encounter in their daily activities. In some cases the manual will point them towards sources of further information that they may wish to explore to gain additional knowledge pertinent to their area of expertise.

In conjunction with other documents, the manual will also help in setting out the operational standards for the eye

retrieval to determine the suitability of the tissue for clinical use. The manual covers a number of topics that are relevant to understanding the process of eye donation in the UK as well as giving some background knowledge to eye retrieval. The manual also includes detailed retrieval protocols and the accompanying procedures. The main topics of it are as follows:

- Eye donation process in UK
- The information needed to determine the suitability of a donor according to current legislation and professional guidance
- Eye retrieval, including the collection of a blood sample and restoring a donor's appearance following donation

- The responsibilities of individuals and organisations involved in the eye retrieval process
- An overview of the regulatory framework that guides eye donation in UK

The manual will be reviewed annually by the Ocular Tissue Transplantation Standards Group (OTTS) and the Ocular Tissue Advisory Group (OTAG) and updated accordingly.

More information

To get hold of a copy contact
Anthony.Clarkson@nhsbt.nhs.uk

How to become an eye retriever

Committed, well trained and competent eye retrievers are pivotal to the process of eye donation.

To become eye retrievers you must be a health care professional with an underpinning knowledge in basic anatomy, aseptic technique and infections control. Usually retrievers come with a nursing and mortuary background.

Before potential new recruits are accepted on the course they need to confirmation that they will be supported by an active, skilled and competent retriever who can support them following the initial training.

Candidates need to contact Bristol or Manchester Eye Bank in order to register for the course. Both Eye Banks run a one day course on a regular basis and a charge is made to cover the course expenses.

The course provides the student with the background to eye donation in the UK and gives an insight in to regulatory and legal framework governing eye donation and retrieval. It takes the student through the detail of eye retrieval, including blood sampling and provides practical training.

After completing the course, the student must undertake a number of retrievals in their respective trusts under the supervision of active and competent retrievers. Finally, following their supervised training students are assessed as competent before they work independently.

More information

To register for the Eye Retrieval Course please contact either:
Manchester Eye Bank
Isaac.Zambrano@cmft.nhs.uk
Bristol Eye Bank
P.D.Bowerman@bristol.ac.uk

Scoping the Potential for Organ Donation in Emergency Departments in the UK

□ Story in stats

64%

The percentage of hospitals (192) that had undergone a formal potential donor audit.

Background

Due to the critical shortage of donor organs and an ICU donor pool that remains relatively static, it is of great importance to investigate any additional sources of potential donors. The work of the North Thames Donor Team, demonstrated that there was significant potential for donation within Emergency Medicine.

The Organ Donation & Transplantation Donor Advisory Group therefore recommended a national scoping exercise was undertaken to consider the potential for heartbeating and controlled non-heartbeating donors in all Emergency Departments.

Inclusion Criteria for Potential Donor Audit

Organ Donation & Transplantation's national potential donor audit (PDA) collects data on every patient death in an intensive care unit under the age of 75. The majority of teams undertaking PDA in their Emergency Departments have used these criteria although there is considerable variation. Non-heartbeating donor criteria would normally include an upper age limit dependant on local policy and experience.

Findings

In the financial year April 2007 – March 2008, 22,329,796 people required admission to 299 Emergency Department providers. (See table 1).

192 hospitals (64%) had undergone a formal potential donor audit. Those hospitals targeted by the audit were

responsible for 80% of Emergency Department admissions and therefore more likely to be level one acute hospitals.

The duration of the audits varied between teams with 61 hospitals audited for a one year period and the remainder snapshot audits from three months to a calendar year. Collectively, 190 potential heartbeating or controlled non-heartbeating donors were identified. This equated to almost one potential donor per hospital.

Organ Donation & Transplantation Statistics Department have provided details of donors recorded as being registered in the Emergency Department. (See table 2).

There were 21 donors attributed to Emergency Departments according to the Core Donor Data in financial year 2007 – 2008

There is significant variation between the number of actual donors that were referred from Emergency Departments and proceeded to donation. This may in part be explained as the majority of these donors were facilitated in other clinical areas e.g. Intensive Care, medical admissions, recovery, and theatres.

It should also be noted that the conversion rates from potential to actual donors is 23%. It has not been possible to accurately reflect the relative refusal or approach rates with the information provided.

Additional findings and feedback

Several teams indicated in their feedback

that there were concerns within their Emergency Departments that the possibility of donation would impact on the national waiting time. One of the key performance indicators set by the Department of Health for NHS acute hospitals is that a specific percentage of patients attending an Emergency Department must be seen, treated, admitted or discharged in under four hours. In England and Scotland, this is set at 98% and at 95% in Wales and Northern Ireland.

Given the number of admissions annually, between 2% and 5% of patients (depending on the target set), therefore 500,588 patients do not have to leave department within four hours. There is also latitude for departments where some patients deemed clinical exceptions are not considered to breach the target waiting time. One of the quoted clinical exceptions are "patients who, despite the efforts of the emergency department team are expected to die imminently, should not be moved".

By reassuring EMD staff, that donation should not impact on their targets, concerns may be allayed and this may allow appropriate time for controlled non-heartbeating donation. Similarly, if a patient were diagnosed, using brain stem death criteria as recommended by the Organ Donor Taskforce Report, within the first four hours, they would not breach the target.

General concerns regarding donation in Emergency Departments centred on the management of the patient and whether they should remain in the department or be transferred to another area e.g. ICU, Theatres, and Recovery. The main concerns raised were similar from the feedback provided by the donor teams.

- Which clinician took responsibility for the patient and if death did not occur following withdrawal of supportive care who and which service continued to provide palliative care.
- Anaesthetists were unwilling to commit to managing a potential donor or performing brain stem death testing, as these are Emergency Department patients.
- The emergency doctors feel that they do not have sufficient competency to perform brain stem death testing
- Nursing staff in Emergency Department, Recovery or Theatres do not have sufficient competency looking after a ventilated patient

- Some areas do not having the space or facilities to accommodate the potential donor or their family.
- The Critical Care Directorates are also reluctant to accommodate these potential donors, as they feel uncomfortable about admitting someone they or the neurosurgeons have already decided not to treat which may disadvantage future admissions to the Unit.

Where possible, most teams tried to provide two co-ordinators, however, this was not always feasible. The Birmingham team provided their referral flow chart (see below), which is being introduced to their units and has been positively received.

Recommendations

- Organ donation developmental programmes to be introduced in all EMDs as part of a hospital development plan.
- Introduce EMD guidelines for identification and referral of all potential donors.
- Local decisions should be proactively developed to augment the management of potential brain stem dead patients until formal diagnosis can be made. These should include where the patient should be managed, by whom and who is best suited to carry out formal Brain Stem Death testing.
- Formal testing of all patients who meet criteria for brain stem death should become the norm.
- Consider extending the PDA to all Emergency Departments to ensure any variation from referral standard is documented and investigated.

Conclusion

This exercise has demonstrated that there is potential for organ donation in EMDs. If all these 190 potential donors were realised it would increase cadaveric donor numbers by 23% on 2007/2008 levels.

Government region	Total Emergency Department admissions
Scotland	1,401,988
England	19,127,993
Wales	1,090,489
Northern Ireland	709,326
Total	22,329,796

Table 1

Donated organs	Number of donors
Kidneys	23
Kidneys & liver	7
Kidneys & pancreas	2
Kidneys, liver & pancreas	3
Kidneys, liver, pancreas & lung(s)	3
Total	38

Table 2. Emergency Department organ donors, April 2005 - March 2008 UK

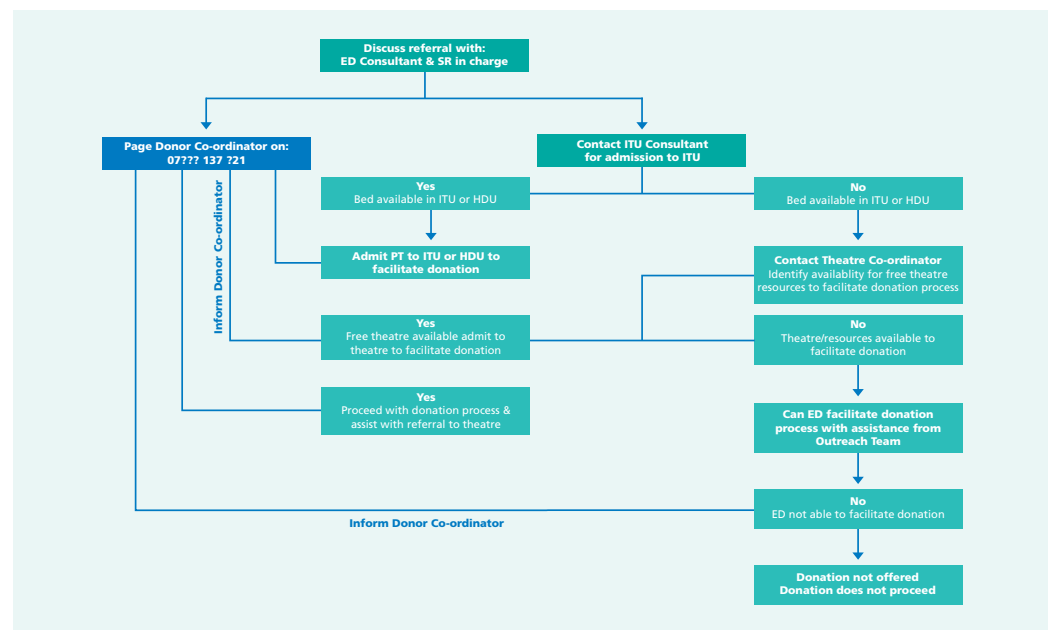
There is an acknowledged ethical conflict here with regard to what is in the best interest of the patient between emergency medicine, critical care and neurosurgeons, however, regard should be given to those patients who have registered their decision to donate with respect to end of life choices.

Maximising the potential of EMDs is a realistic option in addressing the critical shortage of donor organs.

Neil Healy
Donor Transplant Co-ordinator
Scotland

Deirdre Cunningham
Donor Co-ordinator Team Leader
Midlands

Lesley Logan
ODT Regional Manager
Scotland



Birmingham Team Emergency Department Referral Flowchart

Controlled non-heartbeating organ donation from the Emergency Medicine Department

Andy Eynon is the Clinical Lead for Organ Donation at Southampton University Hospitals NHS Trust and The College of Emergency Medicine's representative on the Donation Advisory Group of NHS Blood and Transplant (NHSBT). In this article he looks at how organ donation can be facilitated through hospital Emergency Medicine Departments (EMDs).

The process of controlled, non-heartbeating organ donation (NHBOD) is established within many intensive care units in the UK. Audits from EMDs have revealed significant potential for donation from non heart beating donors and a few hospitals have facilitated NHBOD from the EMD. In a department where timeframes are foreshortened and clinical demands are often more pressing even than in the Intensive Care Unit (ICU), donation can be difficult but not impossible to facilitate. This article highlights both the opportunities and obstacles to NHBOD and how Clinical Leads for Organ Donation (CLODs) can facilitate the process in the emergency department (ED).

What is the potential for organ donation from EDs?

Data presented to the Donation Advisory Group of NHSBT indicates that in 2007/8 there were 190 potential donors identified nationally in EMDs, of which 21 donors proceeded. (www.organdonation.nhs.uk/ukt/about_us/advisory_groups/dag/pdf/dag_minutes_08_2.pdf). Of the potential donors, the majority (120) were NHBOD. In Southampton, there were two referrals

from the EMD in 2007 both of which proceeded. In 2008, four referrals were made of which three proceeded.

Futility

Decisions regarding the futility of continued treatment are daily occurrences in the EMD. There are defined standards produced by professional and regulatory bodies to support doctors and nursing staff in this regard. Once the decision has been made that continued treatment is not in the best interests of the patient, there follows discussion with the family as to the reasons for that decision and details of how treatment would be withdrawn. It is at that point that our practice is to raise the question regarding the patient's wishes regarding organ donation. The organ donor register provides a means of checking whether the patient had indicated a preference that may not have been communicated to the family. Decisions regarding futility must be clearly documented, including details of the staff consulted and the family members informed.

Facilitating

Donor co-ordinators are now focusing on the potential for organ donation in the EMD and work closely with staff to deliver an education programme that identifies potential donors and facilitate donation. Embedding donor coordinators within hospitals means that they are increasingly available to answer relatives' questions regarding the process and to seek consent. The time and space required to organise the

donation is probably the most difficult part of the process for most emergency departments EDs. The four-hour target can be suspended for clinical reasons (The Department of Health in 2003, stated that 'patients who, despite the efforts of the EMD team are expected to die imminently, should not be moved') but it should be recognised that the resuscitation room is not the ideal place for the management of such patients. It is essential that the necessary investigations are obtained quickly, that the transplant team arrive promptly and that theatre space is available immediately when required. The CLOD can help EMDs in ensuring that all parts of the donation process are expedited.

Withdrawal of therapy

By no means all patients who have been considered for controlled NHBOD will die within the time frame allowed for donation. Indeed, most CLODs will have had experience of patients who have recovered after discussions regarding futility have been held with family members. The Intensive Care Society advises against specific interventions designed to improve the chances of organ donation; patients should continue to be managed within a clinical environment and standard palliative care practices should be followed. If the patient does not die within the given time frame for donation, their care should be transferred to an appropriate ward setting.

There are obstacles to the success of NHBOD programmes, including a significant proportion of the physicians

who have voiced concerns regarding its ethical and moral framework. A UK-wide ethics committee is being established to help to address these concerns. NHBOD programmes can help to ensure that a patient's final wishes are fulfilled with regard to organ donation. The role of the CLOD in the EMD is to ensure not only that the opportunity is available but also that the process has the minimum disruption to the running of the department.

More information

If you would like to contact Andy Eynon, these are his details.

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Next issue

The special section in the next issue of Bulletin will look at the quality of life in paediatric patients with contributions from Dr Amy McNaughton Clinical Psychologist, Cardiopulmonary Transplant at Freeman Hospital and Girish Gupta, Consultant Paediatric Hepatologist special interest: Small bowel transplantation, Liver Unit Birmingham Children's Hospital.

Educating EMD staff about Organ Donation

Paula Aubrey is team leader for the London Transplant Co-ordination Service and a doctoral student writing her thesis on how to increase organ donation from deaths in Emergency Medicine departments.

Paula has developed an education programme to maximise the organ donor potential from Emergency Medicine departments (EMDs). The programme has been operating in the North Thames area since 2005 and has resulted in a dramatic increase in solid organ donation.

Here, she explains how the education programme works.

Every day three patients die in the UK whilst waiting for a transplant operation. It is absolutely crystal clear that we have no margin in the UK to miss any potential organ donors. There is evidence to suggest that we are missing organ donors from other areas of the hospital such as the EMD and medical admission wards.

In order to address this, it is essential that donor transplant co-ordinators develop and deliver an efficient and effective organ donation education programme to all EMDs across the UK.

The two major barriers to transplantation in the UK are the lack of deceased donors and the refusal rate of relatives, which stands on average at 41% across the UK. The majority of organ donors are referred from the intensive care unit (ICU) and despite numerous initiatives to increase potential donor referrals from the ICU, the numbers remain static. The Organ Donation Taskforce stressed that organ donation should be embraced as 'a usual not an unusual event'. This involves exploring all

areas of a hospital that may have a potential for organ donors including the EMD and medical admission wards.

“The two major barriers to transplantation in the UK are the lack of deceased donors and the refusal rate of relatives, which stands on average at 41% across the UK.”

■ The North Thames EMD education programme was shaped by the findings of a retrospective audit of deaths undertaken in a group of EMD departments in the area. This identified a significant missed potential of solid organ donors that had not been realised. The EMD programme involved assessing

the educational needs of EMD nursing and medical staff, and developing instructive programmes aimed at helping key clinicians to identify potential donors. Key clinicians are all those who have some responsibility for caring for potential organ donors and their families and include:

- Hospital Consultants – EMD, Anaesthetic & Neurosurgeons, Trauma Leads,
- Emergency trauma team
- EMD nursing and medical staff
- HM Coroners and HM Coroners officers.

Appropriate educational forums in which to capture the above key healthcare professionals have been identified as the following:

- Hospital grand rounds
- Emergency trauma meetings
- Critical care delivery groups
- Critical care networks
- Senior nurse meetings
- Clinical governance meetings.

There is no doubt that as healthcare professionals we all have a responsibility in addressing the organ donor shortage. During the audit phase factors that contributed to non donation in the EMD were identified as:

- Lack of confidence and experience in offering donation to acutely bereaved families
- Limited resources, lack personnel, physical space and a shortage of ICU beds
- Prevention by HM Coroner
- No contact details for DTC.

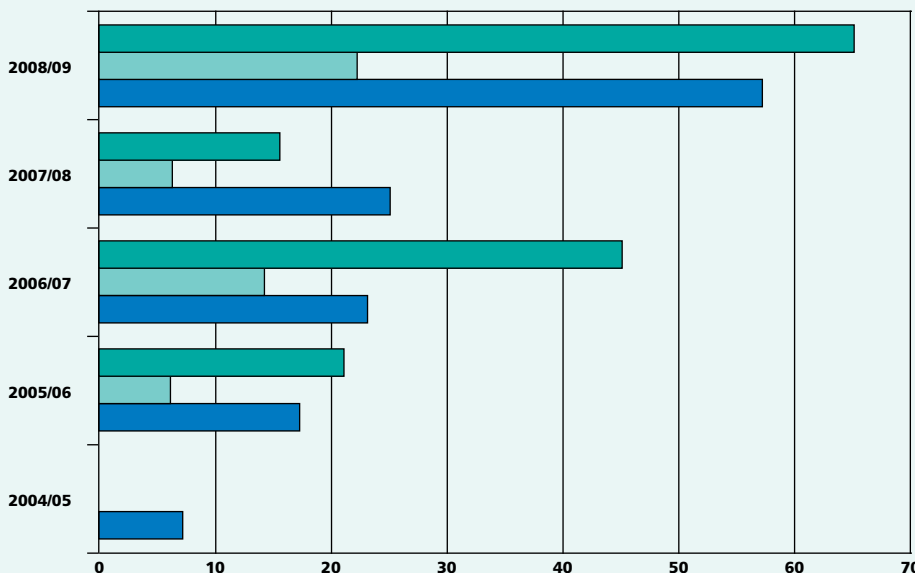
However, the major contributing factor why we had a missed potential of organ donors in the EMD was a direct result of a non-existent donor education development programme which focused on organ donation from the EMD.

DTCs play a fundamental role in ensuring all EMDs are delivered an efficient and effective organ donation education programme. This should be introduced in all regions across the UK. I also strongly recommend that all EMD deaths are audited in the UK in line with ICUs. This would provide a solid basis on how we shape the EMD programme nationally. It would also require the DTC to have a regular presence in the EMD which is invaluable in raising the profile and developing new relationships with key staff.

Medical practitioners who work in the EMD play a pivotal role in identifying potential organ donors from within the emergency department and referring them to the local donor transplant co-ordinator. We should be aiming for 100% referral rate from the EMD. One initiative towards achieving this objective would be for DTCs to be informed about every patient whose situation is deemed futile. This would enable DTCs to assess whether the patient is a potential donor before they are extubated.

“Every day three patients die in the UK whilst waiting for a transplant operation.”

The North Thames DTCs have proven that a potential for organ donors exist in the EMD. They also are confident that the same potential exist across the UK. In 2003, North Thames reported that there were eight donor referrals from the EMD resulting in one donor and three solid organ transplants. In 2008/09 we had 58 donor referrals resulting in 23 donors and 65 solid organ transplants. Although these results are encouraging they are far from the 100% referral rate that we are aiming for.



North Thames Donor Activity from the EMD 2004/05-2008/09.

Next steps

Following on from the success of the North Thames donor transplant co-ordination (DTC) team in implementing organ donation programmes in Emergency Departments (EMDs) in their region many other DTCs have reported

similar successes in their own regions. Activity for 2007/08 and 2008/09 can be seen in the following tables.

As well as facilitating donation in EMDs it will be as important, as it has been in intensive care units (ICUs), to audit the potential for donation. Again some DTCs teams have already started auditing in the EMDs in their regions

Donor type	07/08	08/09	% inc.
HB	9	9	0.0%
NHB	13	19	46.2%
Total	22	28	27.3%

UK organ donors from EDs, Apr 07 - Mar 09

Organ	07/08	08/09	% inc.
Kidneys	18	18	0.0%
Pancreata	5	7	40.0%
Livers	8	9	12.5%
Lungs	5	4	-20.0%
Hearts	0	4	
Total orgs	36	42	16.7%

Organs donated: HB

but not all. But with the significant expansion to the workforce and the fact that all acute hospitals will have an identified resident DTC this will ensure that this can happen across the UK.

On 1 October 2009 the revised electronic Potential Donor Audit will go live. The audit tool is now compatible for auditing deaths in both ICUs and

EMDs and this will provide valuable information to both DTCs and Clinical Leads in working together to ensure that opportunities for organ donation are maximised in all hospitals.

Sue Falvey

Head of Nursing Development, Organ Donation and Transplantation, NHSBT

Organ	07/08	08/09	% inc.
Kidneys	26	35	34.6%
Pancreata	3	8	167.7%
Livers	3	9	200.0%
Lungs	0	2	
Hearts	0	0	
Total orgs	32	54	68.7%

Organs donated: NHB

Organ	07/08	08/09	% inc.
Kidneys	44	53	20.5%
Pancreata	8	15	87.5%
Livers	11	18	63.6%
Lungs	5	6	20.0%
Hearts	0	4	
Total orgs	68	96	41.0%

Organs donated: HB + NHB

DTC update

Following the very successful TUPE transfer of six DTC teams in 2008/9 work has continued to meet the objectives outlined in the ongoing plan.

The Yorkshire team, which is a merger of those staff previously working in Leeds and Sheffield, are now operating from a central office base at Capitol Park.

The South Thames team, previously based at Kings College, are working with other relevant teams to reconfigure the hospitals they cover and begin functioning as the South East Team. The permanent central office hub at Horsham has been fully functioning from 1 September.

The South Central team (Portsmouth and Oxford) were successfully transferred to NHSBT employment at the beginning of July and the team took occupation of their central office base at the Oxford Science Park in mid September.

The teams based in the East and West Midlands transferred into NHSBT employment at the beginning of August to form the Midlands Team. Their central office hub is based at the Research and Development Park in Birmingham.

In September the Plymouth and Bristol teams successfully transferred to

form the South West team. The team take occupation of their office in Exeter during October.

The plans for the remaining teams across the UK are to transfer their employment and reconfigure them as per the remapping that was consulted on and agreed in 2008/09.

- 1. Eastern (Cambridge) – Premises in Cambridge. Planned transfer October 2009**
- 2. Wales – premises in Cardiff. Planned transfer October 2009**
- 3. Northwest (Manchester and Liverpool) – premises at Speke. Planned transfer November 2009**
- 4. Northern Ireland - premises in Belfast. Planned transfer February 2010**
- 5. Newcastle premises in Newcastle Blood Centre. Planned transfer March 2010**

Work continues across the UK to negotiate the placement of co-ordinators within each of the acute hospitals. There are currently circa 62 coordinators based within acute hospitals and dedicated IT resources have been identified to work closely with them to ensure effective and efficient IT solutions are in place. The fifth national recruitment campaign goes live in October and to date recruitment targets have been met.

Clinical Leads in Organ Donation update

There are now 133 out of 195 potential Clinical Leads appointed across the UK. In the main these Clinical Leads are in hospitals with the highest donation potential. Sixty out of a final 183 Donation Committee Chairs have been appointed (non Clinical Champions) and 53 out of a potential 183 Donation Committees are now set up and functioning.

A Professional Development Programme consisting of both clinical and leadership elements is in the process of being designed for Clinical Leads to roll out next year. NHSBT are working with Deloitte, a business advisory specialist, and medical professional bodies to develop a training programme for Clinical Leads to ensure they have the full range of skills to ensure an increase in organ donation.

Chairs of Donation Committees will also be able to access some elements of the programme.

NHSBT are working with Deloitte, a business advisory specialist and medical professional bodies to develop a training programme for Clinical Leads to ensure they have the full range of skills to ensure an increase in organ donation.

“ NHSBT are working with Deloitte, to develop a training programme for Clinical Leads to ensure they have the full range of skills to ensure an increase in organ donation. ”

Cardiothoracic Advisory Group

CTAG met on 11 March 2009

■ At the last meeting it was agreed that the '18 week' clock would start upon referral for transplantation against the agreed criteria and the clock would stop when a decision to add the patient to the transplant list is communicated to the patient or original referrer. Subsequent to this agreement the Department of Health agreed that any referral for transplantation would start the '18 week' clock and that no minimum criteria could be stipulated in this way. This process will be monitored by NCG over the coming year to assess how centres are able to respond to this target.

■ The limits for the adult urgent heart allocation scheme will continue unchanged for 2009/10 at six registrations for each adult centre and one for Great Ormond Street Hospital.

■ CTAG endorsed the proposed inclusion/exclusion criteria for the paediatric urgent heart allocation scheme which had been agreed between the two paediatric centres at the Freeman Hospital, Newcastle and Great Ormond Street Hospital, London. Any requests for patients outside these criteria will first be discussed with the other centre before being referred to the Chair of CTAG.

There are plans in place for NCG to provide funding for two 18-month fellowships in cardiothoracic transplantation at Papworth Hospital and at the Freeman Hospital, Newcastle.

■ Representatives from adult centres expressed reservations about including desensitisation as a criterion of urgency for paediatric patients due to adult outcomes, and the paediatric community will make a decision based on their knowledge of their individual practices. If there is a case to be made for paediatric desensitisation then CTAG will consider a joint proposal from both centres.

■ Discussion took place on the options available to address the inequality between the two paediatric centres, including the possibility of Newcastle forfeiting its access to zonal donors for paediatric patients and instead having a preferential offering system on a rotational basis with GOSH. Due to concerns that any changes

may detrimentally affect the adult population, further work will be carried out on allocation according to donor size and reported to the next meeting. In the meantime, the existing arrangements remain in place.

■ As the number of patients with anti-HLA antibodies is increasing and patients who are sensitised to most donors are very unlikely to receive a transplant, CTAG considered a proposal for a sensitisation threshold above which patients should not be listed for lung transplantation. It was felt that it would not be practical to set a standard threshold for use in all centres and the decision whether to list should be at the discretion of the individual centre.

■ There are plans in place for NCG to provide funding for two 18-month fellowships in cardiothoracic transplantation at Papworth Hospital and at the Freeman Hospital, Newcastle. It is hoped that funding will be provided for additional fellowships in 2010 and details will be e-mailed to centres.

■ The Royal College of Surgeons and the British Transplantation Society have been offered the opportunity of temporary post-CCT fellowships for organ retrieval, and those centres involved in either abdominal or cardiothoracic organ retrieval will be contacted to ask if they wish to participate.

Pancreas Advisory Group

PAG met on 3 April 2009

■ Following a review of the first six months of the new National Pancreas Allocation Scheme for sensitised patients the qualifying limit was increased to a 75% calculated Reaction Frequency in November 2008.

■ The proposed pancreas allocation scheme will use a newly defined computerised Pancreas Matching Run (PMR) which orders patients according to pre-defined priority criteria. Patients will accumulate a total points' score which will be used to sort patients into a priority offering sequence and the patient with the highest total points score will receive the first offer. The Duty Office will continue to offer in priority sequence until the organ is accepted. The scheme will be developed and implemented as soon as IT systems can be put in place. Data can then be collected to allow further refinement of the scheme.

■ PAG endorsed a proposal to compensate patients for loss of waiting time caused by administrative or transcription errors. This would be similar to that which exists for kidney allocation whereby the lost waiting time is reinstated for the purposes of allocation and, on rare occasions when the patient has missed an offer

of a kidney, the patient is prioritised for allocation of a suitable alternative kidney. At the moment the process for a missed national offer will only apply to patients in the sensitised patients' scheme.

■ In order to ensure continuity of the current islet transplant service all patients listed for islet transplant will need to be re-registered with ODT at least one week prior to the ODT official launch date of the new allocation arrangements for pancreas islet transplantation. Once the programme is live within ODT, centres can maintain and register patients for an islet transplant by returning a paper copy of the Kidney/Pancreas and Islet Recipient Registration Form to ODT. In addition, those centres with access to the UKT online system may use this to maintain and register patients. There will be two islet transplant lists; a priority list for those patients who have received a previous islet transplant and require a second islet transplant as part of their full treatment regime; and the routine transplant list for all patients receiving their first islet transplant or those who are clinically considered to be starting their islet transplant treatment regime, regardless of historical islet transplant treatments. Within these groups waiting time will be used to prioritise blood group identical (or blood group AB when the donor is blood group A) and HLA compatible patients for offers of organs. In the event of an insufficient islet yield or positive cross-match then, in order to reduce the transport arrangements for cross-matched material, the offering sequence should revert to:

- Any priority patient at the same centre (longest waiter first)
- Any other national priority patient (longest waiter first)
- Any routine patient at the same centre (longest waiter first)
- Any other national routine patient (longest waiter first).

To avoid delays in implementing the islet registration and allocation arrangements this arrangement was not included in the scheme. However, this will be monitored and any changes required will be implemented when necessary.

Donation Advisory Group

DAG met on 27 April 2009

■ The policy for pregnancy in potential deceased organ donors has been finalised and will be disseminated to donor transplant co-ordinators/intensive care units.

■ Work is ongoing on the commissioning of Donation Committees and the appointment of Clinical Leads for Organ

Donation within Trusts; engagement of the wider NHS; development of a professional development programme; development of national standards for deceased donation; and development of a regional network. A personal development programme and toolkit is being developed for the Clinical Lead role and going forward it is hoped to add national standards for donation to the NHS Choices website using Map of Medicine health guides.

A sub-group will be established to debate the issue of organs from non-heartbeating donors.

■ DAG noted evidence that the codes of practice for the diagnosis and confirmation of death are causing concern in the intensive care community as they are being interpreted in different ways. This will be reported to the Chair of the Academy of Medical Royal Colleges.

■ A sub-group will be established to debate the issue of organs from non-heartbeating donors. These are subject to local programmes supported by national guidance which allows a degree of latitude in some management issues, which can possibly lessen the donation potential of some donors unnecessarily. There is also little clarity, and therefore some variation in practice, about the diagnosis of death within the context of donation after cardiac death (DCD).

■ The aims of DAG are to act as a source of advice to the ODT directorate; assist in the development and introduction of processes to increase all aspects of organ and tissue donation; and to act as a conduit between ODT and the various professional groups involved in donation. It is important that DAG should have a life beyond the implementation of the Taskforce recommendations. At that time the Group will need to offer strategic advice and feedback from users; develop guidelines and hold a much greater ownership of the PDA. The UK-wide Donation Ethics Committee, established as a result of the Organ Donation Taskforce recommendations will not be considering day-to-day ethical problems within its remit and in light of this consideration will be given to the establishment of a PDA forum and an Ethics sub-group of DAG.

■ Revised DAG terms of reference will be circulated to members for comment and finalised prior to the next meeting when the membership will be reviewed to strengthen and reinforce the work of DAG going forward.

■ The results of the ACRE study show there is no statistical difference between

the two approaches used for consent to organ donation, namely an approach by the clinical team alone (routine requesting), or by the clinical team and a donor transplant co-ordinator (collaborative requesting). A paper on the study has been submitted to the British Medical Journal.

Liver Advisory Group

LAG met on 6 May 2009

■ As part of a review of NHSBT Advisory Group work it is planned to engage with a wider group of interested parties. This would accommodate requests from patient support groups such as the British Liver Trust to be represented on LAG.

■ A paper is being taken to the NHSBT Board in support of NORIS (National Organ Retrieval Imaging System). This system is desirable in terms of giving clinicians more confidence in accepting an organ and it is hoped to incorporate NORIS into the electronic offering system in the future.

■ The UK Liver Transplant Audit is a joint undertaking between NHSBT and the Clinical Effectiveness Unit of the Royal College of Surgeons. Currently there are variances in the mechanisms for investigating signals and work will be taking place in an attempt to make them consistent across the different organ groups.

■ The question of whether to include more categories for the registration of an adult patient for an elective first liver transplant was raised. Currently the patient must satisfy at least one of the criteria of chronic liver disease, hepatocellular carcinoma or a variant syndrome. No further categories will be added at this time. Any cases outside of the list of variants would need to be considered via the National Appeals Panel process.

■ A paper providing information on adult elective registrations from 1 April 2008 to 31 March 2009 and which focused on a centre's registration percentage share and the donor pool that is required to match this registration percentage share, was received for consideration. A similar analysis was carried out looking at registrations over the 19 month period after the introduction of the new elective liver transplant list on 1 September 2007. For comparison, the

percentage share of registrations and donors used in the calculations to revise the liver zones introduced on 1 July 2008 were also presented. Currently all centres are within a 2% difference between registration and donor percentage share. The zones will not, therefore, be changed at this time but will be reviewed annually. If changes to the zones are required this will take place when the difference between a centre's share of donors is deemed to be statistically significant in terms of the numbers, rather than using a simple percentage difference, that a centre is over/under what they should be for the purpose of their registrations. An analysis of registrations for one year and donors for three years will take place annually. If no changes are required this will continue on a cumulative basis from the baseline. If, for any one centre, there is a statistically significant difference between the proportion of donors and registrations then the liver zones will be changed and centres notified.

As part of the plans for a national retrieval service it is anticipated that in the retrieval of livers from non-heartbeating donors the recipient centre will be invited to send an observing surgeon to accompany the team and, if necessary, to assist with the retrieval process.

■ LAG members considered whether an adult patient outside the selection criteria for a first elective liver transplant can receive a liver from a domino donor identified from a centre's own list, hence be registered on the national liver transplant list without having to go through the Appeals Panel for that patient. Members agreed that as retrieving centres have preferential use of domino livers outside of the formal liver allocation process then the intended recipient must be on the transplant list and therefore should fulfil minimal waiting list criteria. Any

exceptions must be agreed by the National Appeals Panel.

■ Due to the fact that indications for Cystic Fibrosis are nebulous each case should be discussed by the Appeals Panel on an individual basis rather than Cystic Fibrosis being classed as a separate variant syndrome category.

■ Members considered whether the liver allocation rules should change if the circumstances of a donation alter, ie from non-heartbeating to heartbeating donation. The allocation process should remain the same even if the circumstances of donation change after the offer has been accepted. However, a patient listed as super-urgent would have priority on that graft.

■ As part of the plans for a national retrieval service it is anticipated that in the retrieval of livers from non-heartbeating donors the recipient centre will be invited to send an observing surgeon to accompany the team and, if necessary, to assist with the retrieval process. It would not be appropriate to have both the designated retrieval team and a team from the recipient centre on site to retrieve these organs.

■ The BTS Executive suggested that the monitoring of outcomes of living organ donors should be mandatory and it would be desirable for NHSBT to take on this role. NHSBT has no mandatory authority to collect this data but LAG members felt it would be useful for NHSBT (ODT) to collect long term data on living liver donors.

■ NCG has developed a tariff for liver transplantation following discussions between NCG and all seven liver transplant centres. The anticipated implementation date for the tariff is April 2010. A system of adjustment will be in place for those centres which are severely affected by the change after the first year.

Kidney Advisory Group

KAG met on 20 May 2009

■ Funding for EBV testing is not included in the reimbursement to hospitals for identifying potential donors but further work is being carried out on the issue of reimbursement. The concerns of KAG around the feasibility of screening for HTLV1 and EBV are to be taken up with SaBTO.

■ KAG had previously agreed that a

patient whose renal function had failed immediately following live kidney donation would be entitled to priority on the kidney transplant list for a deceased donor kidney. Following the meeting this decision was extended, with the agreement of KAG members, to include priority for the first and also any subsequent renal transplants that are required.

■ Robust reference costs for kidney transplantation are being developed with the aim of moving to a tariff during 2010/11. A separate workstream is also considering H & I services for transplantation.

■ A national paired donation workshop has been arranged for Wednesday 30 September in London.

■ KAG had previously decided that it was not appropriate for a pair from outside the UK to be registered in the paired donation scheme. However, in light of the geographical proximity, KAG members agreed to a request from the Republic of Ireland for inclusion. The HTA have confirmed that there is nothing to prohibit the inclusion of a pair from elsewhere, provided that they are assessed in accordance with HTA procedures.

Robust reference costs for kidney transplantation are being developed with the aim of moving to a tariff during 2010/11. A separate workstream is also considering H & I services for transplantation.

■ A proposal for priority allocation of kidneys to paediatric patients in whom dialysis access is running out was agreed in principle with the caveat that a protocol should be developed to specify the procedure to be followed and who will be involved in the decision-making process on behalf of the paediatric sub-group. Any decisions will be advised to the centre concerned which, in turn, will be responsible for advising ODT to ensure the patient is listed. There is no requirement for KAG to endorse the prioritisation of individual patients under this proposal.

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Monday 19 and Tuesday 20 October
Cord Blood Transplantation -
Future Challenges

A joint Anthony Nolan Trust, BBMR and NHS Cord Blood Bank and BSBMT Symposium

Location: Telford Lecture Theatre, One Great George Street, Westminster, London SW1P 3AA

The next BSBMT meeting is a joint symposium with the Anthony Nolan Trust, BBMR & NHS Cord Blood Bank. The registration fee is £50 per person while Dinner on Monday evening is subsidised at £40 for UK attendees. There are limited places for Dinner and early registration is essential to secure a place.

Contact: Carla-Jane Earl, Meetings Manager, Hartley Taylor Medical Communications Ltd
 Tel 01844 275650
 Fax 01844 274407
 E-mail carla@hartleytaylor.co.uk
 Web www.hartleytaylor.co.uk

Tuesday 27 October
SaBTO Public Meeting: Blood Donation –
Selection, Deferral and Exclusion
Location: Royal Horticultural Halls,
 London SW1P

The 2nd annual public meeting of SaBTO, the Advisory Committee on the Safety of Blood, Tissue and Organs. This meeting will focus on blood donor selection.

Contact: The event is free of charge. If you are interested in attending, email SaBTO@dh.gsi.gov.uk by 25 September.

Sunday 1 November
Mind, Body and Soul Exhibition
Location: Layer Marney Tower, near
 Colchester 1100-1700 - £5 entry on the day

From aromatherapy and reflexology, to healing hands and holistic therapy, visitors will have the opportunity to learn about the many different ways to sooth mind, body and soul. Exhibition space is still available. Support Kidney Research UK in providing a brighter future to the three million people whose lives are threatened by chronic kidney disease. Discount available until Friday 25 October.

Contact: Georgia McCormack, Community Fundraising Manager, Kidney Research UK
 Tel 0148 021 6016
 Mobile 0795 051 0745
 Email georgiamccormack@kidneyresearchuk.org

Tuesday 3 - Wednesday 4 November
13th Annual NHSBT/BTS Organ
Retrieval Workshop

Location: University of Birmingham Conference Centre, Birmingham
 This is a two-day workshop designed to optimise the quality of organs offered for transplant by improving the quality of retrieval practice between time of identification of the donor to retrieval, storage and preparation for implantation. The course is aimed at retrieval team members involved in the surgical retrieval of organs intended for transplant and includes lectures and workshops together with practical demonstrations of retrieval techniques. The course fee of £150 includes all training and one night's hotel accommodation and meals.

Contact: Kathy Zalewska, Corporate Services, Organ Donation & Transplantation Directorate, NHS Blood & Transplant
 Tel 0117 975 7589
 Email kathy.zalewska@nhsbt.nhs.uk

Wednesday 3 - Friday 5 March 2010
Diabetes UK Annual Professional
Conference 2010

Location: Liverpool
Contact: Claire Opaleye, Diabetes UK
 Tel 020 7424 1000
 Fax 020 7424 1081
 Email conferences@diabetes.org.uk
 Web www.diabetes.org.uk/apc

Saturday 15 - Tuesday 18 May 2010
Florence 2010
Immune-related Gene Polymorphism in
Health and Disease

24th European Immunogenetics and Histocompatibility Conference (EFI) and 17th Annual Meeting of Italian Society for Immunogenetics and Transplantation (AIBT) Registration and abstract submission opens on 1 October 2009
Contact: Organising Secretariat
 Tel +39 02 2643 2454
 Fax +39 02 2643 3754
 Email info@efi2010.eu
 Web www.efi2010.eu

Sunday 15 - Thursday 19 August 2010
XXIII International Congress of the
Transplantation Society (TTS)

Vancouver Convention and Exhibition Centre, British Columbia, Canada
 Abstract submission opens September 2009. Online registration opens November 2009

Contact: Grit Schoenherr, International Conference, Services Ltd, 2101-1177 West Hastings Street, Vancouver BC Canada V6E 2K3
 Tel +1 604 681 2153 ext. 112
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 Email tts2010-marketing@meet-ics.com
 Web www.transplantation2010.org

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