

**NHS BLOOD AND TRANSPLANT
ORGAN DONATION AND TRANSPLANTATION DIRECTORATE**

**MINUTES OF THE TWELFTH MEETING OF THE NHSBT CTAGH HEART ADVISORY GROUP
ON WEDNESDAY 10TH OCTOBER 2018 11:00-16:00
AT CORAM CAMPUS, 41 BRUNSWICK SQUARE, LONDON, WC1N 1AZ**

PRESENT

Jayan Parameshwar (JyP)	Chair of CTAG, Royal Papworth Hospital
Nawwar Al-Attar (NAA)	Heart Surgeon, Golden Jubilee National Hospital
Ayesha Ali (AA)	Highly Specialised Services, NHS England
Mike Burch (MB)	Heart Surgeon, Great Ormond Street Hospital
Pedro Catarino (PC)	BTS Rep, Royal Papworth Hospital
Ben Davies (BD)	Cardiac Surgeon, Great Ormond Street Hospital
Melissa D'Mello (MD'M)	CTAG Lay Member
Owais Dar (OD)	(Deputising for Andre Simon) Cardiac Surgeon, Harefield Hospital
John Dark (JD)	NORS Clinical Governance Lead
Paula Darlington (PD)	Deputising for Lynne Ayton for Transplant Managers Forum
Rob Graham (RG)	Co-Chair of CTAG Patient Group
Margaret Harrison (MH)	CTAG Lay Member
Asif Hasan (AH)	Heart Surgeon, Freeman Hospital
Clive Lewis (CL)	Heart Surgeon, Royal Papworth Hospital
Sern Lim (SL)	Heart Surgeon, Queen Elizabeth Hospital
Lesley Logan (LL)	Lead Transplant Recipient Coordinator
Jorge Mascaro (JM)	Centre Director, Heart Surgeon, Queen Elizabeth Hospital
Jonathan McGuinness (JMCG)	Observer – Cardiothoracic Surgeon, The Mater Hospital, Dublin
Jackie Newby (JNe)	Head of Offering, NHSBT
Jane Nuttall (JNu)	Recipient Coordinator, Wythenshawe Hospital
Gareth Parry (GP)	(Deputising for Guy MacGowan) Heart Physician, Freeman Hospital
Nicky Ramsey (NR)	Recipient Coordinator, Harefield Hospital
Sally Rushton (SR)	Senior Statistician, NHSBT
Rajamiyer Venkateswaran (RV)	Heart Surgeon, Wythenshawe Hospital
Sarah Watson (SW)	Programme Director, Highly Specialised Services, NHS England
Mike Winter (MW)	National Services Division, NHS Scotland

IN ATTENDANCE

Ms Lucy Newman (LN)	Secretary, NHSBT
Mrs Nicola Schulz (NS)	Information Officer II, NHSBT

APOLOGIES

Lynne Ayton, Gareth Brown, Vaughan Carter, Catherine Coyle, Jonathan Dalzell, John Forsythe, Sue Fuggle, Ben Hume, Guy MacGowan, Joe MacGee, Rutger Ploeg, Anthony Snape, Laura Stamp, Mick Stokes, Craig Wheelans

	Item	Action
	Apologies and welcome JyP welcomed members and thanked them for their time and attendance today.	
1	Declarations of interest There were no declarations of interest from members in relation to the CTAG Hearts Meeting today.	
2	Minutes of the meeting held on Wednesday 25th April 2018	
2.1	Accuracy One alteration was required to the Heart Minutes (CTAGH(M)(18)01(Am)) 1. Section 8 – a similar process to the lung or kidney utilisation telecons could be adopted, feeding back to centre directors. Two alterations were required for the Shared Minutes (CTAGS(M)(18)01(Am)) 1. Section 4.1, paragraph 3 – Around 30% of cardiothoracic offers are group offers and when group offers are made, it seems that some centres won't speak to the transplanting surgeon <i>when the centre is low down on the allocation sequence.</i>	

2.2	<p>2. Section 6.4, paragraph 2 – It has been noted that within CTAG there is a data deficit with no data collected on the quality of life that a recipient has after they receive a donor organ. <i>This may be due to inadequate clerical support.</i></p> <p>These amendments have now been made and the minutes can be approved as an accurate record of the last meeting.</p> <p>2.2 Action points HEART action points CTAGH(AP)(18)01 have all been updated: AP3 – HASG will be discussed under item 5.2 AP4 – Prolonged waiters have been checked; it is important that NHSBT have the correct information as they get requests for information on particularly long waiting patients AP6 – Ideal Heart Donors will be discussed under item 10.1</p> <p>SHARED action points CTAGS(AP)(18)01 have all been completed aside from those listed below AP3 – Cardiothoracic Offering will be discussed under item 6.1 AP4 – The work on transplant Centre Profiles is on-going AP9 – Combined Cardiothoracic and other solid organ transplants will be discussed under item 5.2 All other actions points raised at the last meeting have been completed</p>	
3 3.1 3.2	<p>3 Associate Medical Director's Report</p> <p>3.1 Developments in NHSBT JF was unable to attend this meeting but JD reported that NHSBT are currently involved in a potential inquest. Work is progressing on consent and communication of risk.</p> <p>3.2 New appointments Sally Johnson is appointed as interim Chief Executive for NHSBT, taking over from Ian Trenholm who resigned. Anthony Clarkson is interim Chief Executive of ODT, taking over from Sally Johnson, pending a permanent appointment in spring.</p>	
4 4.1 4.2 4.2.1	<p>4 Governance Issues</p> <p>4.1 Non-compliance with Heart Allocation There have been no incidents of non-compliance with heart allocation.</p> <p>4.2 Heart Incidents for Review Heart incidents for review will be incorporated in the Clinical Governance Report. Heart Incidents for Review can be removed from future agendas.</p> <p>4.2.1 Clinical Governance Report The Clinical Governance Report is produced in a better format, clearly highlighting learnings from incidents.</p> <p>INC 3432 identified replacement ice machines must produce slush for packing.</p> <p>INC 3379 & 3410 identified a lack of clarity over the use of T-A NRP/NRP and this caused delays to retrieval. It has been decided that abdominal NRP takes precedence over cardiothoracic retrieval, at least while a trial of the former is ongoing. RINTAG (Research and Innovation in Novel Technologies Advisory Group) and NRG (National Retrieval Group) are discussing how to accommodate changes as new perfusion technologies become increasingly more routine. Protocols need to be agreed between abdominal and cardiothoracic teams.</p> <p>INC 3420 identified that a suboptimal paediatric heart was offered to and declined by centre 1 but would potentially have been accepted by centre 2, however it was not offered beyond centre 1. Following this incident, CTAG is asked to consider the following:</p> <ul style="list-style-type: none"> • Do organ specific contraindications need to change to ensure that paediatric hearts are offered to both centres (in sequence) • Should we stop offering adult hearts when the accepting centre declines on function following an onsite assessment? <p><i>ACTION: JNe will review Hub Operations Policy to ensure that both centres are offered to when paediatric hearts are available.</i></p>	JNe

4.3	<p>INC 3425 & 3479 identified a prolonged offering time on two occasions when HLA information was not available. JNe reported that system changes made by Hub Operations now means that offers will no longer commence without HLA and Virology Reports, it is anticipated that this change will be implemented week commencing 15/10/18, however, it should be noted that awaiting HLA and Virology reports will not reduce prolonged offering time.</p> <p>INC 3207 identified damage to the heart at the point of retrieval. The accepting team were present with the OCS and it was commented that it has been years since a heart has been lost due to damage. The CT team discussed the incident to raise awareness and highlighted that utmost care must be taken during the retrieval, and every retrieval approached according to the individual specifications of the donor.</p> <p>ACTION: Incidents are to be included in minutes and communicated.</p> <p>CUSUM Monitoring of 30 day outcomes following heart transplantation As agreed at the CTAG Meetings in April, the monitoring baseline has been updated to include transplants performed between January 2013 and December 2016, while the outcome monitoring period was updated to January 2017. There have been no CUSUM signals reported since the last CTAG in April 2018.</p>	LN Centre reps
5 5.1	<p>Heart Allocation Review of Allocation Zones In 2017 CTAG decided to review and separate the cardiothoracic donor organ allocation zones into Heart and Lung allocation zones, with the zone for each centre proportionate to the number of patients registered on the waiting list at the centre. An annual review of allocation zones was agreed, and any more frequent reviews will be triggered by significant differences between the number of patients on the waiting list and the number of transplants completed at each centre. Three years of heart donor data has been compared with two years of heart patient registration data, with no significant differences found. No alterations will be made to the heart allocation zone at this time.</p> <p>5.2 Heart Allocation Sub-Group (HASG) The Heart Allocation Sub Group shared proposed new Heart Tiers for listing Super Urgent and Urgent Heart Patients at the last CTAG meetings in April. At the HASG Telecon (28/09/18) appropriate listing for patients requiring multi-organ transplants including the heart was discussed, and it was agreed that patients who are listed for a kidney or liver as well as a heart can be referred to the heart adjudication panel for a decision on urgency. The new system still needs review by the Hub as well as coordinators. Once agreed it will be taken to the next TPRC meeting for approval, following this it will take approximately two years for NHSBT's IT to implement the changes.</p> <p>It was discussed that one condition of this scheme is that centres must be able to consider offers for patients in lower tiers when receiving an offer. It is a step towards fully patient specific offering but recognises that a score such as LAS in the US is not possible due to a lack of objective markers of prognosis. The role of the adjudication panel was discussed and the idea of a "multi-centre MDT" raised by one member. While this is a good idea it is impractical at present.</p> <p>CTAG was not able to agree on how to list highly sensitised patients at this stage; further data is needed. Centres have agreed to review their patient sensitisation data for the past 12 months as it is not captured on the registration forms received by NHSBT. If highly sensitised patients are to be listed within the new system, the process must be simple; it is suggested at this stage that this would include patients with a calculated reaction frequency of 80% or higher.</p> <p>Great Ormond Street Hospital will not receive offers of adult hearts for larger paediatric patients once allocation is made on the basis of size rather than age. To avoid these patients missing out on potentially suitable offers, GOSH will be given an allocation zone proportionate to the number of larger patients ($\geq 145\text{cm}$) registered on their waiting lists. Newcastle's zone will be increased in a similar manner to take into account their larger paediatric recipients. It was agreed that Paediatric patients should have the option to be listed as Super Urgent; JyP will discuss with SR and the paediatric centres to try and establish when paediatric patients would qualify for Urgent or Super Urgent listing. If the paediatric patients are competing for adult hearts, it would seem reasonable to have the</p>	

5.3	<p>same criteria for both groups of patients. JNe will make necessary changes to HUB Operations algorithms once the criteria have been established</p> <p>ACTION: JyP/SR/JNe to explore super-urgent registration for paediatric patients</p> <p>ACTION: JyP will circulate the Tiers with comments from today included, for consideration by clinicians and feedback to JyP before close of play on Friday 19/10/18. (Post Meeting Note: This action has now been completed)</p> <p>Summary of Adjudication Panel Appeals The summary of CTAG Adjudication Panel Appeals was reviewed at CTAG today for the first time. Applications had previously been reported in Review of Heart Allocation Schemes paper at CTAG in April 2018. In the 10 months from October 2017 to August 2018, 42 of 54 (78%) of applications to the Adult Heart Adjudication Panel were approved and all eight (100%) of the paediatric applications to the Paediatric Adjudication Panel were approved. During the same timeframe, a total of three applications were made to the Adult Heart Adjudication Panel for implantation of a Total Artificial Heart, two (67%) were approved. Details of applications are available on request.</p> <p>JyP reported that almost all decisions are made within 24 hours, many have majority responses within 4-6 hours and thanked members of the Heart Adjudication Panels for their commitment.</p> <p>ACTION: SR will establish whether the Summary could be differentiated between those which were VAD requests and those which were not.</p>	<p>JyP/SR/JNe</p> <p>JyP/LN</p> <p>SR</p>
6 6.1 6.2	<p>ODT Hub Update</p> <p>HUB Operations Cardiothoracic Offering Cardiothoracic offering (except for DCD hearts) was redirected to Hub Operations from the Specialist Nurses in Organ Donation (SNOD) in December 2017. This decision was taken to enable Cardiothoracic offering to be managed centrally, because the SNODS didn't have access to make group or fast track offers. This also ensures that only one group of people are responsible for making organ offers. In future the Hub are looking to introduce case management so that one person is responsible for each donor.</p> <p>Minimum dataset required for Cardiothoracic Offering Best practice is to have all necessary information relating to donor organs available to the recipient surgeon at the time of offering; no accurate data is available to record the number of times that further information was requested. SNOD refresher training is taking place in October to reiterate the importance of providing all necessary data using the core donor data form which requests chest x-ray, blood results, blood gases, MRI or CT results, ECG, ECHO, PA catheter or cardiac output monitoring, haemodynamic status and inotropic levels.</p> <p>CTAGH is asked to agree the following (detailed in CTAGH(18)15):</p> <ul style="list-style-type: none"> • Donor HLA and Virology will always be documented on EOS before any cardiothoracic offer is made. Regional Managers must be consulted in the exceptional circumstances listed in CTAGH(18)15. • Where a SNOD shares the decision with Hub Operations that on screening a centre states it doesn't want to receive any organs from a specific donor, Hub Operations will document the decline reason against the centre and not offer to them. This also applies to group offering. This process will be introduced when further changes are made in Hub Operations systems, hopefully in March. • Centres who cannot decide whether to accept an organ offer because there is no ECHO available will be documented as having declined the offer and the Hub will move on. • Centres receiving multiple organ offers will be given additional time to decide whether to accept or decline organs. 80% of organ donors are registered between the hours of 2200 and 0800 – this is unavoidable. However, there is some work going on to look at larger ICUs and delaying donation until the next evening if donation doesn't proceed before 2am. <p>Revisiting the contraindications for cardiothoracic donation was discussed. Some of this will be taken forward by the new CTAG Audit Fellow in collaboration with Andrew Broderick, Donor Assessment Programme Lead.</p>	
7 7.1	<p>Statistics and Clinical Studies reports</p> <p>Summary from Statistics and Clinical Studies</p>	

	<p>The Organ Donation Activity Report was published in July and showing over 5,000 organ transplants last year, of which 8% were cardiothoracic. The Annual Report on Cardiothoracic Transplantation was published last month and is available online. The MCS report is in progress and should be published by the end of 2018. There are no Statistics presentations of note.</p> <p>Work will start on the CTCAG approved standard Cardiothoracic Dataset in line with other solid organ advisory groups which would only be made available when specific criteria are met in the application. The new CTCAG Fellow will be based at Freeman Hospital who proposed the winning projects for the appointment. Work is underway to identify changes to be made to the VAD Database; SR, SS and RH met earlier in the Autumn to start planning the alterations required to the VAD database.</p> <p>While reviewing the (CTAGH(18)16, Table 2) Regular Reports, two centre specific reports were identified, 20 – Harefield Transplant Record Report and 21 – Glasgow Survival Report. NAA confirmed that the Glasgow Survival Report can be cancelled, SR will establish the purpose of the Harefield Transplant Record Report and confirm whether this report could also be stopped.</p> <p>ACTION: SR to investigate two centre specific reports and explore discontinuing</p>	SR
7.2	<p>Summary of heart-lung transplants</p> <p>The report covers the period January 2017 to April 2018, during this time, 13 patients received an urgent heart-lung transplant, resulting in three deaths within 90 days of transplantation, a 23% mortality rate. Over the same period 18 patients were registered for a heart-lung transplant, of these patients, two died on the waiting list, two were removed, six were transplanted and eight remain on the waiting list. Overall the number of heart-lung transplants have increased but the number of registrations has remained relatively stable.</p>	
7.3	<p>Group 2 transplants</p> <p>No Group 2 Cardiothoracic transplants have been performed since the last meeting.</p>	
8	<p>Reports and Discussion Points from the Chair</p>	
8.1	<p>CT Core Group Telecon key discussion points</p> <p>The Core Group Telecon involves the cardiothoracic Centre Directors, the group name will revert to CTAG Centre Directors Telecon with immediate effect. Most of the discussion points are covered by the agenda here at CTAG Hearts or at CTAG Lungs. The next item to review at the Centre Directors Telecon will be the Cardiothoracic Advisory Group Terms of Reference.</p> <p>ACTION: LN to arrange Centre Directors Telecon in the next two months</p>	LN
8.1.1	<p>Reasons for declining donor organs</p> <p>Reasons for declining donor organs was a pilot project set up to identify why cardiothoracic donor organs were declined and establish whether organ utilisation rates could be improved. Data shows that between June and August 2018, there were 1551 cardiothoracic organ declines across six centres, 566 hearts, 843 lungs and 142 heart-lung blocks. Data collected is on declined offers meaning that one donor could have been declined more than once and could have been accepted in the end. It was agreed that data would be collected for one year, with a decision to be made on whether this data is useful. Free-text is added when 98 Other, please specify is listed at the reason for declining the organs. The free-text from the 151 submissions in this category will be reviewed and some of the more common reasons will be added to the pick list of reasons to decline organs. This will be reviewed again once 12 months' worth of data has been collected. It was acknowledged that these data are useful in light of Group Offering which has led to incomplete reporting of reasons for decline to the Hub.</p> <p>ACTION: Centres to continue collecting reasons for declining donor organs until December 2018</p> <p>ACTION: SR to present 12 months of data, broken into those eventually used and not used</p>	Centre reps SR
8.1.2	<p>Grading retrieved Cardiothoracic Organs</p> <p>Centres had fallen behind in the return of the grading of retrieved Cardiothoracic Organs forms; Organ Grading Form Champions have now been identified at each centre and return rates have now increased above 60% as required prior to any analysis being carried out.</p>	

<p>8.1.3</p> <p>8.2</p> <p>8.3</p> <p>8.4</p> <p>8.5</p> <p>8.6</p>	<p>When set up, the Heart Utilisation Group, led by Aaron Ranasinghe will report on ideal donor hearts which are then declined. It was agreed that this data collection should continue until the electronic HTA As/Bs are introduced.</p> <p>Centre identified organ grading form champions All centres have identified their organ grading champions which should increase numbers of organ grading forms completed and returned to NHSBT.</p> <p>Issues with completing Registry Data NHSBT form returns are falling behind for a number of cardiothoracic centres. Historically, NHSBT commissioned Quintiles to provide registry data, but to reduce unnecessary expenditure, the contract with Quintiles came to an end, and centres are required to provide this data themselves in line with the NHS England Service Specification. One issue that has been identified is a lack of hospital resources available to support this. Newcastle employs temps to complete this work, and there is a training backlog at present. Birmingham have one Full Time Equivalent member of staff (FTE), but there can be difficulties gathering data. Papworth has a 0.6FTE starting work on late October. Glasgow has one FTE who is new and in training at present. Manchester has one FTE Band B6 Audit Nurse who is also responsible for the VAD and other data forms and form returns.</p> <p>Employing administrative staff on low pay leads to poor staff retention and creates inconsistencies due to a lack of clinical knowledge.</p> <p>ACTION: JyP will follow this up with the Transplant Managers Forum, SW is in full support and if necessary, will write to centre directors to request the forms are completed and returned.</p> <p>ACTION: SR will bring an update of form return rates to CTAG in Spring 2019.</p> <p>Scout Update (Workforce Transformation Working Group Sub Group) The Scout Pilot was deemed successful by an external review and so a subgroup of the NORS Workforce Transformation Board was established to build a business case for a funded Scout service in the UK. The first business case was rejected by ODT SMT as being unaffordable. A new subgroup was set up (chaired by John Stirling) to see if a lower cost model could be delivered. A revised business case only includes three teams; it is anticipated that approximately 70% of potential cardiothoracic donors could be scouted with this model. A potential solution is a fixed tariff model where NHSBT pay a fixed amount per scout episode, however this may not be financially sustainable for centres. Another solution is to pay a tariff in advance and for teams to Scout on their off duty NORS weeks. Discussion is ongoing and a submission to SMT is planned in December 2018.</p> <p>NRG Update VR reported that Algonics had applied to NHSBT to be involved in a trial of their ice boxes, which maintain a constant temperature of 4°C. Peter Friend has suggested a pilot study, and the company are prepared to give 5 of the boxes to trial with cardiothoracic transplants. Emma Billingham is conducting a study over the next 12/18 months to evaluate organ transportation boxes. Currently the boxes on offer by the company are priced at £4-£5k per box if they are deemed suitable following the pilot scheme and used for all organs, costs could be reduced to nearer £2-£3k each.</p> <p>Hep C in Donor Organs Under SABTO guidance, a working group was set up to investigate the use of Hep C positive donor organs as this would increase the number of cardiothoracic donor organs available each year by about 20. NHS England have yet to confirm that anti-viral therapy for these patients will be funded. Appropriate patient consent will be crucial. JF, A Elsharkawy and NHS England will be discussing this further on Friday. It is likely that Hep C positive donor organs will be in use from next year.</p> <p>Communicating Risk and Consent Solid Organ Advisory Groups have been asked to review the way they convey information and explain risks to patients in advance of their transplants. It has been suggested that information is provided in a layered format with levels of detail. In parallel NHSBT is also developing Infographics for their website.</p>	<p>JyP</p> <p>SR</p>
<p>9</p> <p>9.1</p>	<p>Reports from sub-groups</p> <p>CTAG Clinical Audit Group (CAG) Chairs Report</p>	

	<p>CTCAG meets four times per year, twice as telecons and twice face to face. Since NRB retired, NAA has chaired two meetings, one telecon and one face to face. Marius Berman (Organ Retrieval and Transplantation Representative), Stephen Pettit (Heart Transplantation Representative) and Katie Morely (Allied Health Professional) have all been elected as new members to the group.</p> <p>CTCAG Members have recently published two papers using data from the VAD database, BTC VAD Project and the paper on PGD. Over the coming months Stephen Pettit and Steve Shaw will be working together with SR to determine updates to NHSBT data collection to add to the IT workstream. A draft will be produced for approval by centres prior to final submission.</p> <p>CTCAG would like to try and increase funding available for research and other projects, NAA will discuss further at CTAG Meetings and with JyP.</p> <p>Work will start on the CTCAG approved standard Cardiothoracic Dataset in line with other solid organ advisory groups. Data would be available only when application criteria are met. CTCAG would like to see evidence of how the data has been used following its release.</p> <p>9.1.1 CAG Lung Transplantation Representative The CTCAG Lung Transplantation Representative position on CTCAG will be open for election following this meeting, NAA thanked RT for his commitment over the last three years, RT is welcome to reapply for the role.</p> <p>ACTION: LN will circulate and oversee the election documentation.</p> <p>9.2 Appointment of New CTAG Audit Fellow The new CTCAG Fellow will be based at Freeman Hospital who submitted the winning project for the appointment. The proposed studies focus on Cardiothoracic Organ Utilisation and the development of a lung scoring system which takes into consideration recipient and donor variables. Congratulations to the Freeman Hospital (Newcastle) for their submission, the recruitment process is underway.</p> <p>9.3 CTAG Patient Group RG thanked JyP for inviting him to the meeting. RG outlined the constitution and purpose of the CTPG and updated CTAGH members on activity within the group. RG summarised activity, including writing to local MPs about funding for DCD Heart transplantation promoting centre specific patient support groups and raising funds, and supporting patients and their families pre or post-transplant. The group is well attended and includes patients, representatives from each centre, and organisations such as British Heart Foundation and Cystic Fibrosis Trust. RG thanked NAA, JyP, JNU, MH, SR and LN for their attendance and support and extended invitation to any CTAGH or CTAGL Members wishing to attend the patient group.</p>	LN
<p>10 10.1</p>	<p>Heart Utilisation Heart Utilisation Lead Following from the Lung Utilisation work completed by JD and Lung Utilisation Group, JyP is keen to progress the work of the Heart Utilisation Group. Aaron Ranasinghe from Birmingham has been appointed as the CTAG Heart Utilisation Group Chair. Aaron Ranasinghe will discuss with JD and Chris Callaghan (Kidney utilisation lead) and develop his ideas for increasing heart utilisation.</p>	
<p>11 11.1 11.2</p>	<p>VAD Update Changes to VAD Database Steve Shaw (SS) met with SR and Rachel Hogg earlier this year at NHSBT to discuss changes to the VAD Database. A proposal will be written up and circulated to centres. SR was advised that coordinators should be involved in the plans and that changes should be aligned with international registries as much as possible. Paediatric involvement is also required</p> <p>MCS in Patients with recent or active malignancy NHS England does not approve bridge to candidacy with a LVAD in patients with an active or recent malignancy. Bridge to candidacy is only funded in patients who have a heart failure related complication that can be reversed by a LVAD. It was therefore thought to be perverse that a TAH could be used in this way by applying to the Adjudication Panel. SW agreed that at present this was not appropriate and there was general agreement that a TAH</p>	

	should not be used in a patient with recent or active malignancy. OD asked whether there was interest to extend the boundaries of MCS in this way; most members felt it was not appropriate.	
12	For Information	
12.1	Transplant Activity Report For information, no questions raised	
12.2	RINTAG DCD Hearts Working Group Update For information, no questions raised	
12.3	NHSBT ICT Update for Advisory Groups For information, no questions raised	
13	<p>Any other business</p> <p>LL reported that there are numerous strategies underway to encourage families to support organ donation and that Recipient Coordinators are working closely with patient groups to change culture and increase the number of letters written by recipients to their donor families following transplant.</p> <p>LN advised members that papers will be sent as one PDF next time rather than individual papers which would be available on request. Members reminded to ensure that LN receives apologies/deputy details in advance of the meeting.</p> <p>Quality Of Life (QOL) – the Multi Visceral and Composite Tissue Advisory Group (MCTAG) have recently completed a piece of work on Quality of Life data collected for post-transplant patients as it has been decided that this information should be shared with patients when they are deciding which centre to register with for treatment. QOL will be added to the CTCAG Agenda for discussion at the next meeting in January.</p> <p>BTS NHSBT Congress 6th-8th March communication to follow</p> <p>JMcG advised the group that Irish donor hearts are not always used because of a lack of recipients, unused donor hearts are used for homografts instead. He estimated that approximately five hearts a year from relatively young donors would be available to the UK. Hearts from ROI could be offered in a fast-track system as organs are offered from Europe. Moving forward, donor hearts from Dublin will be offered using the same paper process as Hearts from European donors to generate fast track offering to be accepted within the hour. Hearts from ROI will always be retrieved by their team, and machine perfusion will not be an option at present.</p> <p>QUOD are keen to develop an atlas of cardiothoracic organs for research and letters have gone to centres today to explain expectations. QUOD will now start collecting heart biopsy tissue and BAL samples.</p> <p>There is a temporary pause on the recruitment of into the peri-CCT transplant surgical post as the last three trainees all secured posts, but not in the field of cardiothoracic transplantation. It has been predicted that a further five cardiothoracic transplant surgeons will be required in the next two years, and it is anticipated that the training programme will restart in the next year.</p>	
	<p>Date of next meetings (venues TBC)</p> <p>CTAGL Lungs – Wednesday 20th March 2019, CTAGH Hearts – Thursday 28th March 2019 CTAG Patient Group – Monday 13th May 2019 CTAGH Hearts – Wednesday 18th September 2019, CTAGL Lungs – Thursday 26th September 2019 CTAG Patient Group – Monday 11th November 2019</p>	