NHS BLOOD AND TRANSPLANT
ORGAN DONATION AND TRANSPLANTATION DIRECTORATE

THE SIXTEENTH MEETING OF THE NHSBT CTAG(L) LUNGS ADVISORY GROUP ON THURSDAY 17TH SEPTEMBER 2020, 11:00-16:00 VIA MICROSOFT TEAMS/TELECON

PRESENT:

Jayan Parameshwar (JyP)	**CTAG Chair**, Royal Papworth Hospital
Martin Carby (MC)	**CTAGL Deputy Chair**, Respiratory Physician, Harefield Hospital
Lynne Ayton (LA)	Transplant Managers Forum Representative
Ayesha Ali (AA)	Highly Specialised Services, NHS England
Marius Berman (MB)	Joint Associate Clinical Lead Organ Retrieval, NHSBT
Ian Currie (IC)	UK Clinical Lead Organ Retrieval, NHSBT
Melissa D'Mello (MDM)	CTAG Lay Member, NHSBT
John Dark (JD)	Professor of Cardiothoracic Surgery, Newcastle University
John Forsythe (JF)	Medical Director, OTDT, NHSBT
Anushka Govias-Smith (AGS)	Scotland National Services Division
Rob Graham (RG)	Co-Chair, CTAG Patient Group
Gill Hardman (GH)	CTAG Clinical Audit Group Cardiothoracic Fellow, Freeman Hospital
Margaret Harrison (MH)	CTAG Lay Member, NHSBT
Jim Lordan (JL)	Respiratory Physician, Freeman Hospital
Derek Manas (DM)	Joint Clinical Governance Lead, NHSBT (left at 12.15pm)
Jorge Mascaro (JM)	Centre Director, Queen Elizabeth Hospital
Lisa Mumford (LM)	Head of ODT Studies, NHSBT
Jasvir Parmar (JP)	Respiratory Physician, Royal Papworth Hospital
Nicky Ramsay (NR)	Recipient Co-Ordinator, Harefield Hospital
Karthik Santhanakrishnan (SK)	Respiratory Physician, Wythenshawe Hospital
Philip Seeley (PS)	Recipient Co-ordinator Representative, Freeman Hospital
Frederick Smith (FS)	Statistics & Clinical Studies, NHSBT
Helen Spencer (HS)	Centre Director, Respiratory Physician, Great Ormond Street Hospital
Ulrich Stock (US)	Interim Centre Director, Harefield Hospital
Richard Thompson (RT)	Respiratory Physician, Queen Elizabeth Hospital
Rajamiyer Venkateswaran (RV)	Consultant Surgeon, Wythenshawe Hospital
Sadie Von-Joel (SVJ)	Lead Nurse Recipient Co-ordinator
Hester Ward (HW)	Consultant in Public Health Medicine, NHS Scotland
Julie Whitney (JW)	Head of Service Delivery (ODT Hub), NHSBT

OBSERVERS:

Amit Adlakha (AA)	Consultant, Royal Papworth Hospital
Jenni Banks (JB)	Statistics & Clinical Studies, NHSBT
James Feely-Henderson (JFH)	Specialist Nurse in Organ Donation Representative, ODT
Dan Harvey (DH)	National Innovation & Research Clinical Lead, ODT
Rochelle Pointon (RP)	Lead Co-ordinator, Queen Elizabeth Hospital, Birmingham
Sally Rushton (SR)	Senior Statistician, Statistics & Clinical Studies, NHSBT

IN ATTENDANCE:

Trudy Monday (TM)	Clinical and Support Services, OTDT, NHSBT

Item		Action
	Apologies and welcome Apologies were received from Liz Armstrong, Richard Baker, Sam Baker, Paul Brookes, Stephen Clark, Anthony Clarkson, Catherine Coyle, Jonathan Dalzell, Ben Davies, Paul Flynn, Diana Garcia Saez, Ben Hume, Suzannah Laws, Debbie Macklam, Jane Nuttall, Stephen Pettit, Karen Redmond, John Richardson, Marian Ryan, Nicola Steedman, Mick Stokes, Sarah Watson, and Craig Wheelans.	
	The Chair welcomed all to the meeting and wished everyone good health in the current climate. All to bear in mind papers will be uploaded to the ODT website unless specifically asked not to.	
1	**Declarations of interest** There were no declarations of interest at the meeting.	

2	**Minutes of the CTAGL Meeting held on 1st April 2020**	
2.1	The Minutes of the previous CTAG Lungs meeting held on 1st April 2020 were accepted as a true record.	
2.2	**Action Points**	
	Action Points from the previous CTAG Lungs meeting were addressed on the agenda, and reports were given for the following:	
	AP5: Length of Donation Pathway: J Whitney reported that there is no paper, however a lot of actions have been completed since.	
	AP6: Fast-tracking of European paediatric offers: Refer to minute 6 (ODT Hub Update).	
	AP8 and 9: Refer to minute 11.3.	
3	**Medical Director's Report**	
3.1	**Developments in NHSBT**	
	J Forsythe expressed his thanks to everyone for their hard work and commitment over recent months. The following key points were noted: • During mid-pandemic, transplantation in the most urgent patients was maintained. Pancreas and islet transplantation programmes have now re-opened. • Centres have been very good at data monitoring re. recording COVID positive patients on the transplant list which NHSBT are very grateful for; this information has helped to inform second surge planning. • It was noted that the nation is heading towards a second surge – most cases of infection are currently out of hospital although this could well change. There is a second surge document on the ODT website which details guidance/plans about trying to keep transplant centres open/minimise the closing of transplant programmes during a second surge. Everyone is urged to read the documents. • It was noted that in the event of some members of a retrieval team needing to isolate, this would be more problematic than for members of a transplant team (where there is more flexibility). • Whilst transplant centres were closed, many staff were diverted to caring for patients on the frontline. It is hoped that if there is a lockdown it will be a local lockdown rather than a national lockdown; any lockdown would be more difficult for the lung transplant teams as the risk is probably higher for these patients. If units were to close it is likely that with managers needing to manage different priorities, they will not necessarily understand the comparative risks. Trusts have been contacted to explain the complexities, and the NHSBT documents are meant to help. • Manchester and Papworth are the two transplant centres which are involved in the highly specialised VV ECMO service, and it needs to be ensured that one specialised service does not affect the other. Once a particular level of VV ECMO is reached at a centre it would be helpful to divert referrals to a non-transplanting centre. A Ali asked for centres to contact NHS England in the event of concerns so that issues can be addressed without delay. • Organ utilisation: it has been the busiest July and August in 10 years. During the Lung Summit, barriers to utilisation were explored, and there was a call to ask clinicians to communicate what the problems are and how they can be overcome. There will be a letter from NHSBT circulated via email to Centre Directors tomorrow to call for applicants to a new post 'Clinical Lead for Organ Utilisation (CLUs)'. The post holder will be required to submit data on the main barriers to transplantation in their unit. The post will be for a limited time as funding is only available for this financial year.	
3.2	**New appointments**	
	No new appointments were reported.	
4	**Research Proposals:**	
4.1	**Donor Statin Study**	
	Members viewed a presentation by J Dark, to be given to all the Advisory Groups, outlining the findings from a study published by Karl Lemstrom from Helsinki in 2019. This led to the	

	design of the SIGNET Study which is awaiting approval in October. The Helsinki Study involved 84 recipients, of whom half received organs from donors given Simvastatin and analysed the outcomes on the heart and the effect on all other organs. It was noted that there was no harm in lung recipients but may have helped improve outcome, with a halving of PGD rate. The SIGNET Study is envisaged to start in April 2021 for a period of 4 years. Donor family consent will be required for donation and research. All potential recipients will receive information about the study, with a description of the potential benefits; no consent will be required by recipients. No additional data or samples are required from recipients. This will be the largest donation intervention study in the world. The following was confirmed: • Simvastatin 80mg given as a single dose is a safe drug to use with no measurable amount transferred to the recipient. The delay between consent and retrieval is usually around 24 hours, so by the time the organ has been flushed and on ice, essentially no drug will be present.	
5	**Governance Issues**	
5.1	**Non-compliance with Lung Allocation**	
	There were no incidents of non-compliance reported.	
5.2	**Clinical Governance Report**	
	D Manas reported that there were a low number of retrieval incidents since the last CTAG Lungs meeting due to reduced activity during the pandemic. From 1st April 2020 to 31st May there were 5 transplants compared to 40 for the same period the previous year. The following were highlighted: • Communication issues between abdominal and cardiothoracic teams are still a problem. Discussion between teams (including retrieval and implanting teams should occur at a senior level. This is much more likely to lead to resolution of the problem. Surgical leads are asked to discuss these communication issues with their teams/units. It was noted that it would be sensible to include such discussions as part of the Organ Retrieval Masterclass – I Currie agreed, and stated that there have been some papers published through a collaboration with Edinburgh University re. human performance psychology in the context of organ retrieval surgery, and would be of benefit to involve the performance psychology group, working with G Hardman, to build something which would be useful and relevant for retrieval teams. G Hardman agreed to email I Currie re. collaborative work around this. • Issues around combined transplants: A problem has been identified when a patient is listed for a lung-liver transplant on the routine list. The lung does not appear as a named patient offer unlike the liver and the patient may not therefore receive offers. It was suggested that the lung should be offered after the Urgent patient offers. This would create a new tier between the routine and urgent categories. It is not ideal to have to alter the allocation algorithm because of inadequacies in NHSBT's IT but pragmatically this is the best solution. This was agreed by all centres. • Some transmission of disease with some organs (not lung) – it was reminded that certain diseases like melanoma are very high risk and the guidance on melanoma will be revised in the future. • Lung activity has been relatively low, picking up again now, but there is a concern that second surge of COVID 19 might impact on activity again.	**Surgical Leads** **G Hardman / I Currie**
5.3	**CUSUM Monitoring of 90-day outcomes following lung transplantation**	
	There have been no CUSUM signals in lung transplantation reporting in the last six months. In May 2018 the baseline period used to calculate the expected mortality rates was updated – this will be reviewed, and the proposed baseline change will be presented at the next CTAG Lungs meeting (spring 2021). Work has been in progress around the process for looking at CUSUMS and how the various stakeholders respond to them. NHS England Commissioners have made some useful comments re. the timetable for completion, however, concerns have been raised from the Welsh commissioning side. Discussions have taken place following the suggestions received, and a response is awaited re. the last draft.	

5.4	**Group 2 Transplants**	
	There have been no group 2 transplants since 2018.	
6	**ODT Hub Update**	
6.1	**Changes in offering process**	
	J Whitney reported on the following: • The recipient co-ordinators have had meetings over the last couple of months as a shared practice forum, trying to make small improvements across the pathway which require no IT changes. In line with that, a newsletter has been sent to recipient co-ordinators today, and will be circulated to CTAG members also. This details some of the operational changes and scheme changes (which will be in place from next month). Surgical leads are asked to ensure that recipient co-ordinators have seen the document. • In terms of offering: a single point of contact is now coming into effect at the end of September – offers will be communicated directly to centres via one dedicated number. This will ensure that there are no missed offers for named patients. A checklist has been drawn up to ensure all essential information (chest x-ray, echocardiogram report, blood gases) is to hand for recipient co-ordinators to pass on. This will help to minimise delays. The aim is to ensure that the 45-minute timeframe is not exceeded. On 3 occasions during the last month the 45-minute timeframe was not met. Improvements have been made, but still more can be attained. A call will be taking place between J Whitney, J Parameshwar and Sadie Von Joel (who is covering L Stamp's maternity leave) to consider how the offering process can be made to work better for all concerned without extending the length of the donation pathway. The deviation process (which was put in place during COVID) will be reviewed to ensure the best way of sending out offers. • European offers to Newcaslte and GOSH: nothing more can be done to improve this because there is competition with European countries. The offers are sent out to GOSH and Newcastle simultaneously and a quick response is required – there have previously been delays because offers have been received on a ward at GOSH, but following some changes into how the offers are received by co-ordinators it is anticipated that this will no longer be an ongoing issue. H Spencer suggested that for GOSH and Newcastle to have an agreement that the offer would go to super-urgent, then urgent paediatric patients, and then to a listed patient. J Whitney and H Spencer agreed to discuss this further offline and then communicate to the Hub Operations the decision on how the offering should work. It was noted that the preferred time for retrieval was during the night to alleviate pressure on cardiothoracic centre activity. The point was also made re. a longer pathway being associated with worse lung transplantation outcomes.	**Surgical Leads** **J Whitney / J Parameshwar / S Von Joel** **J Whitney / H Spencer**
6.2	**Length of Donation Pathway**	
	Refer to minute 6.1, above.	
6.3	**Update on Heart/Lung Offering Scheme Changes**	
	There has been a delay with IT changes due to COVID; the new release date is hoped to be 14th October. L Mumford apologised on behalf of NHSBT. A summary of the changes was given: • The non-urgent small adult tiers are being removed from the allocation sequence; • Paediatric lung centres will be prioritised to have first refusal on all paediatric donors.	
7	**Lung Utilisation**	
7.1	**Lung Summit: Actions**	
	A copy of the Summary Report from the Lung Utilisation Summit held on 31st October 2019 was re-circulated to members. J Forsythe reported that the issues within units have been noted, and it has been recognised that these are very different from unit to unit. It is hoped that once the COVID situation stabilises, beyond the second surge, these issues can be explored and addressed through the clinical leads for utilisation. Some of the issues were highlighted: • some units are restricted by patient numbers being admitted to ITU; • theatre access; • staffing. NHSBT have tried to engage with commissioning colleagues to try to identify a way forward, but the pandemic has delayed further discussion. It was noted that centres find it difficult to attract and retain cardiothoracic surgeons – surgeons are required who are interested in performing cardiothoracic transplantation in general and lung transplantation in particular, not those who are just on a transplant rota 'on	

	call' as an 'additional role'. Most transplants are performed out of hours, between 12am and 8am, making the job unattractive and recruitment into the transplant programme more difficult. The SCTS is forming a subgroup for transplant surgeons; a Chair will be appointed soon.	
7.2	**NHSBT Lung Utilisation Project: Lung Risk Score**	
	G Hardman is based at the Freemen Hospital and is the NHSBT Clinical Research and Clinical Audit Fellow in Cardiothoracic Transplantation; the focus of her PhD is lung utilisation – slides were presented to members re. the Lung Utilisation Project.	
7.2.1	**The UK lung risk index**	
	This is the primary project within the utilisation work, and it is hoped to devise a numerical objective measure of lung quality at the time of offering, very similar to that which has been devised for kidneys. This will be derived from the NHSBT UK transplant registry data set. It is hoped that the work produced at the end of this is going to be used by the lung transplant community in the UK, so it needs to be acceptable to all CTAG Lung members, who will be included at various stages in its development. Before further data collection and statistical modelling is carried out, members were asked about two points: • what is preferred to be included as the outcome measure: mortality, PGD, or both? • involvement from members to review the candidate variables that will be included in the model building. Any objections or further discussions around these should be sent to G Hardman.	
7.2.2	**Uncontrolled DCD lung transplantation**	
	G Hardman presented slides on the potential for and the feasibility of uncontrolled DCD lung transplantation in the UK. It looks to expand the donor pool by considering DCD donors in Emergency Departments and Intensive Care Units. The impetus for this came from Dale Gardner and Andre Vercuil, and it is understood that it will be supported by NHSBT. Looking at the experience from around the world, it is felt that this pilot/study would be initially best placed locally as a small, well-funded research project. Looking at the feasibility of this with a donor hospital emergency team department, the following would be required: a SNOD team, retrieval team that can place the organ on EVLP; an implanting team, a physician, and a recipient population that would be acceptable to this. It would be of benefit to have a patient representative on board also. M Berman has already expressed interest from the retrieval side. Following discussion, these points were highlighted/addressed: • There is some concern that while utilisation of controlled DCD is poor, exploring uncontrolled DCD may not be worthwhile. It was agreed that interested clinicians would form a working group to consider this further. • From a Lay Member point of view, the terminology 'uncontrolled DCD' sounds worrying, so it is important to involve a patient representative and use relevant language. Centres who are interested should contact G Hardman by 31st October.	**G Hardman / Centre Reps** **Centre Reps**
7.2.3	**The impact of the SARS-CoV-2 pandemic on UK lung transplantation**	
	Members received a report giving detail on this study which G Hardman has been conducting with the CTAG Clinical Audit Group. The aim of the study is to understand the impact on UK heart and lung transplantation at both national and centre level, for the early pandemic period from 1st March to 31st May 2020. G Hardman expressed thanks to Ruth Sutcliffe for the data collection on this, as well as Rachel Hogg and Lisa Mumford at NHSBT, the CTAG Clinical Audit group, and in particular, thank you to the co-ordinators and centre directors for responding and giving the information which was needed to pull this together. Resources consisted of the UK Transplant Registry, the national reporting of what was happening to transplant recipients and patients on the waiting list in terms of COVID infections, and a survey was sent to centre directors. The aim was to achieve as comprehensive a picture as possible to gauge the effect of the pandemic on waiting list and transplant patients. The summary of results is included in the report. The findings have been presented to the CTAG Clinical Audit Group and will be published. The June data will be added, followed by data to be collected in the latter half of this year, with a comparison between that and what happened from March to May 2020.	

	The presentation from the Clinical Audit Group can be shared with members on request, however the report discussed at today's meeting awaits the addition of data from June and therefore should remain confidential at this stage.	
7.2.4	**Proposal for a prospective observation study of reasons for cardiothoracic organ decline**	
	G Hardman explained the background behind this study which examines why cardiothoracic organ offers are declined, and a regular audit of the cardiothoracic organs which are declined. At the time of organ offering full comprehensive information may not be available, and such situations cannot be recorded as a simple code. A regular audit of organs which are declined has already started on the kidney and liver side, however there is no conclusive data available yet to suggest if it helps understand utilisation. The two project areas would be conducted over a 3-month period in centres who have agreed to participate, and involving cardiothoracic co-ordinators who are trained to collect this data around reasons for organ decline, and perception around what was happening to try to draw a narrative. Each month participating centres would receive a report re. those lung numbers which have been declined and ask questions around what behaviour may change within the centre. Members agreed that this is a great initiative and would be happy to participate; in addition, R Graham confirmed that the Patient Group would strongly support this. It would highlight best practice and help to co-ordinate a standardised approach.	
8	**Lung Allocation**	
8.1	**Summary of Adjudication Panel Appeals** Members received a paper detailing a summary of adjudication panel appeals/referrals. The following were highlighted: • There has been a total of 25 appeals since the introduction of the urgent and super-urgent lung allocation scheme. • Of the adult lung appeals, 72% were approved and all paediatric lung appeals were approved. • Newcastle had the highest number of adjudication panel appeals and had the highest number of urgent registrations for adult lung recipients. • Adjudication panel appeals were equal between Newcastle and GOSH paediatric centres whilst GOSH had the highest number of paediatric urgent lung registrations. • Of the 27 appeals, 19 were approved. • Table 2 footnote: it says 'Excludes' but should say 'Includes'. • There have been no super-urgent appeals in the last year.	
8.2	**Update of Allocation zones**	
	Members received a report of the third annual review of the lung allocation zones since the cardiothoracic allocation zones were split into separate heart and lung allocation zones over two phases (May 2017 and January 2018). The following were highlighted: • No significant differences observed when comparing the lung registrations made by each centre against lung donors in each of the current lung allocation zones. Therefore, there is no evidence for a change in the zones at this time. • The utilisation rate is similar across all zones. • Overall, 59% of transplants in the 31-month period (to 31st July 2020) were performed using imported lungs. The questions was raised around what change in number of donors/registrations was required to trigger a change in the zones. This will be looked at further by NHSBT Statistics and Clinical Studies.	**L Mumford**
8.3	**Lung and Liver transplant allocation**	
	J Parameshwar reported on an issue which arose two weeks ago, whereby there was a potential problem re. a lung liver patient in relation to how offers were being made. Refer to minute 5.2.	

9	**Statistics and Clinical Studies reports**	
9.1	**Summary from Statistics and Clinical Studies: Autumn 2020**	
	Members received the autumn summary report from Statistics and Clinical Studies. The following were highlighted: • Two weeks ago, the draft annual report on cardiothoracic transplantation was circulated, and L Mumford expressed thanks to those who have commented – the suggested changes have now been made and these will appear on the website from tomorrow. The same has also been done with the VAD report, and again, that will appear on the website shortly. • Members were informed that L Mumford is currently the statistical lead for cardiothoracic transplantation; S Rushton will be returning to this role from December, with F Smith and J Banks supporting. • Work has continued in collaboration with the Winton Centre for Risk Communication, to develop a tool to support conversations between patients and clinicians at the time of listing. • The ODT Hub Programme has now come to an end, although Statistics and Clinical Studies continues to provide support to IT developments coming through. • Interviews have taken place for an IT developer to implement the changes to the UK VAD Database.	
9.2	**COVID-19 Update**	
	Members received the COVID-19 weekly report for the period 1st March to 2nd September 2020, which is updated every Friday and circulated to centre directors. It is available on the ODT clinical website. The following were highlighted: • Figure 1 shows the number of donors and transplants by week and donor type. • March shows an overall drop in transplant and donor numbers. Week by week the figures have improved and are now where they were prior to the pandemic. • Figure 3 shows incident rate and death rate by organ. Rates are very low: 0.6% waiting list patients tested positive; 0.3% patients died on the list who were positive; 0.6% deaths amongst transplant recipients who tested positive. • Looking at the number of lung transplants performed in 2020 so far this year, there have been 68, of which 3 of these have tested positive with no deaths. Members are asked to email L Mumford if further information is required.	
10	**NHSE Update**	
10.1	**VV ECMO Update**	
	The ECMO bridge to lung transplantation policy was circulated for public consultation over the summer. It has been delayed due to COVID. A lot of feedback and queries have been generated which will be worked through before going to the next stage of the process which will be a prioritisation meeting in November.	
10.2	**Extra Corporeal Photopheresis update**	
	Following submission of the proposal and review of the evidence for NHSE, the evidence for ECP was said to be inadequate. This will be re-submitted to the clinical panel in November after further comments on the review are received.	
11	**Reports and Discussion Points from the Chair**	
11.1	**Recovery planning**	
	Members should refer to the NHSBT documents located on the ODT website regarding recovery planning and the second surge.	
11.2	**COVID-19 second wave planning**	
	Refer to minute 3.1.	
11.3	**RAG (NRG) Update**	
	M Berman reported that there had been two recent incidents whereby lungs were lost because of unfamiliarity of a cardiothoracic retrieval team with A-NRP. The retrieval was abandoned. The incidents have been reviewed and the protocols refreshed. All the retrieval protocols will be reviewed in due course. Confirmation has recently been received re. the annual Organ Retrieval Masterclass, and centre directors will be asked to encourage at least one trainee from their retrieval teams to join. The focus of the course will include CT retrieval with abdominal NRP.	

11.4	**QUOD Update**	
	In order to maintain the safety of the retrieval teams pragmatically, it has been decided that samples will only be taken for DBD lungs once they are accepted for transplantation.	
11.5	**Lung Referral Proforma**	
	Work has begun with Bloomsbury Health, and negotiations are in progress with the hospital which has agreed to purchase the system. The pathway and requirements for referral will hopefully provide a platform for elements of education for referrals as well. M Carby will share the first iteration with centres once received. It is hoped that it will be acceptable to all centres and taken up as a national lung transplant referral platform.	**M Carby**
11.6	**Quality of Life Measurement**	
	This work focuses on gathering quality of life information in order to identify where gaps in services are, and to target intervention where required to maximise quality of life. Centres were going to collate data, anonymise it, and send it to L Mumford to tabulate for national sharing, however, nationally this is unlikely to happen. Therefore, Harefield have decided to take a slightly different approach and carry out an annual review proforma to include a lot of information around quality of life and functional status. The method includes emailing patients for information prior to their annual review visit. Once the first iteration of the proforma is available it will be shared with centres; centres will then be asked to build this into their annual review process. Quality of life and functional status information can then be collected prospectively at yearly annual review, and the information can then be sent to L Mumford for analysis over a two- or three-year period. H Spencer and M Carby agreed to collaborate before the November meeting, and have it included as an agenda item at the ALTP meeting.	**H Spencer / M Carby**
12	**Reports from sub-groups**	
12.1	**CTAG Clinical Audit Group (CAG) Chairs Report**	
	The CTAG Clinical Audit Group has submitted a report which has been circulated. A question was raised about the lack of involvement of all centres in Audit Group projects; J Parameshwar agreed to look into this matter. L Mumford reported that there have been no new applications received in recent months.	**J Parameshwar**
12.1.1	**CTCAG Retrieval Rep renewal**	
	M Berman has been representing the donor and retrieval side of the transplant pathway on the Audit Group, and his term finishes at the end of November. The Audit Group will be asking for applications from someone who is currently performing retrievals or has an interest in quality of donors.	
12.2	**CTAG Patient Group**	
	The CTAG Patient Group have met twice (virtually) since the last CTAG meetings. It was helpful for ongoing concerns to be expressed about the kind of physical, emotional and mental impact of the virus on both the pre- and post-transplant community. In addition, group meetings being cancelled, the British Transplant Games being cancelled, and next the potential of the second surge has caused further worries especially with the onset of the colder months approaching. It was acknowledged that patients and their families have been going through a really challenging time, and that there is no end in sight. Centres are asked not to underestimate the effect on the emotional well-being of their pre- and post-transplant patients, especially with reduced face to face meetings. On the positive side, the group is very encouraged by the level of transplant activity that has been taking place – hugely impressive – and are happy to support CTAG in whatever way they can from the patient side. J Parmar wanted to register thanks to the Patient Group re. screening clinical trials and reading/reviewing the documentation which comes out – an enormous bonus in this area. Regarding the new electronics spirometry app, the Patient Group are happy to promote it in any way. The project has support from NHS England, and it is hoped that all units will collaborate and embrace this technology. An update on the project will reported at the next Director's Teleconference. It is hoped that in 12 months' time it can be ascertained if it has influenced patient management. Members were thanked for their support.	

13	**For Information**	
13.1	**Transplant Activity Report** The paper showing the Donation and Transplantation Monthly activity report as at 14th August 2020 over the last two financial years, was circulated for information.	
13.2	**NHSBT ICT Update for Advisory Groups** This paper was circulated for information**.**	
13.3	**Lung Selection Policy POL231/4 and Lung Allocation Policy POL230/11**	
	A section will be added re. the lung liver as discussed earlier (refer to minute 8.3).	
14	**Any other business**	
14.1	M D'Mello reported that this meeting is likely to be her last with CTAG; she has been a Lay Member on various Advisory Groups for over 6 years. She expressed that it has been a privilege to work with everyone and conveyed her thanks. J Parameshwar expressed his thanks for all of her help and support.	
14.2	Ulrich Stock is the interim Centre Director at Harefield and is looking forward to working with colleagues from all centres.	
14.3	J Parameshwar stated that if the next meeting is a Teams Meeting there is more flexibility with having it scheduled in either the morning or afternoon; everyone to consider this and to please email any preferences.	**All**

Date of next meetings

CTAG Hearts Meeting – Monday 28 September 2020, via Microsoft Teams – 11:00 to 16:00
CTAG Patient Group – Wednesday 18 November 2020, via Microsoft Teams 12:00 to 16:30

HOLD THE DATE – Proposed Meetings 2021

CTAG Hearts Meeting – Monday 22 March 2021 – 11:00-16:00 – TBA
CTAG Lungs Meeting – Wednesday 31 March 2021 – 11:00-16:00 - TBA