NHS BLOOD AND TRANSPLANT
ORGAN DONATION AND TRANSPLANTATION DIRECTORATE
CTAG HEART ALLOCATION SUB-GROUP
ON WEDNESDAY 22 SEPTEMBER 2021
MINUTES

Present:

Rajamiyer Venkateswaran	Chair CTAG Hearts, ROA Manchester
Sern Lim (Chair)	QEH, Birmingham
Sai Bhagra	Royal Papworth Hospital, Cambridge
Paul Callan	ROA Manchester
Jonathan Dalzell	Golden Jubilee National Hospital, Glasgow
Guy MacGowan	Freeman Hospital, Newcastle
Fernando Riesgo Gil	Royal Brompton and Harefield Hospital
Sally Rushton	Principal Statistician, Statistics and Clinical Research, NHSBT
Julie Whitney	Head of Service Delivery - OTDT Hub, NHSBT

Attending:

Caroline Robinson (Minutes)	Clinical and Support Services Manager

		ACTION
1.	**Welcome**	
	R Venkateswaran welcomed those present to the meeting. Apologies were received from Stephen Pettit.	
2.	**Purpose of the meeting**	
	R Venkateswaran stated that in June it was agreed that as the 6-tier system agreed some time ago is not currently working due to the IT complexities involved, a solution should be found to resolve urgent heart allocation issues. Currently this relies on zonal supremacy while super urgent allocation is a national system. Because of the need to balance ischaemic time with inappropriate waiting times, it was unanimously agreed that there should be an investigation to see if a national urgent system is possible and Sern Lim has been invited to lead this project.	
3	**History and Current Position**	
	S Lim gave a presentation of slides (previously circulated to those present) which detailed how the current system developed. • The current 3-tier system has been in operation since October 2016; the third tier that was added was the super-urgent category related to mechanical circulatory support, with a brief period when the balloon pump was included but this has since been removed. • In January 2018, a heart allocation subgroup produced the 6-tier system that has not yet progressed very far. This included a great deal of detail that incorporated various categories of patients (LVAD, congenital heart disease, inotropes etc) One of the main problems with the 6-tier system is that it was developed by clinicians but is too complicated to deliver operationally. As it cannot be implemented there is a need to move to a simpler system if any change is to be actioned. The impact of super urgent scheme on urgent patients has been about a median waiting time of a month. Waiting times and numbers of patients on the waiting list also show a huge variation between centres. There needs to be a balance between zonal allocation and ischaemic time. This meeting discussed whether to: • Stick with the status quo	

	• Review and revise the heart allocation system, agreeing what the principles for urgency are and ensuring there is consistency across centres.	
4.	**Areas for Discussion in Revision of Heart Allocation System.**	
	The main points for future discussion were: • Mortality on the urgent list has not changed since the introduction of the super urgent category. • COVID has had a differing impact on units • Any new allocation system devised must include IT input from NHSBT to ensure that it is operationally feasible, and any complexity is balanced with being realistic. • It is important to understand how patients are added to the urgent waiting list as there is a lot of variation in the patients. At present, it is possible that a lower ranking patient could be transplanted quicker depending on the zone they are in because of current zonal supremacy although it is not clear how often this happens. It is also likely that patients on LVAD will wait longer for transplant. • While ischaemic time is important it can result in patients being treated differently because of zonal supremacy currently and so while clinicians will factor ischaemic time in when they make decisions, it should not be the dominant factor in any new system developed. • A new allocation system should be easy to administer and not favour one part of the population over the other (eg there are more people in the south which could disadvantage northern centres like Glasgow and Newcastle). • At present, the data that is being collected is outdated and the group should consider the information it needs to inform decisions about allocation in future. • The length of pathway and its impact on co-ordinators needs to be considered alongside the development of a new allocation system. • The measurement of urgency if zonal priority is removed needs to be considered, eg, estimated mortality risk without transplant over a 1-year timeframe. Consistency across centres is important in agreeing national allocation. • The super urgent scheme is working well and there is no need to review this at present. • Overall, what does a change in the allocation system hope to achieve so this can be measured?	
5.	**Next steps**	
	It was agreed: • S Lim will circulate a summary of 10 cases to the group to get views on predicted mortality is likely to be at 1 year with and without transplant and to assess how consistent centres are in estimating risk. If there is a lot of inconsistency, this group will discuss this. The group should then consider what risks are considered when deciding on urgency to determine heart allocation. It was agreed that the cases can be discussed with other members of each unit's team. • S Rushton will look at the current urgent list and how this fits into the 6-tier system, eg LVAD patients, patients' waiting to transplant times.	S Lim / S Rushton
6.	**Next meeting**	
	The next meeting of the group will be after CTAG Hearts in October. Further information will follow in due course.	