NHS BLOOD AND TRANSPLANT
ORGAN DONATION AND TRANSPLANTATION DIRECTORATE

THE NINETEENTH MEETING OF THE NHSBT CTAG(L) LUNGS ADVISORY GROUP ON WEDNESDAY 6 APRIL 2022, 10:30-14:30 VIA MICROSOFT TEAMS

Attendees:

Jasvir Parmar	**CTAG Lungs Chair**, Royal Papworth Hospital
Ayesha Ali	Highly Specialised Services, NHS England
Lynne Ayton	Transplant Managers Forum Representative; Golden Jubilee, Glasgow
Richard Baker	Associate Medical Director - Clinical Governance, OTDT, NHSBT
Jennifer Baxter	BTS Representative
Malcolm Brodlie	Paediatric Respiratory Physician, Newcastle
Rossa Brugha	Respiratory Consultant, Great Ormond Street Hospital
Robert Burns	Co-Chair, CTAG Patient Group
Andrew Butler	MCTAG Chair, NHSBT; Addenbrookes Hospital
Martin Carby	Respiratory Physician, Harefield Hospital
Ian Currie	Associate Medical Director – Retrieval, OTDT, NHSBT
John Dunning	Centre Director, Harefield Hospital
Catherine Exley	Dean of Population Health Sciences Institute, Newcastle
Andrew Fisher	NIHR BTRU Representative, Freeman Hospital, Newcastle
Dale Gardiner	Associate Medical Director – Deceased Organ Donation, NHSBT
Vicky Gerosavili	National Lung Clinical Lead for Utilisation (CLU)
Gill Hardman	CTAG Clinical Audit Group Cardiothoracic Fellow, Freeman Hospital
Margaret Harrison	CTAG Lay Member Representative
Delordson Kallon	Head of H&I Laboratory, Barts Health NHS Trust
Jim Lordan	Respiratory Physician, Freeman Hospital, Newcastle
Derek Manas	Medical Director – OTDT, NHSBT
Jorge Mascaro	Centre Director, Queen Elizabeth Hospital, Birmingham
Gerard Meachery	Joint Centre Director, Freeman Hospital, Newcastle
Nkechi Onwuka	Statistician, Statistics and Clinical Research, NHSBT
Karen Redmond	NI CTAG Lungs Observer
Sally Rushton	Senior Statistician, Statistics and Clinical Research, NHSBT
Karthik Santhanakrishnan	Respiratory Physician, Wythenshawe Hospital
Philip Seeley	Transplant Co-ordinator, Freeman Hospital
Linda Sharp	Professor of Cancer Epidemiology, Newcastle
Laura Stamp	Lead Nurse Recipient Coordinator, NHSBT
Debra Thomas	Deputy Physician Representative, Royal Papworth Hospital
Richard Thompson	Respiratory Medicine, QEH, Birmingham
Teressa Tymkewycz	Team Manager, SNOD, Oxford
Julie Whitney	Head of Service Delivery, OTDT Hub, NHSBT
Claire Williment	Accountable Executive – Organ Utilisation Programme; Legislation Implementation, NHSBT

In attendance:

Caroline Robinson	Advisory Group Support, NHSBT (Minutes)

Item	APOLOGIES AND WELCOME	Action
	• J Parmar welcomed everyone to the meeting. • Apologies were received from Marius Berman, Iolo Doull, Catherine Coyle, Craig Hannam, Stephen Pettit, Richard Quigley, Tracey Rees, Rachel Rowson, Michael Stokes, Rajamiyer Venkateswaran, Sarah Watson, Craig Wheelans	
1	**DECLARATIONS OF INTEREST**	
	There were no declarations of interest raised at the meeting. ***NB: It is the policy of NHSBT to publish all papers on the website unless the papers include patient identifiable information, preliminary or unconfirmed data, confidential and commercial information or will preclude publication in a peer-reviewed professional journal. Authors of such papers should indicate whether their paper falls into these categories.***	

2	**MINUTES AND ACTION POINTS OF THE CTAG LUNGS MEETING HELD ON 08/09/2021 – CTAGL(M)(21)02 and CTAGL(AP)(21)02**	
2.1	The Minutes of the previous CTAG Lungs meeting held on 08 September 2021 were accepted as a true and correct record. One amendment has been made to Item 5.2 of the Minutes to read: '*Hub Operations is currently looking at data pulled off the national transplant database to investigate how long offers are taking, whether there are any significant delays in long offers where a decision has been made or the reason for delays'.*	
2.2	The Action Points from the previous CTAG Lungs meeting on 08 September 2021 were discussed as follows:	
2.2.1	**AP1: Clinical Governance Report:** G Hardman has discussed collaborative work re. human performance psychology in the context of organ retrieval surgery, involving the performance psychology group, to build something which would be useful and relevant for retrieval teams as part of the Organ Retrieval Masterclass with I Currie and M Berman	*See Item 7.2*
2.2.2	**AP2: Lung Referral Proforma**: M Carby stated that despite significant work, this has now stalled as Harefield has now moved to EPIC as IT provider and the relationship with the existing IT company re the lung proforma has now ended. Heart Failure and neuro surgical teams have a national platform that integrates with EPIC so it may be possible to resurrect this work in future. J Parmar will discuss with M Carby.	**J Parmar / M Carby** *See also Item 10.1*
2.2.3	**AP3: Clinical Governance:** At the last meeting D Manas reiterated that donation and retrieval communication needs to be consultant to consultant. Clarification on these communication problems is needed. D Manas has written to retrieval surgeons regarding communication issues and will now discuss how to maintain this communication with I Currie.	**D Manas / I Currie**
2.2.4	**AP4: CUSUM Monitoring of 90-day outcomes following lung transplantation:** D Manas agreed to send updated guidance of the process that takes place following a signal to J Parmar.	**COMPLETE**
2.2.5	**AP5: Hub Ops Update – Offering Processes:** Hub Operations is currently looking at data pulled off the national transplant database to investigate how long offers are taking, whether there are any significant delays in long offers where a decision has been made or the reason for delays. It was noted that heart offers come out first as these are done on urgent named patient basis. If the heart is not accepted, it is offered as a heart lung group offer. Lung liver offers should be made ahead of group offers. J Parmar has discussed this with R Venkateswaran to ensure consistency	*See Item 6* **COMPLETE**
2.2.6	**AP6: UK Lung PGD**: G Hardman reported on the work she has been doing on a national collection of retrospective primary graft dysfunction data and gave a report on the results of the data analysis.	*See Item 7.2*
2.2.7	**AP7: Automated UK donor lung allocation tool/Newcastle study**: A Fisher and S Kennedy attended the last meeting to discuss this feasibility study. The goal shown in the presentation is to move towards a named organ allocation process with a scoring system for each lung transplant patient using an analytic hierarchy process to consider criteria when making decisions on diagnosis, clinical urgency, recipient CMV status, diabetes status. A working group has now been set up which has had two meetings so far in January and March to decide on the data points needed going forward.	**Further information to follow at CTAG Lungs in the Autumn** *See Item 8.1*
2.2.8	**AP8: Quality of Life**	*See Item 10.4*
2.2.9	**AP9: Patient Group:** Robert Burns has been appointed to replace Rob Graham as Co-Chair of the Patient Group. He will attend both CTAG Lungs and Hearts meetings.	*See Item 11.2* **COMPLETE**
3.	**LUNG PERFORMANCE REPORT** – **CTAGL(22)01**	
	D Gardiner presented some key metrics on UK lung transplantation with a comparison with data from Canada. The graphs shown indicate that while lung transplantation is improving post pandemic it is still nowhere near 2019 levels. It was agreed that the graphs shown are a good way of illustrating cumulative results and present transplant rates without setting targets. These graphs will continue to be shown in future at the start of each CTAG Lungs meeting.	
4.	**MEDICAL DIRECTOR'S REPORT**	
4.1	**Developments in NHSBT**	
	In his first report as Medical Director for OTDT, D Manas stated: • The AMDs appointed are being given specific remits and each will be associated with an advisory group. D Gardiner will attend CTAG Lungs. • Spending review – although some of the devolved nations have specified future funding, there is no news from NHSE on how much money NHSBT will have in 2022-23. This makes it difficult to plan ongoing or future work. Some bridging funding for lead CLUs has been found and recommendations have been written for OUG work which will be publicised more widely in May/June when there is more access to the minister responsible. • ARC Project – Despite lack of information currently on funding, it is hoped the ARC Project will move forward with lung and liver organs initially.	

	• ARP – Funding confirmation is still awaited but it is anticipated and so work now needs to progress with TA-NRP. • Use of mOrgan machine – A change control board is being introduced to enable use of this machine which will start soon. • OTDT Together – K Quinn is leading this project at NHSBT to bring together the work of Tissues, Eyes and Organs into one directorate. • Histopathology – NHSE have agreed to fund a national service to ensure a pathologist is on call every night. Implementation is not likely to be live for 15 months so an interim plan will enable SNODs to access histopathology via a digital platform. • Photography/Filming – I Currie will bring together 3 groups to look at this issue to ensure photos are not sent via personal devices. D Manas also paid tribute to Professor Paolo Muiesan who worked for many years as a liver surgeon in Birmingham and who has sadly died recently.	
4.2	**New appointments**	
	The following new appointments have been made: • Richard Baker becomes AMD for Clinical Governance • Lorna Marson becomes AMD for Research & Development to be link with BTRU and QUOD and the UK Organ Donation network. • The new surgical Clinical Governance Lead will be Sanjay Sinha (replacing D Manas) • Ian Currie has been appointed as a new AMD for Retrieval starting from 1 April. Workstream leads for the Organ Utilisation Programme (OUP) appointed to support Claire Williment's work are Agimol Pradeep, Jessica Jones and Helen McManus. Although the outcome of the funding review is not yet known, OUP work remains an important programme that includes ARCs, CLUs and education. Diana Garcia Saez will also retain her Organ Utilisation lead role. Robbie Burns has also been appointed as a new lay member.	
5	**GOVERNANCE REPORT**	
5.1	**Clinical Governance report** – **CTAGL(22)02**	
	• There are no incidents in the report, however a recent incident related to histopathology where a lung nodule was sampled which lead to the loss of organs was mentioned. Activity back to normal numbers with about 40 incidents a month and not too many for lung. • It was clarified that the governance report covers the process from identification of a donor, testing, allocation, retrieval, transport and implantation through to the outcome of the transplant. Any incidents are monitored, and feedback is given in a constructive manner aiming to educate. Responsibility for any issues of harm or post-transplant care lies with individual trusts so a donor/patient may fall under both the trust and NHSBT's governance. R Burns expressed concern that as transplant patients are one of many groups cared for in a trust there is a risk that harm and post-transplant issues get lost. Communication of any issues around post-transplant care do go to NHSE, and it was suggested that the Patient Group could consider ways to help with ensuring these issues are understood across transplant centres. A Ali stated that the Health and Social Care bill will bring about changes to quality and monitoring for NHSE. **ACTION: A Ali to share details of changes with R Burns**	**A Ali / R Burns**
5.2	**CUSUM Monitoring of 90-day outcomes following lung transplantation – CTAGL(22)03**	
	The report summarises the most recent CUSUM results sent to all centres monthly. Since the last CTAG meeting, there have been 36 CUSUM reports and one lung signal in September at Harefield.	
5.3	**Shared Learning from recent Harefield CUSUM trigger**	
	• Following a run of 10 deaths over a period of time a detailed report was completed. Questions around donor size matching, venous access and whether there had been full anaesthetic discussion pre-transplant have been raised and there will be a further update in June 2022. • J Dunning reported that he had taken over as Centre Director in November 2021 following a turbulent period which included the departure of the previous director, appointment of an interim director and relative paucity of surgical experience in the service. A lot of work has been done regarding assessment processes, what happens in the operating room and how patients are cared for in ICU. A new way of sizing patients has been put in place using TLC. All centres also confirmed that anaesthetic assessment takes place pre-operation although each centre does this differently. D Gardiner suggested that there should be a national standard and offered to work on this with an anaesthetist. **ACTION: All to email potential names to J Parmar to pass onto D Gardiner**	**D Gardiner / J Parmar**

5.4	**Group 2 Transplants**	
	There were no Group 2 Transplants to report	
6.	**OTDT HUB UPDATE**	
6.1	**HTA B completion returns** – **CTAGL(22)04**	
	Since the last meeting, the return rates for HTA-B forms have improved and all centres are doing well indicating that the chase process implemented is effective. The report circulated will be produced every 6 months for information.	
6.2	**Performance Report for Registry Forms** – **CTAGL(22)05**	
	Although the circulated report is for kidney, this shows what an information dashboard for Lung could look like. The dashboard will be combined for hearts and lungs and will include offer rates, HTA B return rates, return of transplant record and 3 month and 12-month post- operative forms and is not designed to be a league table. It will come out monthly and will be sent to clinical directors and lead co-ordinators. This will keep track of forms throughout the year rather than finding information missing at the end of year and will identify any problems that need rectifying.	
6.3	**Super Urgent Liver – 3 months report – March 2022** – **CTAGL(22)06**	
	This pathway was introduced as recipients listed for super urgent liver transplant are at risk of rapid and fatal deterioration during the time between listing and transplantation. The deterioration may occur over hours, and in some cases the patient may become un-transplantable. The pathway was brought in on 8 April 2021 under an "opt-in" trial where liver centres could choose to activate the pathway, which expedites the offering of cardiothoracic organs, upon acceptance of the liver for a super-urgent patient. This had varying levels of utilisation across centres and so on 1 November 2021, a pilot began where this pathway would be implemented for all super-urgent liver acceptances where cardiothoracic offering occurs. Data from 2019 indicates that out of 140 super urgent liver registrations, 18 died pre operation and 9 died immediately post-transplant - a 20% mortality. The pilot aims to improve the situation and looks at what undue delays there are and how these can be overcome. Results are shown in the paper circulated and utilisation results are encouraging. Communication between surgeons in different centres and between liver and CT surgeons is shown to be vital to improve the situation for these recipients. The review is continuing and there are meetings on a regular basis to look for further improvements.	
7	**LUNG UTILISATION**	
7.1	**CLU update - CTAGL(22)21 and CTAGL(22)22**	
	V Gerosavili gave an update on the work of the CLUs which is outlined in the documents circulated. • Offer Declines – Higher quality donor definitions have been agreed for heart and lung with the CLU community, where utilisation should approach 100%. Out of 200 lungs it was found that 38% would meet those strict criteria and the utilisation rate is less than 50%. Offer decline schemes are now running for all abdominal organs and similar schemes are now being introduced for heart and lung. If a centre turns down a higher quality donor, a report needs to go back to CTAG, NHSBT and the CLU team to explain why the organ has been declined. If an organ has been declined for logistical reasons this should not be included and a separate stream will examine this issue. The duration of the study is 8 months. This is an important initiative and cardiothoracic organs should not be out of step with other organs. • Patient deaths on the waiting list following offer decline - This report will inform centres of incidents where a patient has died on the urgent or super-urgent waiting list after a deceased donor lung has been declined for them and the lung was subsequently implanted into another patient with reasonable outcomes. The report will come out annually.	
7.2	**Audit Fellow project updates**	
	G Hardman's term as Audit Fellow comes to an end in August. There is now a very rich data set of primary graft dysfunction with definite diagnosis and grading for 1720 pts over 10 years in the UK. The work will see if it is possible to predict PGD grade 3 linked to reduced survival at 90 days, 1 year and 3 years. Anyone can apply for access to this data which will be held by NHSBT. G Hardman will report back on the modelling of the lung risk index at the autumn meeting. There is also HRA approval for a qualitative interview study of CT surgeons and co-ordinators for cognitive interviews to understand decision making at the time of offering. Interviews will last 45 minutes to 1 hour and will take place over Zoom or Teams. Participation from every centre and with all levels of experience is needed and an invitation will go out to everyone this week.	
7.3	**Donor Lung Utilisation by donor type and higher-quality donor status – national figures – CTAGL(22)07**	

	This is a high-level document tracking quarterly national utilisation rates for hearts and lungs offered from deceased solid organ donors. The line graphs are split by donor type (DBD/DCD) and also higher quality donor status. These graphs will be useful for CTAG to see on a regular basis in order to identify if OU initiatives are making a difference. It was requested that the graphs split by higher quality donor status are split into two separate graphs. **ACTION: S Rushton to look at separating the higher quality donor graphs into two separate figures**	
7.4	**Organ Utilisation Programme Update**	
	• In addition to work of the CLUs and the ARC detailed elsewhere in this meeting, C Williment highlighted work on a new digital infrastructure to replace EOS and a prototype is now in testing mode. Another workstream is looking at education and culture.	
7.5	**Organ Utilisation Group Update** - **CTAGL(22)08**	
	C Williment highlighted the terms of reference for the group: • Deliver improvements in the number of organs that are accepted and successfully transplanted for adult and paediatric patients • Optimise the use of the existing skilled workforce, investment and infrastructure • Provide equity of access and patient outcomes • Reduce unwarranted variations in practice • Support innovation. There has been extensive stakeholder engagement with both clinicians and with patient focus groups. The main themes from patients include the need for psychological and social support, inequity of access, a disjointed service, inconsistency of advice and poor communication and data. Workforce issues were key for clinicians as well as logistical problems and KPIs/access to data. The next steps will be a further meeting of the OUG in May along with socialisation of feedback with stakeholders before finalisation of the implementation plan which will be published in the summer parliamentary session. There is a National Organ Utilisation Conference being held on 27 May 2022, which members should have received an invite for.	
7.6	**Lung Assessment and Recovery Centres (ARC) update**	
	A Fisher stated that he co-chairs this Lung ARC FTWU with M Berman which has now met 3 times. There is representation from all implanting centres in the UK and a document has been produced outlining the case and rationale for the lung ARC. The group is now focussing on the organisational structure for the ARC, indications for which organs are suitable for EVLP, governance, custody and responsibility for the organ from the donor centre to the ARC and onto the implanting centre. The allocation sequence should not be impacted by the use or request of an ARC. Data collection forms have been developed and once there is confirmation of funding, tendering for the device and protocol development will follow. The intention is to start modestly with 30 perfusions a year and to future proof any investment as innovative therapies come online to see if they can be incorporated into the work of the ARC.	
8	**LUNG ALLOCATION**	
8.1	**Lung Allocation Working Group (15.3.22)** – **CTAGL(22)09**	
	There have now been two meetings to look at what opportunities there are to change non-urgent lung allocation to improve transparency and inequalities. The group is being informed by work done by A Fisher and Sam Kennedy in Newcastle using US and UK datasets to model different allocation policies. S Rushton has also provided UK data to inform the discussion. The group are deciding whether more data is needed to create an allocation score similar to the Liver Transplant Benefit Score or whether there is sufficient data available. The simulation engine developed by S Kennedy aims to replicate UNOS data and looks at post-transplant survival and waiting lists. A further meeting is planned for the end of May and in the meantime, S Kennedy and A Fisher are meeting with UNOS to discuss the data and the new continuous distribution LAS that the US have been developing. S Rushton will also catch up with S Kennedy in the coming weeks.	
8.2	**Allocation Zone Review** – **CTAGL(22)10**	
	When comparing the proportion of lung registrations made by each centre with the proportion of lung donors in each of the current lung allocation zones, significant differences were noted for Newcastle, Harefield and Papworth. This is evidence for a need to change the lung allocation zones. A further document to be circulated to clinical leads in the next week will indicate the 24 hospitals that will move to new allocation zones. **ACTION: S Rushton to circulate the paper and give clinical leads a week to respond with any concerns.**	**S Rushton**
8.3	**Summary of Adjudication Panel Appeals** – **CTAGL(22)11**	
	This regular report shows the number of patients who are referred for urgent and super urgent listing over a period of 5 years. • There were 40 lung appeals over the period of which 77.5% were approved.	**J Parmar**

	• 2 super urgent appeals were also approved • There were 11 paediatric appeals, all of which were approved. • There were 28 urgent heart lung appeals of which 71.4% were approved It is noted that there is a well-structured proforma for heart appeals. **ACTION: J Parmar will work on an equivalent proforma for appeals for lung**.	
8.4	**Review of Adjudication Panel cases**	
	J Parmar stated that he has done a review of adjudication panel cases over the last 6 months and notes the acceptance rate is quite high and mainly fibrotic patients. There are no CF patients. This is unlikely to change unless the threshold for oxygen changes.	
8.5	**Selection and Allocation Policy Updates** – **CTAGL(22)19** and **CTAGL(22)20**	
	• Proposed changes to the Lung Selection and Allocation policies have been circulated to the group for awareness. They were approved by OTDT CARE members this week following previous approval by the Advisory Group Chairs. Members are asked not to save these copies to local files and should wait for the official versions to be published online. • Members discussed super urgent lung criteria and the previous requirement for patients to be on the non-urgent or urgent scheme in *POL231 –Lung Candidate Selection Criteria* and it was agreed to edit Section 6.3. Patients not previously on these schemes will require adjudication panel approval. **ACTION: S Rushton to remove requirement for super-urgent patients to have previously been on the non-urgent or urgent scheme from POL231**	
9	**STATISTICS AND CLINICAL RESEARCH REPORTS**	
9.1	**Summary from Statistics and Clinical Research – CTAGL(22)12**	
	This update on the team and work projects was circulated for information.	
10	**STRATEGIC DEVELOPMENTS FROM THE CHAIR**	
10.1	**Workplan/Strategic Aims**	
	The workplan for CTAG Lungs was discussed at last year's meetings. The Allocation working group, CLU Programme, NHSBT data handling and image transfer projects are now all up and running and an NHSE meeting is planned for 16 June. J Parmar would now like suggestions for other initiatives that could be adopted in the next 18 months to 2 years. • It was suggested that electronic referrals could also be added to the workplan. **ACTION: J Parmar to discuss work done to date and future work with M Carby** • Quality of life is now being driven by the BTRU funded stream but could also be incorporated under Priority 4. • Care of post-transplant patients with psychological support should be considered going forward and is part of the national NHSBT strategy and the work of the Organ Utilisation Group. **ACTION: All to forward further ideas to J Parmar** **ACTION: Workplan to be updated with progress**	**J Parmar / M Carby**
10.2	**QUOD Update** – **CTAGL(22)13**	
	The latest data was circulated for information. BALs were not being collected for a while but now an established process in place.	
10.2.1	**QUOD named UK Biobank of the Year – CTAGL(22)14**	
	QUOD has been named UK Biobank of the Year 2022. All are thanked for their collaborative work in this endeavour.	
10.3	**CTAG Clinical Audit and CTAG Research and Innovation Groups**	
	The Clinical Audit group has now been disbanded. A new CTAG Research and Innovation subgroup will meet for the first time on Weds 11 May. Membership to date includes representation from GOSH, Birmingham, Papworth, Harefield, Manchester and Newcastle. Lorna Marson (AMD for Research at NHSBT) and Gavin Pettigrew (Chair of RINTAG) are also being invited to the meeting. The hope is that a champion will be identified to steer the group, focussing on creating well structured, large databases and to lobby the NHS for funding for collaborative studies.	
10.4	**Patient Reported Outcomes and Experiences in Lung Transplantation**	
	A Fisher introduced Professor Catherine Exley, Dean of Population Health Sciences Institute and Professor Linda Sharp, Professor of Cancer Epidemiology at Newcastle who will be working on a new BTRU award focussing on quality of life and inequalities in healthcare to be hosted at Cambridge and Newcastle. Their research aims: • To improve how we measure quality of life after transplant • To identify areas for improved care and tackle inequalities in experience The views and experiences of transplant patients and carers will be central. The methodology will use:	

	• PROMS – patient reported outcome measurements – which look at the patient's view of their health status and how implementation of treatment impacts on this – These are either generic or disease specific and help to identify which patients are at risk of worse outcomes or experiences. They are useful in research and audit. • PREMS – patient reported experience measurements – which examine the patient's perception of experience of using healthcare (eg intervention while in health care) as an indicator of quality of care Both these approaches are patient centred, comprehensive and responsive to change and will be followed by evaluation and implementation. Over the next few months, decisions will be made on what is to be measured and in what patient group to facilitate recruitment of patients and carers. Clinical colleagues will also be consulted for input into PROMS and PREMS. A pilot will be run. Ultimately a protocol will be developed to embed PROMS and PREMS into the work of each unit at the end of 5 years life of the project. There was a lot of support at CTAG Lungs for the project: • C Exley and L Sharp will be invited to present the project at a future CTAG Patient Group meeting. • Feedback on the work will come out at different stages during the life of the project. • Capturing paediatric patient and carers' views would also be helpful. It was agreed that an audit fellow would be helpful to move the project forward across all units.	
10.5	**Review of CTAG Lungs Terms of Reference** – **CTAGL(22)18**	
	• The updated terms of reference were circulated and include changes in structure within NHSBT and the separation of CTAG into individual heart and lungs advisory groups. They also detail what and who should be at each meeting and are a reminder that both a surgical and physician rep should attend from each centre. The Audit group has been taken out and the Research and Innovation group has been added. The Terms of Reference will be discussed at the next Centre Directors' meeting. **ACTION: Any comments on the Terms of Reference to be sent to J Parmar and S Rushton.** • The Transplant Managers' Forum is included in the Terms of Reference and was discussed recently by the Centre Directors. It is noted that this group does not meet at all at present. The distribution list is being updated currently and it is noted that the remit of many of these people in hospitals has changed considerably in recent years. it is agreed that it would be helpful for this group to meet again. L Ayton stated that she would like to step down as the representative at CTAG Lungs when a suitable replacement has been identified.	
11	**REPORTS FROM RELATED GROUPS**	
11.1	**Retrieval Advisory Group Update (29.03.22)**	
	I Currie highlighted the discussion about Blue Light travel from the Retrieval Advisory Group meeting held on 29 March. This stemmed from a wish by the Department of Transport to stop all blue light travel for organ transport 2 years ago due to concerns around governance, audit and monitoring. Now every time a blue light is activated it is monitored and recorded by IMT. The average use of blue lights is modest and comparable to police or ambulance activation. Only organ or patient deterioration are reasons to activate a blue light and a recipient consultant's name will be required as the requestor. It is hoped these actions will ensure appropriate use of blue lights for organ transport.	
11.1.1	**Update from RAG: MV and CT sequence of offering**	
	A Butler (Chair of MCTAG) attended the meeting to raise the order of sequence needed to avoid delays in cross clamp where both MV and CT organs are retrieved. The explant procedure is often long and complicated, and donation is constrained by delays to cross clamp and cold ischaemic time so as soon as MV organs are accepted, the recipient is prepared for implantation and the anaesthetic procedure starts. Once that happens there is no way to turn back. There is often assessment on the CT side which can delay the process further. A Butler highlighted that although a request for laparotomy prior to any CT intervention to reduce delays in cross clamp, it is often not granted and there is perhaps lack of understanding currently between CT and MV surgeons of each other's needs. This applies to approximately 15 donors per year. **ACTION: J Dunning and J Parmar to take this issue to Centre Directors' meeting to discuss further. Involve I Currie and A Butler as well at later stage.**	**J Dunning**
11.2	**CTAG Patient Group (12.05.2021), new co-chair and future meetings (22.06.2022 and 07.12.22) – CTAGL(22)15 and CTAGL(22)16**	
	R Burns introduced himself as new co-Chair of the Patient Advisory group. His plans are to reach out to as many different support groups as possible. Patients are expressing a lot of concerns around COVID currently, particularly uncertainty about a 5th vaccine, treatments and non-symptomatic testing going forward. Almost all complaints centre around post-transplant care, especially lack of information. He has also been invited to the next meeting of PACT and	

	will be discussing concerns raised around access to psychiatric and psychological services. He plans to produce a written report for future meetings of CTAG Hearts and Lungs Advisory Groups.	
11.3	**CT Centre Directors' meetings (18.02.22 and 01.04.22)**	
	The Centre Directors meet every 6 weeks, most recently on 1 April. The main issues discussed recently include the initiation of the ARC and how this might be supported and staffed and where it will be located. A discussion about mutual aid between centres will be re-scheduled. The new heart risk communication tool was highlighted, which joins a suite of tools across all organs. There was also discussion about COVID treatments and how patients can access tests and treatments in future. R Burns also attended as a guest to introduce himself as the new co-Chair of the Patient Group.	
12	**FOR INFORMATION**	
12.1	**NHSBT ICT update for Advisory Groups – CTAGL(22)17**	
	This update was circulated for information prior to the meeting for information	
13	**ANY OTHER BUSINESS**	
13.1	**SIGNET Study**	
	This trial led by John Dark which started in September, randomises DBD donors with research consent to have Simvastatin as a single dose or best standard care. There are now 140 donors randomised and about 80% of major donor hospitals are now involved. There have been no SAEs and generally the roll-out has been very smooth. Recruitment will take place for 4 years (2600 donors in all). Lung data, principally 90-day survival (all collected via the UK Transplant Registry), are amongst the secondary outcome measures. A co-enrolment mechanism to allow data sharing with any studies that might be affected has been developed, and it is important to know about intervention that might affect lung outcomes. **ACTION: If there are any parallel clinical studies, or service evaluations that are affected, members are asked to contact John Dark john.dark@newcastle.ac.uk or Dan Harvey Dan.Harvey@nhsbt.nhs.uk**	**ALL**
13.2	**Process for urgent heart lung adjudication**	
	It is agreed that J Parmar and R Venkateswaran will look at a more streamlined process alongside S Rushton. **ACTION: J Parmar, R Venkateswaran and S Rushton to look at this**	**J Parmar / R Venkateswaran / S Rushton**
13.3	**Date of next meeting**:	
	The date of the next meeting will be re-scheduled in the autumn due to a clash with another event and further information will follow in due course. Those at the meeting stated their preference for a virtual rather than a face-to-face meeting. If opting for a virtual meeting for CTAG Lungs, there is perhaps an opportunity for some of the working groups to meet face to face.	