NHS BLOOD AND TRANSPLANT
ORGAN DONATION AND TRANSPLANTATION DIRECTORATE
CTAG HEART ALLOCATION SUB-GROUP
ON MONDAY 4 APRIL 2022
MINUTES

Present:

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
Andrew Morley-Smith	Royal Brompton and Harefield Hospital
Stephen Pettit	Royal Papworth Hospital
Sally Rushton	Principal Statistician, Statistics and Clinical Research, NHSBT
Rajamiyer Venkateswaran	Chair CTAG Hearts; ROA Manchester
Julie Whitney	Head of Service Delivery - OTDT Hub, NHSBT

Attending:

Caroline Robinson	Advisory Group Support (Minutes)

		ACTION
1.	**Welcome and Minutes of the last meeting**	
	• S Lim welcomed all to the meeting. • There were apologies from Jane Cannon, Owais Dar, Fernando Riesgo Gil. • There were no amendments to the Minutes of the last meeting on 6 December 2021	
2	**Update on the Urgent Heart Allocation Scheme**	
	At the last meeting it was discussed that there is no good risk-stratification method for the urgent list and the previously proposed 6-tier system was too operationally complex. Therefore, it was agreed to review Category 21: '*Adult inpatient dependent on intravenous inotropes and/or IABP which cannot be weaned'* which is the largest group of patients registered on the urgent scheme. S Rushton has provided each centre with 20 patients registered on category 21 to collect more specific information on the reason for inotrope initiation. The data to be collected is: • Aetiology • Hemodynamic data • Organ function data • Indications for inotrope Full details are in the presentation circulated with these Minutes. The next steps are to: • Each centre to collate the necessary data and specify indications for starting inotropes in each of the 20 cases • Use this information to try to draw up criteria for inotrope initiation • Decide what patients will benefit from urgent listing Issues: • Some patients are already on inotropes when they are assessed by a transplant centre, so the decision to initiate inotropes does not lie with the centre.	

	• If the criteria are tightened too much there is a danger that it will appear care is being rationed**.** It is agreed initially to concentrate on: • Why inotrope use has been prompted: • Data will be analysed once it is received from all centres. So far about 50% of centres have returned data. • For data to be meaningful, it should be the set of results that led to inotrope initiation and closest to urgent registration. • For those on inotropes already, data should be the closest to urgent listing. • Arrythmia cases do not need to be recorded in data; some of these cases go through adjudication and often get approved and it is not a reason for inotrope dependence. • May need to consider why some patients wait over a year (are they LVAD patients, congenital, highly sensitised?) but this is not the forum to address this question. **ACTION: SL and SR to meet in 2 weeks to analyse data.**	
3.	**Heart and Liver Transplant**	
	There is an increase in the number of people waiting for combined liver/heart transplants. Over the last 4 years there have been about 1-2 of these transplants per year. Since 2015, 2 have died and 4 remain alive. There are now 6 people on the waiting list (3 urgent; 3 routine) and the average waiting time is 9 months. Where these patients sit on the heart allocation scheme is key. If on the routine heart list, they are not named but they are on the named list for liver. This can cause issues with offering and becomes a manual task for Hub Ops to remember to allocate them for combined transplant. There is also a delay in liver allocation while the heart is being offered. The group discussed: • The feasbility of defining criteria for heart-liver listing. Common listing criteria is important to ensure patients are treated fairly and to refer them to a centre offering liver and heart transplants (ie, Papworth, Newcastle, Birmingham) • Clinical criteria for congenital or non-congenital patients are needed. Involvement of congenital heart colleagues in these discussions would be helpful. • A separate tier for heart allocation could be considered so the patient is named to improve offering • Mechanical support bridging to combined heart and liver transplant is generally felt to be a contraindication. • Assessment of risk is important. Although this is hard to quantify, if the risk is too high, combined transplant may not be a good use of organs when there are so few available. • Age is not the only risk factor to consider. • All centres need to see the outcomes for these patients (30 days, 90 days) so there is an awareness of risk and to monitor the numbers being listed. • At present, outcomes are excluded from CUSUM analysis. Is this appropriate? A separate analysis of heart liver transplants may be included in the Annual Cardiothoracic Report. • These issues will be discussed further at the next meeting.	
4	**Update on Heart Transplantation in LVAD Complications**	

	The paper shared at the last CTAG Hearts meeting indicated there were 48 transplant patients with LVAD complications. Following a check with Adjudication, the cohort number has risen to 61 and numbers per centre vary. **ACTION: S Rushton to send out a spreadsheet listing these patients with columns for each centre to complete within the next 2 weeks. The data will be presented at CTAG Hearts in May.**	
5	**Any Other Business**	
	NAD	
6.	**Date of next meeting**	
	No date for a future meeting was set. A follow up meeting will be arranged after review of the data.	