# NHS BLOOD AND TRANSPLANT
# ORGAN DONATION AND TRANSPLANTATION DIRECTORATE
# THE TWENTY-SECOND MEETING OF THE NHSBT CTAG HEARTS ADVISORY GROUP
# ON WEDNESDAY 18 OCTOBER 2023
# VIA MICROSOFT TEAMS

## MINUTES

**Attendees:**

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| Rajamiyer Venkateswaran | **CTAG Hearts Chair;** Centre Director, Wythenshawe Hospital |
| Waqas Akhtar | Cardiology & Intensive Care, Guy's and St Thomas' Hospital, London |
| Lynne Ayton | Transplant Managers Forum Representative |
| Marius Berman | Chair, Retrieval Advisory Group; Papworth Hospital |
| Robert Burns | Co-Chair, CTAG Patient Group |
| Paul Callan | Consultant Cardiologist, Manchester University NHS Foundation Trust |
| Ian Currie | Associate Medical Director – Retrieval, NHSBT |
| Philip Curry | Consultant Cardiac Transplant Surgeon. Golden Jubilee National Hospital |
| John Dark | University of Newcastle |
| Margaret Harrison | CTAG Lay Member Representative |
| Rachel Hogg | Statistics and Clinical Research, NHSBT |
| Sern Lim | Cardiologist, Queen Elizabeth Hospital, Birmingham |
| Guy Macgowan | Cardiologist, Freeman Hospital, Newcastle |
| Debbie Macklam | Head of Service Development, OTDT, NHSBT |
| Derek Manas | Medical Director, OTDT, NHSBT |
| Fiona Marley | Head of Highly Specialised Commissioning, NHS England |
| Jas Parmar | CTAG Lungs Chair, Royal Papworth Hospital |
| Stephen Pettit | CT Centre Director, Royal Papworth Hospital |
| Karen Quinn | Assistant Director, UK Commissioning, NHSBT |
| Aaron Ranasinghe | Lead CLU Hearts; Cardiac Consultant Surgeon, Queen Elizabeth Hospital, Birmingham |
| Tracey Rees | Scientific Advisor, NHSBT |
| Zdenka Reinhardt | Cardiologist, Freeman Hospital, Newcastle |
| Fernando Riesgo-Gil | Consultant Cardiologist, Royal Brompton and Harefield Hospital |
| Philip Seeley | Recipient Transplant Co-ordinator, Newcastle |
| Jacob Simmonds | Consultant Cardiologist, Great Ormond Street Hospital |
| Lewis Simmonds | Statistics and Clinical Research, NHSBT |
| Raynie Thomson | Product Owner, OTDT, NHSBT |
| Craig Wheelans | Specialist Healthcare Commissioning, NHS National Services Scotland |
| Daniel White | Recipient Transplant Co-ordinator, Royal Papworth Hospital |
| Julie Whitney | Head of Service Delivery, OTDT Hub, NHSBT |

**In attendance:**

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| Caroline Robinson (Minutes) | Advisory Group Support, NHSBT |

**Apologies received:**
Ayesha Ali, Liz Armstrong, Jonathan Dalzell, John Dunning, Dale Gardiner, Shamik Ghosh, Anna Lamont, Jorge Mascaro, Simon Messer, Mick Stokes

| No. | Item | Action |
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| | **Welcome and Apologies** | |
| | R Venkateswaran welcomed all to the meeting. Apologies are shown above. | |
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| 1. | **Declarations of Interest in relation to the Agenda CTAGH(20)22** | |
| | There were no declarations of interest in relation to today's Agenda. | |
| | ***Please note that 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.*** | |

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| | ***Authors of such papers should indicate whether their paper falls into these categories*** | |
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| 2. | **Minutes and Action Points of the CTAGH Meeting held on 9 November 2022 CTAGH(M)(23)01 and CTAGH(AP)(23)01** | |
| 2.1 | The Minutes of the CTAG Hearts Meeting held on 10 May 2023 were accepted with two amendments as follows:<br>• Item 3.1 – DCD hearts accounts for 24.5% of the 213 transplants<br>• Item 8.1 – The ODT 2030 strategy states that organ utilisation improvements planned will be delivered for each organ group. However, there is no specific organ utilisation committee within CTAG, and the utilisation programme overall is led by Chris Callaghan (NHSBT AMD for Organ Utilisation) and will be discussed further as part of the implementation work from OUG/IOUS. R Venkateswaran also stated that for the first time since 2013, heart transplantation this year has exceeded 200 transplants which should be celebrated. | |
| 2.2 | The following Action Points were discussed: | |
| 2.2.1 | AP1 - Inclusion in CUSUM – An analysis plan on how the outcome of re-transplantation can be included in CUSUM reporting is presented at this meeting under Item 4 and will be discussed further by Centre Directors. | *See Item 4* |
| 2.2.2 | AP2 - CLU update – It was confirmed there is no Heart Utilisation Improvement Plan which is suggested in the NHSBT Strategy. R Venkateswaran, I Currie and D Gardiner are discussing Heart Utilisation Improvement, and this will be ongoing as part of the OUG/IOUS programme. | **COMPLETE** |
| 2.2.3 | AP3 - LVAD Complications Project – It was previously agreed, results will be reviewed as an ongoing exercise to increase numbers of patients in the cohort, expanding the scope to include non-urgent patients where survival is better, particularly as LVAD is being used as a bridge to transplant; An updated report is presented in *Item 9.4* | *See Item 9.4*<br>**COMPLETE** |
| 2.2.4 | AP4 - Conditional Survival - Reporting is on long term adult only survival post-heart transplant both nationally and on a centre specific basis as well as survival conditional on surviving the first-year post-transplant between April 1995 and March 2015. A report is under *Item 11.2* on the agenda | *See Item 11.2*<br>**COMPLETE** |
| 2.2.5 | AP5 - Cardiac Allograft Vasculopathy (CAV) | *See Item 9.1* |
| 2.2.6 | AP6 - SIGNET trial | *See Item 7* |
| 2.2.7 | AP7 - Non-Compliance with Heart Allocation - Transport issues – NORS and recipient teams are asked to refer to the guidance circulated regarding use of blue lights which should be for emergency use only. Exemptions include graft of patient deterioration. It is suggested that all units have a policy on the use of blue lights. The issue has been discussed at the CT Centre Directors' meeting. | **COMPLETE** |
| 2.2.8 | AP8 - Super-Urgent Listing of Long-term LVAD patients - Some incidents (including 3 incidents in one unit) have been reported of patients being moved from an LVAD to a temporary RVAD to facilitate early transplant. It was highlighted that this should not happen without appropriate adjudication. The heart allocation policy is being updated to reflect this. | **COMPLETE** |
| 2.2.9 | AP9 - Transplant Path | *See Item 5.1* |
| 2.2.10 | AP10 - DCD Heart Allocation | *See Item 6.3* |
| 2.2.11 | AP11 - Zonal Review - Z Reinhardt suggested looking into paediatric allocation zones to see if they need It was agreed R Hogg would look at paediatric zonal results | **COMPLETE** |
| 2.2.12 | AP12 - Adjudication Referrals - CTAG Hearts agreed that the process would be changed to exempt paediatric patients from the adjudication panel process. However, following a subsequent case, it was decided all paediatric patients on mechanical support will go through the adjudication process | **COMPLETE** |
| 2.12.13 | AP13 - CTAG Patients Routine Blood Monitoring Report – This has been discussed at the CT Centre Directors' meeting and some joint decisions will be made at a future meeting that can be standardised across centres. To be discussed further at CT Centre Directors' meeting on 20 October. | **ONGOING** |
| 2.12.14 | AP14 - ISHLT - There has been no data submission to ISHLT since 2018-19. However, the USA has now signed up to this and multi-centres have signed up to | **ONGOING** |

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| | submit data from Euro-Transplant. A new agreement is being finalised for UK data for heart/lung patients and a DPIA now needs to be completed with IG. | |
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| **3.** | **Medical Director's Report** | |
| 3.1 | Developments in NHSBT | |
| | D Manas gave an update on current issues:<br>• Finance – money remains very tight with minimal funds for transformation. DCD Hearts are funded until the end of the financial year after which a new application will be needed. The aim is still to get sustainable funding as numbers will drop by one third if there is no continuation of funding. There is no funding for ANRP, machine perfusion or ARCs. Business cases for DCD Hearts and ANRP are now with the Treasury, and it is hoped that policy leads at DHSC are noting support from transplant colleagues and the letter from CT colleagues will help. Short extensions in funding are not helpful as it is difficult to recruit and teams are losing surgeons and other critical staff due to uncertainty in financing the programme. R Burns offered to rally support within the patient group if this will help.<br>• CLU programme – Lead and local CLUs are funded until next year.<br>• OUG/IOUS – work is ongoing to implement the recommendations by NHSBT and NHSE.<br>• CT Review – The last review was in 2012. It is hoped the scope of this new NHSE review will be determined by end March (eg, all ages, hearts, lungs, both organs) and will include issues such as loss of clinicians and international comparators.<br>• Collaboratives – these are currently in development, starting with liver and kidney. | |
| 3.2 | New Appointments | |
| | • Anya Adair has taken over as new Liver Lead CLU from Raj Prasad<br>• Varuna Aluvihare succeeds Doug Thorburn as Liver Advisory Group Chair with Steve Masson as Deputy Chair.<br>• Retire and Return – Tracey Rees, Scientific Officer plans to retire and it is hoped will be able to return. Lisa Burnapp will also retire and return, working 3 days a week from beginning of April.<br>• Vacancies - Two adverts are out currently; a Transplant Development Support Officer (Band 7) will work alongside D Manas and a Living Donor Co-ordinator will support Lisa. An OUG Project Lead is also planned but is not advertised as yet. | |
| 3.3 | Sustainability and Certainty in Organ Retrieval (SCORE) overview | |
| | D Macklam presented the work of SCORE which aims to deal with issues of an ageing workforce, impacts of Brexit and COVID, staff sickness and changing, more complex healthcare needs in an ageing population alongside pressures of finite funding. SCORE is:<br>• A programme of work to bring improvements to the whole pathway.<br>• It aims to provide certainty and support for sustainability.<br>• A change in culture will be needed to move away from *'as fast as possible'* to *'certainty'* across the pathway.<br>• It aims to identify and deliver improvements over a 10-year period.<br>The 5 key areas identified for initial work are:<br>• To increase certainty of donor potential through better donor screening to reduce non-proceeding donation.<br>• To achieve financial sustainability by re-aligning costs within affordability, and to identify system inefficiencies.<br>• To increase efficiency and achievability of retrieval by defining an optimal retrieval model<br>• To commission a framework for perfusion technology to stabilise and sustain DCD and ANRP service.<br>• To enable the NORS workforce to be sustainable so future recruitment is an attractive prospect. | |

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| | The 7 working groups are set up and running; Donation, NORS Service Model, Support Services and NORS workforce make up the operational groups and Communication and Stakeholder Engagement, Business Care and Commissioning will make up the support and working groups. It is hoped the first stage of approval will be in November before moving onto more detailed design and implementation prior to the deadline of March 2025. There are no specific targets, but the working groups will set key achievements and how these will be monitored. Contact SCORE@nhsbt.nhs.uk for more information. | |
| 3.4 | SCORE – NORS Modelling Workstream | |
| | I Currie gave a presentation on the NORS Modelling Workstream which will lead to timing changes in the retrieval pathway.<br>• Referral of both DCD and DBD donors from ICU to the SNOD and the time of consent from donor families are largely unchanged over the 10-year period 2011 to 2021.<br>• In 2011, the time from family decision to first offers/registration with the Hub was 3 hours.<br>• In 2021 this has increased to 9 hours with first offers coming after midnight illustrating the effects of changes in practice. Activity is spread out over 24 hours.<br>• There were 683 responses from theatre staff, nurses, anaesthetists in all transplant centres with the majority expressing a preference for starting at transplant from 6 am to midnight rather than after midnight.<br>• In 157 responses from retrieval services starting a combined abdominal and CT case at 4 am is not popular, although all other times would be considered.<br>• In a survey of clinical leads, considering the needs of the family and those caring for the patient, all times were considered with the possible exception of 8-10 am when there is handover.<br>• Nurses asked what time they would prefer, taking into account the needs of the family, were mostly supportive across 24 hours for DBD donors and from 6 am for DCD donors.<br>• For heart and lung, 9 AM, midday and 3 pm theatre access gives DCD heart reperfusion at 5, 8 and 11 am which are all reasonable. Theatre access at 6 am means reperfusion at around 2 pm, 3 am will mean reperfusion at midday, midnight access to theatre gives a reperfusion time of 8.42 pm and this means starting the heart 5 or 6 am.<br>IC will update at future CTAG meetings as the project continues and advise re recommendations. | **ONGOING** |
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| **4.** | **Governance Issues** | |
| 4.1 | Non-Compliance with Heart Allocation | |
| | R Venkateswaran highlighted 2 major issues one of which is covered in the report in Item 4.2.<br>• The first incident features a DCD recipient who was anaesthetised prior to the heart going on OCS in breach of the national protocol. Teams are reminded that patients should not be anaesthetised until at least 2 gases have been taken after the heart has gone on OCS and the surgeon is happy to go ahead. In this incident, the heart was not used and the outcome for the recipient is unknown.<br>• In the second incident, a transplant centre arranged for the Police to transport an organ to the transplanting centre using blue lights with a member of the CT NORS team travelling in the Police vehicle with a CT organ. NHSBT Commissioning advised the Trusts' Director of Operations, Medical Directors and ODT Sector Licence holders and the local Police force Chief Constables that NHSBT does not endorse the use of blue lights or speed outside the national speed limits to transport organs. NHSBT also does not endorse the use of the Police force to transport organs or members of NORS teams. This information has been shared with all NORS teams. | **ONGOING** |
| 4.2 | Clinical Governance Report - **CTAGH(23)48** | |

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| | This report was circulated prior to the meeting. | |
| 4.3 | CUSUM Monitoring of 90-day outcomes following heart transplantation - **CTAGH(23)49** | |
| | This report was circulated prior to the meeting. Over the 6-month period since the last CTAG meeting there have been no CUSUM signals for heart transplantation. | |
| 4.4 | Re-transplant into CUSUM calculation – **CTAGH(23)50 –** | |
| | In Autumn 2022 it was agreed to update the heart CUSUM monitoring to change from patient survival to transplant survival. This would allow inclusion of re-transplant cases in monitoring. The paper circulated presents full results of the transplant failure rates for the baseline period 1 January 2015 to 31 December 2018.<br>• 90-day transplant failure rates for adult patients were 13.6% with 4 centres having a lower rate than this<br>• Paediatric failure rate was 4.2%<br>The meeting discussed the following:<br>• Re-transplant is more likely to fail and therefore a centre doing more of these will be more likely to trigger. Centres could be put off doing a re-transplant if there are concerns about triggering CUSUM.<br>• Although CUSUMs give real time monitoring, they are not risk adjusted. This is a concern if they are the primary source of monitoring and indicates the importance of looking at all available information regarding outcome and quality.<br>• Young adults could benefit from re-transplant so there needs to be careful thinking about who would be eligible to ensure organs are utilised wisely. Risk adjustment has the effect of making differences between centres disappear.<br>It was agreed that the proposal needs further discussion at the Centre Directors' meeting, and it will be returned to the agenda for the Spring 2024 CTAG Hearts meeting. The proposal will be submitted to OTDT CARE for sign off. | |
| 4.5 | Group 2 Transplants | |
| | There were no recent transplants to discuss. | |
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| **5.** | **OTDT Hub Update** | |
| | • SCORE – Some workshops have been held to look at changes in offering to fit in with the new retrieval windows. Further details on the proposals will come to centres as they become available, and this will be discussed again at the next CTAG Hearts meeting.<br>• HTA-B forms – J Whitney acknowledged the work of all teams in submitting forms on time.<br>• Peaks in service – J Whitney thanked NORS teams who have helped to deliver organs on their way back to base. This has helped to decrease use of flights during peaks in service. | |
| 5.1 | Transplant Path | |
| | • R Thomson reminded all who still need to ask for access to TransplantPath to do so before the final date of 30 October by using the link https://forms.office.com/e/KT3rRMip98<br>• R Thomson demonstrated some features of the software which enables inclusion of up to 5 images and 15 seconds of video. The software will go live in February 2024.<br>• If there are any queries about TransplantPath, please email TransplantPathTeam@NHSBT.nhs.uk | |
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| **6.** | **DCD Hearts** | |
| 6.1 | DCD Hearts Oversight Meeting | |
| | F Marley gave an update on this meeting held on 17 October.<br>• The protocol and any design issues are being finalised for the mOrgan trial, due to start April 2024. A meeting will be held shortly with the MHRA and a paediatric model is progressing<br>• Meetings are in progress for the TA-NRP subgroup prior to taking findings to the transplant commissioners. | |

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| | • A paediatric DCD heart meeting will be set up to be chaired by M Berman to look into the potential for new technologies.<br>• Funding is projecting an underspend. However, if funding is exceeded, NHSBT will fund that risk.<br>• Concern was expressed about losing surgeons and the risks associated with this.<br>• Governance – there have been some occasions when teams were not available. This needs to be quantified so that it can be submitted in a formal document.<br>• Data on flights will be reported in 3 months.<br>The next meeting will be in November. | |
| 6.2 | DCD Hearts Regular Report - **CTAGH(23)51** | |
| | The paper circulated presents DCD heart retrieval and transplant activity between 1 February 2015 and 31 July 2023.<br>• In period 1 February 2015-31 July 2023, 461 heart retrieval attendances were recorded of which 294 proceeded to DCD heart retrieval. 259 DCD hearts were successfully transplanted.<br>• Of the 134 DCD heart transplant recipients since 7 Sept 2020, there were 8 deaths within 30 days. One recipient transplanted in July 2023 had missing data. Of these, 49 (37% of 132 patients) required post-transplant mechanical support.<br>Retrieval teams were congratulated for their efforts performing very labour-intensive activity in stressful situations. Full results are given in the paper circulated. | |
| 6.3 | DCD Heart Allocation – **CTAGH(23)52** | |
| | The first meeting of this short-term working group (chaired by I Currie) met in August to decide whether DCD heart allocation should be on a named basis. The group will meet again in November with patient representation included. The group discussed:<br>• Potential allocation on a named patient basis - Currently hearts are allocated on a regional/centre basis and implanting clinicians choose the recipient. This results in a significant number of hearts going to non-urgent patients. For DBD, hearts are allocated on a named patient basis. The meeting agreed that a change warranted further investigation.<br>• Ensuring allocation of DCD hearts to urgent/super-urgent patients – the meeting agreed that sicker patients should be a priority over non-urgent recipients. For non-urgent patients, the waiting time is approximately 2000 days.<br>• Ensuring sustainable funding beyond 2024 – Agreeing funding on a year-by-year basis is likely to adversely affect continuation of the service. There is also a serious and real risk of losing experienced CT surgeons.<br>• Increased use of LVADs – If LVADs are used, this has the effect of demoting a patient to the non-urgent list and decreasing the likelihood of transplant.<br>• Flights – While offering to the sickest patients is favoured, offering on a national basis is likely to increase flights and have a knock-on effect on other organs. OCS timings are likely to increase resulting in more ECMO usage.<br>• Incentivisation – DCD retrieval and transplantation is an intense arduous process involving huge technical demand. Incentivising clinicians to continue the DCD programme is critical for its survival long-term. | **ONGOING/ UPDATE** |
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| **7.** | **Update on SIGNET Trial – CTAGH(23)65** | |
| | J Dark gave an update on this NIHR funded prospective randomised study investigating a single dose of simvastatin given to adult brain stem dead donors. Despite a delay in recruiting donor hospitals in the post-COVID era, some money saved on site visits was used earlier this year to add some centres to the study. The relative reduction in brain-dead donor numbers has led to a continuing small shortfall. However, performance remains better than many clinical studies open | **ONGOING** |

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| | during what has been a challenging period. As of 10 October 2023, numbers were:<br>• Number of Trusts/Boards Open - 89<br>• Eligible Donors - 1098<br>• Donors Consented - 837<br>• Donors Recruited - 825<br>J Dark stated that nowhere else in the world could run this study and it shows the transplant infrastructure in the UK is almost uniquely, suited to this big study. It is hoped to build on this in the future and any other potential studies suggested by the group would be welcomed at john.dark@newcastle.ac.uk | |
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| **8.** | **Heart Utilisation** | |
| 8.1 | CLU Update | |
| | A Ranasinghe reported that heart transplantation is doing well with more than 200 transplants performed last year. This would not have been possible without the DCD programme.<br>• The first multidisciplinary utilisation conference was held recently at Filton. Feedback was very good with excellent interaction in the groups. It is hoped to hold these events 1-2 yearly.<br>• Work is ongoing regarding implementation of an organ utilisation document.<br>• Standardisation of donor audits amongst centres is an initial initiative to analyse data on donor turn downs. Metrics for utilisation to send out to trust CEOs are being set up.<br>• The Offer Review scheme has been ongoing since December 2022. The purpose is to ensure higher quality organs are not turned down. To date there have been only 20 donors to review and of these, only 3 required letters to centres. The definitions of the scheme are perhaps the reason for this and a heart CLU meeting to be held later this year to discuss this. The issue of some centres receiving letters despite responding to the first letter was raised and this will be addressed in a review of the process. The aim will be to standardise the declines across all organs.<br>**ACTION: A Ranasinghe will review the process for offer declines**. | **A Ranasinghe ONGOING** |
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| **9.** | **Heart Allocation** | |
| 9.1 | Heart Allocation Sub-group and update from Vasculopathy Working Group (19.06.2023) – **CTAGH(23)53** | |
| | This working group was set up at the request of the Patient Group who want greater focus on modified risk factors. The 1st meeting was held in June. It is clear there is variability across centres due to expertise and access to local imaging modalities.<br>• Most at the meeting agreed on lipid targets, but there was some unresolved discussion about what wider cardiovascular risks are relevant.<br>• Attempts to standardise hypertension, diet, exercise and weight management targets are suggested for future discussion, although it is noted that a lot of this falls under post-transplant follow up rather than within NHSBT.<br>• Any standardisation will rely on having high quality evidence to support it. While collection of information about practice is useful, dictating standards could be challenging.<br>• Involvement of GPs in more management was discussed at CTAG Hearts, but it was noted that this may be excluded in the GPs' Quality and Outcomes Framework (QOF) if patients are being monitored elsewhere. However, their potential to help with patient management is acknowledged.<br>• It was noted that the ISHLT guidelines are US centric where teams involved in transplant care are large and include nurses, pharmacists, social workers etc. These resources are not available in the UK currently.<br>**ACTION: S Lim to arrange a 2nd meeting of the Vasculopathy Working Group** | **S Lim ONGOING** |

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| 9.2 | Super-urgent paediatrics and ECMO | |
| | The meeting agreed to change the policy to state any paediatric patient on ECMO should be SU listed. If the patient on ECMO needs re-transplant this should be discussed with other centres and then go through the adjudication process. The smallest babies, however, will not be SU listed.<br>**ACTION: J Whitney to agree wording in the policy with J Simmonds and Z Reinhardt** | **J Whitney / J Simmonds / Z Reinhardt** |
| 9.3 | SU and Urgent Heart Allocation review – **CTAGH(23)66** | |
| | The paper circulated looks at adult registrations (≥ age 16) from 26 October 2016 to 31 July 2023 and includes heart-lung block registrations/transplants. For post-transplant survival only, first-time transplants are included. Full results are shown in the paper circulated prior to the meeting. | **ONGOING Update Autumn 2024** |
| 9.4 | LVAD Complications – **CTAGH(23)54** | |
| | This paper looks at the outcomes of urgent heart transplantations in patients with LVAD-related complications in the UK between 26 October 2016 and 31 March 2023.<br>• In this new analysis circulated, of 70 urgent patients receiving an urgent transplant due to LVAD-related complications, survival at 90 days was 75.6% which is lower that both 89.8% for non-urgent patients on LVAD at time of transplant and 92.1% for first adult DBD transplants who are not on support.<br>• The sample size is small so results should be considered with caution. | **COMPLETE** |
| 9.5 | Six-month review of 20 CM rule change for GOSH – **CTAGH(23)67** | |
| | The paper circulated outlines the six-month review of 20 cm rule change for GOSH. When a heart from an adult donor gets offered to non-urgent recipients, GOSH can only accept for recipients who have a height difference of <20cm and can consider for any recipient only after decline by all other centres.<br>• In the 6 months since the rule change, there were no non-urgent heart transplants with a height difference of >20cm between donor and recipient at GOSH.<br>• There were 29 donors from Harefield's zone available to GOSH, one of which was accepted and used which had a height difference of 9 cm.<br>• Of the remaining 28, only 3 were transplanted by any centre.<br>• Although a longer assessment period was suggested to notice any impact the rule change will have in the long term, GOSH commented that out of 2637 patients on the list during the period only 12 were big enough to accept adult organs. There are always 6-10 paediatric patients who are waiting for an organ, but because there are so few aged 12-16, they're almost completely limited to an adult organ so GOSH has to wait until all other centres have turned them down before they can be considered.<br>• The impact on adult centres of the rule change is likely to be 1 less organ every 2 years. The impact on paediatric waiting times on the list is however, considerable. Ensuring paediatric patients have equity is important.<br>• It is suggested that the 6-month rule is assessed further over the coming 6 months to gather more data and then discussed again at the Spring CTAG Hearts meeting<br>**ACTION: To be discussed further at CT Centre Directors' meeting (20 October)** | **Centre Directors Update Autumn 2024** |
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| **10.** | **Transplantable hearts myocardium biopsy IRAS 309998. HRA & HCRW Approval issued** | |
| | This project has been discussed previously at CTAG and has been approved by RAG for transplanted myocardial biopsies on transplanted hearts at Papworth, retrieved at Papworth with recipient consented at Papworth. The unlikely issue of the heart being retrieved and then declined by Papworth has been discussed and there has been no objection raised from other centres to consider the heart in these circumstances. | **COMPLETE** |
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| **11.** | **Statistics and Clinical Research reports** | |

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| 11.1 | Summary from Statistics and Clinical Research – **CTAGH(23)55** | |
| | This paper was circulated for information | |
| 11.2 | Conditional Survival – **CTAGH(23)56 / CTAGH(23)57** | |
| | These papers were circulated but not discussed in the meeting. | |
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| **12.** | **Report and Discussion Points from the Chair** | |
| 12.1 | RAG Update (08.06.2023) – **CTAGH(23)58** | |
| | The Minutes of the last meeting in June were circulated. The next meeting will be held on 30 November 2023 at the Royal National Hotel in London. | |
| 12.1.1 | No need for LN and Spleen to accompany hearts on retrieval | |
| | There have been several incidents where a deceased donor heart has been delayed leaving theatre due to waiting for lymph/spleen samples. To prevent this, and to set an aspiration that all hearts should leave theatre within 30 minutes of cross clamp, it is proposed to move away from sending spleen/lymph samples with the organ and instead, send 40ml of peripheral blood. This should enable any retrospective testing and DNA storage if required. The proposal was circulated 1 month ago but to date, only Cambridge has responded.<br>**ACTION: Centres are asked to contact their H&I labs regarding this issue. CT Centre Directors to discuss further (20 October)** | **Centre Directors COMPLETE** |
| 12.2 | Workplan Update – **CTAGH(23)09** | |
| | The current workplan was circulated prior to the meeting but was not discussed. | |
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| **13.** | **Reports from subgroups** | |
| 13.1 | CTAG Patient Group (CTPG) report – **CTAGH(23)59** | |
| | R Burns reported that patient feedback from all the support groups has been re-done recently and the areas of most interest for both pre- and post-transplant patients are highlighted in the report appendix paper circulated – **CTAGH(23)60.** | |
| 13.1.1 | CTAG Patient Group appendix – **CTAGH(23)60** | |
| | This paper was circulated for information. | |
| 13.1.2 | Update on COVID and Shingles vaccine – **CTAGH(23)61** | |
| | The Patient Group has engaged with NICE regarding COVID prevention and treatment and is disappointed at the lack of information on treatments being provided at national and local levels despite the challenge COVID-19 still presents to patients' quality of life.<br>• Patients and their families are eligible for a COVID booster this autumn.<br>• Many post-transplant patients have chosen to fund tixagevimab and cligavimab privately despite NICE stating in their guidance (TA900) that they do not recommend this for preventing COVID-19.<br>• NICE have also been contacted regarding the possible expansion of the eligible patient population to Paxlovid. At the last CTAG Hearts meeting, R Burns asked if any advanced heart failure clinicians would be interested in supporting the Patient Group in this issue, but no response was received. However, the British Society of Heart Failure did engage and support the Patient Group in this issue.<br>• Patients report issues accessing appropriate treatment which has caused anxiety. Partner charities are being asked to develop a directory of COVID treatments for patients. The best available patient information is hosted by Blood Cancer UK Antibody and antiviral treatments for people with blood cancer \| Blood Cancer UK<br>• Since 1 September 2023, immunocompromised people aged ≥50 and those anticipating immunosuppressant therapy are eligible for the Shingles vaccination, Shingrix.<br>Overall, the CTPG recommend that all clinicians working in CT transplant services are made aware of the latest information on Covid 19 prevention and treatments and the change in eligibility for the Shingles vaccine. | |
| 13.1.3 | Covid Update Appendix – **CTAGH(23)62** | |
| | This was circulated for information prior to the meeting | |
| 13.1.4 | CTAG Patient Group draft agenda – (25/10/23) – **CTAGH(23)63** | |
| | This agenda for the forthcoming Patient Group meeting on 25 October was circulated for information. | |

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| 13.2 | CT Centre Directors' Report (08.09.2023) | |
| | Recent topics discussed at the 6-weekly meetings include:<br>• Lack of confirmation of sustainable funding for DCD Hearts and the effects this is likely to have on heart transplantation overall.<br>• Changes to age restrictions for lung donation.<br>• Management of the CT retrieval service during periods of industrial action and the effects this is having on centres.<br>• Development of a 'buddying' scheme across centres for both hearts and lungs. | |
| 13.3 | CT Transplant Co-ordinators' Report | |
| | There was no report at this meeting. | |
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| **14.** | **For Information** | |
| 14.1 | Transplant Activity Report | |
| | See link https://www.odt.nhs.uk/statistics-and-reports/annual-activity-report/ | |
| 14.2 | NHSBT ICT Update for Advisory Groups | |
| | To be circulated when it is available. | |
| 14.3 | QUOD Update – **CTAGH(23)64** | |
| | This paper was circulated for information | |
| | | |
| **15.** | **Any other business** | |
| 15.1 | Key points from this meeting to cascade to teams | |
| | • Governance issue<br>• Transplant Path deadlines | **Centre Directors COMPLETE** |
| 15.2 | US Echo meeting – **CTAGH(23)68** | |
| | W Akhtar gave a presentation of the project, established 12 months ago looking at Donor Heart Transthoracic Echo Assessment. The group consists of NHSBT, FUSIC national leads, transplant surgeons and physicians.<br>• A survey showed 50% of echoes performed for donor hearts are done by staff who are FUSIC accredited.<br>• There is a national issue with 24/7 provision and there is no guidance regarding focus scanners and what images are needed for donor hearts.<br>• This results in variable quality of scans available for review of donor hearts.<br>The proforma developed was circulated to CTAG Heart members to give basic guidance to follow when performing echoes. Some of the imaging is not the standard part of physical assessment but there is information on how to do measurements for thickness and dimension. A separate piece of work is looking at image sharing.<br>• Some caution was noted that while this level of detail can help nurses and acceptance of organs in a timely way, it could act as a barrier to organ offering and centres declining organs if all the information listed is not available. If this leads to requests for repeat echoes this could cause operational problems. However, standardising information to eliminate requests for repeat scans is useful.<br>• Minimum critical criteria would be useful to ensure decisions can be made in a timely way.<br>• Some adult-specific criteria have been removed for paediatric patients.<br>• A meeting will be held shortly to discuss the PACs system for NHSBT.<br>CTAG Hearts gave support for the process. | **COMPLETE** |
| 15.3 | Shortage of biopsy forceps and other equipment. | |
| | P Callan raised this issue which is a pressing problem once again. Other centres confirmed they are doing no elective biopsies or outpatients due to equipment shortage. It is suggested this may be an argument for a business case to go forward to gain access to alumap or cardiac MRI as the UK is becoming an international outlier in the way endomyocardial biopsies are done. | **COMPLETE** |
| 15.4 | Next CTAG Hearts Meeting | |
| | The next meeting is provisionally set for **Weds 17 April 2024**. Venue and further details will be confirmed in due course. | |

## Dates of future CTAG meetings

CTAG Lungs Meeting –Thursday 16 May 2024 – 10:30-14:30 – via Microsoft Teams