NHS BLOOD AND TRANSPLANT
ORGAN DONATION AND TRANSPLANTATION DIRECTORATE
THE TWENTY-THIRD MEETING OF THE NHSBT CTAG HEARTS ADVISORY GROUP
ON THURSDAY 18 SEPTEMBER 2025 AT MARY WARD HOUSE, LONDON

MINUTES

Attendees:

Aaron Ranasinghe	**CTAG Hearts Chair;** Cardiac Consultant Surgeon, Queen Elizabeth Hospital, Birmingham
Paul Callan	Consultant Cardiologist, Manchester University NHS Foundation Trust
Jonathan Dalzell	Centre Director, Golden Jubilee Hospital, Glasgow
Corinna Freeman	H&I Support, NHSBT
Shamik Ghosh	CTAG Lay Member Representative
Eleanor Johnson	NSA for Transplant Co-ordination, UHB
Maggie Kemmner	National Head of Transformation, NHS England
Louise Kenny	Consultant Cardiologist, Freeman Hospital, Newcastle
Sern Lim	Consultant Cardiologist, QEH Birmingham
Guy Macgowan	Cardiologist, Freeman Hospital, Newcastle
Debbie Macklam	Head of Service Development, OTDT, NHSBT
Derek Manas	Medical Director, OTDT, NHSBT
Andrew Morley-Smith	Lead Heart CLU; Cons Cardiologist, Royal Brompton and Harefield Hospital
Stephen Pettit	Deputy Chair CTAG; CT Centre Director, Royal Papworth Hospital
Carla Rosser	H&I, NHSBT
Sally Rushton	Principal Statistician, Statistics and Clinical Research, NHSBT
Marian Ryan	Specialist Nurse Organ Donation
Fernando Riesgo-Gil	Interim Centre Director (Hearts), Royal Brompton and Harefield Hospital
Jacob Simmonds	Consultant Cardiologist, Great Ormond Street Hospital
Paul Smith	Statistics and Clinical Research, NHSBT
Radha Sundaram	NHS Services Scotland
Sarah Watson	Highly Specialised Services Senior Commissioning Manager, NHS England
Julie Whitney	Head of Service Delivery, OTDT Hub, NHSBT

In attendance:

Lawna Pugh	Advisory Group Support, NHSBT
Caroline Robinson	Advisory Group Support, NHSBT (Minutes)

Apologies received: Lynne Ayton, Marius Berman, Rossa Brugha, Anthony Clarkson, Ian Currie, Iain Harrison, James Palmer, Zdenka Reinhardt, Philip Seeley, Michael Stokes, Daniel White

No.	Item	Action
	Welcome and Apologies	
	• A Ranasinghe welcomed everyone to the meeting. • Apologies received for today's meeting are listed above	
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. Authors of such papers should indicate whether their paper falls into these categories	
2.	**Minutes and Action Points of the CTAGH Meeting held on 26 March 2025 CTAGH(M)(25)01 and CTAGH(AP)(25)01**	
2.1	The Minutes of the CTAG Hearts Meeting held on 26 March 2025 were accepted with one amendment. S Pettit will send through a correction to C Robinson to Item 4.3 in the Minutes for amendment.	**S Pettit**
2.2	The following Action Points were discussed:	

2.2.1	CTAG Patients Routine Blood Monitoring Report – T Courtenay attended the Centre Directors' meeting in July to discuss the potential for a shared monitoring agreement with GP practices and better follow up of patients.	**COMPLETE**
2.2.2	CAV Vasculopathy – A further meeting has not happened due to insufficient national evidence currently to guide best practice and the availability of local guidance only. S Lim will feedback to the Transformation Programme who will take this item forward.	**COMPLETE**
2.2.3	SU Heart Data Review – A fixed term working group with representation from all centres continues to look at centres' data to decide on future steps.	***See Item 10.2***
2.2.4	CUSUM Monitoring of 90-day outcomes following heart transplantation - S Pettit has shared learning points from CUSUM 286.This is now closed.	**COMPLETE**
2.2.5	Sustainability and Certainty in Organ Retrieval (SCORE) - A 2-hour interactive session on Teams to bring all up to date with SCORS and to look at any challenges centres have has now taken place.	**COMPLETE** ***See Item 6.1***
2.2.6	CT ICE Phase 2 Survey results - R Burns previously stated that there is a feeling that the infographics in the survey which come from NHSBT are poor. As many patients live long distances from centres, it will not always be possible to have a face-to-face discussion with a clinician and more needs to be done to ensure that information is accessible and understandable. A Ranasinghe and R Burns have discussed this issue, and it is agreed that more information is needed on how patients would like infographics presented. In his absence, R Burns was thanked for his contributions to both CTAG Hearts and Lungs as Patient Group Co-chair.	**ONGOING**
2.2.7	Super Urgent Heart Data review – It has been agreed all potential SU patients will be adjudicated to ensure a timely response and equitable access to transplantation. J Whitney previously agreed to send an urgent communication to centres to be cascaded to all relevant colleagues.	**COMPLETE**
2.2.8	Paediatric Heart Allocation - Following concerns about paediatric priority in the current heart allocation sequence, a FTWG was convened chaired by S Pettit. Membership was representation from all transplant centres, the HUB and Stats teams.	**COMPLETE** ***See Item 10.1***
2.2.9	Paediatric survival from listing – The paper circulated at the meeting was preliminary. Limitations in methodology are acknowledged and there is no requirement for a 2nd iteration.	**COMPLETE**
2.2.10	Adjudication Panel Activity – It was agreed the outcome of those who are turned down by the adjudication panel would be useful information. However, NHSBT does not hold this information. **ACTION: G MacGowan to chair a working group on this issue and the scope of the work will be decided at the first meeting.**	**ONGOING G Macgowan / L Kenny**
2.2.11	Workplan update – A Ranasinghe to provide an update.	***See Item 13***
3.	**Medical Director's Report**	
3.1	Developments in NHSBT – D Manas gave an update as follows: • ARCS Funding – A pilot scheme will run for 2 years, and a final service specification and applications deadline is 26th September. To date there have been 12 expressions of interest. • SCORE – an update will follow in Item 6.1 • DCD Hearts – funding for this is now included in baseline funding. • Paediatric DCD hearts – Discussions are ongoing about the potential for flights to Europe. A decision will be made at SMT. • NRP – This is being rolled out to all abdominal centres. The cardiac NRP protocol is being updated. In the trial to include 5 TA-NRPS for CT, if there is no blood flow to the brain consideration will be given for roll out across CT centres for adults only initially. • ISOU – NHSBT been working on the recommendations from ISOU and is on track with these. Agreement with commissioners is needed and TOG has been formed to align with NHSE and NHSBT. The working group will look at all CUSUMs and outcomes and there will be a committee to look at emerging concerns. A National Clinical Panel will be chaired by D Manas with the NEC from Royal Free. All Advisory Group Chairs will be invited to	

	join that group. The purpose of TOG will be for escalations of CUSUM problems. • Workforce Sustainability Group – I Currie will chair this group.	
3.2	New Appointments – the following appointments were noted. • NHSBT CEO and Deputy - Following the recent resignations of the CEO and Deputy CEO from NHSBT the interim CEO will be Caroline Walker. Gail Miflin will be interim Deputy CEO. • Deputy Medical Director - John Casey has been appointed as deputy for D Manas in his Medical Director for OTDT role. Rommel Ravanan will cover R&D issues. • AMD for Patient Engagement – Interviews will take place shortly for this new role. • AMD Transplantation - Transplantation is to be a focus at SMT. An AMD for Transplantation will be appointed to work alongside D Manas. • Utilisation - Chris Callaghan is moving on from this role. As significant improvements have taken place there will be no replacement for his role. On a national level, Nick Inston (Abdominal) and Vicky Gerovasili (Cardiothoracic) will lead the offer review scheme(s).	
4.	**Patient Safety Issues (formally Clinical Governance)**	
	Please report cases to the Patient Safety Team - OTDT NHSBT Policies and guidance - ODT Clinical - NHS Blood and Transplant	
4.1	Non-compliance with Heart Allocation – In R Baker's absence, the issue of communication between different teams was highlighted. At the Centre Directors' meeting, A Butler highlighted ways to improve retrievals of CT and intestinal transplants from the same donor to reduce delays in cross clamp (for MV recipients). At CTAG, it was agreed that direct communication between two implanting teams is initiated with a pilot scheme at level 1 centres that will be driven by the two centres concerned.	
4.2	Patient Safety Report – **CTAGH(25)19** – This report was circulated prior to the meeting.	
4.3	CUSUM Monitoring of 90-day outcomes following heart transplantation – **CTAGH(25)20 -** Following agreement at CTAG, in July 2025 the outcome for heart transplant CUSUMs was changed from 90-day mortality to 90-day graft failure or mortality. • Re-transplants are now included in both the expected mortality rates as well as the monitoring cohort. • DCD heart transplants have been included since 2022. • Over the six-month period since the last Cardiothoracic Advisory Group meeting there has been one signal in the CUSUM reporting for heart transplantation. **ACTION: D Manas, A Ranasinghe and R Baker to meet to discuss CUSUM Signal 303 (Newcastle) which is still open.**	**D Manas / A Ranasinghe / R Baker**
4.4	Group 2 Transplants – There were no Group 2 Transplants. The issue of eligibility for Group 2 transplants was discussed in light of a patient listed in Glasgow. Group 1 transplant patients must be ordinarily resident in the UK and be registered with a GP. Other patients will be Group 2 and overseas visitors departments in trusts will make decisions about eligibility. NHSBT should not offer guidance and NHSE will be responsible for arbitration. • It was noted that long term care of Group 2 patients is an issue as patients cannot necessarily be sent back to their home countries. This issue will be discussed at SMT. • Donors – The suggestion is to offer donors (within Scotland) outside the agreed offering criteria to facilitate this patient receiving a donor organ. This would be DBD patients over 65 and DCD patients over 50. All of these donors will first be offered to **all** Group 1 patients and only on decline for all Group 1 patients will they be offered to the Group 2 patient. This decision is ongoing within NHSBT SMT.	
5.	**NHSE CT Review – Update and Progress Report – CTAGH(25)34**	

	This paper is circulated with these Minutes and M Kemmner gave an update on current developments. The Transformation Programme has outcome-focused ambitions for adult and children's services underpinned by ambitions in three further areas. The aims are improvements in outcomes, access to transplant, and patient experience and reducing inequalities across the whole population to include: • Excellent patient and family-centred care • Services that are clinically excellent, consistent and resilient • High-quality whole-pathway data to enable continuous improvement and patient choice Workstreams are being set up and work teams are being led by NSAs. Consultation is taking place on a range of ambitions for these workstreams with an emphasis on ensuring there is strong validation for change. The aim is for a single model of care provision. Areas under discussion are: • Workforce issues and sustainability • Financial arrangements • Referral into transplant • Holistic care (eg therapies, psychology and social work support). • Utilisation • Long term care Members from all centres are needed so feedback is needed on whether monthly meetings or meetings about specific topics are needed. The programme's timeframe is likely to last for NHSE's remaining lifetime, but it is hoped that the model set up will be appropriate for whatever succeeds NHSE.	
6.	**OTDT Hub Update**	
	J Whitney gave an update. • There is now funding to recruit 3 full-time specialist nurses to help with allocation in the Hub during daytime hours. • The potential for donor care centres (which have been expensive in USA) was discussed. For ARCs, the idea of asking ICUs to care for donors in specific beds is being considered. This makes sense for retrieval teams and families tend to be happier for donors to go to centres of expertise. However, the cost needs to be considered carefully before a decision is made.	
6.1	Sustainability and Certainty in Organ Retrieval (SCORE) – **CTAGH(25)32** – This paper is circulated with these Minutes and J Whitney and D Macklam gave an update at the meeting: • There is now investment committee approval to progress the programme. • The development phase is ongoing. More detail and data will be added to the operating model. • Work continues with commissioners to find the best route to support any challenges faced. • There is approximately 1 year to go. Transplant centres are strongly encouraged to review how changes from SCORE and local practice / arrangements can be aligned. Where changes may be required, transplant centres should make progress to implement them. • NORS teams have been sent a letter outlining the impact of SCORE on contract values. This will be discussed at a future RAG meeting. The shadow modelling phase for PAW (Planned Arrival Window) aims: • To test the viability of PAW timings • To involve colleagues to identify the operational implications across the pathway, any barriers or issues that could impact implementation and to ensure there is confidence in changes planned. Results of the shadow modelling phase 8 April – 24 July 2025 are shown in the paper attached. Organs are arriving mostly between 6-10 am with 87% of hearts arriving at transplant centres before 10:30 am. (Lungs arrive between 8-10:30 am with centres utilising the fridges if hearts and lungs are accepted at the same centre).	

	• Flights remain busy and the aim is to have better use of resources. There is a reduction in flights of 11% in the shadow period. Sharing flights is one issue under consideration. D Macklam stated that a survey will be sent out to find out what the biggest challenges are and to look at the range of people/organs involved. This will include knowledge of SCORE. Centres will need to have regular meetings every day. Implementation is planned for summer 2026.	
7.	**DCD Hearts**	
7.1	DCD Hearts Oversight Meeting update – **CTAGH(25)21** – D Macklam reported that substantive funding was agreed in April 2025 to support delivery of DCD Heart Retrieval using perfusion technology. • DCD Heart Donor Data Application – a request for additional DCD adult data for a research study using data collected on the DCD heart passport at retrieval has been submitted. This has been agreed with some conditions. • DCD Hearts attendance – 3 out of 6 CT teams have been supporting the national DCD Heart retrieval rota. Since September 2020, 27% of hearts from this pool have contributed to heart transplants in the UK and the number of DCD retrievals is increasing. A working group has been set up look at the implementation of imaging to support a reduction in resources deployed where a heart is not transplanted. • DCD Heart Service Stabilisation Group (FTWG) – This group aims to engage with centres who don't currently carry out DCD heart retrieval on the rota. Initiatives agreed have included an 11-hour rest period for teams and training and competency completion supported by a team of proctors with oversight from NHSBT. A webinar has also been held with good attendance from across the cardiothoracic community to support the training. • XVIVO – Data will be included in the next report. There have been good outcomes at Newcastle (paediatric only - on a compassionate grounds) and 1 XVIVO case to date. This is now included in standard reporting. • Paediatrics – <50kg cannot be facilitated using existing OCS technology. However, GOSH is almost ready to start using XVIVO as a perfusion for either DCD or where extended travel time is needed. Separate groups have been set up to support operational implementation of charity funded initial retrieval and to seek substantive national funding. • TA-NRP – 2 cases have been successful. Logistical challenges have been identified around radiographic staff availability. One more successful case is needed before moving to the next stage of implementation. • mOrgan – the trial will start next year **ACTION**: **M Berman to update at a future meeting.** It is possible HOG will become a Perfusion Oversight Group, and it will meet in November to decide on ToR.	
7.2	DCD Hearts Retrieval Sustainability – **CTAGH(25)22** – This paper highlights some of the fragility in the current retrieval system for DCD Hearts. • Delivering DCD hearts service is increasingly complex and time consuming. The introduction of perfusion technologies has created other challenges. • Experienced DCD heart staff has been lost to overseas countries where funding of DCD services has been more robust. Attracting younger surgeons and perfusion specialists has been difficult as a result. • Funding is not necessarily reaching the teams doing retrievals. However, the DCD/DBD workload is changing with a big swing to DCD and one team busier. • DCD HOG has identified that the current service delivery model is no longer fit for purpose. In 2024 it appeared that one or more DCD Heart Retrieval team would withdraw from the rota. One team on call is not sustainable. DCD substantive funding should ensure there is way to redesign the service. The DCD Heart Stabilisation Group (DCD HSG) has been set up (chaired by Ian Currie) to look at solutions to the above issues and to bring another centre into the retrieval rota.	

	• One initiative is for non-DCD centres to be involved. • Centres could collect if they are allocated a heart. Birmingham, Newcastle and Manchester have sent team members on perfusion training to collect hearts for their centres. This service would need to become operational without additional funding. • Birmingham, Newcastle and Manchester have shown interest in assisting in the rota to alleviate pressures on Papworth. A decision will be made in October. Recommendations will go to SMT for approval.	
7.3	DCD hearts regular report – **CTAGH(25)23** – This paper was circulated prior to the meeting and looks at activity from 1 February 2015 to 30 June 2025 and patient outcomes and offer data from 7 September 2020 to 30 June 2025. XVIVO activity is now included. Results are given in the paper circulated. • The meeting discussed whether there would be more granular information on why hearts are not used. It was noted that there will always be a discard rate, and a decision is needed on what is reasonable going forward. Some of the data pre-dates Hep C treatment and there is a blanket decline that is not specific. Some narrative would be useful when a heart is declined. • Highest utilisation is in a subset of DCD without A-NRP. • Teams are reminded to return the DCD Heart Passport forms in a timely manner.	
8.	**Patient Engagement Update**	
	Two heart and two lung reps have been appointed to represent patient issues at CTAG. As interviews are planned for the AMD for Patient Engagement shortly and an induction process and meeting for all patient representatives is planned, they were not present at this CTAG meeting. They will attend future advisory group meetings.	
9.	**Heart Utilisation**	
9.1	CLU Update – A Morley Smith gave an update: • Donor Characterisation – a working group for all organ types is looking at the pros and cons of CT scans to help reduce unnecessary donor runs. In the next 6 months, certain donors will have contrast CT scans to assess their value. • Cardiothoracic donors' imaging – This is available through the PACS interface and surgeons and physicians will need to sign up for this via an NHSBT account (rather than a hospital trust account). This will show when SNODs update the echo. • Donor management on ICUs – monthly meetings are taking place between CLUs and hospitals. This helps ICU teams to understand what donor optimisation is needed. • Decision Review – There is now an NHSBT template for organ utilisation meetings and local CLUs will audit this. This review will look at specifications and quorum requirements, whether information can be shared and how often and discussion of individual cases and shared learning. • Higher Quality Review Scheme – This will look at offers and not transplants. Issues will be flagged to the CLU and local CLUS will be contacted for further information. If a declined organ should have gone for transplant a letter will be sent to the centre and the trust CEO. Kidney CLUs have found this helpful. A survey will be sent out to centres to look at the definition of higher quality donors and whether it should be changed. • NOUC – will take place on 13 November when there will be a workshop on higher quality donors. Centres are asked to encourage team members to go. The conference will include discussions on ARCs, SCORE and organ utilisation. • Trust Organ Utilisation Strategy – each trust should have a strategy and annual report. The process should be led by trust executives. There will be further information on this in due course.	

10.	**Heart Allocation**	
10.1	Paediatric Heart Allocation Working Group update – **CTAGH(25)24 –** S Pettit reported that a FTWG had met twice to: • Review the allocation scheme for adult DBD and DCD hearts, with specific reference to the prioritisation of donor heart allocation by patient age category. • Provide an opinion regarding potential changes to the current allocation policy (POL228/17). Colleagues from every centre contributed to this alongside J Whitney and S Rushton from NHSBT. The summary and recommendations are shown in the paper circulated covering the following: • POL228/17 may disadvantage children on the paediatric waiting list by excluding them from potentially suitable donor organs in the adult donor pool. • Changes to POL228/17 should be considered to reduce waiting times for children • Inclusion of age in organ allocation systems is believed to be lawful if clinically justified. • Allocation of super-urgent status to Berlin Heart patients is not advised as this would limit access to heart transplantation for patients unsuitable for this support. • Sequence changes could have unintended consequences eg by combining adult and paediatric lists at both super-urgent/urgent levels and allocating according to waiting time. Zonal allocation would be eliminated in these tiers. meaning organs will travel further and there could be an increase in transport costs, longer total ischaemic times, and potentially higher rates of primary graft dysfunction in adult recipients. • Modelling of proposed sequence changes is advisable. The likely impact needs to be understood before CTAG Hearts can agree changes. Modelling would also be essential from an NHSBT operational perspective. Potential sequence changes proposed by GOSH and Newcastle would involve IT changes. J Simmonds thanked all centres for their support. **ACTION: S Rushton to look at work needed on modelling. S Pettit (FTWG) and D Manas to show both GOSH and Newcastle proposals to Ruth Clarke and to get legal advice.**	**S Pettit / D Manas / S Rushton**
10.2	Super Urgent Heart Working Group update – **CTAGH(25)25** – The paper circulated summarised the work of this group which has reviewed the Super-Urgent Heart Allocation Scheme (SUHAS). This followed concerns that numbers of adult patients on the SUHAS were increasing resulting in an impact on other patients registered on the Urgent Heart Allocation Scheme (UHAS) and Non-Urgent Heart Allocation Scheme (NUHAS), travel / cold ischaemic times and potentially heart transplant outcomes. The group had several meetings supported by a comprehensive review of relatively contemporaneous data. The FTWG did not achieve consensus in all areas which reflects the current limited evidence base of MCS in cardiogenic shock and more specifically MCS bridging to transplantation. S Lim outlined the following recommendations: • Proposed SUHAS criteria for patients with single ventricle physiology congenital heart disease to be adopted. • Patients on isolated left ventricular support should not be excluded from the SUHAS. • Numbers of patients registered on the new SUHAS criteria for congenital heart disease and their outcomes should be reviewed at 12 or 24 months (depending on activity). • Numbers of patients on isolated LV support registered on the SUHAS and their outcomes should be reviewed at 12 or 24 months (depending on activity). • The Heart Allocation Scheme should move from a tier-based to a points-based system. This should be simple to ensure transparency and easy for	**G Macgowan / S Rushton / S Lim**

	patients to understand. Points cannot be awarded according to age, but must be clinical or outcome based. • CTAG Heart Adjudication Panel should be approached for paediatric requests for super-urgent listing on the Adult list whereby a maximum acceptable donor size has been specified to be ≥160cm in height or ≥60kg in weight with more than single organ failure/support on temporary MCS. Some concerns remain regarding congenital patients and where they would sit in the allocation priority list. A wording change to super-urgent category 11 is suggesting regarding listing of large paediatric patients becoming adults. **ACTION: G Macgowan to discuss issues around congenital patients and definition of new category 13 with S Lim. S Rushton to coordinate wording change to category 11 for paediatric patients. A points based system working group is suggested.**	
10.3	Heart Allocation Activity Review – **CTAGH(25)26** – This paper presenting outcomes of adult patients on the heart transplant list, survival from listing and post-transplant survival, by centre and urgency group was circulated prior to the meeting. The cohorts of registrations and transplants both cover three years, from 1 April 2022 to 31 March 2025. Results are shown in the paper. • It was agreed that it would be useful to know how many deteriorate on the U scheme and become SU. • It is important to know how many patients listed have deteriorated in the category 21 list according to their subgroups. • Overall, it was agreed that more work needs to be done as the data is not complete enough. It would also be useful to know how data is collected. **ACTION: S Rushton to feedback to centres about data.**	**S Rushton**
10.4	Terms of Reference for Adjudication – **CTAGH(25)27** – This paper was circulated prior to the meeting. J Dalzell stated that at the Spring 2025 CTAG meeting, it was decided to temporarily mandate that all requests for registration on the super-urgent heart allocation scheme should be panel adjudicated. The adjudication process carries clinical and ethical responsibilities that can be challenging and stressful. To reduce ambiguity, current terms of reference (ToR) for the panel (published in document POL229/12) have been reviewed alongside other aspects of panel activity. Recommendations agreed at CTAG Hearts are: • The CTAG Hearts adjudication panel decides on access to the transplant list based on established current CTAG eligibility criteria. • Panel members should place overall UK transplant outcomes and organ utilisation at the centre of decision making. • Whilst panel decisions should respect the autonomy of the requesting centre as far as possible with regards to suitability for listing, the panel must be able to make decisions regarding suitability if there are clear and significant concerns regarding prohibitive risk. • The panel does not dictate individual treatment pathways/therapeutic strategies (eg: regarding temporary or durable MCS strategy). • Panel members should take a wider opinion from within their respective teams, especially in complex and/or potentially contentious cases • Any agreement/request for the panel to potentially function outside established CTAG guidelines requires comprehensive and specific ToR prior to initiation. • The current panel membership and voting method should not change. An amendment is suggested to POL229/12 which is included in the paper circulated. **ACTION: J Whitney will compare this with other advisory group adjudication processes.**	**J Whitney**
11.	**Statistics and Clinical Research reports**	
11.1	Summary from Statistics and Clinical Research – CTAGH(25)28 – This paper was circulated prior to the meeting. S Rushton reported: • The 2024/2025 Annual Report on Heart Transplantation and the 2024/2025 Annual Report on Lung Transplantation have been published on the ODT Clinical Site https://www.odt.nhs.uk/statistics-and-reports/.	

	• The Annual Report on Mechanical Circulatory Support Related to Heart Transplantation is in production. • There are no major staff responsibility changes in support of organs and tissues. • Details of publications and applications are shown in the paper. • Recent and future work is also listed in the paper. Lung allocation modelling is the highest priority work alongside supporting other sub-groups and the Transformation Programme. The Stats team is also supporting a large IT project across NHSBT, and data is needed for the Lung ARC programme.	
12.	**Reports from sub-groups**	
12.1	CT Transplant Co-ordinators' Report – Due to the absence of both D White and P Seeley there was no report at the meeting.	
13.	**Workplan Update – CTAGH(25)33**	
	This paper from A Ranasinghe is circulated with these Minutes. He reported that much of the existing work planned is now in place including work on utilisation and achieving sustainable funding for DCD Hearts. Three priorities are suggested: • Implementation of fair and equitable urgent heart donor organ allocation. • To increase resilience of DCD retrieval (and retrieval overall). • To consider collaborative work with each unit regularly meeting with one other 'buddy' unit. **ACTION: All to review plan and to email AR with any suggestions or changes**	**All**
14.	**H&I Report – CTAGH(25)29 / CTAGH(25)30**	
	These two papers were circulated prior to the meeting. C Rosser / C Freeman stated that concerns have previously been raised regarding a perceived disparity in the application of the Human Leucocyte Antigen (HLA) calculated reaction frequency (cRF) tool for cardiothoracic transplant waiting list patients between different Histocompatibility and Immunogenetics (H&I) laboratories and thereby transplant centres. It has been suggested that this impacts on equity of access and indicates cRF should be standardised across H&I laboratories. HLA matching is not currently considered in allocation for CT transplant, but it remains important in consideration for immunological compatibility of a patient with a potential donor. Recommendations are given in the paper circulated. It was noted: • The cRF value of a patient is for local information only and does not impact on the patient's likelihood of a deceased donor organ offer. It is a tool to help decide what the best course of action should be. • Clarification is needed on how cRF could be used to facilitate CT transplantation. • It is important to understand it for patient management. • Consistency across labs as well as centres is needed as results will have a bearing on how patients are consented / treated. **ACTION: C Rosser / C Freeman to consider offering a webinar and national joint meeting on transplant immunology.**	**C Rosser / C Freeman**
15.	**For Information**	
15.1	For Transplant Activity Report please see link https://www.odt.nhs.uk/statistics-and-reports/annual-activity-report/	
15.2	QUOD Update – **CTAGH(25)30 –** The latest information was circulated for information.	
15.3	ARCS update – see https://youtu.be/rDt6C4C213w	
16.	**Any other business**	
16.1	• Key points from this meeting to cascade to teams – A Ranasinghe highlighted key points for CTAG members to cascade to their teams: • SU and paediatric FTWG have been combined into a Heart Allocation Working Group to look at a points-based system for donor heart allocation	

	• New SUHAS category for patient with single ventricle physiology • New ToR for Adjudication panel – emphasis on best practice of including the MDT in decision making • There will be a number of donor hearts offered outside of the normal criteria to try and facilitate transplant for a Group 2 patient. These offers must be declined for all Group 1 patients prior to offering to the Group 2 patient.	
16.2	Terms of Reference for CTAG Hearts – There is no change to the ToR currently.	
16.3	Date of next CTAG Hearts meeting – Dates for 2026 advisory group meetings are being finalised currently and invitations will be sent out for next year as soon as they are available. CTAG Hearts Spring meeting will be held via Microsoft Teams.	

Future Dates of CTAG meetings
CTAG Lungs – Thursday 4 December 2025 – via Microsoft Teams
Proposed dates for 2026
CTAG Hearts – Wednesday 25 March 2026 – via Microsoft Teams
CTAG Lungs – Thursday 4 June 2026 – Venue TBC
CTAG Hearts – Thursday 17 September 2026 – Venue TBC
CTAG Lungs – Thursday 3 December 2026 – Via Microsoft Teams