NHS BLOOD AND TRANSPLANT
ORGAN AND TISSUE DONATION AND TRANSPLANTATION

THE TWENTY-FOURTH MEETING OF THE NHSBT CTAG(L) LUNGS ADVISORY GROUP ON THURSDAY 4 DECEMBER 2025 VIA MICROSOFT TEAMS
MINUTES

Attendees:

Jasvir Parmar	**CTAG Lungs Chair**, Royal Papworth Hospital
Amit Adlakha	Cons. Intensivist/Lung Transplant Physician, Royal Free Hospital
Kaveed Ali	Lay Member, CTAG, NHSBT
Paul Aurora	Paediatric Consultant, Great Ormond Street Hospital
Adam Barley	Specialist Nurse Service Delivery, North-West
Raymond Braid	NHS Services Scotland
Heather Chapman	Pharmacist, Royal Papworth Hospital
Kavita Dave	Consultant, Respiratory & Transplant Medicine, Royal Brompton and Harefield Hospitals
Andrew Fisher	Deputy Director BTRU, Freeman Hospital, Newcastle
Rosie Fitzgerald	Patient Representative
Corinna Freeman	H&I rep, British Society for Histocompatibility and Immunogenetics (BSHI)
Leo Freitas	University of Newcastle, Freeman Hospital
Vicky Gerovasili	Centre Director, Royal Brompton and Harefield Hospitals / Interim CLU Lead
Shamik Ghosh	CTAG Lay Member Representative
Maggie Kemmner	NHS England
Jim Lordan	Lung Transplant Physician, Newcastle
Haifa Lyster	Consultant Pharmacist, Royal Brompton and Harefield Hospitals
Gerard Meachery	Consultant, Respiratory Medicine & Lung Transplantation, Newcastle
Imogen Miller	Statistics and Clinical Research, NHSBT
Aaron Ranasinghe	**CTAG Hearts Chair**; Queen Elizabeth Hospital, Birmingham
Rommel Ravanan	Deputy Medical Director, OTDT. NHSBT
Anna Reed	NHSE Transformation; Royal Brompton and Harefield Hospitals
Carla Rosser	Consultant Clinical Scientist, NHSBT / OTDT H&I Lead
Sally Rushton	Statistics and Clinical Research, NHSBT
Craig Sanford	Team Lead Manager, London, NHSBT
Karthik Santhanakrishnan	Centre Director, Wythenshawe Hospital Manchester
Philip Seeley	Transplant Co-ordinator, Freeman Hospital, Newcastle
Paul Smith	Statistics and Clinical Research, NHSBT
Radha Sundaram	NHS Services Scotland
Debra Thomas	Physician Centre Representative, Royal Papworth Hospital
Matt Thomas	Paediatric Lung Physician, Freeman Hospital, Newcastle
Richard Thompson	Physician Centre Representative, QEH, Birmingham
Sarah Watson	NHS England
Daniel White	Transplant Co-ordinator, Royal Papworth Hospital
Julie Whitney	Head of Service Delivery, OTDT Hub, NHSBT

In attendance:

Caroline Robinson	Advisory Group Support, NHSBT (Minutes)

Item	APOLOGIES AND WELCOME	Action
	• J Parmar welcomed everyone to the meeting. This is his last meeting as CTAG Lungs Chair; there will be an advert for a new chair in the next few weeks. • Apologies were received from Lynne Ayton, Anthony Clarkson, Dale Gardiner, Pradeep Kaul, Derek Manas, Stephen Pettit	
1	**DECLARATIONS OF INTEREST**	
	There were no declarations of interest raised at the meeting. • ***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 12 JUNE 2025 – CTAGL(M)(25)01 and CTAGL(AP)(25)01**	
2.1	The Minutes of the previous CTAG Lungs meeting held on 12 June 2025 were accepted as a true record.	
2.2	The Action Points from the previous CTAG Lungs meeting on 12 June 2025 were discussed as follows:	
2.2.1	Combined lung-liver priority – Meetings to prioritise multi-organ transplants are still ongoing and will probably complete next year. There is an issue around prioritisation of re-transplantations for liver if the first liver fails and a process needs to be in place to cover this possibility.	**ONGOING**
2.2.2	ERAS and Collaboratives – An OUG recommendation is for centres to learn from COVID and consider options for mutual aid and collaboration. There is overlap with the NHSE transformation program, this will be discussed at the next NCTP. To continue at CTAG Lungs in June 2026	**ONGOING**
2.2.3	Lung Activity – At the last meeting V Gerovasili agreed to circulate the transplant referral checklist for patients on the waiting list that they were trialling.	**COMPLETE**
2.2.4	Lung Allocation Working Group – *See Item 7.1*	**COMPLETE**
2.2.5	Lung Modelling update – *See Item 7.1*	**COMPLETE**
2.2.6	Matching and Offering Business Case for IT – It was agreed to invite L Ellis Morgan to the June 2026 CTAG Lungs meeting.	**COMPLETE**
2.2.7	CTAG Patient Group – Infectious Diseases Update - Shingles/Chickenpox – It was agreed to discuss this at the July meeting of the CT Centre Directors	**COMPLETE**
2.2.8	CTAG Patient Group - Respiratory syncytial virus (RSV) Vaccine – CTAG Lungs members were previously asked for expressions of interest to act as clinical representatives to help speed up decision making for medication licences and to improve developments and vaccines. To date none have been received.	**COMPLETE**
2.2.9	Environmental Sustainability in Transplantation (ESIT) Project – Lung representation is still required to join this voluntary group that is now a formal part of OTDT workload. Anyone who is interested in representing CTAG L contact J Parmar.	**ONGOING**
2.2.10	COVID 19 Update – I Ushiro-Lumb was invited to the December CTAG Lungs meeting but was unable to attend. *See Item 13.2*	**COMPLETE**
2.2.11	Transplant Oversight Group (TOG) update – There was no update at the December CTAG Lungs meeting. D Gardiner to follow up with D Manas. *See also Item 4.2*	**ONGOING**
2.2.12	CT ICE Survey – R Burns agreed to circulate the report shown at CTAG Hearts.	**COMPLETE**
2.2.13	CUSUM Baseline update – *See Item 5.2*	**COMPLETE**
2.2.14	Lung Allocation Working Group update (May 2025) and Lung allocation modelling update – For completion Spring 2026 - *See Item 7.1*	**ONGOING**
2.2.15	Lung Allocation Working Group update (May 2025) and Lung allocation modelling update - S Rushton to investigate whether younger donors are resulting in better utilisation – *See Item 7*	**COMPLETE**
2.2.16	Lung Sensitisation Working Group – It was agreed that A Reed should join this working group. Others were invited to contact CT Rosser re participation.	**COMPLETE**
2.2.17	CT Patient Group Recommendations - The CT Patient Group recommends the following: • The NHSE Transformation Programme looks at kidney requirements for CT patients (peri-operative care, lifelong care and holistic care) • The CT transplant service specifications should specify the need for sufficient on-site integrated renal services to meet patient need in acute and long-term periods. • Nationally, CT transplant teams work with nephrology colleagues to understand variations in kidney function and develop national care pathways to support long-term kidney function. • More robust collection of data to record the CKD stage for patients is needed. Some caution is needed to ensure patients do not become worried about renal care. NHSE/M Kemmner to consider these issues in CT Transformation Programme.	**ONGOING**
2.2.18	ERAS Update – A Adlakha to give an update in CTAG Lungs in June 2026	**ONGOING**
2.2.19	Summary from Statistics and Clinical Research – *See Item 12.1*	**COMPLETE**
2.2.20	Adjudication Panel Activity – *See Item 13.3*	**COMPLETE**
2.2.21	CT Centre Directors' meetings - Further discussion around collaborative working is needed. M Kemmner to take this to the TOG meeting – *See Item 4.3*	**COMPLETE**
2.2.22	Report from Recipient Co-ordinators - There are ongoing transport issues which have been discussed with IMT.	**COMPLETE**

3.	**MEDICAL DIRECTOR'S REPORT**	
3.1	Developments in NHSBT – R Ravanan introduced himself as the new Deputy Medical Director for OTDT and reported as follows: • Thanks to J Parmar - R Ravanan gave heartfelt thanks to J Parmar for his work as Chair of CTAG Lungs Advisory Group over the last 5 years and particularly for his grace, skill, expertise and exemplary leadership in this role, especially during the pandemic. He has now been appointed as AMD for Patient Engagement which is a big brief. Work is underway to appoint a new Chair for CTAG Lungs. Everyone in the group and colleagues in transplant teams are encouraged to look at the job description which will come out shortly and talk to Rommel or Derek if there are any questions. **ACTION: R Ravanan and J Parmar to discuss interim arrangements for CTAG Lungs Chair offline** • SCORE – has gone through internal funding business case sign off by the Senior Management Team (SMT) at NHSBT. • ARCS – The pilot phase for this for 2026/27 is approved. A business case will be prepared for the long-term funding of ARCS for 2028/29. *See Item 11* • Matching offering scheme – A substantial funding business case has been signed off in the last quarter. Appointments to enable the developments are currently being advertised. • NHSE/NHSBT joint working – D Thorburn/D Manas will chair the National Transplant Clinical Panel (NCTP). The first meeting has been held and Tor are being agreed. Workstreams will include managing quality concerns, CUSUMs, trust engagement monitoring and particularly how trusts' senior management teams prioritise transplant. • Change in donor demographics – eg, DBD to DCD, consent rates – The Organ Donation Joint Working Group is in place and work is progressing to improve these issues. • ISOU - A completion report will be issued in the New Year. Recommendations from the working groups have been submitted and reviewed by the Health Minister. There will be an ongoing process of monitoring of implementation. • Abdominal NRP work - is ongoing and there will be more news in Spring/Summer 2026. • Lung Utilisation – An NHSE survey of trusts suggests trust organ utilisation strategies for Manchester, Papworth, Newcastle and Leicester will be completed by Christmas. These will then be pilots for review by the National Transplant Clinical Panel. NHSE will read strategies in January.	**R Ravanan / J Parmar**
3.2	New Appointments – These were highlighted as follows: • Frances O'Callaghan has been appointed as new CEO for NHSBT to start in February/March 2026. • Chris Callaghan (Guy's Hospital) is the new Chair for the Pancreas Advisory Group (PAG) • The new Chair for MCTAG is Irum Amin (Addenbrookes) • The new National Clinical Director for Transplantation is Doug Thorburn (Professor of Hepatology, Royal Free Hospital) who previously chaired the Liver Advisory Group (LAG).	
4.	**NATIONAL OVERVIEW**	
4.1	Lung Activity – **CTAGL(25)26** – In D Gardiner's absence, S Rushton gave his presentation (circulated prior to the meeting). • The current year 2025 compares closely with the same period pre-COVID in 2019 and shows good improvement. • In 2024 there were considerably higher numbers of transplants in Canada, Australia and Eurotransplant if corrected for population. • However, the last quarter of 2024/25 and first two quarters of 2025 indicate an improving performance in the UK. • All paediatric transplants included in the presentation were done by GOSH. It was noted that there has also been one transplant at Newcastle. . • Annual registration numbers would be useful to understand what the dropping numbers of patients waiting means.	
4.2	Transplant Oversight Group (TOG) update – S Watson described the remit of TOG. Whichis to have oversight and to liaise with the National Transplant Clinical Panel. The work will include looking at outputs from trusts and NHSBT including , CUSUMs and	

	activity and annual reports from NHSBT. Following its first meeting, the Clinical Panel will liaise with CT Transformation work currently underway.	
4.2.1	Transplant Oversight Group Terms of Reference (for information) – **CTAG(25)27** - circulated for information.	
4.3	NHSE CT Transformation – Update and Progress Report – M Kemmner gave an update on CT Transformation work.: • Anna Reed has resigned as NSA for Lung. She was a committed leader for change in this area and will be much missed. Arrangements for a replacement are underway. • The Board has agreed a range of priorities for the programme – Transplant and unmet need geographically, Holistic Care (eg psychological work) beyond what is provided by the transplant team, and Utilisation and Long-term Outcomes (eg post-transplant care. • A resilient platform will be put in for change in the longer term (eg alignment across the centres and having a quality improvement approach). The aim is to look at funding and designing a single model for improvement (being developed by Centre Directors). • Deliverables – the workstreams have been agreed these and they have been signed off by the Board. Task and finish groups are being set up, and these are starting to look at data. • Access to Care – The needs of the community and range of data sets to identify potential transplant candidates. These will be mapped with referrals and listing and transplant data to find any gaps. Transplant centres will then be informed of these to build an education initiative that will identify barriers to referral • Outreach – This area aims to identify what potential methods can be developed (eg impact on staffing needs, impact on data). • Holistic care – Here there will be a focus on staff benchmarking and trying to get consistent information. This workstream will also look at what the outputs from holistic care are likely to be and how this can be delivered without much additional funding. • Organ Utilisation –Work is ongoing with Statistics at NHSBT to understand data more clearly. • Organ acceptance processes – this work will look at what happens currently, how utilisation reviews work and any follow up work that results. • Changing Perception of Risk – Work here will look at whether CUSUM is the appropriate methodology to focus on for risk. • Long term care – This theme will examine protocols and what is needed and is being prioritised for lungs. Centres will be compared to see where there are differences and how each centre can learn from each other. Discussions are ongoing with Centre Directors regarding a single model of care and what structures and resources are needed for centres to work together. Included in this will be testing and feasibility of data collection, support of QI and staff benchmarking to see what the status quo is and what differences there are across units to help underpin where money for transplant goes and how funding and tariffs can be planned in future. The importance of having a national proforma to help collect referral data is also emphasised alongside historic data. Identification of patients dying before they reach hospital for an appointment due to late referrals or being turned down by other centres is also important.	
5.	**PATIENT SAFETY**	
5.1	Patient Safety Report – **CTAGL(25)28** – This report was circulated prior to the meeting. In R Baker's absence, J Parmar highlighted one case where lungs were accepted for research and arrived at the centre incorrectly packaged and without documentation. Its was emphasized that the correct process needs to be adhered to. No current patient safety trends in lung donation/transplantation were identified.	
5.2	CUSUM Monitoring of 90-day outcomes post lung transplantation – **CTAGL(25)29** – This paper was circulated prior to the meeting and summarises the results for the 6-month period since the last CTAG Lungs meeting. • In July 2025, the baseline period for expected rates was moved forward to January 2020 – December 2023. • From July 2025, paediatric programmes were removed from reporting due to low activity, reducing the number of reports issued from this date. • No CUSUM signals have been reported for lung transplantation in this period. It was noted that re-transplantation has been included in CUSUM reporting for hearts (2% of activity). This is not the case for lungs where re-transplantation is risky and outcomes	

	are poor. Re-transplantation accounts for 1% of activity. It will not be included in CUSUM reporting unless activity increases.	
5.3	Group 2 Transplants – There are no Group 2 transplants reported. (One patient was listed for hearts but has now been removed).	
6.	**OTDT HUB UPDATE**	
	J Whitney stated that she has been successful in getting a new role as Transformation Lead and will be leaving her current post for 2 years on secondment. Jo Chalker will fill her substantive post. She is currently Regional Head of Nursing in the South-West and South Wales and will come to future advisory group meetings from the Spring onwards.	
6.1	Sustainability and Certainty in Organ Retrieval (SCORE) update – **CTAGL(25)46** – Full details can be found in the presentation circulated with these Minutes. J Whitney stated that SCORE is due to go live in 2027. All centres are encouraged to complete the survey if this has not been done already. Further information can be found by scanning the QR code at the end of the presentation.	
7.	**LUNG ALLOCATION**	
7.1	Lung Allocation Working Group update (May 2025) and Lung allocation modelling update **CTAGL(25)41, CTAGL(25)42, CTAGL(25)43** - This fixed term working group was established in 2021 and discussions on updating the policies for selection and allocation started in 2022. The current system dates from 2017. The aim of the working group has been to look at urgent and non-urgent allocation. The group included representation from 3 waiting list patients who have since received their transplants. Discussions have included work by Newcastle under the BTRU (initially by Sam Kennedy and now by Leo Freitas, supervised by A Fisher). After 7 meetings, the group is now getting close to a final proposal and to testing the use of a computer simulator in future to decide on allocation. The following reports were discussed at CTAG: Post Transplant Model **- CTAGL(25)41** presents a post-transplant survival model that has been developed to inform the non-urgent lung offering scheme using available data on the UK Transplant Registry. This model is now finalised. Waiting List Model **– CTAGL(25)42** presents a waiting list survival model that has been developed to inform the non-urgent lung offering scheme using available data from the UK Transplant Registry. Further work is required to investigate percent predicted FEV1/FVC rather than measured. Conclusions - are shown in the documents circulated. Non-urgent Lung Composite Offering Score (NLCOS) **– CTAGL(25)43 –** these slides present potential policy attributes and weighting including: • Waiting list survival • Post-transplant survival • Paediatric weighting • Height compatibility • Geographical proximity Possible screening factors include: • Blood group incompatibility • HLA incompatibility • Acceptable donor TLC incompatibility The slides also show the draft data collection form to be introduced alongside the new scheme to collect more granular data. **ACTION: a) S Rushton to re-circulate the form to all centres** **b) A small working group will be set up to include S Rushton, C Rosser, J Parmar and R Ravanan and a member of the Lung Allocation Group to discuss inclusion of HLA data in the future offering scheme**	**a) S Rushton** **b) S Rushton, J Parmar, C Rosser, R Ravanan**
7.2	Lung Allocation Activity Review – **CTAGL(25)30** – this paper shows outcomes of patients on the lung transplant waiting list, considering urgency group, centre and disease group. It also presents post-transplant outcomes by urgency group. Reports cover registrations and transplants over 3 years from 1 April 2022 until 31 March 2025. Full details are given in the paper circulated.	
8.	**LUNG UTILISATION**	
8.1	CLU Update – **CTAGL(25)39** – This paper was circulated prior to the meeting, and this includes the attendance record for all centres. The 'gold medal' goes to Birmingham and GOSH for their engagement and input.	**ALL**

	• V Gerovasili stated that since the last CTAG Lungs meeting in June there has been one Lung Engagement call on 9 September. P Kaul and R Brugha were thanked particularly for their input. The next Engagement call is on 8 December. • A toolkit for all organs has been developed to help CLUs in their roles and within their trusts to help with utilisation. Feedback suggests that CLUS have found this helpful. V Gerovasili is happy to share this, and it should also be available from local CLUs. • NOUC 2026 will again take place in Birmingham and retrieval will be included in this. There were over 100 attendees in 2025 and discussion around SCORE, ARCs and whether transplant should be incentivised were particularly highlighted. The date and venue for 2026 is still to be finalised (hopefully by end of 2025). Members of CTAG Lungs are asked to put forward topics for discussion in 2026. • Higher Quality Definition - For those at the BTS Works Seminar Webinar last week, higher quality lung offers, and increased utilisation rates were highlighted. There is some confusion about higher quality offers that are unclassified due to pO2 and higher PEEP. From Monday the definition of higher quality lung offers will include PEEP of 5-10. There will be a further update at the next CTAG Lungs meeting on how this affects results. • Hep C inclusion in higher quality definition - It was noted that the Heart community is thinking of removing Hep C from the higher quality heart definition because it is a treatable disease. **ACTION: All CTAG Lungs members are asked to feedback to V Gerovasili whether they feel this should/should not be included in the higher quality definition for Lungs.**	
9.	**CTAG PATIENT ENGAGEMENT**	
9.1	Patient Engagement Structure Update – J Parmar stated that he will be moving to a new role as AMD for Patient Engagement in the New Year. • The purpose of this role is to ensure alignment with ISOU recommendations. • The new Patient Engagement group will include representation from all solid organ groups, will sit above the other advisory groups and will feed into advisory group meetings. J Parmar will co-chair meetings with a patient partner. • The initial meetings are planned to consider what a patient partner will do and how the advisory group will develop. The first task for the AMD will be to refresh the website. Long term the plan is to integrate PROMS and PREMS and establish how trusts will respond to issues raised in ISOU's patient studies. • It is not clear how NHSE will fit into this as nothing is formalised yet. Development will be iterative. Flu treatment – R Fitzgerald raised the issue of problems currently for patients trying to access flu treatment. Patients are advised to contact their transplant centres and/or GPs for advice. Some centres have either emailed patients or created information sheets which should help when contacting GPs for vaccinations.	
10.	**H&I REPORT**	
	H&I Update - **CTAGL(25)31**. This paper was circulated prior to the meeting: • Discrepancies - 1 discrepancy was noted between August 2024 and August 2025 which was picked up pre-allocation. • An Electronic Reporting System (DCERT) – This is now being rolled out for HLA which will be reported direct from the labs. 7 labs are now live, and this will hopefully remove the opportunity for transcription error in the entry of HLA data. Previously the labs faxed information for all organs to the Hub. Now it is emailed and manually inputted by staff who are not H&I trained creating the possibility of transcription error. The plan is for HLA information to go directly into NTXD following phased implementation of DCERT with completion for all labs in 2026. • HLA Compatibility – It is important to double check that the correct laboratory report for the donor has been received from ODT-Hub for compatibility assessment. So far, any issues have been picked up but this could be an issue in future. • cRF calculator update - The integration of HLA-DP unacceptable antigens into the cRF calculator tool will align cRF prediction with the matching runs and will be available in early 2026.	
10.2	cRF in CT Transplant – **CTAGL(25)32** – Concerns have been raised in previous meetings and to the OTDT H&I Lead regarding a perceived disparity in the application of HLA cRF tool for CT transplant waiting list patients between different Histocompatibility labs and transplant centres. This could impact on equity of access, and it is believed it should be	

	standardised across H&I labs. HLA matching is not currently considered in CT allocation but is important for immunological compatibility of a patient with a potential donor. Communication with local H&I labs was emphasised to ensure they know what is wanted for patient care. It was suggested at the meeting that this was reviewed every 3 months. • If HLA matching is used for allocation, then patient records, including HLA would need to be recorded in NTXD • To avoid incompatible organ offers, unacceptable antigens would need to be recorded in NTXD The following recommendations were made: • Awareness of BSHI and BTS UK guideline on the detection of alloantibodies in solid organ and islet transplantation (2023) to inform local practice. • BSHI, in conjunction with BTS, will look to arrange some education (e.g. webinars) and a future focused meeting on cRF in CT transplant. • Local H&I teams to be included in patient discussions, MDTs and assessments to ensure understanding of individual requirements, risks and treatment plans.	
11.	**ARCS DEVELOPMENTS – CTAGL(25)33**	
	This paper was circulated prior to the meeting. A Fisher stated that he is Chair of the National Steering Committee for Lung ARC which has multi-disciplinary representation from all 6 lung transplant programmes in the UK. This committee has met 10 times and has made considerable progress to move towards the pilot phase of the Lung ARC. <u>Aims of the lung ARC pilot</u> • To test the feasibility and safety of a national EVLP service supporting increased donor lung utilisation. • To establish the logistics and governance arrangements for the pathway • To generate mechanisms for robust audit and data collection to enable monitoring of ARC performance and impact. • To create a sense of national ownership of the ARC EVLP programme as a service provided by some for the benefit of all • To involve patients/carers in the key steps of establishing the ARC programme Core clinical and operational frameworks have been defined, including EVLP eligibility, exclusion, and acceptance criteria for ARC assessments. Key data collection fields have been agreed as part of an ARC lung passport that will accompany donor lungs on the pathway from donor hospital to ARC and then to recipient centre. • Three pilot locations have been confirmed at Harefield, Papworth and Newcastle starting in January or early February. Only one Papworth has completed the required activity to be active • The perfusion technology used in the pilot will be the XVIVO XPS system and agreed training and experience requirements of at least 5 EVLP assessment and 4 EVLP transplants performed in the 12 months before going live in the ARC pilot. 20 ARC assessments is the goal in the first 12 months of the pilot phase resulting in 15 additional lung transplants. There were concerns raised that a centre could in theory accept lungs for standard transplant only to decide at time of retrieval that the lungs require EVLP. Only centres with local EVLP facilities could do this, so it will be difficult for non-ARC centres to build up expertise with EVLP. Local EVLP use will be monitored as part of the pilot, which is reported via the HTA-B form, and there will be opportunities for revisions to the process if systematic issues arise. **ACTION: Centre reps to email J Parmar during the next week to endorse the plan as indicated in the paper circulated.**	
12.	**STATISTICS AND CLINICAL RESEARCH REPORTS**	
12.1	<u>Summary from Statistics and Clinical Research</u> – **CTAGL(25)34** - Recent presentations, publications, and current and future work for CT transplantation are detailed in the paper circulated and on the ODT website. • The Team is supporting the ARC programme. • The annual extract of UK CT transplant data to the International Society of Heart and Lung Transplantation Registry has been transferred and data on patients implanted with Left Ventricular Assist Devices (LVADs) is being sent to the International Registry for Mechanically Assisted Circulatory Support (IMACS) • Statisticians are contributing expert input for data and organ offering processes for the Digital Offering project which is required for SCORE. Full details are in the paper circulated, including an infographic summary of key activities for 2024/25.	

12.2	Freedom of Information (FOI) Review – **CTAGL(25)40 –** There has been a significant increase in FOI requests made to NHSBT for data held on the UK Transplant Registry or Mechanical Circulatory Support Database. NHSBT has a legal obligation to respond to these requests under the Freedom of Information Act 2000 within 20 working days of receipt. Information can be withheld in certain circumstances, but NHSBT must explain the reason and demonstrate that withholding this is in the public interest. Details of the 15 cardiothoracic related requests over the last 12 months are shown in the paper circulated prior to the meeting. • It was noted that this work can disadvantage other workstreams, but the legal advice is that it is important to respond within the given timescale. Further help from the legal team is given in borderline cases. • If there are repeated requests from one individual any issues about the need to respond must be based on the work rather than the individual concerned. • Currently, no requests have resulted in information being added to the annual reports.	
12.3	PROMS and PREMS – **CTAGL(25)35** – The paper circulated provides a summary of what, why, and how 2 patient-reported outcome measures (PROM) and a patient-reported experience measure (PREM) are being developed within the NIHR Blood and Transplant Unit in Organ Donation and Transplantation at Newcastle University for use with CT transplant recipients. PROM development – • A questionnaire asks people about their quality of life after transplant. This will be applicable to all solid organ transplant recipients • A questionnaire asks people about how much they are bothered by symptoms and new conditions in life after transplant. This will also be applicable to all solid organ transplant recipients and can be used separately or alongside the quality-of-life PROM These PROMs will help identify potential support needs, stimulate discussion at follow up appointments and track changes in quality of life over time. Researchers and healthcare professionals will also benefit from knowing how post-transplant life is affected for different recipients and whether support has been effective. PREM development - • A questionnaire asks heart and lung transplant recipients about their healthcare experiences in hospital for their transplant This PREM will evaluate the quality of healthcare provided and identifying strengths and areas for local and/or national improvement. It will also help identify variations and inequalities in healthcare experiences, for example, across different geographical regions. Issues raised at the meeting were: • The carer's experience is often different from the patient experience • GOSH is also doing work on a lung transplant PREM which is not linked into this work • Making this information accessible to all patients (eg including those for whom English is not the first language or the disabled) is important. Having tablets available in the clinic could help with this. Full information on the PROMs and PREM at Newcastle are in the paper circulated.	
13.	**STRATEGIC DEVELOPMENTS**	
13.1	DBD Optimisation Donor Bundle – Due to D Gardiner's absence this will be included in the June 2026 CTAG Lungs meeting.	
13.2	COVID Positive Donors – a re-think – **CTAGL(25)36** – J Parmar stated that lungs have frequently been discarded due to early observations of severe acute respiratory syndrome coronavirus-2 (SARS-CoV-2) transmission via lung transplantation. It has been noted: • The disease is now in the endemic phase • Many donors may be coincidentally positive • Many usable lungs have been discarded A survey from the Council of Europe indicates that out of 32 nations, 20 countries accepted donors with resolved and active and resolved positive SARS-CoV-2 tests. Full information is in the paper circulated. Possible options include: • Stopping routine testing • Consider moving to more detailed assessment (CT values on BAL's throat swab positive donor; CT Chest if in doubt) • Continue current practice noting limitations • Consider utilising other organs	**A ADLAKHA**

	It is acknowledged that routine testing in ICUs will reduce and testing kits will not be available. The limitations of most donor hospitals who do not have easy access to CT thresholds were also noted. **ACTION: A Adlakha to take this issue to the ALTP group to get the view of other lung physicians.**	
13.3	Guidelines for the Adjudication Panel – **CTAGL(25)45** – K Santhanakrishnan's presentation is circulated with these Minutes and raised the following key points: • Responses are not consistently provided within the expected timeframe • Decisions often lack adequate reasoning. This makes it difficult for MDTs to understand or justify outcomes • Lack of transparency causes confusion within centres and distress for patients and families. Timely Response: • Centre Director and the CTAG representative should both be sent requests to ensure coverage if one is unavailable. • An escalation protocol should be in place if no response if received within 12 hours. The CTAG Chair should be empowered to make an interim decision • A template for panel responses with ticks should be introduced with tick boxes • Panel members should sign to say 'I agree to urgent listing as the patient is declining and meets criteria for urgent listing'. The decline format should be clear, ie 'I would decline urgent listing because': • The individual likely has increased perioperative risk that may not be acceptable • There is an increased long-term risk associated with the procedure • The patient does not meet the criteria for urgency. It is suggested an additional comments section would help with reasons for why decisions have been made and to help reduce ambiguity, support productive MDT discussions and ensure patients and families receive fair and transparent decision. The following issues were accepted as essential for good decision making: • Although the form has already been changed to enable good data collection, level of completion is poor. Decision making needs to be robust to ensure any challenges can be answered. • Panel members stated that it is not easy to complete a form on a mobile form. As a result, additional comments to explain decision making are sent via email which makes it hard to collect data. • The answer should reflect a centre's viewpoint and not a single person's decision. • It is important to have NHS number for registrations. • The number of turn downs and reasons for these is important information to capture themes. This could help with changing allocation themes in future. • An online platform would be useful to upload data in future. **ACTIONS: a) A Ranasinghe to share the ToR and form used for Heart Allocation adjudication with the group b) D White to look at how forms in Microsoft 365 could be used c) K Santhanakrishnan to chair a FTWG with representation from each centre too look at the ToR, decision making times and technological opportunities.**	**A Ranasinghe/ D White/ K Santhanakrishnan**
14.	**REPORTS FROM RELATED GROUPS**	
14.1	Retrieval Advisory Group (19/11/25) – As M Berman was not present, there was no update at the meeting. Work on TA-NRP continues.	
14.2	CT Centre Directors' meetings – J Parmar stated that ToR for this meeting are being developed, and it is to be decided whether these should be for NHSE or NHSBT.	
14.3	Report from Recipient Co-ordinators – **CTAG(25)44** – this paper was circulated prior to the meeting. • It was noted that vaping history is not well-documented, and work is ongoing to get this information onto Transplantpath. • A regional pilot of NHSBT PACS trial was tabled at a Transplant Co-ordinators' meeting where it was agreed that roll out should continue. D White will be point of contact for the Transplant Co-ordination community.	
15.	**FOR INFORMATION**	
15.1	QUOD Update – the latest update was circulated prior to the meeting.	
15.2	Closure of SIGNET – a letter from J Dark detailing the closure of the SIGNET trial was circulated prior to the meeting.	
16.	**ANY OTHER BUSINESS**	
16.1	Key points from today's meeting for cascade to centres –	

	• Lung activity improving • Lung allocation working group will finalise allocation policy in next 6 months • FTWG to establish guidelines for lung appeals panel and improve IT solutions • SCORE go live 2027 • ARCs pilot centres appointed only 1 I able to start (RPH) • COVID donors to be discussed at ALTP • PROMS and PREMS continued development with hope to introduce in clinical practice in the next 2 years	
16.2	Date of next CTAG Lungs meeting – Scheduled for 4 June 2026. Members have been sent a SAVE THE DATE invitation. This meeting will be face-to-face. Venue TBA	

Dates of future CTAG meetings 2026 **CTAG Hearts** – 25 March 2026 – via Microsoft Teams **CTAG Lungs –** 4 June 2026 – Venue TBA **CTAG Hearts –** 17 September 2026 – Venue TBA **CTAG Lungs –** 3 December 2026 – via Microsoft Teams