NHS BLOOD AND TRANSPLANT
ORGAN DONATION AND TRANSPLANTATION DIRECTORATE

TELECONFERENCE MEETING OF
CTAG CORE GROUP
ON FRIDAY 16TH DECEMBER 2016, 16:00 – 17.30

DIAL IN CODE: **0800 032 8069**
PARTICIPANT CODE: **34678083#**

MINUTES

Attendees:	Steven Tsui	CHAIR – Papworth
	Matthew Fenton	GOSH
	John Dark	Newcastle
	Nawwar Al Attar	Glasgow (late join)
	Jorge Mascaro	Birmingham
	Lucy Newman	NHSBT
	Sally Rushton	NHSBT
Apologies:	Anne Sheldon	NHSBT
	Andre Simon	Harefield
	Rajamiyer Venkateswaren	Manchester

Item 1	**Minutes and actions points of TC on 23rd September 2016**	
	The minutes of the last telecon on 23rd September were agreed as an accurate record. There were no matters arising. AP1 – Stephan Schueler has been named as the Newcastle representative for CTAG Heart. AP2 – Sally Rushton will cover this during item 3 AP3 – Bridging the gap between the NHSBT and ISHLT data is in progress but has been held up by CUSUM, to add to the agenda again for the next meeting AP4 – the list of reasons for declining donor organs was altered and presented at CTAG in October. This will be implemented following training of the Duty Office. Minimal amendments are required to the pick list, (Mick Stokes) MS and SR to work together to give a go-live date AP5 – KPI for Cardiothoracic NORS - there was debate at CTAG about using post-transplant survival as KPI for NORS, but measures are required and currently Chris Callaghan (CC) is working with John Asher (JA) to implement this. Chris Callaghan will discuss KPI options with the Advisory Groups. Cardiothoracic NORS KPI would be in three parts: • Process: Measure of the time taken to dispatch retrieved organs • Donor organ structure: Grading of retrieved donor organs	LN SR MS

	• Donor organ function: PDG as measured by requirement for mechanical support at 1, 30 and 90 days post-transplant and post-transplant survival CC and Emma Billingham (EB) co-chaired WG3, but are still undecided on how best to monitor and report on KPI's Prednisolone factor – this has been put on hold, JD will liaise with CW AP6 – Justification for allocating cardiothoracic organs by age – this is ongoing and is one of the actions arising from TPRC. ST will be asked to report back on this, the CTAG Paediatric Organ Allocation Working Group is being convened to review and discuss.	ST
Item 2	**Centre representative list**	
	Newcastle Heart Rep	
	Stephan Schueler (SS) has been elected as the Heart Representative for Newcastle – add to CTAG distribution lists and invite to CTAG Wider Group Meetings next year. Newcastle would like to have a chest physician on CTAG Lung in addition to Steven Clark. JD will write to ST.	JD
Item 3	**Grading of retrieved cardiothoracic organs**	
	SR revised the forms as discussed at the last meeting and the final version has been circulated. An electronic submission form has been created. This will be a pilot scheme in the first instance; NHSBT Statistics and Clinical Studies team will collect and collate the data. SR is trialling the use of the forms on iPad to reduce margin for error. There is a mandatory tick box in each field of the form, so incomplete forms cannot be submitted. The go live date for this will be 15th January and SR will circulate the final version of the form to centre directors, all are welcome to start using the new forms prior to this if desired. SR will send an official communication from ST with the forms and go live date.	SR
Item 4	**Justification for allocating cardiothoracic organs by age**	
	Good clinical justification is required to continue to allocate cardiothoracic organs by age. This will need to go to the CTAG Paediatric Organ Allocation Working Group in January before reporting back to CTAG and TPRC. There is more growth in a paediatric lung than the heart. Further discussion surrounding the allocation of cardiothoracic organs is required. For hearts, we may remove age as a cut off and use size criteria. For lungs, the alveoli are not developed before the age of 2 years so age still needs to be used.	
Item 5	**CTAG meeting format survey**	
	LN sent email votes regarding the CTAG wider group meeting format. The result showed that 8 members voted to maintain status quo alternating the morning between CTAG (Heart) and CTAG (Lung); 1 member voted for 2 consecutive days and 2 members voted for separate heart and lung meetings. The vast majority supported status quo so for the foreseeable future the CTAG Wider Group Meetings will be held on one day 6 monthly. We shall ensure that adequate refreshments are provided for the break between the shared and the afternoon sessions.	
Item 6	**Acceptance of single lung offer**	
	All units should continue to support one another with single lung acceptances. Some centres accept only 1 lung, the accepting centre must specify at the time of acceptance whether it is the right or the left lung. Some patients are only listed for one lung. There are not many single lungs done, although there is usually a	

	preferred side even if both lungs can be transplanted. Clarity at this stage would mean the other lung can also be offered. If the accepting team have picked a side which turned out to be poor when the other lung has been offered to and accepted by another centre, they cannot then change their decision later and take the good lung. All unit reps should remind teams to specify whether they will require the left, right or both lungs at the point of acceptance. This is a sensible and rationalised approach. JD will formulate a paragraph to go into the lung allocation policy. LN to send a reminder to JD after Christmas.	JD LN
Item 7	**QUOD Biopsies**	
	It was proposed that retrieval teams should take biopsies of donor hearts at retrieval, and perfrom research BAL on lungs. There was some concern among recipient centres regarding the heart biopsies, but not regarding the BAL. JD circulated the SOP and patient information leaflets relating to heart biopsy and only Harefield offered any feedback that they did not wish to receive QUOD biopsied hearts. The documents were circulated for a second time in early November, with no further responses. Papworth, Newcastle, Birmingham and Manchester are all happy to accept QUOD biopsied hearts. Glasgow would also prefer not to receive biopsied hearts, but they are prepared to carry out the QUOD biopsy for hearts retrieved and exported by the Glasgow NORS team. Hearts retrieved from under 16 are not biopsied at all and there will need to be a mechanism in place to let the retrieval teams know that hearts accepted by Harefield should not be biopsied JD has requested updates from other centre directors as to where they stand on this matter. There was some discussion on whether the left or right ventricle should be biopsied; the preferred side would be the left as it has a thicker wall – more likely to get a good specimen and probably easier to repair. JD will email all centre directors with the SOP and Sandrine Rendell will visit and train teams.	JD Sandrine Rendell
Item 8	**A O B**	
	• JD and ST have had communication over the last few weeks with Fiona Marley from the Highly Specialised Commissioning Group within NHS England regarding a Swiss publication in 2015 which highlighted a non TB mycobacterial infection in cardiothoracic surgery patient, caused by the use of the heater/coolers during surgery. Patients can present with infection up to 42 months after initial surgery and further investigation showed that all had received prosthetic material. The outcome for these patients was poor. NHS England has written to NHSBT and CTAG to request guidance on how to proceed with advising transplant recipients at risk. JM commented that he had operated on three patients who had presented with late mycobacterium infection. John Forsythe (JF) and ST felt that although the risk of recipients developing an infection of this nature is extremely small, serious criticism could occur if it does. Specific documentation will not be produced at this stage as patients are already given huge amounts of information about donor choices and risks associated with cardiothoracic transplantation. JF and FM will work on this and reach a conclusion on how to proceed. • It is helpful to have an identified clinical lead for VADS at each centre, all centres to send details to SR of who their VAD Lead is • ST has had a telecon with E Jessop (EJ) and S Watson (SW) NHS England about Destination Therapy. The preliminary proposal has gone to the Clinical Panel – the Clinical Panel have requested a Project Working Group be	JF FM Centre VAD Reps SW”

	convened. EJ and SW will write to units in due course to ask them to nominate representatives; the first meeting is planned for Spring 2017 LN will email a week ahead of the next Core Group telecons to remind the Centre Directors and hopefully prevent delayed starts to future meetings	Centre Directors
Item 9	Date of next Core Group Teleconference January/February 2017	

16th December 2016