Approved 30.11.17 **KAG(M)(17)1 (Am)**

NHS BLOOD AND TRANSPLANT

MINUTES OF THE THIRTY-FIRST MEETING OF THE KIDNEY ADVISORY GROUP HELD AT 10.30 A.M. ON THURSDAY 8th JUNE 2017 AT 12, BLOOMSBURY SQUARE, LONDON

PRESENT:

Prof Chris Watson	**Chair**
Ms Lorna Marson	BTS Representative and Deputy Chair
Mr Niaz Ahmad	Representative for Leeds and Newcastle
Mr Simon Boyes	Representative for Sheffield & Nottingham (deputy for Keith Rigg)
Mr Andrew Broderick	Donor Assessment Programme Lead, NHSBT
Mr Tim Brown	Representative for Belfast (deputy for John Connolly)
Ms Lisa Burnapp	Lead Nurse for Living Donation, NHSBT
Mr Chris Callaghan	National Clinical Lead for Organ Utilisation (Abdominal)
Mr John Casey	Chair of Pancreas Advisory Group
Mr Marc Clancy	Representative for Glasgow & Edinburgh
Mr Frank Dor	Representative for Oxford and WLRTC
Prof John Forsythe	Associate Medical Director, ODT
Prof Susan Fuggle	Scientific Advisor, NHSBT
Mr Paul Gibbs	Representative for Plymouth & Portsmouth
Ms Alison Glover	Recipient Co-ordinator Representative
Dr Sian Griffin	Representative for Cardiff & Bristol
Mr Jon Gulliver	NHS England (Specialist Commissioning) Representative
Dr Rachel Hilton	Representative for Guys' & St Georges
Mr Nick Inston	Representative for Birmingham & Coventry
Dr Gareth Jones	Representative for Royal Free & Royal London
Mrs Julia Mackisack	Lay Member Representative
Dr Stephen Marks	BAPN Rep/KAG Paediatric Sub Group Chair
Ms Lisa Mumford	Statistics & Clinical Studies, NHSBT
Mr Gavin Pettigrew	Representative for Leicester and Cambridge
Mrs Kathleen Preston	Lay Member Representative
Dr Tracey Rees	BSHI Representative, Cardiff
Mr Matthew Robb	Statistic & Clinical Studies, NHSBT
Ms Angie Scales	Lead Nurse: Paediatric and Neonatal Donation and Transplantation, NHSBT
Mrs Abbie Wood	TSS/DO representative (deputy for Mick Stokes)

IN ATTENDANCE:

Ms Anushka Govias-Smith	Programme Manager, NSD Scotland (observer)
Ms Emma Laing	Clinical Trial Manager, NHSBT (attending for item 8)
Miss Trudy Monday	Clinical & Support Services, ODT
Prof Rutger Ploeg	National Clinical Lead for Organ Retrieval - ODT
Miss Sam Tomkings	Clinical & Support Services, ODT

APOLOGIES:

Mr Titus Augustine	Representative for Liverpool & Manchester
Mr John Asher	Medical Health Informatics Lead, ODT
Dr Richard Baker	Renal Clinical Reference Group
Dr Alison Brown	Representative for Leeds and Newcastle
Mr John Connolly	Representative for Northern Ireland
Prof John Dark	National Clinical Lead for Governance, ODT
Mrs Rachel Johnson	Head of Organ Donation & Transplantation Studies, NHSBT
Ms Sally Johnson	Director of Organ Donation & Transplantation – NHSBT/ODT
Dr Sian Lewis	Acting Medical Director WHSSC
Dr Philip Mason	Renal Association / Renal Registry
Prof Nizam Mamode	Clinical Lead for Transplantation, Guy's Hospital (for item 6.7)

Mr Keith Rigg	Representative for Sheffield and Nottingham
Mr Anthony Snape	Head of IT Service Management, NHSBT
Mr David Stagg	Business Transformation Services, NHSBT
Mr Mick Stokes	TSS/DO representative
Mr Phil Walton	SNOD Regional Manager – South Wales & South West

ACTION

1 DECLARATIONS OF INTEREST IN RELATION TO THE AGENDA – KAG(17)1

There were no declarations of interest.

2 MINUTES OF THE MEETING HELD ON 5th DECEMBER 2016 – KAG(M)(16)2(Am)

2.1 **Accuracy**

The minutes of the previous meeting were agreed as a correct record.

2.2 **Action points – KAG(AP)(17)1**

Action point 1: R Ploeg presented a verbal update.

R Ploeg met with J Asher and agreed to have a named expert per organ to study the data set. NORS leads will also have the opportunity to study the data set and will consult with members. The aim is to complete the process by the end of July. This will then be delivered to NHSBT in August, where a product will be developed to meet requirements.

All other action points were either completed or included on the agenda.

2.3 **Matters arising, not separately identified**

There were no other matters arising.

3 ASSOCIATE MEDICAL DIRECTOR'S REPORT

3.1 **Developments In ODT**

J Forsythe expressed thanks to the Kidney Advisory Group for their input to the ODT microsite change. Changes are still taking place but the new website is currently being tested. The aim of the newly designed website is to be more user friendly, making information easier to find. A password protected area will be incorporated to improve communication and to identify and provide a quicker response to incidents. This part of the website has been approved, however it will not be up and running immediately. J Forsythe confirmed individual ODT departments will be responsible for their sections to keep information relevant.

Actions for the Length of Donation workshop have been taken forward. J Forsythe will keep the Advisory Groups updated on progress made.

S Fuggle and M Roberts have completed their donor characterisation review and a final paper has been discussed at the NHSBT board meeting where recommendations have been agreed. ODT and NHSBT to meet with NHS England, Scotland and Wales, to identify funding for this. J Gulliver advised a meeting is scheduled for the end of June.

The financial impact of donor characterisation was raised and J Gulliver advised this will be discussed at the meeting taking place end of June. G Jones expressed problems with funding within donor characterisation. J Forsythe confirmed NHSBT are aware of this and this has been discussed with other commissioners across the UK.

3.2 GOVERNANCE ISSUES

3.2.1 Non-Compliance with Allocation

There were no instances of non-compliance with allocation to report.
J Forsythe acknowledged that during recent IT difficulties across the country, the Royal Free and Guys' transplant centres offered their services to enable transplants to go ahead where this was not possible at The Royal London.

3.2.2 Incidents for review: KAG Clinical Governance Report – KAG(17)2a

A Governance Report received from J Dark identified pathology testing of worrisome lesions, with several examples in the preceding two month period. J Forsythe confirmed this is a particular issue within Liver which NHS England are aware of. This is also an issue in Scotland where pathology representatives input has been required.

Concerns were raised regarding pathology testing on frozen sections in Scotland. J Forsythe highlighted it is important to have pathologists available, however the advice would be given remotely or in the lab and is dependent on the severity of the case. L Marson to liaise with R Cacciola and confirm how common such biopsies were in his previous audit.

3.2.2 Summary of CUSUM monitoring of outcomes following kidney transplantation - KAG(17)2b

A CUSUM summary was produced showing that over the last five month period since the last Kidney Advisory Group meeting, there have been 12 CUSUM signals in kidney transplantation; 11 signals in the CUSUM monitoring of 30 day graft failure and one signal from 30 day deaths were identified. An investigation is outstanding for 2 signals at one of the centres; investigations into the other signals identified no underlying problems.

All centres are asked to complete an internal review of cases which have led to a trigger in CUSUM and report back to J Forsythe; if the response is unclear centres may be encouraged to invite external experts to attend internal MDT reviews of each case. A template of the letter and data required to be covered in responding to CUSUM triggers was included for information.

3.3 Hub update presentation

In John Asher's absence C Watson informed members of progress with the liver allocation implementation, scheduled for the end of 2017.

3.4 Recipient-specific matching criteria –KAG(17)3

A paper was received highlighting, as part of the ODT Hub development, opportunities to add data to patient waiting list entries. There were 2 opportunities that this offered:

1. Recipient matching criteria could be specified, reducing the number of inappropriate offers. Members thought this would be beneficial and supported this. It was noted that these codes would be dynamic, and centres would need to be sure to update any changes in preferences/suitability. Members were asked to pass any specific ideas onto J Asher.
2. Centre-specific matching codes, whereby each centre could have a unique set of codes for particular criteria, such as suitability for dual or en bloc kidneys, were discussed; the group also supported this idea. Again members were asked to send any other ideas to J Asher.

3.5 **Update on consent rates for patient data held within ODT –KAG(17)4**
All patients should be asked to consent to their data being held at ODT. Analysis showed 3 centres currently outside of the funnel plot, The Royal London, Manchester and Newcastle, with a below average return of consent information. L Mumford expressed the importance of the data being reported.

K Preston asked if there has been an investigation as to why the 3 centres consent rates are lower. Centres confirmed there has recently been a big drive to improve this. G Jones requested L Mumford let him know if this data has improved. **L Mumford**

3.6 **Proposal for letter to centres on offer declines for high priority patients – KAG(17)5**
Following a review of the current kidney allocation scheme, it was noted that a large number of kidney offers to long waiting and highly sensitised patients were being declined, and those kidneys went on to be transplanted. Centres involved may have good reasons to decline, however KAG agreed that a letter should be written asking for an explanation why the organ was declined in such circumstances.

N Inston, representing Birmingham which has one of the highest decline rates, expressed his approval for this proposal. Members suggested that some of the declines were as a result of the recipient not being available or refusal from recipient.

Discussion took place around data held in centres and the need for improving management of waiting lists to avoid a large number of recipients being unfit to receive an organ offered.

S Fuggle confirmed a current system is in place to look at positive cross-matches as a reason for organ declines and suggested the 2 systems should be linked together.

J Gulliver believed that often patients are not involved in the quality of organ they should accept. J Forsythe agreed and confirmed this will be discussed at the Patient Group meetings. There is currently a pilot scheme being undertaken where patients are involved in each decision made. There have been pros and cons from this which will be taken forward. T Brown suggested this might link into J Asher's work in patient specific matching criteria.

L Marson advised that a risk and consent discussion workshop is in the process of being arranged. If anyone is interested in this workshop they should let L Marson or J Forsythe know.

4 UTILISATION STRATEGY –KAG(17)6
The Utilisation Strategy has been presented at the BTS and been delivered to the NHSBT board.

C Callaghan was thanked for the consultation with this document. J Forsythe has asked for the group's support in taking the decisions made forward.

5 SCIENTIFIC ADVISOR'S REPORT

5.1 **HLA Donor discrepancy follow-up –KAG(17)7a**
S Fuggle confirmed the level of discrepancy in HLA typing is low.
Pre-allocation checks within the Duty Office reveal a discrepancy rate of 0.4%; these usually relate to clerical errors.

Discrepancies identified after the organs have been allocated occur in 0.5% of cases and are usually technical rather than transcription errors. There were 2 errors which impacted on patients: in one case the patient was transplanted against a low level antibody and in the second, there was a change to the mismatch grade at the HLA-B locus.

This information will be circulated to centres and included in the Medical Directors bulletin.

The question was asked how laboratories were monitored to detect those with a higher rate of discrepancies. S Fuggle confirmed it is monitored and as the numbers are low, it is easily identified. The data are not suited to CUSUM type monitoring, however all discrepancies are taken very seriously. The group agreed that end to end electronic reporting should be considered essential to prevent clerical errors.

5.2 **Minimum Resolution For Reporting Donor And Recipient HLA Types -KAG(17)8a**

A minimum resolution for reporting donor and patient HLA types was introduced to coincide with the implementation of the 2006 National Kidney Allocation Scheme **(Table 1)**.

Units achieved high levels of compliance. Overall compliance for the period April 2016- March 2017 was 99.8% for deceased donor HLA types, 100% for living donor HLA types and 98% for recipient HLA types.

6 ALLOCATION

6.1 **DCD Kidney Allocation Scheme Update –KAG(17)9**

A 2 year and 8 months review of the DCD Kidney Allocation Scheme was presented.

On 1st September 2016 the age range for offering the second kidney regionally increased from 5- 54 years to 5-59 years. This is planned to increase to 5-64 years on 1st September 2017.

C Callaghan highlighted the implications of reallocation in centres. In DBD allocation there is currently an 8% rate of reallocation, therefore this should be similar in DCD allocation.

The group agreed it may be necessary to look at rewording the current DCD scheme to reduce reallocation rates.

C Watson suggested highlighting and publishing reallocation rates of organs.

Post meeting note: the rates of reallocation presented in the paper were not accurate for some centres; accurate data will be presented at a future meeting given the importance of this metric's accuracy. **L Mumford**

6.2 **Kidney Screening Update**

Kidney screening is undertaken by Cardiff, Cambridge, Leeds and Guys. Representatives attended a workshop recently to identify problems and achieve consistency across the UK.

The workshop produced the following actions:

1. SNOD education –adding more clinical understanding in training and rephrasing of questions which are asked will provide more clarity.

2. In order to reduce the amount of "reassurance" screening calls, it was resolved to ask SNODs to contact a team manager first before contacting a centre.

This process will be monitored for 6 months and will be reviewed to ensure an improvement is made.

A new form was issued in April, which will help capture more vital information.

There was discussion as to whether it was beneficial to know why a local centre has deemed the kidney as unsuitable, or whether not knowing allowed an unbiased appraisal.

6.3 **Group 2 Patients On The Kidney Transplant Waiting List –KAG(17)10**

A paper was delivered regarding a fast-track kidney being transplanted into a NHS Group 2 patient. Group 2 patients include:

A. Persons ordinarily resident outside of the UK who do not qualify for NHS treatment under the NHS Act
B. Persons not entitled under reciprocal health agreements to medical treatment in the UK
C. Persons not entitled under bilateral reciprocal health agreements

J Gulliver felt it would be necessary to request legal advice, as a NHS Group 2 patient is not eligible for NHS care.

Members felt this could result in Group 2 patients abusing the fast track scheme, the aim of which is to place declined kidneys into Group 1 patients whenever possible. The suggestion was made to consider the wording of the fast track scheme and to ensure principles are adhered to.

J Forsythe confirmed this is something that is happening across all organs however is more frequent in kidney transplants due to the amount of kidneys offered.

Actions agreed were to consider further how we integrate Group 2 patients and provide oversight. C Watson confirmed a decision will be made for the next meeting. **C Watson**

Post meeting note: There were 12 Group 2 patients on the National waiting list, 1 at St Georges, 2 at WLRTC, and 11 at the Royal London. All three centres confirmed that these patients are asylum seekers whose immigration status is the subject of appeal, and who have been listed to accumulate waiting points subject to them being eligible to join the list as Group 1 ("NHS entitled") patients.

6.4 **Neonatal Kidney Offering Group Update –KAG(17)11**

A report was received from K Preston. C Watson expressed thanks to Mrs Preston and everyone who contributed to the report.

The group defined very small donor kidneys as those from donors aged 1 year and 364 days or less. Kidneys from donors 2 to 5 would be allocated en bloc as per current practice. They recommended that just two centres perform transplants with these very small donor kidneys, namely Guys and St James, Leeds. The reasons are summarised in the report. They recommended that the centres:

- Develop an offering sequence for such kidneys;
- collaborate in developing criteria for selecting appropriate recipients;
- develop a programme of learning and training within centres to ensure that it is the centre with the expertise, and not an individual;
- meet with neonatal units (& SNODs and CLODs) to agree guidelines for referral
- present an audit of progress and outcomes at KAG in 12 months

In addition the group recommended that the expertise in retrieving these kidneys should be developed, and that retrieval teams should communicate with the accepting centre.

K Preston concluded, as this report is recommendations only, they are not a final or fixed solution, and accordingly considered that the position should be reviewed after 12 months of implementation.

The report was welcomed unanimously.

J Gulliver advised that he had received procurement advice regarding this paper. As this paper was in effect selecting centres to provide a service, NHS England's requirement is to ensure a process of selection is compliant with legislation therefore NHS England would have to write to all centres across the UK to express interest in undertaking this activity. Each centre which expressed interest would have to demonstrate how they would fit the programme.

J Forsythe expressed concern regarding the time this has taken, as donation of these organs is already happening, therefore as a professional group they should be able to advise in the use of neonatal kidneys. C Watson stated there have been a large number of declined neonatal kidneys, therefore before operational issues are confirmed the 2 centres should proceed as outlined. C Callaghan and N Ahmed to liaise with R Ploeg to discuss specialised retrieval teams for neonatal kidneys.

C Callaghan/ N Ahmed/ R Ploeg

6.5 **Centre Preference For Right And Left Kidneys –KAG(17)12**

A small working group was created at the previous Kidney Advisory Group meeting to discuss centre preference for right and left kidneys.

The group proposed that the preferred left kidney should go to the highest ranking patient; members approved the recommendation.

The working group also recommended that if only one kidney was available, then it should go to a paediatric patient, long waiting patient, or highly sensitised patient, before being offered for combined transplant with lung, heart, intestine, liver, or pancreas, in that order. Only the centre which is allocated the left kidney for a child, long waiting patient or highly sensitised patient could request the right kidney instead of the left, based on anatomy, damage, pathology or perfusion quality.

L Mumford will liaise with the Duty Office to implement the changes. **L Mumford**

G Jones asked what the risk is of a kidney arriving at a centre and the anatomy is not appropriate. It was noted that the centre is advised of the anatomy once it is known.

6.6 **Sequential Heart And Kidney Transplantation And Priority –KAG(17)13**

The Kidney Advisory Group was approached to discuss a specific case regarding a patient needing a heart and kidney in which the proposal was to carry these out sequentially. KAG was asked to allow prioritisation of the patient for a kidney; the patient concerned had APKD and had already been on the list for 3 years. It was noted that there was disagreement in the UK cardiac centres, with some preferring combined procedures and others sequential transplants.

Members agreed this case could be listed as a sequential transplant, with priority of 5 years' worth of points for a subsequent kidney. Members stated that this should not set a precedent for any heart patient requiring a kidney.

6.7 **Transplanting Blood Group Incompatible Kidneys –KAG(17)14**

On behalf of KAG, Nizam Mamode considered whether utilisation of A2 deceased donor kidneys would be worthwhile in the UK, following recent reports on this approach in the US.

L Mumford is currently modelling the effect in both within the deceased donor allocation scheme, and the NKSS.

Members considered the report and agreed that this approach should be explored further.

Post meeting note: Prof Mamode has agreed to set up a group to look at this further on behalf of KAG.

7 UPDATE FROM NEW KIDNEY OFFERING SCHEME MEETING HELD ON 18th May 2017 –KAG(17)15

L Mumford thanked everyone who has taken part in the Kidney Offering Scheme.
L Mumford talked through the 5 simulations and advised there is a further meeting scheduled in July, after which future meetings will be open to include more representation.

8 PITHIA TRIAL

G Pettigrew presented an update on the PITHIA trial which will look to demonstrate the value of pre-implantation histopathology in increasing number and quality of transplants.

Biopsies taken will be processed at the closest centre and the result will be available in 4-5hours; discussion with an on-call pathologist will be available.

Members asked whether consent is required from each patient for the biopsy to take place on retrieval of the organ, however it is anticipated this is not required and would be incorporated into QUOD. The aim would be that the biopsy would be requested by the recipient centre to inform their decision as to whether or not to use the kidney.

G Pettigrew would be visiting each centre to advise that this trial will be taking place and to incorporate a learning process within the teams.

The trial launch event will take place on 3rd October 2017 which all centres are encouraged to attend.

9 **STATISTICS AND CLINICAL STUDIES UPDATE –KAG(17)16**

L Mumford presented the Statistics and Clinical Studies Update.

The Annual Activity report for 2016/17 is in progress and will be published in the summer.

Professor Dave Collett will be retiring the end of June 2017. Rachel Johnson will succeed him in his position.

9.1 **Transplant Centre Dashboards –KAG(17)17**

The Transplant Centre Dashboard reports have been produced to provide more accessible information regarding organ donation and transplantation for the public. Examples of data presentation were given. It was noted that the revised dashboard will not include any more information that is currently available to patients.

C Callaghan queried if a traffic light system will be used as the 'red' may indicate something negative to a patient.

J Gulliver stated he felt involvement of the renal CRG and NHS England in developing transplant centre dashboards could be beneficial.

Any comments regarding the dashboard proposal, please forward them to L Mumford.

10 LIVING DONATION

10.1 **Outcomes And Actions From Shared Learning Events -KAG(17)18**

L Burnapp thanked centres for engaging in the shared learning events. All but one transplant centre has been visited; many with their referring units but some nephrology units were visited individually on request.

The aim of these visits was to make use of generic shared learning and to take this forward across the UK. Three recommendations were presented to KAG for agreement and will be taken forward through the LDKT 2020 Strategy implementation group:

The visits identified that where a lead nephrologist has been involved in living donation it has proved extremely effective, therefore with the support of the BTS and Renal Association, each transplant unit and referral unit will receive a letter requesting the identification of a lead nephrologist. The aim is to create a network of living donation champions to work alongside existing surgical and living donor co-ordinator leads.

KAG agreed to publish PMP living donation rates by transplant centre and individual referring units. To do this L Mumford has contacted the Renal Registry. The transplant centre data will be available later this year and the referring unit data in 2018.

The inclusion of all non-directed altruistic kidney donors into the quarterly matching runs (see 10.2.2).

10.2 **UK Living Kidney Sharing Schemes**

At the last KAG it was agreed that patients who had previously donated a kidney would be prioritised on the deceased donor waiting list if they ever required a kidney in the future. There have been two patients who have subsequently been prioritised through this scheme.

10.2.1 **Update On Non-Simultaneous Surgery**

L Burnapp agreed to provide an update on the impact of non-simultaneous surgery at the Kidney Advisory Group meetings. There have been no missed transplant opportunities since the last KAG as a result of non-simultaneous surgery.

L Burnapp asked members of the meeting whether they would approve a paired/pooled donor at the end of an altruistic donor chain to defer to the next matching run to create a new donor chain. L Burnapp had sought advice from the BTS Ethics committee, who suggested more modelling should be completed to identify potential risks. Given the experience in the USA and the low risk of donors not proceeding in non-simultaneous operations in the UK schemes, KAG were supportive. Practicalities will need to be addressed and this will be taken forward by L Burnapp.

10.2.2 **Utilisation Of Altruistic Donors In The Kidney Sharing Scheme – KAG(17)19**

Since the introduction of short altruistic donor chains into the kidney sharing scheme, non-directed altruistic donors have been offered a choice to 'opt-in' to an altruistic donor chain or to donate to a single recipient on the national transplant waiting list.

In order to achieve the most transplants from a single altruistic donor, members agreed that NDADs should, by default, be included in the UKLKSS, provided there is no recipient of higher priority on the national transplant list. The proposal will start in January 2018.

There will be a workshop on 6th October 2017 regarding the UK Living Kidney Sharing Schemes to inform developments and improve effectiveness. Representatives of all transplant centres and referring units are encouraged to attend.

11 KAG PAEDIATRIC SUB-GROUP

11.1 **Report from KAG Paediatric Sub-Group: 26th April 2017 -KAG(17)20**

S Marks produced feedback from the KAG Paediatric Sub-Group meeting held on 26th April.

The ATTOM project that recently took place within adult units has been replicated for the paediatric units and is called ATTOMIC.

A National Consent form has been created and is currently being trialled. S Marks will be approaching J Forsythe to request if the NHSBT logo can be incorporated on this document.

12 PANCREAS ADVISORY GROUP

12.1 **Report from Pancreas Advisory Group: 5th April 2017**

At the last Pancreas Advisory Group meeting, discussion took place regarding dual listing. A patient listed as SPK since 2012 and 99% sensitised had 2 offers of an organ since 2012, however on both occasions the organ was not suitable therefore resulted in a decline.

C Jansen had asked if this patient would have received a kidney during this time if dual listed. The result produced 14 kidneys which would have matched, however only 1 kidney would have been allocated by the National Allocation Scheme; this was an 80 year old donor.

J Casey asked for the Kidney Advisory Groups thoughts regarding dual listing. L Mumford confirmed the IT systems in NHSBT do not allow dual listing.

C Watson suggested this may be possible in the new offering scheme though criteria would need to be agreed.

J Casey and S Fuggle to review the cut off for highly sensitised patients. **J Casey/ S Fuggle**

13 ANY OTHER BUSINESS

13.1 **Management Of Positive Candida Cultures In Renal Transplant Perfusion Fluid –KAG(17)21**

There has been an increase in reports of a number of positive micro-organisms in renal transplant perfusion fluid. Candida species have been reported in TPF for Newcastle recipients in 8 out of 108 cases.

NHSBT are monitoring TPF culture result however Newcastle upon Tyne hospitals would like to survey UK renal transplant units to establish current practice with a brief questionnaire. KAG agreed to the Newcastle on Tyne proposal to take this forward.

C Watson recounted J Dark's report that NHSBT had reports from October 2016 to March 17 of 47 cultures with 15 positive for candida and one for aspergillus.

A survey of microbiologists across the country is planned to look into practices across the country.

13.2 **Reallocating kidneys after a positive cross match**

P Gibbs asked the Duty Office, if a kidney offer which has been accepted for a highly sensitised patient turns out to be a positive cross match, is there the possibility of a backup, as they are currently advised this is not the case. L Mumford confirmed that if the kidney has not been shipped then the kidney has been offered in sequence on the matching run but agreed to analyse data regarding a positive cross match and how often this happens where the kidney has already been shipped.

13.3 **Disseminating news from KAG**

Members agreed a large amount of decisions are made at KAG and are not disseminated. L Burnapp suggested a key decisions document is created and distributed via the Medical Director's distribution list to all transplant centres; J Gulliver suggested also sending it to referral centres. (Clinical Leads, Directors and including H&I). **C Watson/ Clinical & Support Services**

It was also suggested that it would be beneficial for the paired centres to receive the advisory group papers to enable them to raise items to their KAG representative.

14 Date of Next Meeting:

PLEASE NOTE: Thursday 14th December 2017 has been cancelled.
NEW DATE: Thursday 30th November 2017, ODT, Stoke Gifford, Bristol.

15 FOR INFORMATION ONLY

15.1 **Transplant Activity Report -KAG(17)22**

Noted for information.

15.2 **Review Of Long Waiting Patients – KAG(17)23**
Noted for information.

15.3 **QUOD KAG report –KAG(17)24**
Noted for information.

15.4 **QUOD KAG Application tracking –KAG(17)25**
Noted for information.

Organ Donation & Transplantation Directorate **JUNE 2017**