Approved 27.11.18 **KAG(M)(18)1(AM2)**

NHS BLOOD AND TRANSPLANT

MINUTES OF THE THIRTY THIRD MEETING OF THE KIDNEY ADVISORY GROUP HELD AT 10.30 A.M. ON THURSDAY 7th JUNE 2018 12 BLOOMSBURY SQUARE, LONDON

PRESENT:

Prof Christopher Watson	**Chair**
Mr Titus Augustine	Representative for Liverpool & Manchester
Mr John Asher	Medical Health Informatics Lead & Representative for Glasgow & Edinburgh (deputy)
Dr Alison Brown	Representative for Leeds and Newcastle
Mr Atul Bagul	Representative for Leicester and Nottingham
Mr Simon Boyes	Representative for Cambridge & Sheffield
Mr Tim Brown	Northern Ireland Representative
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 Frank Dor	Representative for Oxford and WLRTC
Miss Anusha Edwards	Representative for Bristol & Cardiff
Prof John Forsythe	Associate Medical Director, ODT
Prof Susan Fuggle	Scientific Advisor, NHSBT
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 Guy's & St George's
Mr Ben Hume	Assistant Director TSS – NHSBT
Ms Maria Ibrahim	Clinical Research Fellow – NHSBT
Mr Nicholas Inston	Representative for Birmingham & Coventry
Ms Sally Johnson	Director of Organ Donation & Transplantation – NHSBT/ODT
Dr Gareth Jones	Representative for Royal Free & Royal London
Dr Stephen Marks	BAPN Representative & Chair – KAG Paediatric Sub Group
Dr Philip D Mason	Renal Association/Renal Registry Representative
Ms Lisa Mumford	Statistics & Clinical Studies, NHSBT
Ms Jacqueline Newby	TSS/Hub Operations
Mrs Kathleen Preston	Lay Member Representative
Dr Tracey Rees	BSHI Representative, Cardiff
Dr Matthew Robb	Statistic & Clinical Studies, NHSBT
Mr Imran Saif	Representative for Plymouth & Portsmouth
Mr Phil Walton	Specialist Nurse – Organ Donation Representative

VIA TELECONFERENCE:

Dr Richard Baker	Renal Clinical Reference Group

IN ATTENDANCE:

Miss Sam Tomkings	Clinical & Support Services, ODT

APOLOGIES:

Prof John Dark	National Clinical Lead for Governance, ODT
Ms Julia Mackisack	Lay Member Representative
Ms Lorna Marson	BTS Representative and Deputy Chair
Mrs Rachel Johnson	Assistant Director Statistics & Clinical Studies, NHSBT
Ms Laura Ramsay	Lead Nurse Recipient Co-ordination
Ms Angie Scales	Lead Nurse: Paediatric and Neonatal Donation and Transplantation, NHSBT

ACTION

1 **Declarations of interest in relation to the agenda – KAG(18)1**
There were no declarations of interest.

2 MINUTES OF THE MEETING HELD ON 30th NOVEMBER 2017– KAG(M)(17)2(Am)

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

2.2 **Action points – KAG(AP)(18)1**
All 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 provided an update on the current developments taking place.

S Fuggle is leading on the H&I and microbiological Donor Characterisation implementation and is progressing well. There are three work streams, one led by K Preston who is looking to establish a commissioning pathway. Keith Rigg is chairing the group that is developing a service specification which is almost complete and the first meeting has been held for the working group who are looking at the end to end electronic transfer of data.

In the last year, there have been 1574 donors and over 4000 deceased donor transplants. This has resulted in additional pressure on the system and on the retrieval teams. A meeting took place to discuss the additional pressure on the teams, and Keith Rigg has been asked to review the NORS service in light of the increase in demand. Various options to improve this will be taken forward and discussed further with retrieval teams and at the BTS meeting taking place in June.

G Jones added their team are considering updating their formal platform for tissue typing and would like to know if there will be any implications when the end to end transfer takes place. S Fuggle confirmed David Turner who is chairing the data transfer group is in contact with all the laboratories as the electronic transfer will have to be individualised for different systems.
G Jones will email S Fuggle to pass this query on.

3.2 GOVERNANCE ISSUES

3.2.1 **Non-Compliance with Allocation**
One non-compliance with allocation regarding a group 2 patient.

3.2.2 **Incidents for review: KAG Clinical Governance Report – KAG(18)2**
J Forsythe presented the Governance Report received from J Dark.

There have been several issues regarding damage at retrieval and late declines without new donor information. The report demonstrates the number of incidents being reported is rising.

Individual items were discussed, including ureter length and kidneys allocated for combined liver and kidney transplantation. With respect to the length of the ureter, members agreed that this would not normally be a reason to **ACTION**

decline a kidney, and that implementation of kidney imaging should help in this respect. With respect to combined liver and kidney transplants since the introduction of the new liver offering scheme, a follow up report on this is due at the next KAG.

C Callaghan highlighted there has been an increase of kidneys entering the kidney fast track scheme. However, it was agreed to defer analysis of the fast track scheme until after the new offering scheme is active. A project taking place is looking at the time the organ arrives at the centre and the time the centre reports that they do not want to transplant the kidney. Members agreed this is a worthwhile project.

3.2.3 **Summary of CUSUM monitoring of outcomes following kidney transplantation - KAG(18)3**

A CUSUM summary paper was received.

There has been one signal in kidney transplantation and an investigation has taken place at the centre concerned where no underlying issues were identified.

3.3 **Hub update**

J Newby gave an update on Hub Operations.

There has been an 11% increase of organs donated. There were 150 non-proceeding donations.

The national liver offering scheme went live on 20th March 2018 and there has been a substantial increase in Hub Operations activity. The data collated so far is encouraging and the scheme is running successfully.

Hub Operations have seen an increase in workload and despite this they have successfully introduced change and maintained high standards in organ allocation; and they have done this with only a 50% increase in front line staffing.

The new kidney offering scheme will be starting development this year.

A digital organ offering scheme will be built into the Hub this year which will be able to streamline offers and improve the monitor of timings. Additionally, when a centre declines an offer, the scheme will automatically remove offers to that centre.

4 Transplant Centre Profiles – KAG(18)4

NHSBT are keen to introduce information on Organ Donation and Transplantation that is more accessible to the public. An infographic had been produced and the comments from KAG members were sought.

The following suggestions were raised;

- Listing the number of transplants per centre is not particularly useful, rather it may be more beneficial to list the number per million population.

- It would be beneficial to include text providing information to explain the average waiting time and the difference in the demographics in the population that effect this. L Mumford advised that inclusion of risk adjusted waiting times had been considered.

ACTION

- Risk adjusted 1 and 5 year survival figures were discussed and it was agreed that text explaining whether a centre was in line with the national average, or outside it, would be included. **L Mumford**
- It was suggested that each centre be identified in the bar charts depicting performance for deceased donor kidney transplants, however due to the large number of centres involved, this was not possible in the infographics.
- A request was made for units transplanting a small number of living donors to be recorded on the transplant centre profile as an overall contributor to the living donor pool. **L Mumford**
- It was suggested to differentiate Ireland and UK on the centre profile map – the map showed the British Isles, not just the UK as labelled. **L Mumford**

5 Update from short-term working group on deceased donor kidney transplantation in Group 2 patients – KAG(18)5

A report was received updating members on the current progress of a short term working group set up to examine the issue of Group 2 patients on the deceased donor kidney transplant waiting list and how they are managed.

The interpretation of the guidance with respect to who is a Group 2 patient varies widely between transplanting centres, therefore clarity was sought from NHS Commissioners for guidance on this.

The working group considered the recommendations from the Elisabeth Buggins' third report which suggests any organ retrieved within the NHS should not be transplanted to a non NHS entitled patient. The working group agreed with the statement and this was also supported by members of KAG.

S Johnson advised the section in the Buggins' report regarding transplanting private patients had not been adopted by the government.

Further clarity is required for application of the ordinary residence guidance to access transplant. J Gulliver agreed to liaise with the Departments of Health concerning this and will update KAG on any progress made. **J Gulliver**

The definition of a group 2 patient will need to be advised by the Departments of Health.

L Burnapp suggested considering eligibility of living donor transplants for asylum seekers.

Going forward, KAG agreed for the working group to review the document and incorporate the comments and identify the clarity required. This document will be circulated to the Advisory Groups and then presented to the Departments of Health.

6 Scientific Advisor's report

6.1 HLA Donor discrepancy follow-up – **KAG(18)6a & KAG(18)6b**

Members noted the summary report of Donor discrepancy monitoring.

The overall discrepancy rate was 0.8% in kidneys offered through the allocation system. There were two discrepancies that impacted on the

patients. One patient was transplanted against a low level HLA-Cw DSA (crossmatch negative) and in the other case incorrect allocation occurred and a patient was not offered the kidney because it was incorrectly thought to express of a registered unacceptable HLA. J Forsythe confirmed NHSBT ensured the two incidents were acted upon.

ACTION

6.2 Minimum Resolution for reporting donor and recipient HLA types – **KAG(18)7a & KAG(18)7b**

High levels of compliance are achieved. Overall compliance for the period January 2017- December 2017 was 100% for deceased donor HLA types, 100% for living donor HLA types and 98% for recipient HLA types.

7 Positive virology and HLA typing

P Walton highlighted the increase in out of hour calls to the regional managers, requesting permission to fast track a set of kidneys without HLA type where there was positive virology of the donor.

J Newby added the Hub Operations wait for the HLA results if the kidney has a positive virology as centres would require the HLA before confirming a match. Waiting for the HLA results generates a delay.

C Watson asked if this can be discussed at the next meeting with data to quantify how often positive virology kidneys are offered and accepted and the details of the positive virology. **P Walton / L Mumford**

8 Kidney Offering Scheme – KAG(18)8

L Mumford provided an update on the new kidney offering scheme and asked members to consider all the information provided for final sign off.

After a lengthy consultation period and wide presentation at BTS, RTSM and through KAG, a final email was circulated for consultation on the scheme which closed on 31st May.

There were seven responses received, two concerning local allocation but with different opinions. One suggestion would like local allocation removed and the other suggestion was to add extra points to ensure it happened. In the current and new scheme, some points are allocated for local allocation of a DCD donor kidney. For DBD donors, there will be no additional points added but there will be additional points for use within one of the four regions.

L Mumford clarified that kidneys from D4 donors over 70 would be offered as a pair to the centre at the top of the matching run. Centres can use the kidneys as a dual transplant or use one and allow another centre to use the other kidney via the offering scheme. Highly sensitised patients will still have access to dual kidneys if the centre requests.

J Asher asked if a patient with a CRF of 85-99% could potentially be disadvantaged compared with the current scheme where they are prioritised. L Mumford confirmed that any patient with a difficult matchability such as this will receive extra points in the new scheme.

It was queried the number of points centres will receive for DCD donors in London. L Mumford confirmed a weighting is applied to DCD donors within London to keep them within London, as it is to donors in the other 3 regions to reduce out of region travel time.

A Edwards requested clarification for patients who receive a transplant but have it removed from a possible malignancy found in the donor. C Watson

advised the level of prioritisation in the current scheme for those patients hasn't been looked at in the new scheme at present, but it would mirror current arrangements as closely as possible.

The possibility of inadvertently sensitising paediatric patients for a future transplant with the current scheme was raised. L Mumford advised centres continue to have the option to register patients with a minimum mismatch grade. S Fuggle added the new scheme is designed to open access to transplant and centres should begin to consider tailoring their criteria for their individual patients. **ACTION**

J Forsythe concluded the next steps for this scheme is for this to be reviewed by the Transplant Policy Review Committee who is a sub group of the board and will also be presented to the Kidney Patient Group in July.

9 Statistics and Clinical Studies update – KAG(18)9

The annual activity report is in process which will include the record breaking number for donors and transplants. There will also be new and updated annual organ specific report available in August.

10 Renal Unit Report – KAG(18)10a & KAG(18)10b

A deceased donor and living donor kidney transplant report are produced annually. KAG is asked if they will support a renal annual unit report using information provided by the UK Renal Registry postcode mapping process of allocating patients to renal units.

The majority of location data which will be included in this report will be sourced from the data recorded for each patient at the renal registry. If this data is not available, the postcode data will be used.

J Asher felt the bar chart was difficult to interpret due to the number of bars. The feedback received from the living donor 2020 strategy was it would be more beneficial to order the bars as the referring unit linked with the transplant unit.

The suggestion was made to include some additional text advising the demographics which will affect the figures. **L Mumford**

11 Risk adjusted waiting time – KAG(18)11

A paper was received showing the risk adjusted waiting times. Included in the centre specific report is unadjusted median time to kidney transplantation and this paper looks at the risk adjusted median time to kidney transplantation which could be incorporated into future centre specific reports. M Robb added this report does not consider donor factors and some recipient factors although the allocation scheme does.

It was acknowledged the "unknown" ethic group should be included. **M Robb**

This analysis will be included in July's centre specific report.

12 Update on pilot kidney imaging at retrieval

C Callaghan updated KAG with the progress made on kidney imaging at retrieval to help improve utilisation.

Centres will receive a letter informing them of the national pilot which will begin in July where SNODs will take three images of the kidney if the organ meets certain criteria.

Hub Operations will inform centres that there are pictures available at the time of the anatomy being taken. The pictures will be emailed to the accepting centre via nhs.net email address. C Callaghan reminded members

that all on call teams must have a nhs.net email address to obtain the images. There are plans to broaden the scheme to pancreas and possibly other organs. **ACTION**

J Newby raised a concern on behalf of Hub Operations that SNODs will initially take images of the agreed criteria, however the number of images will increase to every kidney retrieved. C Callaghan advised the process will only take place if the kidney retrieved meets certain criteria.

T Brown advised Belfast does not have access to nhs.net email addresses. Further options will need to be considered for Belfast. An alternative would need to be identified. **C Callaghan**

Members agreed a trial image should take place and sent to each centre via nhs.net before the national pilot begins. **C Callaghan / Hub Operations**

13 Analysis of schemes to scrutinise offer declines – KAG(18)12

A report presented by C Callaghan described the purposes of the three schemes introduced to improve donation and transplantation practices, minimise offering times and increase organ utilisation. The schemes look at the following events:

i) Where an apparently ideal kidney has been discarded
ii) where an apparently ideal kidney was turned down for a named patient
iii) where a standard criteria kidney was turned down for a high priority patient (long waiter of highly sensitised) and where the kidney was subsequently used successfully in someone else.

Instances are followed up with a letter requesting more information from the centre. 15 such letters have been written to date and data were presented at KAG.

J Forsythe commented that there was a difference between a decline because of a medical problem or a decline because of a resource issue. The duty of candour to the patient when a centre turned down an ideal organ for resource issues was discussed.

Members were asked their thoughts regarding an ideal donor kidney being donated to a long waiting or highly sensitised patient. It was suggested the named patient and kidney could travel to a neighbouring unit where there was a reciprocal arrangement, in order to facilitate the transplant. It was acknowledged that this can be a stressful experience for the transplanting centre and recipient, and that there were additional issues such as availability of recipient records and investigations, and the H&I implications.

S Marks added the KAG Paediatric Sub Group produce a 3-year prospective audit. From the 2017 data, there were two children who didn't receive kidneys because of lack of surgeon availability and one unit didn't not have 24/7 surgeon cover. These issues will be discussed at the BTS transplant sustainability meeting.

A discussion took place regarding how to handle the issues raised by the three projects. It was agreed at the time of listing, patients could be asked if they would want to be made aware of every decline. This will be discussed further with the patient groups. **C Callaghan**

The non-utilisation for non-logistical reasons was raised at PAG. Although it may be a commissioning issue, it was suggested for the Chair of PAG/NHSBT to write to those centres. **ACTION**

C Watson requested C Callaghan lead a small working group to develop a list of principles and how NHSBT can assist centres with resource issues and to examine the duty of candour to the patients when they miss out on offers. **C Callaghan**

An analysis of CIT and graft survival of deceased donor kidney transplant was discussed, which showed longer tolerance of DBD kidneys to cold ischaemia than had previously been the case at the time of the analysis for the 2006 offering scheme.

J Asher suggested breaking down the figures by DRI.

J Gulliver highlighted the service standards state more than 90% compliant for CIT less than 12 hours for DCD and less than 18 hours for DBD kidneys. Commissioners have questioned why the CIT are not within that range.

It was suggested that M Ibrahim could produce a summary paper for circulation, including suggestions made during the meeting.

L Mumford observed that CIT has reduced over the last ten years which may have led to it showing no significant effect on transplant outcome.

14 Analysis of offering both kidneys from donors through the Kidney Fast Track Scheme – KAG(18)13

Oxford have suggested that KAG should consider altering the Kidney Fast Track Scheme (KFTS), so that if more than one centre wishes to accept such kidneys, one kidney each goes to the two centres with the highest ranked patients rather than both to one centre. This may help facilitate shorter cold ischaemic times.

It was agreed that there would be no changes to the KFTS at present, but that it would be reviewed in depth once the new offering scheme was live. It was noted that the centre at the top of the fast track offer can decline the second kidney. **L Mumford**

15 Developments in IT

15.1 Organ Quality (HTA) eforms update – **KAG(18)14**

A paper was received from J Asher on the organ quality (HTA) eforms.

An electronic replacement for the HTA-A and B forms will begin development. HTA-A form will be built within the donor path and will help streamline various forms and the collection of data.

The HTA-B form will be hosted within the CRM platform which is web based. The development of this will begin in July and will initially be rolled out to pancreas.

A version of the HTA-A form will be available for living donors through CRM.

If anyone requires further information, a document is available from J Asher.

15.2 SaBTO aide memoire – **KAG(18)15**
The SaBTO aide memoire has been written in draft form and it is intended to better support clinician's decisions of organ acceptance by providing a summary of SaBTO guidance. **ACTION**

J Asher requested members to visit the prototype at www.txtools.net/sabto/ and provide feedback on the user interface and how easy or difficult it is on the devices most likely to be used when receiving an organ offer. A link will shortly be circulated to KAG members with details of an online survey to send feedback. **All Members**

15.3 Recording of reasons for kidney non-use – **KAG(18)16**
Members noted a set of proposed reduced set of reasons for decline of kidney offers and additional reasons for non-use to replace the current long, non-specific, pick list available to ODT Hub Operations.

16 Reviewing kidney data collection:

- Forms

C Watson established a short term working group to review the kidney data collection forms and to harmonise the information NHSBT and the UK Renal Registry records. R Hilton agreed to chair the group. **R Hilton**

- Codes – **KAG(18)17**

Members received a paper providing information from the joint project which took place using data provided by NHSBT and UK Renal Registry on causes of allograft loss.

The data collected was from over 22,000 recipients transplanted between 2000 and 2013 and analysed the causes of graft failures. The outcome of this work will be available in the NDT paper. During this project, the NHSBT categories for cause of graft failure were looked at which highlighted the current categories not applicable and the free text entries were required. A new cause of graft failure categories has been developed and a new NHSBT coding system is therefore required.

Members agreed a short term working group should consider how to upgrade the current coding system. **R Hilton**

The request was made to consider removing surgical cause and describe the pathology. C Watson requested for hyperacute rejection to remain. **R Hilton**

17 Living Donation

17.1 UK Living Kidney Sharing Schemes: Update and impact of new developments – **KAG(18)18**
L Burnapp provided an update on the implementation of the actions from the UK Living Kidney Sharing Scheme (UKLSS) workshop held in October 2017 and a regular report to KAG on non-simultaneous surgery and recipient prioritisation for transplantation within the UKLKSS.

The number of non-directed donors donating direct into the National Transplant List rather than into the UKLKSS since January has been higher than anticipated because the new arrangements coincided with a change in prioritisation criteria on the deceased donor waiting list that gave newly registered patients additional points because of their time on dialysis. This

has therefore created a slight increase of long waiting patients and as a result, more non-directed donors have donated to single recipients on the NTL. This is anticipated to be a short-term matter.

Despite the changes in prioritisation criteria on the national transplant list, the transition to a new system has been successful and resulted in the highest proportion of non-directed altruistic donors donating into the UKLKSS since **ACTION**

the scheme began. April 2018 matching run was the largest pool size and the greatest number of transplants identified to date.

In summary, few donors have stated a preference to donate directly to the list since January, L Burnapp feels managing donor preferences from the outset is vital and using the designated weeks for surgery as a time frame for proceeding with donation rather than the time of the matching run helps to prevent any misunderstanding.

L Burnapp confirmed in the last six months there has been no requirement for recipient prioritisation to transplant.

At the last KAG, it was agreed all non-simultaneous surgery would be advised to the chair of KAG and those who exceed the 10 days/2 week criteria would be approved by the chair of KAG.

An exceptional case was also brought up for discussion. A short chain had been identified in the latest matching run and immediately after the chain had been identified, the daughter of a last paired donor was diagnosed with end stage kidney disease. From this chain, the donor's wife was due to receive a kidney. The request made from the centre was for the donor (husband/father) to be allowed to donate to his daughter should they be compatible rather than to the national waiting list. C Watson, L Burnapp and the HTA agreed that would be a reasonable request. The waiting list recipient had not been made aware that an organ might become available. C Watson asked KAG members if the waiting list recipient had been made aware, would this still have been the correct decision. Members agreed most people would understand if a donor had prioritised donating to their daughter and felt that would have been the correct decision.

F Dor enquired what the reasons are for alternative transplantation on the centre-specific analysis that was presented on non-proceeding transplants after transplants have been identified in the scheme. L Burnapp advised possible reasons include: the donor or recipient does not wish to proceed; an alternative donor has presented; donor and recipient decide to proceed with an antibody incompatible transplant instead.

Centres with a high non-proceeding rate of identified transplants are asked to consider the reasons why and actions that might be taken to reduce this.

17.2 Living donor policy – **KAG(18)19**
The living donor policy will be effective from July 2018.

18 KAG Paediatric Sub-Group

18.1 Report from KAG Paediatric Sub-Group: 25th April 2018– **KAG(18)20**
S Marks reported from the KAG Paediatric Sub Group meeting held on 25th April.

A study has commenced looking at the data regarding outcomes in smaller children compared to older children under 20kg.

L Mumford has agreed to analyse the numbers for re transplantation of DCD kidneys and poor outcomes. **ACTION**

A request was made from the lead for Nephrotic Syndrome cohort on RaDaR to consider linking RaDaR database with NHSBT database, to identify any

adult and paediatric patient with nephrotic syndrome who is on the waiting list in order to capture their data and biological samples at the time of transplant.

The national consent form for paediatrics has been developed.

S Marks will be stepping down as chair for KAG Paediatric Sub Group and Jan Dudley has been appointed as the new chair and will attend future KAG meetings.

18.2 Reasons for decline of organs for paediatric recipients – **KAG(18)21**
It was suggested at KAG PSG that the updated contraindications should be available on the internet and incorporate more up to date SaBTO guidelines.

KAG members agreed contraindications should be harmonised with SaBTO guidance and requires thorough review before being made available online.

19 Pancreas Advisory Group

19.1 Report from Pancreas Advisory Group: 11th April 2018 – KAG(18)22
J Casey provided an update from the Pancreas Advisory Group meeting held on 11th April 2018.

L Mumford presented the new kidney allocation scheme. Members of PAG agreed SPK/SIK patients should appear in Tier A and there should not be any age restriction in Tier A only. Members also agreed the option to accept just a kidney only would be available. Patients in the new Tier A will have waiting time from the start of dialysis

PAG has been asked to consider any changes to the pancreas allocation scheme, therefore a working group has been identified to consider the necessary changes. Claire Counter will produce various simulations from the suggestions made.

Another working group taking place within PAG have been considering ways to introduce video assessment of pancreases, although this is currently not feasible due to IT restrictions. PAG agreed to continue with the pilot of initially taking and sending pictures.

20 Hypothermia in DBD donation – KAG(18)23
In 2015 a clinical trial took place in USA which randomised 370 donors to being maintained either at 34-35°C, or 37°C. The aim was to maintain the randomised temperature for a minimum of 16 hours. The end point of the study was the incidence of delayed graft function in kidneys transplanted from those donors. The UK would like to conduct a follow up study to see whether a period of DBD donor hypothermia (34-35) can increase eGFR at 12 months, rather than simply reduce delayed graft function.

The proposed endpoint for this study is a difference of 8mls per minute in GFR. C Watson asked members if this is a difference that would be

beneficial or if a smaller or larger difference should be considered. The suggestion was made to consider percentage changes. The question was asked for future studies, would the study protocol preclude doing EVMP. C Watson advised it would be difficult to enrol kidneys into a second study if the donor already had an intervention.

ACTION

C Callaghan asked from the initial study, if there were any suggestion that the effects were greater in one sub group than the other. C Watson confirmed the effects were greater for extended criteria donors. This study will choose

the 10-15 hospitals with the greatest DBD donor activity. The Intensive Care units are supportive of this study.

Members agreed for this study to take place.

21 How should we manage positive cultures from renal transplant perfusion fluid? – KAG(18)24

A paper was received showing the learning outcomes from the Newcastle hospital regarding managing positive cultures.

A positive candid culture was identified which resulted in a kidney unable to be utilised. From this, Newcastle now prescribe 4 weeks of antifungals when Candida is isolated.

C Watson requested this is include as part of the AMD Cautionary Tales. **A Brown**
A Brown will email this to J Forsythe for inclusion.

22 Any Other Business

There were no further items of business.

23 Date of next Meeting:
Tuesday 27th November 2018, Stoke Gifford, Bristol

24 FOR INFORMATION ONLY

24.1 Transplant Activity report: February – KAG(18)25
Noted for information.

24.2 QUOD statistics 2018 – KAG(18)26
Noted for information.

21.3 NHSBT response to APPKG - Transplant Manifesto – KAG(18)27a & KAG(18)27b
Noted for information.