To be ratified **KAG(M)(19)2**

NHS BLOOD AND TRANSPLANT

MINUTES OF THE THIRTY SIXTH MEETING OF THE KIDNEY ADVISORY GROUP HELD AT 10.30A.M. ON THURSDAY 21st NOVEMBER 2019 12 BLOOMSBURY SQUARE, LONDON WC1A 2LP

PRESENT:

Prof. Christopher Watson	**Chair**
Mr John Asher	Medical Health Informatics Lead
Mr Atul Bagul	Representative for Leicester & Nottingham
Dr Richard Baker	National Clinical Lead Governance, ODT
Mr Adam Barlow	Representative for Leeds & Newcastle
Mr Stephen Bond	Recipient Co-ordinator Representative
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 Marc Clancy	Representative for Glasgow and Edinburgh
Ms Jo Chalker	SNOD Representative
Dr Aisling Courtney	Belfast Health and Social Care Trust (invited attendee)
Prof John Forsythe	Medical Director, ODT
Mr George Greenhall	NHSBT Clinical Research Fellow (observer)
Dr Sian Griffin	Representative for Cardiff & Bristol and BTS
Mr Jon Gulliver	NHS England (Specialist Commissioning) Representative
Dr Rachel Hilton	Representative for Guy's & St George's
Dr Gareth Jones	Representative for Royal Free & Royal London
Ms Julia Mackisack	Lay Member Representative
Dr Jennifer McCaughan	BSHI Representative
Dr Adam McLean	Representative for West London Renal Transplant Centre (WLRTC) and Oxford
Mr Steve Mellor	Birmingham & Coventry Representative (deputy)
Ms Katie Morley	Lead Nurse Recipient Coordinator
Ms Lisa Mumford	Statistics & Clinical Studies lead, NHSBT
Mr Ravi Pararajasingham	Representative for Sheffield and Cambridge
Mr Gavin Pettigrew	Principal investigator, PITHIA Trial
Prof. Rutger Ploeg	NHSBT Principal Investigator for QUOD
Dr Tracey Rees	Chief Scientific Officer – ODT
Dr Matthew Robb	Statistics & Clinical Studies, NHSBT
Mr Imran Saif	Representative for Plymouth and Portsmouth
Mr Michael Stokes	Head of ODT Hub Operations (deputy for Julie Whitney)
Mr David Van Dellen	Representative for Liverpool and Manchester

IN ATTENDANCE:

Ms Kathryn Brady	Recipient Coordinator (observer)
Ms Felicity May	Welsh Blood Service (observer)
Dr Rommel Ravanan	Incoming KAG chair (observer)
Miss Sam Tomkings	Clinical & Support Services, NHSBT

APOLOGIES:

Mr John Casey, Mr Ian Currie, Dr Jan Dudley, Ms Anusha Edwards, Prof. Nizam Mamode, Prof. Lorna Marson, Dr Phillip Mason, Mrs Kathleen Preston, Ms Angie Scales, Ms Clare Snelgrove, Mrs Julie Whitney

C Watson noted Mrs Preston's absence due to a recent illness and wished her a speedy recovery on behalf of the members.

1 Declarations of interest in relation to the agenda – KAG(19)2 **ACTION**

There were no declarations of interest.

2 Minutes of the meeting held on 10th June 2019– KAG(M)(19)1

2.1 Accuracy

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

2.2 Action points – KAG(AP)(19)2

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

AP 2 – QUOD punch biopsy – a meeting took place subsequently after KAG, since then the size of the QUOD biopsies have reduced to 2mm and there has been only one incident of a biopsy taken from the wrong site.

AP 4 – Transplant Centre Profiles – A national version of a transplant centre profile as a summary infographic has been developed for each organ which is now published on the ODT website. A survey is also available for feedback regarding the profiles.

AP 6 – Review of infant donors < 2 years – Minimum and maximum age – A message will appear under the matching run for these offers to only be made to Guy's and Leeds. This will be trialled and reviewed after three months.

AP 8 – Provisional offering of pancreases from MVT blocs – A teleconference has been arranged to identify a clear process for receiving multi-visceral offers and an update will be presented next time. **C Callaghan/ L Mumford/ M Stokes/ M Robb**

AP 13 – Patients who died on the waiting list following deceased donor kidney offer decline – C Callaghan confirmed the data has been incorporated and the codes have been provided to Maria Ibrahim and the statistical team.

2.3 Matters arising, not separately identified

J Forsythe thanked C Watson for his work as KAG Chair and welcomed R Ravanan who be taking over as the Chair of KAG.

3 Medical Director's Report

3.1 Developments In ODT

J Forsythe provided an update on the current developments taking place within NHSBT.

3.2 Update from Risk and Consent Working Group

The Risk and Consent work is continuing, J Forsythe paid tribute to the work carried out across all organs and in particular to Matthew Welberry Smith. C Callaghan has been developing the patient information for the website.

The group is working with the Winton Centre to develop a version of the PREDICT tool which was initially going to be rolled out for lung transplantation, however some statistical issues have been identified, therefore it has been agreed to begin with a renal tool as the quality and quantity of data make this more straight forward.

3.3 Transplantation of kidneys from Hepatitis C positive donors

The funding for the antiviral treatment to enable Hepatitis C positive organs to be transplanted into Hepatitis C negative recipients has been secured across Wales, Scotland, Northern Ireland and England. J Forsythe reminded centres that the patient should be properly consented ahead of time and not on the night of the transplant. J Forsythe has written to centre directors informing **All Centres**

ACTION

them of the criteria required to accept such organ offers and if agreed, centres will begin to receive offers via the positive virology fast track scheme. **All Centres**
J Forsythe requested representatives feed this information back to their centres and centres they represent.

There have been 8 successful transplants preformed in Wales, one transplant developed renal vein thrombosis which resulted in the programme being suspended for a short period of time to investigate whether there was a link between HCV treatment or any other aspect of the programme. After investigation, it was agreed to reinstate the scheme as the complication was as a result of the transplant and not due to the treatment.

The need for an offering scheme for these kidneys was highlighted. Currently they will be offered via the "higher biological risk" offering system. Ultimately the aim is to include them into the national matching run once centres/recipients who can utilise the kidneys have been identified

3.4 Sustainability

There remain concerns over shortage of resource particularly since donor numbers have increased. This has manifested recently with one centre closing over two consecutive weekends.

A London collaborative meeting will take place on 4th December to identify how the community can support this situation. This is also being considered as part of the ODT strategy.

A successful Lung transplant summit took place which included commissioners and patients and from that various recommendations were made.

The process established for notifying patients when an organ has been declined on their behalf solely due to lack of resource is being rolled out in renal transplantation. When an offer decline is reported to be due to lack of resource NHSBT will ask centres to confirm this is correct and from that, a formal letter will be sent suggesting the patient should be made aware.

A Bagul highlighted an issue identified in Leicester is the lack of resource for cross match activity.

C Watson emphasised the predicted increase in donor numbers once presumed consent is in place and asked if NHS England are preparing for this. J Gulliver confirmed NHS England are consolidating feedback from English units on the potential impact. The projections from the Opt out process have been shared with commissioners in England with the expectation that the commissioners will discuss this with local units. J Gulliver advised that if a **All Centres**
conversation has not taken place with commissioners to raise this with J Gulliver or through the Chair of KAG. It was acknowledged there is variable connection from trusts to clinicians and trusts to specialised commissioners. J Forsythe encouraged members to speak to their operational managers and trusts to discuss future plans. J Gulliver advised that a Transplant Commissioners meeting will soon be taking place which will be a chance to ensure there is consistency regarding communication across England.

J Asher requested if there are any data shared from commissioners to NHSBT it would be beneficial for this to be shared to centres across Northern Ireland, Scotland and Wales.

ACTION

3.5 Waiting list status of EU nationals moving to the UK

Pending Brexit, there has been no new communication regarding the waiting list status of EU nationals and the advice is to continue to follow the current process for incorporating them onto the national waiting list.

3.6 Hub update

A contact and offering workshop was held to look at how offering and messages are delivered. The two key points identified for kidney were how to stop offering triggers within the organ offering process. It was proposed to stop offering an organ after three centres have declined it for the same reason. However, members felt the organ should continue to be offered to other centres.

The second point was when a NORS retrieval surgeon deems an organ untransplantable would members be happy for that organ to not be offered out. Members agreed there is variation in decision making and would not be in favour of a NORS retrieval surgeon making the decision that an organ is not transplantable.

3.7 ODT strategy update – KAG(19)30

Strategy events have taken place across the UK from which the use of novel technologies, coping with sustainability and commissioning were highlighted.

3.8 Membership of KAG – KAG(19)31

A paper was circulated on behalf of C Watson with the list of members who have reached the end of term as representation at KAG. C Watson thanked the members for their contributions to KAG and requested that an alternative lead from the paired centres is identified and notified to S Tomkings. **All Members**

4. Governance Issues

4.1 Non compliance with allocation

There were no non compliance with allocation.

4.2 Incidents for review: KAG Clinical Governance Report – KAG(19)32

R Baker presented the Clinical Governance Report.

R Baker drew attention to the incident where two recipients did not have crossmatches prior to transplantation due to a breakdown in communication. C Watson suggested that all recipients should have a written cross match report sent (emailed) from H&I to the transplanting surgeon before proceeding to transplantation. **R Baker**

Members discussed cases where kidneys are declined following withdrawal of treatment and prior to knife to skin. C Callaghan felt every opportunity to utilise these offers should be made and highlighted that the time from withdraw to perfusion has minimal impact on the outcome and feel these offers should go through the usual pathways. If the kidney has been offered to centres and the retrieval surgeon has not gone knife to skin, the offer would be made via the fast track scheme. The surgeon should continue to wait with a view to retrieving the kidneys. If the fast track scheme had run with only one acceptance, and that centre has since declined the offer, retrieval could stop.

Since the last meeting, the QUOD process has been refined and it has been agreed to rewrite the patient information booklet which will include figures regarding significant and small bleeds. Also required is that patients should be informed of the possibility of a biopsy at the point of consent within centres as

ACTION

some implanting surgeons do not inform recipients if a QUOD biopsy has been taken.

A discussion took place regarding ethics and whether every patient should be individually consented for QUOD biopsies It was acknowledged that if a patient does not want an organ biopsied this is potentially depriving the patient of a large number of offers. Members agreed it was useful when the ethical group UKDEC was available to support such decisions. R Baker requested that any further comments or suggestions regarding consent for QUOD biopsies are emailed to him. **All Centres**

4.3 Summary of CUSUM monitoring of outcomes following kidney transplantation – KAG(19)33

A request was made to KAG at the last meeting to consider not only monitoring CUSUMs against the centre's own outcomes, but to compare against the national outcomes which will be in place ahead of December CUSUMs.

Since the last meeting there have been 6 signals in kidney transplantation, 5 of them were due to graft failure in adult deceased transplantation and investigations have been undertaken with no underlying issues identified. One investigation at Liverpool is still outstanding.

4.4 New findings made at transplant centres requiring histopathology – KAG(19)34a & KAG(19)34b

Two papers were circulated including an SOP, a flow chart and a histology report to help standardise the way lesions are detected and recorded.
C Watson asked centres to review these forms and request that pathologists either use them, or make sure all the information recorded on the forms is on any written report. **All Centres**

C Watson reminded members of the urgency to obtain histology if a lesion is detected since there may be implications for other recipients.

5. Developments in IT

5.1 Organ Quality eForms update – KAG(19)35

The electronic form B has been very successful and 80% of people have been completing the electronic form. J Asher thanked colleagues who have been completing and returning the forms.

Funding for electronic A forms is still not available. J Asher requested members inform him if centres have concerns around the information they are not receiving because these forms are not available, since it would help support the request for funding of the forms. It was asked whether the length of time taken to complete the HTA A forms is recorded. J Asher advised that it is not but agreed that it would be good to record. **All**

5.2 Transplant activity heatmaps – KAG(19)36

J Asher presented transplant activity heatmaps developed to help demonstrate the level of activity using data from Glasgow.

J Asher informed members if they would like something similar for their centre to contact him and provide him with a set of data including a start time and finish time. J Forsythe encouraged members to consider this. **All**

6 Living Donation **ACTION**

6.1 UK Living Kidney Sharing Schemes: Update – KAG(19)37

A serious incident was discussed regarding the October matching run for the UK Living Kidney Sharing Scheme.

- The case was presented to the meeting in line with our previous discussions and the summary report. Prior to the meeting, L Burnapp had contacted all clinical leads in centres where recipients had either missed an offer of a transplant or had been inadvertently matched due to the error in the original October matching run. All were understanding and supportive and prepared to accept decision from KAG.
- KAG was asked to make a decision about whether the original (October) matching run or the simulated (November) run should stand as the final run.
- Additional detailed analysis provided by Statistics and Clinical Studies and information services was used to inform the discussion about the impact on different combinations of identified transplants in each run.
- It was agreed by a majority (10 in favour, 4 against) that the original October run should be allowed to proceed as planned. Clinical leads from centres where recipients had been affected and who were present at the meeting, participated but declared interest in the discussion. Influencing factors in the decision made included:
    - The lapse of time since the original October run, which meant that the configuration of identified transplants had already changed due to natural attrition (i.e. transplants that would be unable to proceed due to recipient/donor factors). These impacted on new combinations of transplants identified in the November run.
    - Information to date identified that two of the recipients who had missed out on a transplant offer would no longer be eligible to receive a possible match that had been identified for them in the November simulated run. These included the recipient who had originally been excluded from the October run and the patient who was most highly (99%) sensitised.
    - All donors and recipients identified in transplant combinations from the October run, including recipients who had been inadvertently matched due to the error, had all been notified and transplants had already been scheduled or were being coordinated.
    - Given all the above, KAG agreed that revoking/not proceeding with the original October run could cause considerable harm and disruption to patients. Members recognised that not replacing the original run with the November simulation meant that different recipients missed out on the offer of a transplant but felt that the potential benefit that may be gained did not outweigh the risk of harm to other donors and recipients in the original run- particularly those who would have a transplant offer retracted.
- Prioritisation for the recipients who missed out on a transplant in the October run was agreed. Each recipient will be offered:
    - Additional waiting time points for the next (January) matching run of the UKLKSS.
    - The option to be prioritised within their current Tier on the UK transplant list, or to be listed accordingly if not on the list, for either a living or deceased donor kidney until such time as they choose to accept an offer.
    - Prioritisation can be arranged by contacting Matthew Robb/Lisa Mumford in Statistics and Clinical Studies

ACTION

- All clinical leads have since been contacted by L Burnapp to inform them of the outcome of KAG. Letters of confirmation will follow from the Clinical Governance team in due course.

L Burnapp presented the UK Living Kidney Sharing Scheme Update.

An observation from the report suggests that short intervals between transplants through non-simultaneous/staggered chains facilitate more transplants by reducing the risk of non-proceeding transplants due to delay when simultaneous lists cannot be scheduled. L Burnapp reminded colleagues that it is important to manage expectations for potential recipients particularly for those at the end of the chain. C Watson asked that, if there is a staggered chain and the last recipient is suspended from the waiting list for a period of time and that chain falls down, is it checked whether they potentially would have received an offer during that time on the deceased donor waiting list. L Burnapp advised this is not checked as they are not universally suspended but that some centres have recently requested that their patients are not suspended from the waiting list when they have received the offer of a NDAD kidney. Members agreed that this was reasonable until up to 1 week before scheduled date of surgery when the recipient should then be suspended to allow centres time to reorganise an alternative offer to another recipient on the list if necessary. This will be kept under review by L Burnapp.

The level of activity has increased therefore the stipulation of designated weeks of surgery has been removed. Around a third of exchanges are scheduled beyond the 8 week standard that was previously set. A new timeline has been agreed with the aim to achieve as many transplants before the inclusion deadline in the next matching run.

L Burnapp encouraged members to counsel non-directed altruistic donors to help manage their expectations about timeframes and avoid requesting specific dates to help ease pressure on centres. L Burnapp also requested centres, via members of KAG, to help manage the challenges of scheduling transplants in the UKLKSS. The living donor coordinators bear much of the burden of this, which is reflected in some of the recent communications between centres. The support of the wider team would be appreciated whilst all centres are dealing with individual constraints.

A proposal was made to set up a short-term working group to identify ways to increase flexibility in the scheme. L Burnapp requested colleagues who would like to be involved to contact her, particularly colleagues who are involved in collaborative working. **All Members**

The question was asked in what practical terms would it mean for the UK scheme to be involved with other European schemes. L Burnapp, Rachel Johnson from NHSBT and M Robb are part of the European network for the collaboration of kidney exchange programmes, through which different models of collaboration between countries have been suggested. For the UK, this could mean accepting pairs into the scheme to benefit our patients and those from another country. We are currently looking at how this could translate into UK practice through the development of memorandums of understanding with interested countries.

L Burnapp asked whether units would find it useful to have standardised information for patients in the UKLKSS about what to expect in certain scenarios. Centres agreed this would be useful. **L Burnapp**

ACTION

6.2 Proposal to permit internal kidney sharing in exceptional circumstances – KAG(19)38

A proposing to permit a local kidney exchange in the exceptional circumstances was received after a recent case in Belfast when an identified match after an agreed date did not proceed and a better option was subsequently noted to be possible locally.

The proposal raised concerns that this could encourage centres to organise a in house scheme and that this could impact patients on the next matching run. C Callaghan felt this could have the potential to leave the clinical group in a difficult position to decide what is the better option for a patient. A Courtney reiterated this would only apply in exceptional circumstances when an identified exchange does not proceed, and a clear better option is identified.

T Rees suggested having an expert group to look at these offers when these circumstances arise and consider these as an exemption.

After a lengthy discussion, it was agreed that for cases like this that occur for circumstances not within the centre to be considered by L Burnapp and the Chair of KAG. This will be reported at every advisory group for review. **L Burnapp/ M Robb**

7. Allocation

7.1 Two month review of the Kidney Offering Scheme – KAG(19)39

L Mumford provided a two month review of the new kidney offering scheme which went live on 11th September 2019.

Since the introduction of the new scheme, three issues have been identified. The first issue was that the four satellite centres were mistakenly linked to Guy's Transplant Centre where one should have been linked to St George's Transplant Centre. This has been rectified and on investigation no patients were disadvantaged.

The second issue was the way the matchability was calculated which was identified and corrected and no disadvantage to patients was found.

The third issue identified was as slight error in the equation for the recipient risk score for under 25 year old patients. This has been resolved and on evaluation, no patients were found to be disadvantaged.

As a consequence of releasing the new scheme with the liver offering matching run an issue had been identified which is being resolved by the Liver Advisory Group.

There have been 361 transplants performed in the last two months, 92% of those were for DBD single kidney transplants and 94% were for DCD transplants. There has a been a slight increase in dual kidney transplants performed from DBD offering. There has been a slight decrease using kidneys for SPK transplants because more transplants are taking place for those patients in Tier A of the scheme.

It was noted that, as predicted, a higher proportion of DBD and DCD kidneys have been used outside the local region for recipients who were difficult to match or highly sensitised. This is expected to change within first six months to a year after which DBD kidneys will tend to be kept regionally.

The centre specific activity shows Edinburgh, Belfast and Bristol, for example, have noticed reduced transplant numbers in the first two months due to having

ACTION

either more of a white based population or less sensitised patients. The Royal Free and Birmingham have seen an increase in transplant numbers since they have more patients in Tier A due to their ethnic mix.

One patient under the age of 18 has been transplanted since the new scheme has been introduced and it is anticipated that the numbers of transplants will increase in time, since the early part of the new scheme is targeting highly sensitised patients.

L Mumford has put together a spreadsheet for difficult to match patients based on individual centres' waiting lists which can show how many matches that patient may receive at each level. If centres would like this to contact L Mumford. **All Centres**

Overall the scheme is working as anticipated, centres who have experienced lower activity should start to see this level out over the next six months.

G Jones raised on behalf of the H&I team the issues of HLA-DP in the conversion chart and trying to match molecular typing and the reporting of strings and how they would know if a patient is sensitised. The systems at NHSBT cannot accept strings for unacceptable antigens. L Mumford advised there is a DAT sheet for reporting deceased donor type and advice can be provided. G Jones requested this information to feedback to the team. **L Mumford**

7.2 Pre-emptive listing and waiting time – KAG(19)40

M Robb presented data on the effect of the change in the policy on waiting time points.

Since the change in September 2018, there is no clear evidence of an impact on centres' average waiting time points. It was noted that overall 4% of patients that were pre-emptively listed were suspended for 150 days or more within 180 days of being actively listed.

C Watson asked if Glasgow and Cardiff are following a different process and suspended people differently. It was advised that Cardiff sometimes activate patients just going into the national pool and because they are pre-emptive, they do not want to go on the deceased donor waiting list. M Robb will check the data against the national pool for Cardiff. **M Robb**

7.3 Reallocation of kidneys – KAG(19)41

The paper presented looked at the reallocation of kidneys using data based on the previous offering scheme.

Nationally 3% of all DBD kidney transplants were kidneys that had been reallocated. West London's relocation rates are significantly higher than the national rate. A McLean advised that the unit was aware of this.

C Callaghan queried why these offers do not go through the fast track scheme just because the organ has left the centre and suggested that the kidney should go back in the national pool and be offered out.

T Rees asked if the reasons why the kidney is not used by the named individual are collected. M Robb confirmed the data is collected and having looked into the data for some centres the most common reasons is that the recipient is unfit.

ACTION

A Bagul will provided details to Hub Operations of a recent case where the kidney was transferred from Nottingham to Cambridge and would not be redirected. **A Bagul**

C Callaghan suggested excluding from this offers of D4 kidneys from over 70s as this should include named patient offers only.

It was agreed these offers should be offered through the Kidney Fast Track Scheme.

7.4 Sequential liver and kidney for oxalosis

R Baker raised this item on behalf of Leeds who would like clarification on whether once a liver transplant has taken place, is it possible to prioritise the patient for an early kidney transplant.

It was agreed data on outcomes would be required to assist with making a decision, and that R Baker would come back next time with supporting evidence. **R Baker**

7.5 Waiting time of kidney patients transferred to liver/kidney list

C Watson informed members that it had been agreed at the Liver Advisory Group that a patient transferring from the kidney list to the liver list for a liver+kidney transplant will have their waiting time on the kidney list recognised on the liver list – this is important as it forms part of the allocation of livers for patients in the "variant syndrome" category.

8. Review of infant donors < 2 years – KAG(19)42

Since November 2017 any en bloc kidneys under the age of 2 should have been offered to Guy's and Leeds.

Between 1 May 2019 and 31 October 2019 there have been no deviations from this policy.

A Barlow will provide details to the hub for investigation of a case offered to Guy's which was turned down by them but wasn't offered to Leeds. A Barlow confirmed Leeds would have declined the offer for the same reason. **A Barlow**

9 Update on A2 donors for B recipients – KAG(19)43

An update will hopefully be available at next meeting. **N Mamode**

10. Statistics and Clinical Studies update – KAG(19)44

The updates within the statistics and clinical studies were provided.

After publishing the report for kidney transplantation, a couple of centres did query the pre-emptive listing figure data which has now been rectified. This report has now been uploaded.

11 Organ utilisation

11.1 Decline offers due to logistical reasons

Covered under item 3.4.

11.2 CIT and XM practices

A discussion took place at the previous KAG regarding whether it is possible to reduce cold ischemic time (CIT) by ensuring the cross match results (XM) are available before the organ arrives at the transplanting centre. A meeting was held at BSHI where a document was produced to take this work forward. The

ACTION

document has been shared and finalised through BSHI and will be published on BSHI website.

It was noted there are some logistical difficulties in some centres being able to obtain peripheral blood samples and SNODs querying the volume of blood required, since there was large variation between H&I centres. A request was made that a standardised blood sample is agreed. **T Rees**

11.3 Deceased donor kidney offer review schemes oversight committee – retrospective centre comparison of amber events – KAG(19)45

Agreed at the last KAG was that a small committee would be set up to examine responses to C Callaghan's letter regarding organ decline or discard.

C Callaghan sent the committee a number of retrospective offers and responses and colour coded these events. There have been 15 amber events.

It was agreed to de-anonymise the names of centres in future reports and to proceed with this approach. **C Callaghan**

11.4 Deceased donor kidney offer review schemes oversight committee – updated document and proposed refinement – KAG(19)46

The amendments suggested at the last KAG have been included.

Members were happy for the inclusion criteria for the third offer review scheme.

11.5 Hepatitis C NAT testing and the impact on organ utilisation – KAG(19)47

G Jones presented a paper to consider if it is possible to have a national or multi centre systems for NAT testing. R Baker advised there is only one laboratory (out of 17) who have capacity to do NAT testing 24/7. G Jones asked if it is possible to test for HCV antigen testing and R Baker advised that a further 3 out of 17 could provide such a service. A 24/7 nationwide service is desirable but is not currently funded. The service specifications for donor characterisation will be updated yearly and it is hoped that NAT testing will be included in the future.

11.6 PITHIA update

G Pettigrew presented an update on PITHIA which is half way through the trial.

The uptake and use of PITHIA biopsies are variable. G Pettigrew suggested that not enough kidneys were being biopsied and a large pool of elderly kidneys were not being utilised.

The reason centres are not taking biopsies is currently unknown but being explored.

11.7 Referring unit level report of organ offer declines – KAG(19)48

A discussion took place at the last KAG meeting regarding the input of referring units into the organ offer decline process. From this, a paper was received showing the results of a national electronic survey of nephrologists and how they wished to be involved during the organ offering process.

The majority of nephrologist felt involved although 14% did not wish to be.

It was asked whether it was possible to have a referring centre organ offer decline report. M Robb added that if a patient is not on dialysis, NHSBT do not

ACTION

know the referring unit, however this will be available in most cases. M Robb to investigate whether it is feasible to create this report. **M Robb**

12 KAG Paediatric Sub-Group

12.1 Report from KAG Paediatric Sub-Group: 9th October 2019 – KAG(19)49

The minutes from the KAG Paediatric Sub Group were circulated for information.

13 Pancreas Advisory Group

13.1 Report from Pancreas Advisory Group: 5th November 2019

C Watson presented on behalf of J Casey the following requests raised at the recent Pancreas Advisory Group Meeting.

Members of KAG were asked to consider the following suggestions regarding kidney/pancreas offers.

Could the kidney offered with the pancreas be provisionally offered to the centre that eventually gets the offer if the pancreas transplant does not go ahead. Members felt this would not be appropriate.

The second suggestion was whether KAG would support identifying a kidney recipient near the pancreas centre. Members felt this would not be appropriate due to bias in favour of centres close to pancreas centres.

14 Any Other Business

C Callaghan reminded members that the kidney imaging pilot is live and requested that SNODs are reminded to take images of the organ and send these to Hub Operations. **All Centres**

C Watson thanked members of the Kidney Advisory Group for their contributions over his term of office. He particularly thanked Lisa Mumford and Matthew Robb for their work behind the scenes in producing papers for KAG, and developing the new offering scheme, and Sam Tomkings for her contributions behind the scenes.

15 Date of next Meeting:

Wednesday 17th June 2020, 10:30am, The Wesley Hotel & Conference Venue, Euston House.

16 FOR INFORMATION ONLY

16.1 Transplant Activity report: September 2019 – KAG(19)50

Noted for information.

16.2 QUOD statistics 2019 report: November 2019– KAG(19)51

Noted for information.