NHS BLOOD AND TRANSPLANT
ORGAN DONATION AND TRANSPLANTATION DIRECTORATE

THE THIRTY SEVENTH MEETING OF THE KIDNEY ADVISORY GROUP ON WEDNESDAY 17th JUNE 2020 10:00-13:30 VIA MICROSOFT TEAMS MEETING

PRESENT:

Dr Rommel Ravanan	**Chair**
Mr Abbas Ghaznafar	Representative for Guys and St Georges
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 John Casey	PAG Chair
Ms Jo Chalker	SNOD Representative
Dr. Sarah Cross	QUOD Representative
Mr Frank Dor	Representative for Imperial and Oxford
Dr Jan Dudley	KAG Paediatric Sub-Group Chair
Prof John Forsythe	Medical Director, ODT
Ms Anushka Govias Smith	Commissioner for Kidney Transplant NHS Scotland)
Dr Sian Griffin	BTS Representative
Ms Julia Mackisack	Lay Member Representative
Dr Phil Mason	RA Representative
Mr Sanjay Mehra	Liverpool and Manchester Representative
Ms Lisa Mumford	Statistics & Clinical Studies lead, NHSBT
Mr Ravi Pararajasingham	Representative for Sheffield and Cambridge
Mr Gavin Pettigrew	Principal Investigator, PITHIA Trial
Dr Tracey Rees	Chief Scientific Officer – ODT
Dr Matthew Robb	Statistics & Clinical Studies, NHSBT
Mr Debarata Roy	Coventry and Birmingham Representative
Mr Imran Saif	Representative for Plymouth and Portsmouth
Miss Cinzia Sammartino	Representative for Royal London and Royal Free
Ms Angie Scales	Lead Nurse Paediatric and Neonatal Donation
Ms Clare Snelgrove	Recipient Co-ordinator Rep, Oxford University Hosp
Mrs Laura Stamp	Lead Recipient Nurse Coordinator

IN ATTENDANCE:

Chloe Brown	Statistician, NHSBT
Rachel Hogg	Statistician, NHSBT
Rebecca Hendy	Statistician, NHSBT
Miss Lucy Newman	(Deputy for Sam Tomkings) Clinical & Support Services, NHSBT

APOLOGIES:

Marius Berman, Catherine Coyle, Kathleen Preston, John Richardson

1	**Declarations of interest in relation to agenda – KAG(20)01** There were no declarations of interest in relation to the meeting today.	
2	**Minutes of the meeting held on 21st November 2019 – KAG(M)(19)**	
	2.1 Accuracy The minutes of the previous meeting were approved as a correct record.	
	2.2 Action points – KAG(AP)(20)1 **AP1**: Provisional offering of pancreases - this is an ongoing issue but lower priority due to COVID. There were 2 / 3 telecons since the last KAG meeting; another is arranged in the	**M Robb** **C Callaghan**

coming weeks. M Robb and C Callaghan are working with Hub Ops and QA to ensure changes are feasible and they will prepare a report for the November KAG meeting.	
AP2: Hep C Positive kidneys – feedback from J Dudley that Hep C positive kidneys are not currently accepted for paediatric patients due to the lack of available treatment options. This action is now closed	
AP3: Sustainability – scoping work was carried out before centres closed for COVID to establish resource implications in terms of the changes to deemed consent legislation. Some findings were presented at the meeting in January, I Wren will find out what happened with the delayed audit data, he and S Watson will prepare a GAP analysis report, which will include responses from the devolved teams to the November KAG Meeting.	**I Wren** **S Watson**
AP4: KAG Membership action is now closed.	
AP5: Clinical Governance Report – this action related to a local misunderstanding / miscommunication issue which has been resolved. This action is now closed.	
AP6: Form review – this has been completed. This action is now closed.	
AP7: Organ quality eForms update – there is an institutional desire to deliver this project, funding to be secured before J Asher seeks volunteers to work further on this. Centres should make sure they are happy with the Form Bs this is the same platform that will be used to view the result of HTA A retrieval forms, it's important that the surgeons who look at the Form A;s before implanting do have the ability to look at the system. This action is now closed	
AP8: Transplant activity heatmaps – this action is now closed	
AP9: Living Kidney Sharing Scheme will be discussed under item 3.4b on the agenda. This action is now closed	**R Ravanan** **L Burnapp** **M Robb**
AP10: Proposal to permit internal kidney sharing in exceptional circumstances –This is a chairs action to be completed outside the meeting	
AP11: Two-month review of the Kidney Offering Scheme – this was shared, an updated six-month review paper follows under item 5.1 of this agenda; this section of the action is now closed The DAT sheet for reporting deceased donor type will be left as an open action for update by L Mumford at the November KAG Meeting	**L Mumford**
AP12: Pre-emptive listing and waiting time – several patients who had recently been activated on the waiting list were suspended after a short time, with a higher rate of suspensions in Cardiff than elsewhere. Following review of data sent by M Robb, it was found that these suspensions were mainly due to unexpected patient related events, or where a living donor fell through; there was no systematic issue found. This action is now closed.	
AP13: Reallocation of kidneys - A Bagul investigated within centre but couldn't establish which case this related to. This action is now closed.	**R Baker**
AP14: Sequential liver and kidney for oxalosis – this remains open for further work, to be reported at the November KAG meeting.	
AP15: Review of infant donors <2 years - A Barlow obtained the date of the offer to pass on to OTDT Hub, A Barlow, M Robb and J Whitney to follow up outside the meeting. This action is now closed	**A Barlow** **M Robb** **J Whitney**
AP16: Update on A2 donors for B recipients – this action is deferred until November 2020 KAG meeting.	**N Mamode**

	AP17: CIT and XM practices - T Rees confirmed minimum 40ml peripheral EDTA blood volumes for cross matching from laboratories, all centres except one will receive EDTA blood. This one centre uses Heparinised blood but is undergoing validation to move to EDTA blood, timeframe pending. Two centres advised they may request volumes in excess of 40ml (e.g. where lymphocyte yield is lower) but this would be rare and it would be the responsibility of the H & I Lab to communicate this request to the SNODs. Labs list requirements in their SOPs, SNODs could write this into their policies, with the caveat that increased volumes could be requested occasionally. To support SNOD's it was agreed that the OTDT Policy on diagnostic blood testing would be updated to reflect this process. J Chalker will liaise with T Rees to complete this work, A Scales will be involved regarding paediatric sampling. Once the update has been approved, M Robb will add to for OTDT Policy review, and update will follow at KAG in November 2020. **AP18**: Deceased donor kidney offer review schemes - will be discussed under item 8.1 and 8.2. This action is now closed. **AP19**: Referring unit level report of organ offer declines - consideration was given to expand the delivery of the current monthly organ offer decline report sent to transplant centres to also send to referral units. To add this report monthly would require significant work and overheads. This action will be reviewed again in Spring 2021 following the next annual report which will include the renal units. AGENDA ITEM SPRING 2021 **AP20**: Any other business relating to the kidney imaging pilot – this action is now closed	**J Chalker** **T Rees** **A Scales** **M Robb** **M Robb**
	2.3 Matters arising, not separately identified There were no others matters arising from the last minutes or action points.	
3	**Medical Director's Report and COVID update KAG(20)02**	
	3.1 COVID-19 looking back Clinical colleagues have been meeting regularly over the past three months or so. The Medical Team, including Advisory Group Chairs have been meeting twice weekly with the Extended Operational Group and Clinical Group over the last three months in response to changing dynamic of Organ Donation. J Forsythe expressed thanks to the clinical team of about 22-26 people for meeting regularly to review actions which could be taken to support donation and transplantation. These have been useful meeting in terms of people taking actions with quick completion enabling rapid changes and this is due in part to the connection between the managerial and clinical teams which has worked very well. J Forsythe thanked all clinicians for their valiant efforts during the COVID Pandemic and for the work done towards the putative publication using registry data collected via L Mumford and team. There was a collaborative effort with L Burnapp/ BTS, and the professional organisations worked well together. Thanks also to C Callaghan who has written much of the recovery document and I Ushiro-Lumb for the virology expertise. All actions are included in the Bulletins which seem to have been appreciated. Thanks also to O McGowan for assisting J Forsythe with the bulletins which were released three times a week at the surge peak (now weekly). These bulletins are widely circulated, and many members are involved already, with rapid responses to actions when required. Initially NHSBT had daily meetings with UK Commissioners of transplant, these meetings continue weekly and have allowed a collaborative effort between commissioners, clinicians and managerial departments of health (the most recent of these meetings was this morning 17th June 2020). The meetings will continue to try and support centres as they increase activity. Heart and Lung and Liver transplantation centres are largely open. Pancreas is in recovery with one centre transplanting and others opening soon. 13/14 of 23 Kidney centres have re-opened. J Forsythe paid tribute to all at the meeting for working to re-build transplantation and to those who have managed to keep it going throughout. Oxford, Newcastle and Belfast were able to maintain a service during the pandemic because they have the availability of a COVID free / COVID amber area. Belfast have changed hospitals to facilitate this. Cambridge also managed to maintain the service despite not having a COVID free area. Thanks to this collaborative effort, in the last two	

	weeks, there were a total of 37 organ donors, enabling 107 transplants; a significant uptake from the peak of the surge. Teams are moving significantly through the recovery phase, but there is still more to be done.	
	3.2 COVID-19 looking forward Looking forward will involve planning for two phases – a long term recovery and a short-term recovery. Short term, there are three main concerns: <u>1 Reopening</u> Centres finding it difficult to reopen due to governance requirements within trusts, <u>2 Suspension of patients and equity of access to kidney transplantation across UK</u> Several centres have suspended programs and if this is likely to change soon it is manageable, but if there are lengthy delays patients expect us to act in response to the situation. Centres that are open may not be open for the entirety of their waiting list; most have a subgroup of patients who remain suspended. Some patients fear receiving a transplant during pandemic, but what must be avoided is patients remaining suspended exclusively because of lack of resources <u>3 Living donation</u> This presents concerns which will be discussed under item 3.4 of the agenda. Centres feedback is that even if deceased donor transplants restarts soon, living donation will be more difficult. If the living donation pathway can't be reopened across all centres, the next matching run cannot be run. In the long term: The medical team, commissioners and the clinical team are planning for a second surge, whether it will be regional or districts needs to be seen. Blanket indefinite suspension of centres or patients will not be acceptable and sustainable options of continued service delivery necessary. J Forsythe thanked all who have been involved in these plans over the last few weeks. There are still significant concerns for now, but the situation is better than originally feared with active planning for the future. R Ravanan echoed J Forsythe's thanks to all participants at the twice weekly meetings which involve more than 20 people all pulling in the same direction at pace to get things done. J Mackisack asked how is NHSBT communicating information to patients to keep them updated and congratulated the team for their efforts to recover kidney transplant programs. J Forsythe confirmed the bulletin goes widely to clinical members and representatives of patient organisations UK wide. R Ravanan added that centres also share resources, for example FAQ sheets and patient information letters, to provide a framework to ensure consistency across centres. KAG previously put an action in place that all patients are communicated with via formal letter to update them on their activation status, which has been done. J Forsythe asked centres to highlight any difficulties they face with reopening, particularly involving staff shortages. It would be useful to hear from centres in the throes of reopening about what barriers they face / faced and what NHSBT and Commissioners can do to help overcome these barriers. There was a discussion on recent RCS guidance which did not mention transplantation. NHSBT were not consulted in a timely manner prior to RCS guidance publication and J Forsythe working with Derek Alderson RCS President to update the guidance to include transplantation. KAG members should direct Medical Directors or colleagues with any concerns to the letter from Simon Stevens which confirms SOT programs should be recovered and signposts to the guidance from NHSBT. S Watson enquired how NHSE can support the recovery program and a desire to address equity in different parts of the country.	

S Bond - discussed capacity constraints due to diminished resources such as diminished coordinator team in Cambridge

Deceased kidney donor program update:
Centre representatives are asked to give an update on reopening, with details split by adult and paediatric where appropriate. Is the centre open, if not, give reasons why.

Nottingham and Leicester
Leicester is open to living and deceased transplantation
Nottingham is open to deceased paediatric donation from this week and they plan to start deceased adult donor donation next week, when they have finalised the sign off from all remaining SOPs

Leeds and Newcastle
Leeds is open to deceased donation; lack of theatre access due to the pressures on cancer surgery prevents recovery of the LKDT program. Trust are only doing priority patients in line with the RCS document mentioned earlier. Leeds has about 140 active patients on the list, approx. 50%.
Newcastle is open to limited numbers, but activating more patients

Imperial and Oxford
Imperial planning to open early July for deceased donation.
Oxford is open and remained open and living kidney donation restarted a couple of weeks ago. Oxford is covering deceased donors from Coventry until Coventry can open.

St Georges and Guys
St Georges first live donation scheduled for 24th June; deceased donation remains paused until the following week.
Guys C Callaghan reported Guys is looking to resume deceased donor to adults in the next three to five weeks, the living donor program is more complex and may need to use the independent sector in the short term, live and deceased donation for paediatric donors at the Evalina and at GOSH is currently operational.

Liverpool and Manchester
Liverpool submitted a proposal on 18th May to reopen on 1st June, the final decision for this lies with the executive team and is delayed at present for an unknown reason; is any assistance available from NHSBT / NHSE Commissioners?
Manchester the plan is to start to reopen on 21st June, update to follow.

Cambridge and Sheffield
Cambridge remained open throughout.
Sheffield plans to re-start in the next 1-2 weeks. Issue of resilience with small teams (in the event of sickness or self-isolation) and requirement for staff risk assessments discussed.

NHS guidance on staff risk assessments released recently and suggested mitigations to help problem solving colleagues identified as higher risk discussed.

Edinburgh and Glasgow
Edinburgh re-opened two weeks ago with a restricted list which they expanded last week to have about 50% of list active.
Glasgow remained open throughout except for ~two weeks. The centre intends to carry out the first living donor transplant a week today.

Cardiff and Bristol
Cardiff due to open end of June
Bristol re-opened end of May. Paediatric transplantation will be open in the next two or three weeks. LKDT due to re-commence end of July 20.

Coventry & Oxford, and Birmingham
Coventry reopened via Oxford performing the transplants and LKDT expected to re-start in July.
Birmingham likely to open end of June .

Plymouth and Portsmouth
Plymouth due to re-open for deceased donor transplant from 22nd June and have re-started the LKDT program this week. **Portsmouth** awaiting some structural work on the transplant ward. Hoping to re-start deceased donor transplants from late July and working on a network solution for LKDT.

Royal London and Royal Free
Royal London aim to re-start LKDT via IS site in June and deceased donor transplant from late July / early August
Royal Free have commenced LKDT with plans also plans to open around the end of July.

Belfast
Belfast reopened on 17th April and have carried out 72 deceased and one live donor (paediatric recipient) transplants

In summary most centres will be reopen for deceased donor transplants in the next five to six weeks and all by the end of August, LKDT activity recovery is a bigger concern.

S Watson confirmed support to any centres that may need help picking up questions and talking to commissioners and trust managers.

Support options for some centres discussed and S Watson, J Forsythe and R Ravanan will discuss further.

R Ravanan asked the group to consider whether a predictable delay to a centre reopening should mean they need establish whether patients from that centre can access transplantation at another nearby centre? Concerns are acknowledged in relation to considerably large amount of clinical and administrative workload for the receiving centre. He asked centres to consider whether the timeframe of six weeks when most centres will be open is the right length of time to wait before looking at alternative options if centres can't open beyond into August.

S Watson felt that from an equity perspective there is concern for the dates of the London centres, so additional support may be needed in terms of urgency for patients, Each centre that has not reopened is aware of local challenges, London has a Pan London collaborative and centres have been in contact throughout. I Wren and S Watson will be invited to a Pan London meeting by F Dor. **F Dor**

The Northern collaborative has been active last few months with fortnightly telecons, one point of discussion has been potential for kidneys to move between units if need to, so this is on the agenda. It was also commented that a centre that is open and are already at capacity would struggle to take on a significant number of patients from another centre waiting list due to stretched theatre and ward capacity. Also, moving patients will not be easy with the governance issues, information transfer etc and for practicality at the receiving end.

Colleagues in Leeds and Leicester have offered support to Sheffield but both are working at capacity so this would need careful thought

It was agreed that to have a reasonable chance of successful recovery of deceased donor transplants within the next four to six weeks, supporting other centres to reopen is the right thing to do. If one or more centres is still not open for adult transplantation by September, there will be further consideration from KAG to ensure equity of access to transplants.

J Dudley echoes those comments from the paediatric side. Where indicated the group will write to medical directors if there is failure to authorise at a managerial level as there are early signs in paediatric centres of SOPs not being signed off. It's important the group can support centres with some of the sign off issues if this is the only thing delaying the clinical teams.

3.3 Policy Changes during Pandemic

	3.4a LDKT: Transplantation: Options to re-start / expand KAG(20)03 Living donation appears to be falling behind the recovery of deceased donation. The attached paper outlines context and activity with a visible drop off in activity in the middle of March. The paper explores the limitations centres are experiencing mostly in reopening but also in expanding their living kidney donor programs. As there may be further pandemic activity this paper is about thinking ahead. Programs could be permitted to naturally evolve in each centre which is consistent with the policy put in place right at the start of this pandemic due to the local and regional variations, but inequity of access to living donor transplantation now and in the long term must be considered, even in centres who have restarted like Oxford and Leeds, it is still a challenge to get living donation back on the agenda. There are over 100 non-directed altruistic donors, two have already withdrawn if they cannot proceed to donation because their lives are on hold, with concerns more will follow. Non directed altruistic donors make the biggest difference in the kidney sharing scheme, and there is a real risk as the April and July matching runs are already suspended and may have to postpone the matching scheme again in October if pending transplants are not completed. The paper proposes five options. After extensive discussion, it was agreed, KAG will convene a Fixed Term Working Group of key individuals to review the options and make recommendations. Everyone agreed 'Option 1 – Do nothing' should be ruled out. KAG members were requested to send suggestions/feedback to R Ravanan and L Burnapp. Fixed Term Working Group volunteers: L Burnapp and R Ravanan, F Dor, A Bagul, D Roy, S Bond, C Snelgrove, R Baker, I Wren, S Watson. The FTWG will review options 2, 3 and 5 more closely, as options 1 and 4 were ruled out. J Mackisack praised KAG for working so quickly to generate solutions	**R Ravanan** **L Burnapp**
	3.4b UK Living Kidney Sharing Schemes: Update – KAG(20)04 1. The fixed time working group set up for the kidney sharing scheme felt it would be beneficial to remove the requirement for prenotification of non-simultaneous surgery of <2 weeks duration when it is non-directed altruistic starting the chain. KAG approved this at the meeting with no objections raised. 2. The October matching run, following the cancellation of the scheme in April and July may also need to be suspended. KAG is asked to consider the critical mass of patients and centres and whether the October run should be halted now. There are around 80 pairs from February and have already lost two pairs who have withdrawn. After discussion it was agreed, the go / no go decision should be taken towards the end of July with better sight of LKDT recovery and as part of the fortnightly KAG clinical team meeting. A Govias-Smith will review the paper with colleagues in Scotland and support living donation as needed. Note that Max and Keira's Law passed on deemed consent for organ donation in England was passed on 20th May. It completed parliamentary progress, with people aware that side-lining the issues of COVID for consideration of the legislation was inappropriate but after discussion it was agreed that getting the legislation through parliament was the best thing to do, accepting that centres will not be able to make the best of it for many months. There wasn't much publicity as would normally be expected, but it has still had a lot of coverage as a positive story in during the pandemic. In Scotland the legislation is delayed until early 2021	**A Govias-Smith**
	3.5 COVID and Kidney Transplantation UK Data – KAG(20)05	

	M Robb presented the paper which highlights the number of kidney transplant activity and COVID related outcomes. This data was collated 4th June 2020. The first centre closed was Cardiff (14th March), 19 centres closed over the next two weeks and for four days in the middle of April there were only three centres open with a sharp decline in transplants from mid-March. As of last week, more centres are starting to reopen. Further studies into outcome data will be carried out looking at the risk adjusted and variable analysis of these outcomes in terms of inequity of access.	
	3.6 Recovery update This is discussed under item 3.2 – COVID looking forward	
	3.7 Hub update A letter was sent by Hub earlier in the week to advise centres that the Hub has reverted to the national allocation scheme which was implemented as of yesterday, all offering will be the national approach, not centre based as it was at the peak of the pandemic. Thanks to all centres or how they have worked with Information Services in managing transplant lists and suspending patients when closed. The new system for centres wishing to make changes to their centre criteria is now operational. M Robb will email centres to remind them of the opportunity to make changes in advance of the monthly report; and this monthly revision option will be reviewed in three months. L Stamp will work with J Whitney to ensure recipient co-ordinators are kept updated and inform the Hub of any changes at their centres.	**M Robb** **L Stamp** **J Whitney**
4.	**Governance Issues**	
	4.1 Non-compliance with allocation This item can be removed from the standing agenda, there have been no issues of non-compliance since the last report, and only on centre outside the confidence line with no major concerns. **4.2 Incidents for review: KAG Clinical Governance Report – KAG(20)06** There were two incidents. The first incident relates to a living donor who unfortunately died. The final investigation report will be released after the coroner's inquest. The second incident relates to the live donor program and sharing scheme at the hub. Steps have been taken in the Hub with safeguarding measures in place to ensure there is no repeat of this in any future matching run. A business case to introduce digital safeguards to reduce risk has been submitted in ODT.	
5	**Allocation**	
	5.1 Summary of the first 6 months of the new Kidney Offering Scheme M Robb presented a six-month review of the new kidney offering scheme which was introduced on 11th September 2019. In summary there's been an increase in the proportion of highly sensitised patients receiving a transplant from 12% last year to 17% this year in the first six months of the new scheme and an increase in the number of transplants performed in 100% CRF patients during the first six months. There has been an increase in the number of offers being declined for recipient reasons in the first six months the majority of those cited as recipient did not need a transplant possibly because they've received a multiple offers in a short space of time and have already had an offer accepted.	
6	**Developments in IT**	
	6.1 Organ Quality eForms update Update was provided under AP 7 with nothing further to report. A further update will be provided at KAG in November.	

7	**Scientific Advisors Report**	
	7.1 Donor discrepancy monitoring – KAG(20)08 Discrepancy rates are <1%, but clerical transcription discrepancies are around 50% It is hoped the introduction of the donor characterisation project which will require electronic transmission of results will reduce this discrepancy rate. **7.2 Summary of donor discrepancies – KAG(20)09**	
8	**Organ Utilisation Update – Current Situation**	
	8.1 Deceased donor kidney offer review schemes The decision was made in early April to suspend the three offer review schemes: • High quality organ declines • Organ discards • Tier 1 organ declines These will not be restarted until the deceased kidney transplant centres are fully operational, following consultation with J Forsythe and R Ravanan. **8.2 PITHIA** Pithia trial has been suspended during COVID and will be restarted once centres are able to start utilising more kidneys from donors aged 65/70 yrs.	
9	**KAG Paediatric Sub-Group**	
	9.1 Report from KAG Paediatric Sub-Group: 1st April 2020 There was a virtual KAGPSG meeting on 1st April, dominated by COVID discussion. KAGPSG seeks approval from KAG for the following two proposals and J Dudley will present a paper on this at the November KAG meeting. The harmonisation program has resulted in initial publication on the Renal Association website of guidance for immune-suppressant regimes for children and young people. The paediatric community is extremely proud and is potentially unique in allowing protocols including target tacrolimus levels and precise steroid dosing. The second phase of the harmonisation programme is to compare outcomes, as part of that KAGPSG would like to review virology or infectious outcomes. To do this the NHSBT outcome forms would require minor alteration to collect some additional data on PCR for CMB and EBV. This would only require completion by paediatric nephrology consultants for paediatric cases. KAGPSG unanimously supports this addition to the outcome forms and seeks KAG approval. KAG members happy to support the proposal but this will require changes to outcome forms etc. M Robb will investigate how easily this change could be made to the forms and whether the additional data collection questions could be added to specific sets of forms only.	**J Dudley** **M Robb**
10	**Pancreas Advisory Group**	
	10.1 Report from Pancreas Advisory Group: 28th April 2020 - KAG(20)11 The Pancreas advisory group meeting was dominated by COVID and how pancreas transplant can recover. PAG has fortnightly meetings and there is nothing specific to raise with KAG	
11	**Any Other Business**	
	As this is the first time KAG has held a meeting by Microsoft Teams. Members asked to feedback (to R Ravanan or L Newman) on quality of meeting platform vs meeting face-to-face. Discussion suggested, alternate face-to-face and electronic meetings maybe desirable.	

	S Cross QUOD have confirmed they will restart QUOD sampling as centres work through the recovery plan and reopen. L Newman to add 8.4 QUOD update to future agenda M Robb raised that one of the figures in the kidney annual report looks at pre-emptive listing rates that exclude people who have received a living donor transplant. There is a separate figure for pre-emptive rates for living donor transplants. Members agreed that reporting pre-emptive transplantation through living donation would be valuable. M Robb confirmed that where centres don't list patients on the deceased waiting list but manage the transplant by pre-emptive live donor transplant would be reflected in the live donor transplant figures. The KAG fortnightly meetings to continue until the end of August	**L Newman**
12	**Date of next Meeting: 10:30am, Wednesday 25th November 2020 – via Microsoft Teams**	
13	**FOR INFORMATION ONLY**	
	13.1 Transplant Activity report: April – **KAG(20)12** 13.2 QUOD statistics 2020 report: May – **KAG(2013** 13.3 Statistics and Clinical Studies Update – **KAG(20)14** 13.4 Infant Donors Update – **KAG(20)15** 13.5 Liver and Kidney Registrations - **KAG(20)16** 13.6 Summary of CUSUM monitoring of outcomes following kidney transplantation – **KAG(20)17**	**Attached** **Attached** **Attached** **Attached** **Attached** **Attached**