NHS BLOOD AND TRANSPLANT
ORGAN AND TISSUE DONATION AND TRANSPLANTATION

THE THIRTY-EIGTH MEETING OF THE PANCREAS ADVISORY GROUP AT 10:30AM ON THURSDAY 5th NOVEMBER 2020 VIA MICROSOFT TEAMS MEETING

PRESENT:

Mr John Casey	**Chair**
Mr John Asher	Medical Health Informatics
Miss Irum Amin	Cambridge Transplant Centre (deputy)
Dr Arthi Anand	BSHI Representative
Dr Richard Baker	Joint National Clinical Governance Lead, NHSBT
Mrs Hazel Bentall	Lay Member Representative
Mr Chris Callaghan	National Clinical Lead for Organ Utilisation (Abdominal)
Mrs Claire Counter	Statistics & Clinical Studies, NHSBT
Mr Ian Currie	National Clinical Lead for Organ Retreival
Mr Martin Drage	Guy's Transplant Unit
Mrs Kirsty Duncan	Recipient Coordinator Representative
Mr Doruk Elker	Cardiff Transplant Centre
Prof. John Forsythe	Medical Director, NHSBT
Ms Anushka Govias-Smith	NSD Scotland
Dr David Hopkins	Lead Diabetologist for Islet and Pancreas Program
Dr Stephen Hughes	Islet Laboratory Representative
Prof. Paul Johnson	Pancreas Islet Steering Group Chair
Dr Adam McLean	WLRTC & Hammersmith Hospitals Representative
Mr Anand Muthusamy	WLRTC & Hammersmith Hospitals Representative
Mr Simon Northover	Recipient Coordinator
Dr Tracey Rees	Chief Scientific Officer
Prof. James Shaw	UK Islet Transplant Consortium
Mr Sanjay Sinha	Oxford Transplant Centre
Mr Andrew Sutherland	Edinburgh Transplant Centre
Ms Sadie Von Joel	Lead Nurse Recipient Transplant Co-ordination
Ms Sarah Watson	NHS England
Prof. Steven White	Newcastle Transplant Centre
Mr Colin Wilson	Newcastle Transplant Centre (deputy)
Mrs Julie Whitney	Head of Service Delivery, ODT Hub

IN ATTENDANCE:

Prof. John Dark	Simvastatin study
Mr Joseph Parsons	Statistic & Clinical Studies, NHSBT
Miss Sam Tomkings	Clinical & Support Services

Apologies

Ms Susan Hannah, Mrs Julia Mackisack, Mr David Van Dellen

Action

1. DECLARATIONS OF INTEREST IN RELATION TO THE AGENDA

1.1 There were no new declarations of interest in relation to the Agenda.

2. MINUTES OF THE MEETING HELD ON 9th September 2020 – PAG(M)(20)2

2.1 Accuracy

The minutes of the meeting held on 9 September 2020 were confirmed to be a true and accurate record.

2.2 Action Points PAG(AP)(20)2

All action points had been completed or were included on the agenda.

2.3 Matters arising, not separately identified

J Casey notified the group that this is Hazel Bentall's last meeting and Titus Augustine has stepped down as Deputy Chair of Pancreas Advisory Group (PAG) and representative for Manchester. J Casey thanked both Hazel and Titus for their contributions to PAG.

J Casey has reached the end of his tenure as Chair of PAG and this would be his last meeting as Chair. J Forsythe thanked J Casey for his leadership and support contributed over the years. Members welcomed S White as the new Chair of PAG.

3 MEDICAL DIRECTOR'S REPORT

3.1 COVID-19 update

The second surge planning document is available on the ODT website. The main drive behind that document is to try and keep donation and transplantation open. The planning was created on the second surge being more regionally based, but this has not happened and instead coalesced into much larger regions. A comprehensive update of the situation across the country is provided weekly at the Clinical Team Meetings.

J Forsythe reported that COVID numbers are rising and hospital numbers have risen which has had no effect on transplantation, however in the last week the impact of the numbers rising has begun to effect transplant centres. Centres are struggling to manage the situation. It has been reported there has been a 50% reduction in referrals for donation and an increase in declines in the last week.

Two-way communication with centres have dramatically improved the second time around and NHSBT are aware of areas where there is pressure on the service and for those areas have tried to intervene and support units. All centres apart from Belfast remain open. J Forsythe paid tribute to the teamwork across the units.

NHSBT recently wrote out to Medical Directors of all Trust hospitals for each transplant centre which has been well received by units.

3.2 Opt out update

The English legislation has passed and has been in place for a number of months. The consent rate for organ donation has risen and is up to an average of 70%. Date for Opt Out for Scotland legislation with be enacted from March 2021.

Action

J Forsythe announced that support has been obtained from the Department of Health to look at utilisation and due to underspending of Opt Out there is funding in place for NHSBT to appoint Clinical Leads in Utilisation (CLU's). This is a short-term project until the end of the financial year which has been well received. If this is successful, contingency to fund this is not in place. The CLU's will have to demonstrate improvement in utilisation across the board and ensure responsibilities are carried through.

3.3 ODT strategy updates

On behalf of Karen Quinn, J Whitney provided an update on the ODT strategy which has been reshared with over 950 individuals across donation and the transplant community to allow the opportunity for individuals to feed into that. Those comments have been incorporated into the most recent version which has gone to the Executive Team and the final version is going to the board at the end of November for endorsement. As it is a UK wide strategy it will then need to go to the Health Ministers in the devolved administrations for overarching sign off and agreement. The plan will be a formal launch in January, but a definitive timeframe cannot be confirmed due to COVID.

4 COVID-19

4.1 Summary COVID data and pancreas offering – PAG(20)21

C Counter presented a selection of graphs and information from both the weekly COVID report which is available on the ODT website and the pancreas report which has been presented at the fortnightly PAG Sub-group meetings.

The number of transplant recipients testing positive has been increasing. For SPK patients, 5.4% of those waiting list patients have tested positive for COVID but none have died. 1.9% of transplant recipients have tested positive and 0.3% have died. There have been no deaths in the pancreas alone transplant or waiting list patients.

There has been a drop in the number of pancreases from deceased consented donors that have been offered, retrieved and transplanted in the last week compared to recent weeks.

The number of patients on the pancreas and islets waiting list in the UK was 158 as at 26 October. The number of new registrations on the list is increasing each month and the number of removals and deaths on the list is pretty similar to the period prior to COVID.

4.2 Individual centre report

A verbal report was provided by each representative with an update from their unit.

WLRTC

- A McLean reported that the pancreas programme is active and have applied a mild filter holding back what the unit felt were the most challenging patients.
- The unit have been asked to review the list in view of rising numbers of COVID cases.
- There is high COVID prevalence in the renal population in West London however is nowhere near the situation the unit was at in March and April.

Action

- The unit continues to operate on half of the HDU and are taking steps to recreate HDU activity on another ward.

Guy's

- Local prevalence rates of COVID in London seems to be decreasing.
- The unit have two zones for ITU, using side rooms for red patients and one area designated amber and another area designated green.

Oxford

- All the Oxford waiting list is active. The unit have seen a decline in transplant activity and as a result have carried out two transplants in October and one in November which went well.
- ITU is stable.
- The unit had their first COVID positive inpatient last week on the transplant ward, which was a Living Donor Transplant who initially swabbed negative on admission and a subsequent negative swab at day 7, unfortunately the patient had complications and has been a long stayer and the unit cannot identify how the patient contracted the virus. The patient is currently doing OK. The rest of the ward and staff has been swabbed and no other positives have been identified.

J Forsythe suggested S Sinha liaise with Ines Ushiro-Lumb who may be able to assist with genotyping. There have been a number of Nosocomial outbreaks in various units across the transplant centres. Rommel Ravanan (Chair of KAG) is producing a lessons learned document which will hopefully be available next week.

Cambridge

- The pancreas transplant programme restarted in the middle of June. Activity has slowed down with one pancreas transplant taking place in September, none in October and one transplant took place last weekend.
- As of yesterday, the unit had 14 patients with COVID in hospital, four of them are in critical care and one is a liver transplant patient.
- When the programme restarted the unit initially had to share the pancreas theatre with the liver theatre and were told only one liver or pancreas transplant could take place and not both. The unit has since managed to work around that.
- There are four or five people currently active on the waiting list and is working with a normal waiting list.

Cardiff

- Cardiff have a small list of patients active as some patients have chosen to remain suspended and some have medical reasons.
- Referrals and work up is progressing better than a few months ago.
- The unit was initially more active in August, but this has begun to slow down.
- The unit have had one kidney patient that has tested positive.
- Cardiff hospital has 51 COVID patients in hospital and two in ITU.
- The unit is trying to protect the ward from bed pressures and have regular staff testing which is not mandated. Waiting list patients are tested every two weeks as well as on admission.

Action

Manchester – no representative from the unit was available

- On behalf of Manchester, J Casey informed members that the pancreas programme is active and the unit have no immediate concerns.

Newcastle

- S White reported the unit had got back to normal levels of activity in September/October but have in the last few weeks noticed a tail off in the number of transplants. The unit has not been very active with pancreas transplants and have eight patients listed.
- The RVI hospital has 120 patients with COVID with the aim to keep the Freeman Hospital COVID free. The Freeman hospital has one patient on ITU and ventilated who is a dialysis patient.
- The hospital has over 900 staff not at work because of self-isolation. The hospital is not doing routine staff testing. At one point, the unit had three consultant surgeons who were off which was problematic though managed to keep elective surgery going.
- One of the unit's biggest issue is decanting patients from ITU into ward beds because the number of ward beds have been restricted due to social distancing.
- J Shaw reported an islet transplant took place this week. There has been no COVID in any recipients and can continue blood testing and visits to work up patients for actively listing. The unit is taking separate consent for Campath.

Edinburgh

- The number of COVID cases in the hospital are increasing and the number of patients on the ward seems to be increasing, however the number of patients admitted to intensive care is low.
- ITU provision immediately post op continues to have areas which are green or amber.
- The unit is experiencing problems as hospital beds are full, part of that is pressures because of the cohorting of patients and trying to reduce the density and also seem to be pressures from admissions from the community and elective work. The hospitals capacity is struggling.
- There are no plans to close the programme down at any stage, but it is likely that each potential transplant needs to be dealt with on an individual basis.
- Since restarting the programme, four pancreas transplants have taken place, two islet transplants and one SIK transplant.
- Edinburgh have had two significant incidences with COVID infection in the transplant programme. The first was an SIK patient in a four bedded bay on the ward which included a liver assessment patient who came from another hospital who had briefly been in contact with a care of the elderly patient who tested negative before transferring across to the unit. The liver patient was not housed in a single unit but in a four bedded bay and subsequently a renal and SIK patient developed COVID. The SIK patient has been admitted to a referral centre to ITU and has been ventilated for two months. The renal patient is fine. As a result of that, there has been a number of policy changes. The unit does not have the facility for single rooms but is

Action

having a much stricter cohorting of patients and are now testing patients admitted to the wards.

- The second COVID incident was in the renal HDU where there was no policy to test every patient within that ward and there has been a mini outbreak which involves patients and staff which has been genotyped confirming Nosocomial transmission. This has not yet affected any transplant patients.
- M Drage added that within their Trust if a patient is on the amber pathway unless they are a transplant patient, they are not allowed to subsequently progress to green. The only patients that can go from amber to green are the deceased donor recipients and that is after spending 5 days in a side room and a negative swab either side of that. A Sutherland confirmed Edinburgh have proposed a similar process regarding negative swabs to classify recipients as green.

Islets

- All three islet isolation facilities are open and functioning.
- All centres are open for patient work up and new patients are in the programme.
- There are 19 patients on the national waiting list and two centres are "closed" for transplantation. The first is Bristol who have no patients on their waiting list and can reactivate within 10 days. The second is The Royal Free who remained closed during the first wave and remain on high alert. They have one suspended patient on the waiting list. P Johnson confirmed this patient has been looked into and agreed the patient is not ready for transplantation but have discussed alternative measurements for this patient should they become reactivated.

In summary, all UK centres are open and available for transplant, have patients listed and are assessing patients. The pressures are slightly different from the first wave with the issues not necessarily being critical care beds but being ward beds, Nosocomial transmission and potential step down from critical care.

M Drage highlighted that the Government have announced a change in shielding for organ recipients and asked how centres are going to communicate this. In Scotland, a CMO letter has gone out and Scottish guidance is available on the website specifically for shielding. Centres are mostly referring to Government guidance because of the frequent changes. Centres found this challenging the first-time round. The guidance on the website suggests that patients are going to be written to.

4.3 Collaborative working

Collaborative working was discussed at the last PAG meeting and at the PAG COVID-19 Sub-group call where it was agreed that a national collaboration would be best as it was anticipated that outbreaks would be large geographical areas. Based on that, it was agreed to develop a patient passport which lists data required to allow patients to transfer to another unit. The passport was based on the template used for the Oxford and Coventry network structure. The feedback received has been very positive. S Sinha has since circulated the template to the recipient coordinators and have since added some more suggestions. Once

developed, this may need to go to individual centres to ensure this is what each centre requires. **Action**

A Muthusamy feels the work up pathway is bespoke for each centre such as assessing cardiac risk and suggested utilising some time during the fortnightly PAG Sub-group calls to jointly discuss patients similar to a MDT to help anticipate patients that are likely to come up.

M Drage feels the group should consider populating a patient passport for all on call patients and if a patient is sent to another unit and the transplant does not go ahead, should transport be guaranteed for that patient to go home. Members feel populating a passport for each individual patient is a lot of work and the passport may not be used. When an organ is offered there should be sufficient time to create a passport.

C Callaghan highlighted that HLA profiles and donor specific antibody profiles can be problematic. T Rees responded by acknowledging that issues are likely to arise because each H&I lab will work with their transplant centre to agree cut offs and there would be different acceptance of risks for each centre. S Sinha feels cross matching should remain with the parent unit – members agreed.

C Callaghan asked if the suggestion is to potentially transfer all patients or to only potentially transfer more straightforward patients. It was noted that individual discussions would take place regarding which patients are most appropriate which is often more straightforward patients. D Elker added that some patients may not want to consider travelling to another site to receive a transplant. S Sinha feels for a collaboration to work that if a patient has been cleared for a transplant in a unit they have met the standards that your unit would go through.

S Sinha would be reluctant to only offer the option to transfer a patient if they are more straightforward and feels those highly sensitized patients should not miss out on an offer. S White would like colleagues to consider if there is an offer and the centre turns it down because of the complexity of the patient, how would that be explained to the patient. Some units would be happy to transplant a complex patient, but others may be more reluctant and therefore some patients may be denied a transplant due to complexity.

Members feel a national collaboration is still worth considering and patient involvement as part of the decision making to transfer is very important.

It was acknowledged that some additional more complexed issues need to be considered and J Casey feels a small group getting together to resolve this would be useful. **J Casey / S White**

5 Governance

5.1 Non-compliance with allocation

There has been no noncompliance with allocation – this item can be removed from future agendas.

Action

5.2 Incidents for review: PAG Clinical Governance Report – PAG(20)22

R Baker presented the Governance report which saw a peak in incidents largely related to the outbreak of COVID in the beginning though have since reduced as activity has resumed.

An incident regarding transmission of metastatic melanoma which applied to one islet graft recipient with fatal consequences and both renal transplant recipients have subsequently died and as a result, any donor history of malignant melanoma has been considered as an absolute contraindication and a request has been made for SaBTO to look into this again.

It was acknowledged that NHSBT is taking a different approach to donor history of melanoma than SaBTO. SaBTO and DORA guidance states that some donors with a history of malignant melanoma may be appropriate for use and concerns were raised that there is potential for confusion amongst clinicians if there is a different approach between organisations. R Baker agrees the guidance should be aligned and once the incident is fully investigated more information may be available about how much history was known about the melanoma at the time.
J Forsythe added the staging of malignant melanoma guidance has changed over the years which becomes incredibly complicated and, in those circumstances, it was felt that the cautious approach was necessary until SaBTO produces its review of the situation.

5.3 Summary of CUSUM monitoring following pancreas transplantation – PAG(20)23

There have not been any signals in the last 6 months for pancreas graft failure following a pancreas transplant.

It was noted that the kidney outcomes from a simultaneous pancreas and kidney transplant are not being separately monitored with CUSUM analysis and therefore it has been proposed that quarterly monitoring of 30 day kidney graft failure following SPK transplantation will commence and a summary of the signals will be reported to PAG rather than the Kidney Advisory Group (KAG).

5.4 Pancreas imaging pilot

C Callaghan reported that the pilot is still ongoing and the last time this was audited was pre COVID where around 50% of pancreases were imaged.

C Callaghan would like to include a discussion of the pancreas imaging pilot with the pancreas Clinical Leads in Utilisation (CLU's) and obtain a formal assessment of that project through the CLU process. The aim is for this to become part of standard practice. J Whitney and J Forsythe would support this process being taken forward and to ensure SNODs and Hub Operations adhere to the images being taken – members agreed. As part of the key performance indicators, C Counter is reporting, for one month at the beginning of each quarter, information on the percentage of organs that have had an image taken using information that is provided by Hub Operations. **C Callaghan / J Whitney**

I Currie and colleagues are working on a trial of video imaging dialogue between retrieval surgeons and recipient surgeons. As part of that the team will be

communicating to recipient surgeons in the UK that they can easily obtain photographic images via the SNOD and Hub Operations in the usual manner. **Action**

5.5 Pancreas damage

I Currie advised the retrieval information forms have been updated to accurately reflect what damage means and the damage effect. With better clinical validity of the information this will provide a baseline for the UK to see the background level of organ and graft damage. This will allow CUSUMs to be established for the UK meaning individual units and retrieval centres will receive the information indicating if they are outliers for the UK retrieval service. It could be a year before this is implemented particularly for less frequent transplants such as pancreas to enable statistical reporting to be established.

I Currie is setting up a session in Edinburgh using novel technologies to understand how best to do abdominal and cardiothoracic retrieval when novel technologies are at use. The aim from this session is getting access to major vascular structures and possibly retrieving heart and lungs but the abdominal compartment will not necessarily be dissected therefore I Currie has set aside a morning to retrieve pancreases and take images and record video images from a cadaver which will be shared. This will take place on 14th December. I Currie would like to receive colleagues' thoughts via email about key damage areas and key aspects to retrieving pancreases well. **All Members**

S Sinha requested the issue of sacrificing the pancreas for the liver is raised at the retrieval workshop and the Liver Advisory Group (LAG). It needs to be reemphasized that the liver does not take precedence over the pancreas. I Currie agrees the pancreas should not be sacrificed and stated this can usually be divided as specified in the latest NORS guidelines. J Casey and Derek Manas jointly wrote a protocol which clearly states that if there is a right which is genuinely going through the substance of the pancreas then it should be divided at the duodenum. A discussion should take place between the liver and pancreas surgeons particularly if there is any issue around that, but the norm is that it should be divided. S White had a similar case and was contacted to be told the pancreas has been sacrificed for the liver. S White feels centres need to be educated.
J Casey will write to Doug Thorburn (Chair of LAG) today and request that this is raised with the liver transplant teams as an issue. J Forsythe added these incidences need to be submitted as an incident through the formal Governance process. **J Casey S White & S Sinha**

5.6 Solid organ pancreas Clinical Leads in Utilisation (CLU's)

As mentioned by J Forsythe, funding has been secured for CLU's for four months for one CLU per pancreas units. All pancreas units have a nominated person. Meetings will be set up in the next 2/3 weeks with C Callaghan and colleagues from NHSBT to tell those CLU's what their roles will be.

5.7 Pancreas Offer Review Scheme

C Callaghan provided a brief update of the pancreas offer review scheme which is a set of criteria to define "high quality" deceased pancreas donors. In the past if offers from such donors had declined for donor or organ related reasons or if there were pancreas discards that would be highlighted to C Callaghan through NHSBT

and if there were any queries that C Callaghan had about offer decline or organ discard, letters would be sent out. The scheme has been paused due to COVID and will be put on hold for the rest of this year. **Action**

6 Simvastatin study – PAG(20)24a & PAG(20)24b

J Dark presented an outline of the findings from a study published by Karl Lemstrom from Helsinki in 2019. This led to the design of the SIGNET Study which received approval in October. The SIGNET Study is envisaged to begin on 1st April 2021 using adult DBD donors, for a period of 5 years, to be randomized after consent for donation and research to receive as single dose of Simvastatin.

This study will include representatives for all organ groups including J Shaw for pancreas. Data will be shared retrospectively to show there is no confounding effect. J Dark requested if anyone is planning a study to contact J Dark to discuss potential co-enrollment and what it means and whether it is of any scientific impact.

This is one of the largest randomized controlled trial in organ donation in the world. Members involved in this study are applying for a mechanistic study using QUOD specimen in the same cohort.

This has been endorsed by other advisory groups where this has been presented.

C Callaghan asked what outcome measures you would use in terms of pancreas transplantation. J Dark advised we are constrained by the data collected already by the UK Transplant Registry. This is entirely a donor intervention study and we think there is no detectable amount of drug transplanted with the organ but there will be a reduced inflammatory profile within the donor which will be of benefit to the organ.

7 Pancreas Offering Scheme

7.1 POS annual report – PAG(20)25

A report was circulated showing activity in the last 12 months of the Pancreas Offering Scheme since it was introduced in September 2019. Transplant numbers are lower and also waiting list are shown at the beginning of September when only 5 whole pancreas centres were open at that time.

C Counter highlighted at the last PAG Sub-group meeting that a suggestion was made that the maximum donor age is reduced temporarily for DBD and DCD for whole pancreas transplantation. The suggestion was to reduce the donor maximum age for DBD to 55 and the maximum donor age for DCD to 50 from the current levels. All centres that were represented at that meeting agreed it would be reasonable however there was some concern from Newcastle who felt this would reduce the number of offers and potential transplants.

Members agreed due to the change in circumstances in the current climate and the number of declines, it was agreed to keep these criteria as they are and monitor this.

8 Pancreas Transplant Activity

8.1 Fast Track Scheme – PAG(20)26

C Counter presented information from the fast track offering scheme monitoring the

change, introduced at the beginning of April 2019, for organs that had a cold ischemic time (CIT) greater than 8 hours to no longer be offered via the fast track scheme. **Action**

For the 17-month time period there was very little change in the proportion of pancreas donors offered via the fast track scheme, 42% compared to 43% in the previous financial year. Of those 214 offered through the fast track scheme 81 were accepted and a total of 40 transplanted following fast track.

In the last 6 months a large number of organs were offered via fast track due to the offering scheme deviation introduced while some centres were shut for COVID. Looking at the financial year 2019/2020 only, 40% of organs were offered through the fast track scheme which is slightly lower than the financial year 2018/2019.

A further change was requested and introduced 1st October 2020 so that pancreases will not be fast tracked to whole pancreas centres if the CIT is greater than 4 hours. This will continue to be monitored.

8.2 Transplant list and transplant activity – PAG(20)27

The paper was circulated, and no questions were received.

8.2.1 Group 2 patients report

There have not been any group 2 patients in pancreas transplantation.

8.3 Transplant outcome – PAG(20)28

It was noted there was a significant improvement in one year graft survival following first SPK from DBD donors when comparing the time period 2015 to 2017 with 2017 to 2019.

9 Working Group

9.1 SIK (Working Group)

David Van Dellen was unable to attend and provide an update for the SIK Working Group. A Sutherland advised the SIK working group met in June and put together a plan for how units are more integrated in terms of listing criteria and the follow up of SIK patients to robustly look at outcomes.

10 Pancreas Islet Transplantation

10.1 Report from the PAG Islet Steering Group: 22nd September 2020

P Johnson presented a brief report from the last PAG Islet Steering Group Meeting.

Reported at the meeting was an unusual and interesting pathology of donors that had previous COVID and recovered from that but had passed away from unrelated conditions. This has been observed internationally.

Standardization of protocols and optimization of protocols that were historically set up such as the islet transport and developing new strategies were discussed.

The use of oral glycemic agents was raised at the meeting which J Shaw has been steering from the diabetes side. Once data is collected on that, a meeting will be held in the next month with clinical leads to discuss that further.

An NHS England islet autotransplant meeting took place yesterday which is developing well. **Action**

10.2 Islet transplant activity and outcome – PAG(20)29

C Counter highlighted the key points from the paper which saw a similar number of islet transplants performed the last three financial years which is around 30 each year which equated to 21 patients in 2019/2020 financial year.

One year graft survival in the recent time period of 87% and five year graft survival is 51%. Reductions in the median rate of severe hypoglycemic events median HbA1c and insulin dose are also seen at one year post transplant.

10.3 Islet isolation outcomes – PAG(20)30

C Counter presented information around isolation statistics 2019/2020 data which showed 90 pancreases used for isolation and isolation was completed in 93% of those cases. 63% of those met the release criteria overall, and 28 of the 90 used for isolation were transplanted which gives an overall conversion rate of 31%. That rate has improved from the previous year. There were very few grade A donors, just 18 of the 90 in the last financial year.

It was noted patients becoming more complexed and potentially a need to drive towards insulin dependence as a primary achievable outcome and therefore should units consider moving more quickly towards getting a third transplant.

S White asked if further information could be provided for the 53 that met the release criteria but was not transplanted. The majority was insufficient yield for recipient. S White feels it would be useful if we could see what the yields were. P Johnson added its quite rare that the yield is the only reason and that there may be a report in the morphology of those cells. P Johnson is doing a piece of work in terms of trying to understand the number of islets required by a recipient based on the quality of the donor as well as the details of that recipient. Internationally, the same number of islets are given to a recipient regardless of what the donor was like and regardless of whether the recipient requires a high insulin. S White asked if more information should be recorded such as other factors like viability. C Counter highlighted that the reasons stated are those given and recorded by Hub Operations for the reasons for declining the isolation which could be the first or the main reason given. Further information is reported on page 5 of the pancreas donor information form which gives an opportunity for the laboratory to record additional information. S White feels yield could be compromised and try to go for a third transplant.

Members discussed third transplants and the timing of those transplants. P Johnson highlighted that NHS England only fund two transplants per patient and have had two second grafts wipe out first grafts which is something to be cautious of. This was before anti-inflammatories were introduced. J Casey feels it would be worth looking at the Edmonton experience.

11 Standard Listing Criteria

11.1 Summary data – PAG(20)31

The form return rates are good there was one patient in the recent time period who was registered for PTA outside of the criteria who had not been agreed through the

exemption process. This was discussed with Manchester who was not present at today's call. **Action**

11.2 Pancreas transplant listing exemption requests and outcome of previous applications to appeals panel – PAG(20)32
The spreadsheet was circulated prior to the meeting, no new exemptions were received.

12 Any Other Business
Members agreed to reinstate the PAG COVID-19 Sub-group meetings to twice monthly.

A virtual EPITA meeting will be taking place in January and a programme is available on the ESOT website.

C Callaghan thanked J Casey for all the work he has done for utilisation and support as Chair of PAG. This was reiterated by all members.

Mr Casey thanked the members of the advisory group for their support over the last 5 years especially the support from the statistics team (Claire Counter and Lisa Mumford) and the clinical and support services (Sam Tomkings).

13 FOR INFORMATION ONLY

13.1 Summary from Statistics & Clinical Studies – PAG(20)33
The papers were circulated, and no comments were received.

13.2 Transplant activity report: September 2020 – PAG(20)34
The papers were circulated, and no comments were received.

13.3 Current and Proposed Clinical Research Items – PAG(20)35
The papers were circulated, and no comments were received.

14 Date of Next Meeting: Wednesday 28th April 2021 via Microsoft Teams Meetings

November 2020