NHS BLOOD AND TRANSPLANT
ORGAN AND TISSUE DONATION AND TRANSPLANTATION

THE THIRTY- NINTH MEETING OF THE PANCREAS ADVISORY GROUP AT 10:30AM ON WEDNESDAY 28th APRIL 2021 VIA MICROSOFT TEAMS MEETING

PRESENT:

Prof. Steven White	**Chair**
Dr Arthi Anand	BSHI Representative
Mr Argiris Asderakis	Cardiff Transplant Centre
Dr Richard Baker	Joint National Clinical Governance Lead, NHSBT
Mr Chris Callaghan	National Clinical Lead for Organ Utilisation (Abdominal)
Mr John Casey	PAG Islet Steering Group Chair
Mrs Claire Counter	Statistics and Clinical Research, NHSBT
Mr Ian Currie	National Clinical Lead for Organ Retreival
Mr Frank Dor	KAG Representative
Mr Martin Drage	Guys Transplant Unit
Mrs Kirsty Duncan	Recipient Coordinator Representative
Ms Aileen Feeney	Lay Member Representative
Prof. John Forsythe	Medical Director, NHSBT
Prof. Peter Friend	Oxford Transplant Centre (deputy)
Ms Susan Hannah	Regional Manager & SNOD Representative – Organ Donation
Mr Simon Harper	Cambridge Transplant Centre
Dr Stephen Hughes	Islet Laboratory Representative
Mr Ben Hume	Strategy, Transformation & Business Development, NHSBT
Prof. Paul Johnson	Clinical Lead for Islet Laboratories
Mrs Julia Mackisack	Lay Member Representative
Dr Adam McLean	WLRTC & Hammersmith Hospital Representative
Mr Joseph Parsons	Statistics and Clinical Research, NHSBT
Dr Tracey Rees	Chief Scientific Officer, NHSBT
Prof. James Shaw	UK Islet Transplant Consortium
Mr Andrew Sutherland	Edinburgh Transplant Centre
Ms Sadie Von Joel	Lead Nurse Recipient Transplant Co-ordination
Mrs Julie Whitney	Head of Service Delivery, OTDT Hub

IN ATTENDANCE:

Miss Sam Tomkings	Clinical & Support Services

Apologies

Dr Ayesha Ali, Mr John Asher, Mr David Van Dellen, Ms Anushka Govias-Smith, Dr David Hopkins, Mr Anand Muthusamy, Mr Simon Northover, Mr Sanjay Sinha, Ms Sarah Watson, Mr Colin Wilson.

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 5th November 2020 – PAG(M)(20)3 **ACTION**

2.1 Accuracy

The minutes of the meeting held on 5th November 2020 were confirmed to be a true and accurate record.

2.2 Action Points PAG(AP)(21)1

All action points had been completed or were included on the agenda. Those with a verbal update are listed below.

AP1 – Collaborative working was discussed on numerous occasions and it was felt there was little need to implement this as it was highly likely that the pancreas programs would reopen individually.

AP2 – Internal conversations have taken place and it was agreed the pancreas imaging pilot would no longer be a pilot but now business as usual. Photographs are accepted and SNODs are actioning this and comms have been circulated. A Sutherland added that routine photographs are being received at pancreas retrieval but found the quality of the photographs vary. A Sutherland asked if quality control on photographs taken is in place. Agreed at the last Retrieval Advisory Group (RAG) Meeting was to set up a working group to look at techniques of photography, in addition, C Callaghan has been speaking to colleagues on how to improve imaging.

AP3 – Useful discussions have taken place regarding pancreas damage. It was acknowledged that pancreas damage has the highest organ discard rate for damage. Colleagues will be looking to collate all of the serious adverse events reported to the HTA due to organ loss over the last 3 years and look for patterns of injuries then translate that into a document for discussion with NORS leads and for cascade to team members. The document will highlight those surgeons who are not involved with pancreas surgery and highlight key areas pancreas retrieval surgeons must be more careful with. The possibility of setting up a pancreas retrieval day like the Masterclass but focusing specifically on pancreas retrieval has been discussed but comes with a high level of cost. It was suggested this is something which could be held every 2/ 3 years. P Friend felt this is something that should be done more regularly to include turnover of retrieval teams as most retrieval surgeons would not be exposed to enhanced training during the time of doing retrievals and feels that it should be included as part of the Masterclass but to focus more on the pancreas. P Friend suggested whether there should be some requirement on surgeons that damage more than 1 or 2 pancreases to attend. I Currie agreed and has discussed the possibility of focusing more time at the Masterclass on dissection. The plan is to include this for the December 2021 Masterclass and to invite NORS leads and their teams and clinical leads from this group who will disseminate this information.

S White and I Currie have liaised with D Thorburn regarding the issue of the pancreas being sacrificed for the liver. The guidance is clear, and it is documented that the pancreas should not be sacrificed for the liver. It is felt this is an education issue and as team's turnaround, they must be informed there are guidance and protocols to follow. This will be a part of the retrieval training program. S White has had some email correspondence to suggest expanding on the current rules and

regulations of pancreas sacrifice particularly with split liver retrieval. **ACTION**

2.3 Matters arising, not separately identified

There have been a few changes to the composition of the PAG committee. J Casey has been re-elected as Chair of ISG and a role has been created on PAG for P Johnson as Clinical Islet Laboratory Lead. S White thanked P Johnson for his work as PAG ISG Chair. S Sinha has been appointed as deputy Chair of PAG for 2 years. C Wilson has been appointed as Newcastle representative and A Feeney is the new lay member representative on PAG which S White welcomed to the group.

3 MEDICAL DIRECTOR'S REPORT

3.1 COVID-19 update

J Forsythe expressed thanks to all who have worked tirelessly to ensure the system continues to work as well as it has throughout the pandemic and acknowledged around a 22% reduction in transplantation over the last year which is remarkable in those circumstances.

Activity monitoring shows numbers are increasing again in donation and transplantation. All pancreas programs have reopened, and J Forsythe would encourage colleagues to look at their waiting lists as many units have dealt with the pandemic by reducing the waiting lists and to continue to ensure this is well managed.

NHSBT have been heavily involved in Vaccine Induced Thrombocytopenia and Thrombosis (VITTS) and that many of these deaths have been potential donors. Of the 19 fatal cases that MARA reported, NHSBT reported 13 of those 19 cases and have been able to provide a fair amount of donor details because of our record keeping and have been able to give some access to samples collected from donors. NHSBT will continue to be involved to try and offer facilitation to help understand the pathophysiology of VITTS.

J Forsythe thanked colleagues who have help put together the UK experience of donation and transplanted organs from those donors with VITTS and submitted an article to the lancet hoping that will be published to make clinicians and patients aware of the experience we have had so far. Guidance is available on the website for management of VITTS donors and management of retrieval and recipients.

3.2 Opt out update

The opt out legislation is in place in England and Scotland and consultation has taken place which is now closed in Northern Ireland.

Due to the pandemic, this has gone under the radar but as the ODT strategy develops further we would look to make best use of that legislation.

NHSBT are hoping to announce in the not so distance future a development which pivots towards transplantation and looks at better utilisation of donor organs such as more marginal organs.

3.3 ODT strategy update

B Hume presented the strategy ''Organ Donation and Transplantation 2030 *Meeting the Need*'' which is aimed at meeting transplant availability and needs.

ACTION

Since 2008 the UK have achieved a doubling of deceased donors. One of the challenges pre pandemic which will also be an issue after the pandemic is that the transplant waiting list initial fell but did not fall as much as hoped and the narrowing of the gap between donors and the number of transplants was evident but did not close. There are a set of impacts that are not completely understood but that it is likely to take us back to around 2013 /2014 levels based on the modelling by statistics and clinical studies. There is also more progress seen in deceased donation than living donation. This new strategy will give deceased and living donation equal visibility and clarity.

The next steps will continue to focus on people saying yes to donation, increasing the number of organs transplanted and will continue to focus on consent or authorisation as well as organ utilisation.

The strategy for donation will have a different set of actions and different nuance for deceased, living, paediatric and neonatal donation and will make the most of the opportunities within the new legislation and laws that are now in place and will be looking to increase public visibility of deceased and living donation. Agreed for transplantation, is to systematically overcome the barriers to organ utilisation and will look to support development in transplantation and particularly in transplantation technology.

The 6 key areas are donation, transplantation, outcomes, diversity, sustainability, and research.

NHSBT are hoping to work towards launching the strategy early June.

S White asked that digitising data collection would need a lot of investment and to make a change in the way we collect data, will there be an overhaul for that.
B Hume confirmed there is a plan for an overhaul and the way the data is collected and involving less paper is critical. NHSBT will be looking to invest in these areas to collect data in a better way. J Forsythe highlighted part of the donor characterisation work is to do electronic transfer of donor details particularly H&I details.

3.4 Hepatitis C positive donors to Hepatitis C negative recipients

Utilising hepatitis organs was previously discussed at PAG in November 2019 where it was acknowledged that centres must opt in to utilise these organs. It was recognised that if centres opt in for kidney utilisation of these organs, this can include acceptance for pancreas utilisation in an SPK setting. S White has a meeting with Ahmed Elsharkawy and asked if centres had a feel for opting in for solitary pancreas transplantation (PAK and PTA). It is understood that no hepatitis C kidneys have been used in a SPK transplant so far.

There was unanimous support from centres for accepting the pancreas for solitary pancreases and S White will work on the logistics for implementing this.
J Whitney advised there is an application process and some centres who have already stated they are interested will have approval to accept kidneys but are not on the list for accepting hepatitis C pancreases. Once all centres are on board, the next step is to consider how these organs are offered as at the moment they are

offered via fast track as they are classed as a positive virology. The agreement is that if all centres approve, around 75% of waiting lists would consider these organs we would go back to named patient offering rather than using the fast track system. S White will coordinate with J Whitney the application process for centres to opt in. **ACTION** **S White & J Whitney**

R Baker asked if there is any concern about quality of hepatitis C pancreases. S White has looked at the literature which there is not a lot. S White will speak to Ahmed Elsharkawy about this. **S White**

4 COVID-19

Centres have been meeting once or twice a month since March 2020. Most pancreas programs have reopened and have around 190 patients on the national pancreas waiting list. S White asked units if there are any issues since restarting or any foreseeable problems.

A McLean advised that Imperial are in the process of getting their HDU back. One SPK took place late last year before the last lockdown within a temporary HDU area put together.

Blocked contracts have provided a few issues for Guys when swapping organs between units and M Drage is not sure how the tariff system will work with block contracts. S White suggested speaking to Sarah Watson or Ayesha Ali from NHS commissioning. Newcastle were doing liver transplants for Royal Free patients and S White will liaise with Derek Manas about if whether the unit would have exceeded the number of transplants the Trust had paid for, how this would have been reimbursed. S White will share the outcome of this with M Drage. All transplants at Guys for the first 5 days need to be in a side room which is a potential issue. **S White**

4.1 Summary COVID data and pancreas offering – PAG(21)2

In March 2020 pancreas transplants dropped off but since the second lockdown things have picked up. Despite heavy immunosuppression, pancreas patients have not been particularly at risk of COVID which is very reassuring.

C Counter reported that 11.6% of the waiting list tested positive and 1.2% of the waiting list have died. C Counter confirmed that is active patients on the list at February 2020 or registered on the list subsequently. 5.9% of transplant recipients tested positive and 0.7% died.

One patient had a SPK transplant who died of COVID related complications. That patient did require a graft pancreatectomy, but the patient did not take their immunosuppression and the kidney also failed therefore neither graft was functioning at the time of death.

4.2 Individual centre report

Covered under item 4.

5 Governance

5.1 Incidents for review: PAG Clinical Governance Report – PAG(21)3

An incident reported an issue of a ligature slipping off the bile duct and the learning point from that was to double check the knots before packing. This incident was discussed with I Currie and Derek Manas who agreed even if the ligature slipped

the graft could have still been used if the preservation fluid was clear. M Drage would disagree with this and would not have used the pancreas due to duodenal contents. P Friend agreed and felt that the correct decision was made to not use the graft. **ACTION**

S White suggested educating surgeons to over sew the ligature to make it less likely to fall off. On reflection it was felt that when requesting something additional such as extra suturing this could result in accidental damage to the pancreas. I Currie would suggest sticking with what we do but that an email could be circulated to suggest making sure that the ligature is secure on the duct attached to the pancreas. R Baker proposed incorporating into lessons learned which members agreed. **R Baker**

Meetings have been taking place regarding problems with DCD kidneys going with pancreases and then being reallocated. There was an issue of graft survival of kidneys that got reallocated after a pancreas was turned down. M Robb did an analyses on this and R Baker requested the analyses was split just on DCD kidneys and it was found there was no significant difference in graft survival in DCD kidneys that are initially allocated with the pancreas and then reallocated elsewhere vs the other kidney that goes to one centre. R Baker will circulate the paper. **R Baker**

5.2 Summary of CUSUM monitoring following pancreas transplantation PAG(21)4

There were no recent CUSUM triggers. S White asked if there was any data on kidney graft survival. C Counter advised that kidney outcome following SPK using CUSUM monitoring is currently being developed.

5.3 Pancreas imaging

The pancreas imaging pilot was introduced a year ago and is now business as usual which John Richardson is leading on from an NHSBT and SNOD perspective.

Issues have been noted regarding quality and use of the images which C Callaghan is working with colleagues to try and have a better process for organ images. Work is ongoing for that.

5.4 Pancreas damage

CUSUM is used routinely for transplant outcome monitoring but is not yet applied for retrieval as it is difficult to determine what damage means. A FTWG has been set up to look at organ damage and how to define this.

An update in the definitions of damage focusing on the effect in the RTI forms and on the electronic B forms which will soon be changed. The current damage is being defined on the retrieval side in an unclear way and on the B form does not allow for the detail that is needed. The purpose for this is to allow CUSUM for damage to monitor individual teams and whether they comply with the national CUSUM monitoring and will be reported like CUSUMs are for transplant centres. It is hoped this will be available in 2022 when a baseline has been established. S White asked if the mild, moderate and severe categories will be removed and replaced with 0,1,2,3. I Currie advised this is correct as the group felt mild and moderate was not distinguished properly and mild and moderate were grouped together in the NORS report and grouping them together gives a challenging statistic to understand. S White feels this could be left open to interpretation and

when bringing in CUSUM analysis to each individual centre it would be difficult to categorise the level of injury. I Currie agreed that one person's decision to not use an organ is different from a person's decision to use an organ and cannot legislate for that degree of nuance and could end up with lots of free text which cannot be analysed. **ACTION**

S White asked if a centre does trigger on a CUSUM how this will be dealt with. I Currie advised teams meet annually with I Currie or Marius Berman and head of commissioning for NHSBT and go through performance of individual retrieval teams over the last 6 months which includes the SAEs where an organ has been damaged and lost and reported to the HTA.

For islet isolation, if a severe capsular injury was detected that leads to the organ not being used, the islet labs have a duty to complete the form including the grade of injury. P Johnson has emphasised at PAG ISG that it is imperative that that happens and to include a photographic record. I Currie would be keen to see more photographs particularly if the organ is declined by all centres due to the artery dissected and unusable, I Currie would encourage colleagues to open the artery and take photographs or send to pathology. It was emphasised this would only take place after the organ has been definitively declined by all clinical centres and for all relevant purposes.

J Whitney requested that the B forms are submitted in a timely way to enable the information to be collected as if the teams have a back log of forms, that will skew the CUSUM reports. **All Centres**

5.5 Organ damage report – PAG(21)5

The Organ damage report was circulated, no comments were received.

5.6 Solid organ pancreas Clinical Leads in Utilisation

The CLU scheme was a short-term scheme from November 2020 – March 2021 which has been very productive. A national virtual conference will take place which will include the unit reps as CLUs and clinical leads and clinical directors, it was noted that this will not be open to the general transplant community at present.

Funding for the CLU scheme has been secured from July/ August this year to March/ April next year and more information on the appointment process will be circulated.

C Callaghan reported a wider issue in terms of relative profile of organ utilisation within NHSBT which is rising for all sorts of complex reasons and is a priority in the new strategy. An organ utilisation package is going through NHSBT to get funding. More information will be provided on those schemes and packages.

5.7 Pancreas Offer Review Scheme

A scheme has been running within NHSBT where ''high quality'' deceased donor pancreases are declined or discarded and are alerted to C Callaghan who looks at the core donor data form and the reasons units have given for organ decline or discard. C Callaghan would then write out to individual units and thanked colleagues who have written back.

Those offer review schemes are on pause and C Callaghan asked if PAG are at a point when those offer review schemes should be put back in place. It was acknowledged that C Callaghan's role has changed and therefore it may not happen straight away pending reorganisation. P Friend would be in favor of restarting this but to have a lenient approach. It was noted that the kidney offer review scheme is not activated at the moment and liver does not have this system in place. **ACTION**

Members agreed to keep this on hold for a further 3 months and to rediscuss this.

6 DCD SPKs

A presentation was given at the BTS on the use of DCD organs for SPK transplants which potentially would have some implications for the allocation scheme and whether PAG would be happy to change the allocation scheme to incorporate more points for potential recipients who may receive a DCD organ.

An analysis of around 2000 DBD SPK transplants and around 400 DCD SPK transplants going back to the start of the UK DCD program suggested that even with risk adjustment, there is no fundamental difference in graft survival in DCD or DBD or kidney and patient survival and no evidence at present that there is a differential effect of cold ischemic time (CIT) on DCD vs DBD and no differential effect of donor age on pancreas graft survival. It was acknowledged that is a challenging analysis as we have fundamentally different cut offs for DCD donor age and DBD donor age.

C Callaghan's suggestion would be to reexplore the allocation scheme of DCD SPKs which may be beneficial for equity of access because currently DCD SPK have local weighting in the attempt to minimise CIT. It would also be beneficial for units who find it hard to implant DCD SPKs because they are multi organ units and the way the liver allocation scheme and the SPK allocation scheme work together is that for the DCD, it is very common for the young liver donor to be offered to one centre and for them to be offered the SPK at the same time from the same donor placing a huge amount of pressure on theatres and for those centres in the north of the country, means their DCD donor is offered out to the south and there are pressures for transport and time.

A Asderakis has done a lot of work on CIT and would air caution to this analysis when the CIT has shrunk as the range has reduced significantly in the last few years and are much more likely to find less effect but does not mean there is no effect because if the range were to increase again the effect would appear.

Those results are only achieved by a fairly high level of selectivity. The DCD status is one of several approved risk factors and the way we get these good results is by minimising the other big risk factors which are age, CIT and others. That comes out in all analysis that there is a tendency that clinicians will try and avoid all other risk factors if going for a DCD. P Friend would prefer not to have a DCD organ with a 6 hour road journey but understands the predicament of the multi organ units which is something that can be planned out, such as a unit does not need to accept a DCD pancreas and liver from the same donor and whether this can be engineered into the offering system without engineering in something we do not want which is a systematic increase in travel time.

ACTION

S White agreed and feels this may come back to the potential of collaborative working for centres who are adjacent to one another to minimise travel time.
J Casey reported that since the new liver offering scheme has been introduced, the number of DBD liver transplants done in Edinburgh have reduced and are looking at more DCD organs to try and increase that. Edinburgh have experienced issues with doing DCD pancreases because of doing a DCD liver transplant. J Casey would support looking at how these organs are offered to try and help centres who are further away from the biggest concentration of donors to carry out DCD pancreas transplantation.

S White proposed forming a working group and asked for volunteers. J Casey asked how we can more widely offer or distribute DCD pancreases in the UK while keeping CIT reasonable. C Counter could look into the possible options and the factors included in the offering scheme and how we can use some of those to possibly distribute DCD organs or give more priority to other centres, not just the closest. A Sutherland, P Friend, A Asderakis and S White volunteered to be part of the working group and other members will be approached out with the meeting. **C Counter A Sutherland / P Friend / S White / A Asderakis**

C Counter will forward a copy of C Callaghan's paper on DCD kidneys to S White. **C Counter**

7 Pancreas Transplant Activity

7.1 Fast Track Scheme – PAG(21)6

C Counter highlighted a couple of recent agreed changes to the fast track scheme: from 1st April 2019 not to fast track any pancreases if the CIT was over 8 hours and from October 2020 not to fast track to a whole centre if the CIT was over 4 hours, but the organ could still be fast tracked to islet centres.

Between April and September 2020, a process deviation was put in place for the allocation scheme therefore more organs were fast tracked, 45% in that time period.

Between October 2020 and March 2021, 35% of donors were fast tracked which C Counter feels should be monitored more before making any decisions as to whether the changes have had an impact on reducing the number of organs fast tracked.

7.2 Transplant list and transplant activity – PAG(21)7

The transplant list and transplant activity paper was circulated showing in 2020 there were 116 transplants from 249 donors which is a utilisation rate of 47% and there were 136 patients on the list at the end of 2020 but as at yesterday there were 212 patients on the list.

7.2.1 Group 2 patients report

There have not been any group 2 patients.

7.3 Transplant outcome – PAG(21)8

C Counter highlighted from the transplant outcome paper that DBD SPK pancreas graft survival for the latest time period was 95% at 1 year and 88% for 3 year survival and kidney graft survival for DBD SPK for that same cohort was 98% at 1 year and was 95% at 3 years. DCD SPK pancreas graft survival showed 1-year

graft survival of 96% and 3 years was 88% and kidney graft survival was 100% at 1 year and 90% at 3 years. **ACTION**

C Counter mentioned in the pancreas after deceased kidney cohort, there were 3 deaths with a functioning graft, one was before 1 year, one was just before 2 years and one was just before 3 years post-transplant. The number of solitary pancreas transplants remains low.

8 Working Group

8.1 SIK (Working Group) – PAG(21)17

J Casey has taken over Chair of the SIK working group as it was felt that as a group, we wanted to review criteria and review the number of previous transplants.

SIK was discussed at the ISG meeting and the paper reviews the SIK activity in the UK since the agreed allocation scheme was put in place in 2016.

There have been 23 SIK transplants done in the UK. The data is taken up to the end of March where it was noted that it is early days for outcomes but there are 75% of grafts known to be functioning but do not have complete follow up data.

One of the main discussion points at ISG was around the listing criteria and follow up monitoring of these patients particularly from an islet graft point of view. Another discussion point was for listing patients who are C-peptide positive. There are a few patients who have been considered, discussed, and transplanted who are C-peptide positive. It was acknowledged that it is difficult with those patients who are renally impaired, and it was discussed at what level do you feel they would not benefit from an islet graft and how to subsequently monitor graft function. The ISG group concluded if patients had a C-peptide measured over 50pmol/l at the time of listing for an SIK they would undergo a meal tolerance test and these patients would be documented and monitored and whether they gain benefit from their islet transplant. Going forward, the suggestion was made to keep monitoring of SIK transplantation through the advisory groups. Some areas such as short- and long-term outcomes from diabetes measuring biochemically and clinically is important and should be looked at and, kidney outcomes.

It was agreed this work could take place through PAG ISG and then feed back into PAG.

J Casey would like to further discuss SPK centres who are not islet transplant centres but can discuss SIK patients and have access to SIK. S White feels any centre that offers whole pancreas transplantation should also offer islet transplantation for patient benefit. J Casey agreed that this is an important point. Centres who do not offer islet transplantation could consider buddying up with a centre that does offer this. J Casey feels it is imperative to offer patients both options where applicable. J Shaw added that it is crucial that we have an MDT and the patient can make an informed decision. P Johnson supported alignment of whole pancreas and islets in each centre but until that is in place, feels that we should ensure close piggy backing and that no patient should be considered for a whole pancreas or islet transplant without each being considered in an objective manor even if that includes movement of the patient and P Johnson would suggest including within that a robust assessment of hypoglycemia or optional diabetes

management. Members fully supported piggy backing the solid organ units onto the islet units but recognised there are some complexities when many units are close such as those in London, in particular, complexities of how decisions for SIK patients are made in King's College. J Casey proposed that a national MDT could be useful. A Sutherland is working with David Van Dellen putting together early experience of these transplants. **ACTION**

It was raised whether we are overthinking the eligibility for those who have a slightly high C-peptide as they are getting a kidney from a donor and are at relatively low risk and could receive islets as well. J Casey feels there are two ways for assessing a patient, one is clinical from their insulin requirement or from their HbA1c or from their diabetic control but there are points around how we define graft function that are more complex if they are C-peptide positive. It was noted there are differing thoughts about this. Colleagues were reminded that one patient who had a SIK died from the islet infusion. Members acknowledged there is no procedure risk free and agreed there is a risk benefit balance which should be discussed with each patient.

9 Pancreas Islet Transplantation

9.1 Report from the PAG Islet Steering Group: 20 April 2021

J Casey presented a brief report from the last PAG Islet Steering Group Meeting and once again thanked P Johnson for his contributions as Chair of PAG ISG.

A number of meetings took place regarding the HTA input into islet isolation which P Johnson did a lot of work with the labs in refining that and complying with the HTA recommendations.

PAG ISG discussed donor criteria and BMI of donors. As part of the development of the offering scheme which changed things around in terms of BMI and age with interaction of offers, the group affirmed that donors with an age under 25 and BMI of under 25 would have a low chance of a successful isolation and should be as much as possible prioritised for solid organ transplantation, equally those donors age 18-25 but with a high BMI can in many cases have a successful islet isolation.

9.2 Islet transplant activity and outcome – PAG(21)9

In 2020 there were 14 islet transplants performed and at the end of the year there were 20 patients on the list, 19 of those were routine and 8 of those 19 were SIK patients and 1 priority patient.

9.3 Islet isolation outcomes – PAG(21)10

C Counter reported 1-year graft survival is 80%- and 5-year graft survival is 51% after first islet transplant and have seen reduction in median rates of severe hypoglycemia and HbA1c and insulin dose at 1,3- and 5-years post-transplant compared to pre-transplant.

S Hughes reported activity overall has been low compared to the previous year due to COVID. Oxford have had particularly low activity and poorer outcomes than others, but the data shows that Oxford have had a lot of marginal donors.
P Johnson reported that those figures have been looked at in detail and provided a summary of that including the different variables. S White feels that for some of the cases purification seems to be an issue. It was noted that centres should be using

the same basic formula for purification and counting as far as possible. S Hughes advised that labs can employ slight modifications depending on the donor. J Casey highlighted that Edinburgh do not refrigerate their COBE. Edinburgh are looking at more enclosed processing and purification and more standardised purification and J Casey suggested this should be looked at on a UK wide basis. P Johnson highlighted that the COBE is being phased out and will not be serviced in a few years' time. A session will be taking place at IPITA to look at this internationally. S White is keen to minimise the loss of some of these younger donors that have had failed islet isolation and could have been used for whole pancreas transplantation **ACTION**

10 Standard Listing Criteria

10.1 Summary data – PAG(21)11

In 2020, there were 158 new registrations for whole pancreas and have so far received 87% of supplementary registrations forms. C Counter requested centres ensure their forms are submitted to Information Services for processing. **All Centres**

10.2 Pancreas transplant listing exemption requests and outcome of previous applications to appeals panel – PAG(21)12a & PAG(21)12b

The policy document for NHSBT states that a minimum of 5 centres must respond for a clinical exemption decision to be made. For islet exemptions it is not quite as straight forward and on occasions have only had 3 centres responding. S White reiterated the importance of centres responding to the exemptions as it will prolong the waiting time for the patient.

S White requested that all involved respond particularly those involved in islet exemptions. **All Centres**

11 Any Other Business

PAG COVID meetings have been paused but will be reinstated if required.

12 FOR INFORMATION ONLY

12.1 Summary from Statistics & Clinical Studies – PAG(21)13

The Summary from statistics & clinical studies was circulated and no comments were received.

12.2 Transplant activity report: March 2021 – PAG(21)14

The Transplant activity was circulated, and no comments were received.

12.3 Current and Proposed Clinical Research Items – PAG(21)15

The Current and proposed clinical research items paper was circulated and no comments were received.

12.4 QUOD – PAG(21)16

The QUOD report was circulated and no comments were received.

13 Date of Next Meeting: Thursday 11th November 2021, 10:30am, via Microsoft Teams Meeting