To be ratified **KAG(M)(21)1**

NHS BLOOD AND TRANSPLANT
ORGAN AND TISSUE DONATION AND TRANSPLANTATION

MINUTES OF THE THIRTY-NINTH MEETING OF THE KIDNEY ADVISORY GROUP ON WEDNESDAY 9th JUNE 2021 VIA MICROSOFT TEAMS MEETING

PRESENT:

Dr Rommel Ravanan	**Chair**
Mr John Asher	Medical Health Informatics Lead
Mr Atul Bagul	Representative for Leicester & Nottingham
Dr Richard Baker	Joint National Clinical Governance Lead, NHSBT (attended part meeting)
Ms Victoria Banwell	Surgical Trainee Representative
Mr Adam Barlow	Leeds & Newcastle Representative
Mr Stephen Bond	Recipient Co-ordinator Representative
Ms Lisa Burnapp	Clinical Lead Living Donation, NHSBT
Mr Chris Callaghan	National Clinical Lead for Organ Utilisation (Abdominal)
Ms Rebecca Curtis	Statistic & Clinical Research, NHSBT
Mr Frank Dor	Deputy Chair and Imperial & Oxford Representative
Dr Jan Dudley	Chair of KAG Paediatric Subgroup
Dr Sarah Cross	QUOD Representative
Ms Anusha Edwards	Cardiff & Bristol Representative
Prof John Forsythe	Medical Director, OTDT
Ms Anushka Govias Smith	Commissioner for Kidney Transplant NHS Scotland
Ms Heidy Hendra	Nephrology Trainee Representative
Ms Dela Idowu	Patient Representative
Dr Gareth Jones	Lead London Collaborative
Dr Helen Jones	Representing KAG Paediatric Subgroup (deputy)
Dr Lazarus Karamadoukis	Dorchester Representative
Dr Phillip Mason	Renal Association Representative
Ms Julia Mackisack	Lay Member Representative
Mr Sanjay Mehra	Liverpool & Manchester Representative
Mr Pramod Nagaraja	Cardiff & Bristol Representative
Mr Ravi Pararajasingham	Sheffield & Cambridge Representative
Dr Paul Phelan	Glasgow & Edinburgh Representative
Mr Gavin Pettigrew	PITHIA
Dr Tracey Rees	Chief Scientific Officer – OTDT
Dr Matthew Robb	Statistics & Clinical Research, NHSBT
Mr Debarata Roy	Birmingham & Coventry Representative
Mr Aamer Safdar	Lay Member Representative
Ms Angie Scales	Lead Nurse Paediatric and Neonatal Donation
Dr Jennifer McCaughan	BSHI Representative
Ms Rachel Stoddard-Murden	SNOD Representative and Regional Manager
Dr John Stoves	Bradford Representative
Mrs Julie Whitney	Head of Service Delivery – Hub Operations
Prof. Steven White	Chair of Pancreas Advisory Group

IN ATTENDANCE:

Mr James Hunter	To present item 9.3
Ms Lisa Mumford	To present items 19 & 20
Prof. Christopher Watson	To present item 12
Miss Sam Tomkings	Clinical & Support Services, NHSBT

APOLOGIES:

Mr Tim Brown, Mr Ian Currie, Mr George Greenhall, Mr Abbas Ghazanfar, Mr Imran Saif, Ms Clare Snelgrove, Ms Susan Spence, Dr Raj Thuraisingham, Ms Sadie Von Joel, Mr Ian Wren.

ACTION

1. Declarations of interest in relation to the agenda – KAG(21)1
There were no declarations of interest.

2. Minutes of the meeting held on 20th November 2020– KAG(M)(20)2
The minutes of the previous meeting were approved.

2.1 Accuracy
The previous minutes were agreed as a true and accurate record.

2.2 Action points – KAG(AP)(21)1
All action points were either completed, included on the agenda and those with a verbal update were listed below.

AP1 – Referring unit level of organ offer declines
A request was made to investigate whether the offer decline report could be produced for referral units. M Robb advised that data is published on an annual basis by transplant unit. Referral unit information only comes to NHSBT a year in arrears from the UK Renal Registry. Having checked the recent data received from UK Renal Registry against the current waiting listed it was noted that there is still a lot of information we do not have on referral units. G Jones felt this would be useful to have to provide feedback to referral units and the patients that they look after that may have been declined by a transplant unit and asked if as part of the registration process there is an option to add where the patient is looked after. M Robb confirmed that some information is available on dialysis units and this is checked against the UK Renal Registry data where it was recognised that around 20% did not agree with what the UK Renal Registry had and because that data is in arrears there is a lot of data NHSBT do not have to be able to check it. J Asher highlighted this was initially raised by SMT who were concerned about the number of organs declined because of recipient unfit. Until the UK Renal Registry data becomes more real time it will not be easy for NHSBT to meet this request. R Ravanan and M Robb will look to see if there is any solution possible for this but for now this action will be closed.

AP2 – Sustainability – delayed audit data
I Wren sent his apologies for this meeting; therefore, no further update was available.

Update on A2 donors for B recipients
A small working group met to discuss if centres could have the donor A2 sub typing within the time that is reasonable for offering. This was set up as blood group B patients were disadvantaged by the kidney allocation scheme at the time and it was discussed whether this has changed since the new kidney offering scheme (KOS) has been in place. The new KOS system introduced in September 2019 had tools built in to address some of the inequity and there have seen some improvements but will need some more time to see what level of improvement has been made for blood group B recipients from the 2019 KOS.

L Burnapp asked if the group have considered those living donors that go into the kidney sharing scheme that are unmatched in exchanges as the greatest number are blood group A and if we knew the differentiation in their group that would be straightforward to offer them to B recipients on the waiting list. The group did not discuss living donors, but T Rees added that if a clinician was willing to accept an A2 kidney for a group B patient with low titres time would be on our side as the real barrier would be getting the A2 sub type on the deceased donors. L Burnapp, R Ravanan, T Rees and M Robb will put a paper together for the November meeting to look at how we can introduce unmatched blood

L Burnapp / R Ravanan / T Rees/ M Robb

ACTION

group A sub typed non directed altruistic donors from the kidney sharing scheme or any donor from the sharing scheme can feed into this and match to a group B recipient.

Report from KAG Paediatric Sub-Group

Ongoing work is taking place to change the donor age for paediatric recipients which will hopefully be completed by September 2021.

AP6 – Summary of CUSUM monitoring of outcomes following kidney transplantation

Following a query raised after the CUSUM paper presented at the last KAG meeting M Robb asked whether any other information would be useful. It was agreed to show a breakdown of donors and recipients going in to centres in the next centre specific activity report and are working towards publishing this in the next few months.

2.3 Matters arising, not separately identified

R Ravanan welcomed Ms D Idowu new patient representative, Dr L Karamadoukis and Dr J Stoves from the non-transplanting units and Ms V Banwell and Ms H Hendra to the meeting.

3. Medical Director's Report and COVID update

J Forsythe presented a graph showing the number of donors and transplant procedures performed weekly as at 8 June 2021 which showed the effects the pandemic had on transplantation and the good response post surge thus far.
J Forsythe expressed thanks to colleagues who have tried to keep retrieval and transplantation going throughout the pandemic. Only a 20% reduction in transplantation was noted in the last financial year which is remarkable in the circumstances.

NHSBT have been heavily involved with the issue of Vaccine Induced Thrombocytopenia and Thrombosis (VITT) and have a unique ICU network across the UK and have also been involved in some of the research and the pathophysiology research in VITT. Our registry set up earlier in the pandemic of those waiting list or transplant patients who have been affected by COVID and their outcomes has been utilised and have most recently been able to add vaccine data.

R Ravanan made a request to members of KAG that centres who receive a kidney from VITT donors to feedback the recipient outcome data to NHSBT and to please let your twin centres know to submit the data. J Forsythe reemphasised the importance of reporting the outcomes as NHSBT are trying to collate data as quickly as possible to help draw up the best-informed guidance. **All Members**

The NHSBT strategy was launched last week and a lot of people on this call have been involved in this ambitious strategy.

In the last Medical Director's bulletin circulated it was announced that a new organ utilisation group chaired by Steve Powis which will look at ways to improve organ utilisation in centres and look at how we might improve by recommendations across the board. This is mainly England focused but there is very strong collaboration between Department of Health's across the UK.

R Ravanan made an advanced request to members of KAG for the assistance which will be required to represent colleagues' thoughts and needs and what will work for patients.

J Forsythe drew attention to a number of packages, some of which are now available for clinicians and patients to use and some which are yet to come. The first was the aide memoir to the SABTO regulations which is now available as an electronic tool which is meant to help navigate through a large document of SABTO. J Forsythe thanked colleagues who have worked hard to put in place the patient information which is available on the website which addresses some FAQs. The TRAC tool which will hopefully be available in the not so distant future will allow clinicians along with patients to access an electronic tool which will demonstrate based on our data what would happen with different transplant scenarios for a particular patient with particular characteristics.

4. Living Kidney Donor update – KAG(21)2

L Burnapp presented a regular update to the group of Living Kidney Donor activity, the kidney sharing scheme (KSS), any exceptional requests received and reporting of transplants that have taken place outside of the UK.

The best comparison of the data available so far shows that 422 living donor kidney transplants were performed in 2020/21 which is around a 60% reduction in activity due to the COVID pandemic.

L Burnapp proposed KAG consider going back to the quarterly timetable of the KSS. Members of KAG supported this suggestion. L Burnapp highlighted that just because a matching run is going ahead it does not mean centres have to participate in it. If individual centres foresee issues with delay, which makes it difficult for all centres involved, please discuss this with L Burnapp and R Ravanan before entering donors and recipients in a matching run.

The digital transformation to underpin living donation is in progress and the KSS is the focus for the first phase of delivery and an outline business case is going to the board in July. L Burnapp thanked KAG members on the external user group and confirmed that they would be approached throughout the project for their input.

A provisional request for exceptional prioritisation for transplantation in a recipient who missed out on a living donor kidney and had an early failure of a subsequent deceased donor graft will be deferred and discussed at the November KAG meeting.

The national focal point 'travel for transplantation' work is in place to try and identify those transplants that have happened outside of the UK for illegitimate reasons. The 2021 data collection exercise for recipients transplanted in 2019 has identified 6 possible cases and L Burnapp and M Robb are working with units to receive more detailed information back. One further report of a patient returning from Iran with a deceased donor kidney transplant in 2021 will be followed up. L Burnapp encouraged centres to continue to report recipients who receive a transplant outside the UK through ODT on-line reporting.

5. Governance Issues

5.1 Non-compliance with allocation

There was no non-compliance with allocation.

5.2 Incidents for review: KAG Clinical Governance Report – KAG(21)3

The Clinical Governance Report was circulated, and no comments were received.

6. Transplant MDT workforce survey **ACTION**

The Transplant MDT workforce survey was devised following a point raised about whether we have benchmarking for workforce be it surgeons, nephrologist etc. Following the last KAG meeting, R Ravanan and L Burnapp did some work in the background to see what data is out there. The BRS published some data but this does not meet all requirements for this group. G Jones had done some work in London and F Dor has done some work in the surgical society and have looked at that data. The conclusion was whilst there are bits of information available, it does not provide up to date answers to the relevant questions.

The suggestion put to KAG was that a task and finish group is pulled together to create a survey tool which will allow the questions required to be asked from all 23 kidney transplant adult centres. In future, this may be extended to paediatric centres. Once the first draft of the tool is available this will be checked by KAG to ensure this is fit for purpose. The plan is to devise the tool and feedback at the next KAG meeting and then to deploy the tool by January 2022. KAG members supported this approach and J Stoves would like to ensure non transplanting centres are involved. F Dor discussed this at the Chapter Of Surgeons at the BTS who are supportive for the project to move ahead but recognised it will be challenging to capture the multiple roles surgeons often have within departments and how the transplant service is organised. S Bond is keen to assist with this from a recipient coordinator perspective. R Ravanan requested clinical colleagues let the leads in their twin centres know that this will be taken forward. **All Centres**

7. Pancreas offering with MVT bloc – KAG(21)4

C Callaghan was approached by a transplant surgeon from Cambridge highlighting an issue where on occasions they have patients with portal vein thrombosis who may need a liver and most of their gut transplanted but often a definitive decision cannot be made as to whether or not they need a pancreas until they are in theatre and on occasions the surgeon has said yes to organs that are later not needed. The question for KAG was whether it is possible to have some type of offering scheme whereby the pancreas may be offered for solid organ transplantation and if the decision from the Cambridge team is that they do not need the pancreas, then explore whether or not a kidney offering scheme could be put in place so that a kidney could be attached to that pancreas if there was an appropriate SPK patient on the list.

Currently if only the liver is needed for the MVT transplant the pancreas is offered alone and as there is often limited time to call in a recipient and only a small number of pancreas patients on the list. The proposal is to combine that with the kidney offering. The proposal is if the kidney has not been placed at the point where the pancreas has been identified as not being required for the MVT transplant, then simultaneous kidney/ pancreas offers should be made to the kidney/ pancreas list. S Bond raised that this scenario is likely to be around 2/ 3 patients per year.

It was asked what is the cold ischemic time (CIT) likely to be on the pancreases which are reoffered? The common scenario is that a surgeon will do the dissection and often there is no CIT by the time that decision of not needing the pancreas is made. It was acknowledged that the numbers will be very small and do not think there will be much of an impact.

Members supported this becoming policy.

ACTION

8. Paediatric dialysis capacity pressures – options for KAG to consider

This item was brought to KAG to raise the issue of capacity pressures on units for paediatric dialysis patients and to discuss how KAG can assist with resolving this as soon as possible.

Just before the pandemic hit in February 2020 there were just over 200 paediatric patients on dialysis, as off 30 April 2021 there are 300 (an increase of 50%) of children and young people on dialysis over the last 16 months.

There are several factors which could have contributed to the issue including fewer deceased and live donor transplants over the previous 18 months.

There are no concerns that a particular patient has come to harm but there is evidence that patients have had to be transferred out to another centre which increases stress on families and creates additional pressures on services. This is predominantly a concern in England.

A small group has been convened which includes R Ravanan, L Burnapp, Statistics & Clinical Research members, paediatric nephrologist and surgeons who take part in paediatric living donation to consider potential solutions.
R Ravanan made an advance request to KAG that this group is meeting weekly and anticipate it will take 3 or 4 meetings to put together a discussion paper for KAG to consider by the end of June.

R Ravanan proposed that the clinical voting members of the panel meet again in around 4 weeks' time to review the recommendations in the paper. Members supported this.

The first option is to potentially ring fence or increase additional resources to enable living donation aimed at children and young people as recipients.

The second option is whether there would be an option of allowing more deceased donor transplants to happen to children over a short space of time but it was acknowledged that there is no easy way of doing that in the organ offering scheme.

All clinical voting members of KAG agreed that both options should be considered and will be happy to discuss these options at the next meeting.

R Ravanan

H Jones suggested that the 16 – 18-year-old group of patients could move over to the adults. It was acknowledged that this is a reasonable option to discuss at the task and finish meeting.

For now, Scotland, Wales and Northern Ireland are not reporting substantial stresses.

9. Organ Utilisation

9.1 Unit Clinical Leads in Utilisation update

The CLU scheme was a short-term scheme from November 2020 – March 2021 whereby each transplant centre had the option to nominate a CLU for their centre. Funding for the CLU scheme has been secured from July/ August this year to March/ April next year and an email has been circulated providing information on how to nominate a CLU.

9.2 PITHIA update

G Pettigrew presented an update on the PITHIA trial which will restart on 1 July 2021.

ACTION

G Pettigrew reemphasised the reasons for engaging in the trial are to provide greater confidence in the selection of 'marginal' donors and provides the opportunity to further expand donor selection and to help address the ongoing concern of the underutilised elderly donors.

Two refresher dates will be held on 16 June at 10am or 24 June at 2pm,
G Pettigrew requested if colleagues would like to join to email Emma at PITHIA@nhsbt.nhs.uk

The finish date of the PITHIA trial is January 2022.

9.3 QUOD

S Cross presented an update on QUOD noting that the number of QUOD donors have increased and are almost back to pre-pandemic levels. The pause on DCD sample collection in Scotland has recently been lifted.

J Hunter (QUOD Clinical Coordinator) presented an overview of an audit carried out on the background of a number of surgeons, tissue handling technicians and researchers' comments on the 2mm biopsies that are currently taken from kidneys for QUOD. Discussion re clinical & research utility vs safety with 2mm and 4mm biopsies ensued.

J Forsythe felt this is not just a KAG decision but more of a RINTAG and Governance and must reflect that patients did come to harm with the bigger biopsies. The QUOD team will take this further forward with RINTAG and Clinical Governance team. **S Cross**

10. KAG Paediatric Sub-Group

10.1 Report from KAG Paediatric Sub-Group: 26th April 2021 – KAG(21)5

J Dudley reported from the last meeting that all paediatric centres were functioning at pre COVID level of service notwithstanding the discussions around the paediatric dialysis capacity issue discussed today.

One of the key items agreed was that the donor age would be increased to 60 for children and young people. There are a few IT issues to get over as the donor age has been hard wired in the system but that this will hopefully be in place by September 2021.

The electronic version of the aide memoir has been hugely welcomed for children and young people.

H Jones is doing a post take analysis of COVID looking at the impact of COVID particularly during the first wave when the paediatric programmes were paused for both living and deceased donors and therefore how many children ended up on dialysis that may have received a pre-emptive transplant because they had a date lined up. H Jones has received around two-thirds of data from centres. Stephen Marks is leading on a piece of work which is looking at children who got COVID and what happened to them.

11. Pancreas Advisory Group

11.1 Report from Pancreas Advisory Group: 28th April 2021

S White reported that all pancreas centres have now reopened. Pancreas transplant activity has been down in the last 12 months by 54%. The year before 212 pancreas transplants took place and this year 97 pancreas transplants took place.

ACTION

S White is liaising with J Whitney regarding the use of hepatitis C donors as there was unanimous agreement by clinicians who are happy to utilise these donors for SPK transplantation.

PAG discussed the use of DCD kidneys that have been reallocated when they have not been used for SPK and R Baker reported that M Robb has looked into this which shows no disadvantage in terms of outcomes for DCD kidneys that have been reallocated when they have not been used for SPK transplantation. M Robb confirmed that is correct although numbers are small and that the only thing flagged up is that the CIT could be longer.

C Callaghan has looked at UK DCD outcomes for SPK and as a group will be looking at whether the pancreas offering scheme should be tweaked to utilise more DCD donors for SPK. A working group has been formed for that.

PAG reviewed the 23 SIK transplants which have taken place. Some logistical issues have been identified with some islet transplants being done in centres where they do not perform the kidney transplant, therefore the groups thoughts will be given to how this is changed to improve patient service. Of those 23 transplants, 75% have good graft function and PAG will continue to monitor that group of patients. It was recognised that we may need to change some of the data we collect on the kidney recipients who are diabetic and do not have any beta cell replacement therapy to enable them to be compared with our SPK and SIK patients as the HbA1C is not collected in kidney transplant alone patients who are diabetic, therefore, S White has requested that information is collected.

12. NRP – evidence of better outcomes

C Watson presented NRP activity, utilisation and outcomes where the real benefits particularly in liver transplantation has become apparent and kidney related outcomes were discussed.

J Forsythe highlighted that a business case has been built for NRP which demonstrates the improvement in outcome for liver transplant. Funding has been secured from Northern Ireland, Scotland, and Wales but that NHS England has not supported currently which will hopefully change.

So far, Cambridge and Edinburgh are doing NRP and Royal Free, Cardiff and Leeds are keen and would imagine by the end of the year that 4 or 5 centres will be doing it.

13. Fast Track Scheme Outcomes – KAG(21)6

R Curtis presented the overall activity and outcomes from the Fast Track Scheme.

It was acknowledged that the introduction of the new kidney offering scheme was designed to reduce the number of fast track kidneys whereas there seems to have been an increase recently and discussion ensued on the effects of the pandemic. M Robb opined that there may be an effect of the new scheme but there will also be an effect due to COVID and it will be some time before we can see the effect on the fast track scheme of the new kidney offering scheme alone.

The paper presented looked at combined DCD and DBD survival at 5 years which gave an inferior outcome, but the original paper showed an inferior outcome for DBD but not DCD fast tracked kidneys. M Robb advised this data can be split for DBD and DCD. **R Curtis / M Robb**

C Watson asked if the delayed graft function was controlled with CIT. M Robb suggested the adjusted data has not been looked at yet, but this work is planned in the next stage of the analysis.

A concern was raised that the proportion of kidneys going through the fast track scheme may be putting an unnecessary strain on the on-call teams.
C Callaghan suggested as a group to look at the fast track criteria and identify if this is still sustainable.

The question was asked whether the recipient age and comorbidity were corrected for patient survival. M Robb advised that the unadjusted data has been presented, but the plan is for the next section to include all factors and will be presented.

It was raised that 20% is a national level but that some centres are performing a much higher percentage from the fast track scheme than other centres and therefore, what does that mean for the formal allocation scheme and what does that mean for recipients with access to the formal allocation scheme.

G Jones suggested drilling down into why the kidney had been fast tracked in the first place as if there is a common theme and the kidney has a good outcome there is learning points for the units in the UK. J Asher suggested looking at centres which have turned down because of the donor or because of the kidney rather than for recipient related reasons. C Callaghan added that if an organ is declined on recipient related reasons it does not class as an entry criteria to the kidney fast track scheme.

R Ravanan suggested waiting for the more detailed analysis including the multi variable analysis which will provide more detail and suggested coming back with some options in November.

It was raised whether patients in units that do not have access to the fast track scheme have equity of access and perhaps this is something which could be looked at as part of the organ utilisation group.

14. DCD liver/kidney offering – KAG(21)7

M Robb presented an update on a regular paper which is presented to KAG on liver and kidney patients and ran through the activity and offering.

In the latest period, no high priority patients have missed out on an offer from DBD donors. There is currently no offering procedure for liver and kidney patients for DCD donors.

C Watson contacted the Chairs of the Liver Advisory Group (LAG) and KAG in December 2020 asking whether both advisory groups would consider offering DCD kidneys for liver and kidney patients. The proposal for KAG to consider is that subject to there being no high priority patients waiting for a kidney in Tier A, that a DCD kidney could be offered with the liver to the liver zonal centre and link centre before being offered to the rest of the kidney offering scheme. This paper was presented recently to LAG and approved by members of LAG and the only request received was that it be reviewed after 15/ 20 cases to ensure there were no issues in terms of prolongation of the offering sequence for kidney.

No objections were received to changing policy to allow DCD kidneys to be given to patients who are simultaneous liver/ kidney.

15. Membership of KAG – KAG(21)8

The membership of KAG was circulated to the group highlighting when a representative's current tenure finishes.

R Ravanan highlighted the inadvertent position where all voting members of KAG are male and a general discussion ensued on ways of ensuring KAG membership reflected the workforce it represents. The suggestion was made to write to the Clinical Directors of each individual centre and highlighting this for them to keep in mind the diversity of the group when they are exploring the options when nominating and representing their units. It was acknowledged that KAG is already a very diverse workforce.

Some of the pairing for the twinned centres were done for historical reasons and since the twinning has been in place for nearly 20 years, R Ravanan suggested reviewing the pairing arrangements to ensure they are still relevant. The purpose of twinning was to make the meeting more feasible and practical and partially linked to the fact that meetings were previously face to face and would be difficult to accommodate such a large group. R Ravanan asked if people are happy for R Ravanan and F Dor to potentially look at pros and cons for continuing with a twin centred approach or to consider opening the membership out to all 23 centres and bring this back to KAG in November.

J Forsythe added that if face to face meetings are being considered a plan would need to be in place for how many members could attend a meeting and that the budget would have to be taken into account. The suggestion was made that the Renal Transplant Services meeting could be the annual face to face meeting for KAG.

KAG are happy to explore review of membership and meeting formats of hybrid, face to face or virtual meetings.

16. Developments in IT

16.1 Organ Quality eForms update

As the Organ Quality eForms still require funding, J Asher advised members that a working group has been set up to look at organ imaging from a clinical perspective and looking at what the essentials and desirables are in terms of organ utilisation, quality control, damage assessment and Clinical Governance. The group has had its first meeting and the next steps are to meet with NHSBT and IT to identify how this can be implemented and to improve the organ imaging system.

17. Feedback from non-transplanting reps

This is the first meeting that L Karamadoukis and J Stoves attended and found it a useful meeting and are keen to further identify how they can contribute on behalf of the constituency of the non-transplanting centres and to share the learning of what is discussed at these meetings. L Burnapp feels there is an opportunity for L Karamadoukis and J Stoves to work alongside the well-established living kidney donor network and would suggest discussing this further and linking up with the co-chairs of the group to coordinate and collaborate. Both L Karamadoukis and J Stoves would be keen to be central for the Transplant work force group.

18. Feedback from trainee reps

H Hendra and V Banwell were welcomed to the group and have agreed that they will issue a newsletter/ email providing relevant information from these meetings to fellow trainees and any projects that require trainee input, H Hendra and V Banwell are happy to be involved with the workforce survey project.

ACTION

19. Transplant Centre Profiles

L Mumford shared with the group the Transplant Centre Profiles which is not planned to be patient facing on the website but that all the information is available in the annual report. Colleagues felt this should be available on the website. KAG felt an opportunity to sense check the information by units is required for the first time but after that has taken place, members agreed this information should be uploaded to the website at the same time as the annual report. **L Mumford**

20. Winton Centre

L Mumford presented to the group the Transplant Risk/ Benefit Assessment and Communication (TRAC) tool where centres can go online with their patient at registration to look through information for how long they will have to wait for a transplant and survival rate post-transplant given patient factors.

It is hoped the lung TRAC tool will go live by the end of July 2021 and the kidney tool will follow soon after.

L Mumford will be contacting members of KAG and other colleagues requesting that the tool is tested. R Ravanan requested that once this is available for colleagues to test the tool and provide their feedback.

21. Any Other Business

J McCaughan advised that the H&I community are in the process of reviewing the antibody guidelines for kidney and will be approaching clinical colleagues on this call further down the line.

22. Date of next meeting:

Tuesday 23rd November 2021 via Microsoft Teams Meeting.

23. FOR INFORMATION ONLY

23.1 Update on KAG Offer Review Schemes

The offer review schemes are currently on hold due to the pandemic.
C Callaghan asked colleagues if they are happy for this to remain on hold for another month. Several members would be in favour of restarting this sooner rather than later.

R Ravanan asked for those representing a twin centre to check with their twin centre whether there is resilience to respond to these letters and to let
C Callaghan and R Ravanan know and a decision will then be made when to restart this. **All Centres**

23.2 Statistics and Clinical Studies Update – KAG(21)9

Noted for information.

23.3 Infant Donors Update – KAG(21)10

Noted for information.

23.4 Summary of CUSUM monitoring of outcomes following kidney transplantation – KAG(21)11

Noted for information.

23.5 QUOD statistics report – KAG(21)12

Noted for information.

23.6 Transplant Activity report: April 2021 – KAG(21)13

Noted for information.