To be ratified **KAG(M)(21)2**

NHS BLOOD AND TRANSPLANT
ORGAN AND TISSUE DONATION AND TRANSPLANTATION

MINUTES OF THE FORTIETH MEETING OF THE KIDNEY ADVISORY GROUP ON TUESDAY 23rd NOVEMBER 2021 VIA MICROSOFT TEAMS MEETING

PRESENT:

Dr Rommel Ravanan	**Chair**
Mr John Asher	Medical Health Informatics Lead
Mr Atul Bagul	Representative for Leicester & Nottingham
Ms Victoria Banwell	Surgical Trainee Representative
Dr Richard Baker	Joint National Clinical Governance Lead
Mr Adam Barlow	Leeds & Newcastle Representative
Mr Stephen Bond	Recipient Co-ordinator Representative
Ms Lisa Burnapp	Associate Director – Living Donation and Transplantation, NHSBT
Mr Chris Callaghan	Associate Medical Director – Organ Utilisation, NHSBT (joined part meeting)
Ms Joanna Chalker	SNOD Representative and Regional Manager
Ms Aisling Courtney	Northern Ireland Representative
Ms Rebecca Curtis	Statistic & Clinical Research, NHSBT
Mr Frank Dor	Deputy Chair and Imperial & Oxford Representative
Dr Jan Dudley	Chair of KAG Paediatric Subgroup
Prof. John Forsythe	Medical Director, NHSBT (joined part meeting)
Mr Keith Graetz	Plymouth & Portsmouth Representative
Mr George Greenhall	Clinical Research Fellow, NHSBT
Mr Abbas Ghazanfar	Guy's & St George's Representative (joined part meeting)
Ms Heidy Hendra	Nephrology Trainee Representative
Dr Gareth Jones	Lead London Collaborative
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 & MELODY
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
Mr Nicholas Torpey	Renal Services Transformation Programme
Ms Clare Snelgrove	Recipient Co-ordinator Representative
Dr John Stoves	Bradford Representative
Mrs Julie Whitney	Head of Service Delivery – Hub Operations
Prof. Steven White	Chair of Pancreas Advisory Group
Mr Ian Wren	NHS England

IN ATTENDANCE:

Mr James Hunter	To present item 10
Ms Maria Jacobs	Statistics & Clinical Research, NHSBT
Ms Tanya Machale	Business Support Manager, Clinical & Support Services, NHSBT
Ms Claire Mitchell	Clinical Governance, NHSBT
Mr Roderick Jacques	Statistics & Clinical Research, NHSBT
Miss Sam Tomkings	Clinical & Support Services, NHSBT (minutes)
Mr Alun Williams	Incoming KAG Paediatric Subgroup Chair
Ms Claire Williment	To present item 9

APOLOGIES:
Mr Ian Currie, Dr Sarah Cross, Ms Anushka Govias-Smith, Ms Dela Idowu, Ms Angie Scales, Ms Susan Spence, Ms Sadie Von Joel.

ACTION

1 Declarations of interest in relation to the agenda – KAG(21)14
There were no declarations of interest.

2 Minutes of the meeting held on 9th June 2021 – KAG(M)(21)1
The minutes of the previous meeting were approved.

2.1 Accuracy
The previous minutes were agreed as a correct record.

2.2 Action points – KAG(AP)(21)2
All action points were either completed, included on the agenda and those with a verbal update were listed below.

AP1 – (AP3 – Sustainability – delayed audit data)
I Wren confirmed that the data was sectioned up into individual nations for the sustainability audit. I Wren or NHS E does not have any further info sources/data to share. Subsequent to the initial data collection in January 2020, NHSBT have done another data collection which projects demand figures for the next 10 years. R Curtis will search for the deceased donor transplant projection 10 year data and circulate to the group and the possibility or re-running the data will be considered. Members will review the document to identify whether that can be used. **R Curtis / S Tomkings All members**

AP 6 – (FTS) – R Curtis is working on a larger piece of analysis on the Kidney Fast Track Scheme, but the action from the previous meeting was to present the DCD and DBD data separately as in the previous paper the data was combined. R Curtis looked at five year graft survival and patient survival for DCD and DBD separately and the only significant difference found was in the DCD graft survival which is unadjusted. The larger analysis will be shared with the group at the next KAG meeting.

Members agreed it would be useful to know the reasons for the organ being fast tracked. R Ravanan advised that a small group will be looking at logistical reasons for fast tracking compared to clinical reasons etc and a paper will be submitted to KAG. The question was asked when both kidneys go to the same centre, will there be separate analysis of outcomes of second transplant? R Curtis will look into this. R Ravanan is happy to work with R Curtis to understand the reasons for fast track depending on the data that is available. R Ravanan and J Whitney noted that there is a separate group looking into the possibility of kidney group offers in cases where a full matching run cannot be performed. **R Ravanan / R Curtis**

AP7 – The Transplant Centre Profiles are ready to go on the website. As a lot of the data is from the annual reports, as soon as the most recent survival information is available the profiles will go on the website.

2.3 Matters arising, not separately identified
J Dudley will be stepping down as Chair of KAG PSG. R Ravanan and colleagues thanked J Dudley for her support during her time as Chair.
A Williams has been appointed as J Dudley's successor and was welcomed to the meeting.

ACTION

This will be J Mackisack's last meeting as lay member representative and colleagues thanked her for her contributions to KAG over the last 7 years and wished her well.

This will also be S Tomkings last meeting as secretarial support for KAG. R Ravanan and colleagues thanked her for her support over the years.

3 Associate Medical Director's Report and COVID update

Prof. J Forsythe will be stepping down as Medical Director at the end of 2021 and his successor, Derek Manas will start in January 2022. R Ravanan on behalf of KAG thanked J Forsythe for his leadership and support over the years and wished him the best for the future.

L Burnapp has been appointed as Associate Director for Living Donation and Transplantation and a new position is out to advert for an Associate Medical Director for Research and Development.

L Burnapp updated members on the work of the Organ Utilisation Group (OUG) and the Organ Utilisation Programme (OUP) which are two different things. The OUG has now had three meetings as a whole group and there are four work streams that are very much in flow. There have been seven site visits in total including three pancreas centres which the team found extremely useful and L Burnapp thanked colleagues who have been involved in that.

A stakeholder engagement group which is chaired jointly by Deirdre Kelly Executive Director of NHSBT board and Fiona Loud, policy lead for Kidney Care UK is due to report from that in the spring.

L Burnapp reported inevitable fluctuations in donation and transplantation activity, but that it is pretty much business as usual, considering some of the constraints that are out there. Reported at the last Clinical Meeting were pressures on retrieval teams and retaining the continuity of service which at times have been a struggle. A winter pressures document has been sent out to all Chief Executives of Trusts with the idea of that providing colleagues at a clinical level support to help make the case for keeping transplantation going. The document is available on the ODT website and COVID information website.

L Burnapp highlighted to the group the track tools which are decision making tools that have been developed and will be available soon. J Forsythe emphasized the track tools and encouraged colleagues to trial them.

3.1 ODT Hub Update

J Whitney informed members that the change to DCD kidneys to be allocated with a liver started at the beginning of November. It was agreed to monitor the first four or five transplants to make sure the change did not have any negative impact on either organ groups. None of these transplants have taken place yet so that will continue to be monitored and report back to KAG when a successful retrieval and transplant has taken place.

3.1.1 HTA B Forms – KAG(21)15

Identified back in April was a significant backlog of HTA B forms and J Whitney and colleagues have been working closely with units to address this.

ACTION

J Whitney shared with centres their data and advised that the chase process for the outstanding forms has been changed and a regular chase to all HTA B users will now take place.

It was highlighted that hospitals such as Glasgow have a separate team who complete the HTA B forms for the paediatric hospital and when previously chased for missing forms, it has come to the adult coordinators for forms that are missing from the paediatric team. It would therefore be useful to separate the information for centres that run a paediatric program in a different institution.

R Baker added from a governance side it is very important to have form A and form B promptly and it is incredibly useful to have photos when reviewing cases. G Jones suggested feeding this information back through the London network on a quarterly dashboard. J Whitney is happy to provide this information and will be in touch. R Ravanan suggested having this as a standing agenda item yearly. **S Tomkings**

4 Living Kidney Donor update – KAG(21)16

L Burnapp presented the Living Kidney Donor update.

Living donation is usually reported a month in arrears however it was noted there has been quite a lot of slippage over the last two years and therefore L Burnapp made a request that the timeliness and the accuracy of this data is improved to enable the annual report to be produced.

Activity overall is aiming on a trajectory of around 75% of the usual thousand achieved in a year. This year is a slower recovery than we would like, but this is an inevitable consequence of what units have been through and how difficult it has been to reinstate living donation. A decision recently made is to continue with the four matching runs of the Living Kidney Sharing Scheme.

L Burnapp would like centres to consider and make use of mutual aid when centres are struggling to schedule transplants. As this is something which is underutilised L Burnapp proposed when offers of mutual aid are received to share with the representatives of KAG.

L Burnapp drew attention to the data in table 3.1.2. where the conversion rates look very good however are still awaiting 15 transplants to go ahead from April, which may not all proceed. For October, there have already been several collapses and we are on a bit of a downward trend in terms of converting identified transplants. L Burnapp asked colleagues to think very carefully about who is going in and are they really ready.

Data on non-proceeding transplants are being collected again and L Burnapp highlighted the blank category which is not known because that data has not been returned and L Burnapp would like a better understanding of what the problems are for centres, so they can be better supported.

One of the things highlighted around the kidney sharing scheme is the delay in arrival of kidneys at implanting centres and the access to theatre and other difficulties such as transporting kidneys, and the impact that is having on theatre staff. Commissioners would find it helpful to understand which centres are particularly having difficulty and therefore causing delays because then there can be more meaningful discussions about how those centres can be supported.

J Asher suggested adding an additional category of donor recipient unexpectedly testing positive for COVID. L Burnapp proposed adding this to clinical recipient unsuitable and have the detail in the survey.

Agreed at the last meeting was to report back in this paper on an initiative that we agreed with the paediatric working group to address some of the pressures on paediatric patients on dialysis and to increase their transplant opportunities. Agreed at KAG was that any unmatched non directed donors from the kidney sharing scheme which are mostly blood group A and AB would be preferentially offered to paediatric recipients after the matching run. This began in July and from the data presented it shows a high number of unmatched AA and AB donors and the number of paediatric recipients that were identified and matched with those were two. One of those were offered and accepted and the other was initially accepted and then declined.

L Burnapp provided an updated on the National Focal Point Work which focuses across the European Community for Travel where the request was made to report any recipient who have returned with a transplant from abroad in real time. A publication of this data will be available shortly.

P Mason raised that before putting donors into the paired exchanged, the donor is contacted by telephone to confirm they are ready to go and there have been a couple of occasions where the donor has decided not to go ahead. Oxford have made the decision to write to the patients formally to request they sign and consent to committing to going into the programme and if the donor decides not to go through with this for any non-medical reason, other recipients will be disadvantaged. This will not mean the donor cannot withdraw at any stage this is to make the donor aware of the consequences. L Burnapp asked colleagues thoughts on this approach. Some colleagues felt this is not something they would adopt therefore L Burnapp suggested this continues in Oxford and if any other centre would to take part in that, to let her know.

A Barlow raised the difficulty of getting theatre access for extended sessions which has not been helped by the large number of transplants that went into the July matching run. The vast majority of those transplants had gone into acute theatres because a theatre team could not be secured after 5pm. This is partly due to pressures on the theatre team who cover other organs and retrievals. Leeds is putting a business case together to formally appoint extra theatre staff. A Barlow feels it would be useful if there was some sort of mandate that KAG feels these should be performed in an elective theatre.

Difficulties in transporting organs was discussed as there is a reduction in scheduled flights which is producing excess transport costs for chartered flights.

Costs for chartered flights in England was discussed and I Wren advised the next steps will be to go to individual regional unit levels to have those discussions and to try and link up the demand and capacity issues around for example dialysis with the potential for transplantation and to try to make the data more operationally available for commissioners.

L Burnapp asked I Wren to elaborate on the immediate cost pressures that Trusts are facing with chartered flights and the possible solution for this. I Wren advised if there has been flight activity used before and been paid for then we would not need to negotiate additional budget for that. If large transport costs have not been used before by a transplant centre, a discussion

ACTION

would need to take place to support that. That would be on a regional not a national basis. R Ravanan advised this would not be in the budget as most centres previously had multi options for flights. This is due to

a post pandemic reduction in scheduled commercial flights and therefore would be a new cost pressure.

I Wren confirmed that any centres face the question, and the only option would be to not go ahead with the transplant to reach out to regional commissioners. R Ravanan asked colleagues in Scotland and Northern Ireland, J Asher confirmed Scotland are having to charter flights more often. A Courtney confirmed Northern Ireland are experiencing problems with theatre access.

J Whitney emphasized to keep in mind the availability of charter flights which is not plentiful and although it is a planned activity, Hub Operations are feeling the pressure more and more on deceased donors being able to charter flights and having the availability of flights. J Whitney would like to make sure those conversations take place with the transport provider to make sure that they start factoring in those conversations if chartered flights are going to be used more. L Burnapp will discuss this with IMT separately.

F Dor suggested writing a common guideline for how we plan for negotiating for additional planned late theatre activity to facilitate living donor transplants. L Burnapp is beginning work on this and would like members to join a short term working group. **L Burnapp / A Barlow / F Dor**

R Ravanan requested if I Wren has a list of regional contacts to share with S Tomkings who will circulate to members of KAG. **I Wren & S Tomkings**

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)17

R Baker presented the Clinical Governance Report.

There were three incidents which took place to raise with KAG. One was regarding QUOD biopsy which led to a bleed after two QUOD biopsies were taken. R Baker emphasized that only one QUOD biopsy should be taken even if the results are inconclusive. This was raised at the retrieval group where it was agreed only one biopsy should be taken.

The second incident was an organ which became available but there was no HLA typing which caused some problems in the allocation at Hub Operations and since then a review took place to look for an IT fix to correct that. M Robb advised the IT testing for that will take place this week and understands this will be released late January.

The final incident was relating to a discrepancy on how to calculate cold ischemic time (CIT) as different centres use different definitions. R Baker asked if there is some agreement over the formal definition for how to measure CIT. It was not known whether there is a specific thing for each advisory group to agree CIT therefore R Ravanan will speak to F Dor and the chair of the Retrieval Advisory Group (RAG) and identify an outcome for this. **R Ravanan / F Dor**

ACTION

6. Transplant MDT workforce survey – KAG(21)18

Discussion took place at the previous KAG meetings about trying to benchmark the key professionals in all the kidney transplant units. It was decided that a formal survey was needed although previously a survey had taken place but did not answer all questions required for transplantation.

R Ravanan thanked all colleagues involved in developing the draft survey tool which has been circulated.

The survey will start with adult kidney units and then transplant units and phase two will look at the children and young people as well as non transplanting kidney units.

R Ravanan suggested adding a question for each of the workforce groups about retirements in the next three to five years to try and project what the key workforce gaps might be. It was queried how helpful this information would be and that this may be a sensitive question for some staff. R Ravanan added this would be to gain an idea of potential workforce shortages that could impact the service.

J Dudley suggested piloting adult and paediatric together which R Ravanan will look to see if there is a way we can pilot it in a CRP unit as well.

L Burnapp suggested doing a sense check with the British Renal Society (BRS) who put in a lot of work to update the 2002 document which was published in October 2020 to inform them of this work which is aimed at the transplant community.

J Stoves raised that discussed at length at a Northern Collaborative meeting was the workforce and highlighted the potential duplication within the collaborative. A Barlow confirmed there was a lot of discussion at that meeting about inequity of coordinators across the region and how this fed into access to transplantation. It was not clear at that time how far the National Workforce Survey was and as this is due imminently it is likely the Northern Collaborative group will put this on hold.

R Ravanan suggested this is sent to clinical leads the first week of January with the expectation they will involve the MDT in providing answers to the questions.

L Burnapp would like to address the H&I support within this which T Rees advised that the British Society for Histocompatibility & Immunogenetics (BSHI) are currently looking at the workforce planning and T Rees suggested that it may be worth joining that up at some point. T Rees suggested once this work is out, to let T Rees know and she will pass this on to the chair of BSHI and will contact the Chair of BSHI to find out when that data will be collated. **T Rees**

R Ravanan requested any feedback regarding this paper and piece of work to send to R Ravanan and L Burnapp. **All members**

ACTION

7. Membership of KAG and meeting structure – KAG(21)19

A paper was circulated to the group which included recommendations on the membership of KAG and future meeting structures.

A Barlow asked as the London Collaborative Chair is invited to KAG, will there be any other collaborative chairs included in KAG meetings? R Ravanan advised that if every centre is represented then this is likely to include the Northern Collaborative Chair but highlighted that the London Collaborative Chair position is funded by NHSBT and is a pilot.

The Renal Transplant Meeting (RTSM) was discussed which is an annual face to face meeting that took place typically in January which included various kidney groups. Members were in favour of trialling quarterly meetings but to hold one of those meetings as the RTSM.

Colleagues were in favour of virtual meetings and felt if every unit is represented this would make KAG a very large group but acknowledged that it would be useful to have all units represented. Members supported having one face to face meeting a year which would reduce travel and costs and the rest as virtual.

It was discussed moving meetings around the country but acknowledged that it was easier for all members to get to London than other parts of the country.

R Baker would not be in favour of an NHSBT representative also being the centre representative but is conscious that KAG is already a large meeting and would not be in favour of increasing the numbers.

L Burnapp suggested being flexible to models that work for twined representation of centres.

No objections to the trail were received but the comments raised were noted. R Ravanan requested any further comments on this to let him know.

Once the new NHSBT secretariat is in place, the next steps will be to define the membership list and define the meeting dates for 2022.

8. Developments in IT

8.1 Organ Quality eForms update

J Asher highlighted a number of IT projects that are in the pipeline but constrained by funding. The electronic form A is still in the pipeline and may be built into the new patient path system which is being developed.

There are two groups looking at organ imaging, one looking at organ quality, and whether there is research that can be based on imaging, and as a second group looking particularly at retrieval damage. Both groups are still relatively small, but J Asher asked if any members from KAG are interested in joining the group to let him know. **All members**

Finally, J Asher advised KAG that the Liver Advisory Group (LAG) have been looking at having a national liver waiting list to facilitate people being transplanted in other centres and looking at some of the IT support that would be required for that. J Asher asked members of KAG if that is something, they feel would be useful for kidneys.

ACTION

G Jones stated that a central database of all the details of patients would be useful to make it easier for patients to be transplanted at other centres rather than sending emails. G Jones also added that if that could be built in as an assessment tool pathway and standardizing the work up that takes place on all patients as well would be very useful. J Asher is not sure the work up is something which could be built into this.

S Bond would be keen to be involved in this piece of work.

One of the workstreams as part of the Renal Services Transformation Programme (RSTP) which N Torpey is leading on is to create some sort of national portal for patients on the kidney transplant waiting list and there is an IT platform to do that which is going to be the new iteration of the renal registry. The group are already meeting with the involved people in that. This programme can also import documents and all sorts of things that the patient and their clinician can see. This will be for England only. J Asher will speak with N Torpey offline about this. **J Asher / N Torpey**

S White advised this was discussed at the Pancreas Advisory Group (PAG) and if this does take place in KAG it would be good if we were all joined up together. J Dudley would also like this to include representation for children and young people.

T Rees added that if the premise is that transplants can take place everywhere we would need to know who is going to assess the final H&I compatibility because it is likely that there are very many different nuances within each of the transplanting centres over lots of different things. There are also very many different risk appetites in terms of compatibility, therefore that will need to be discussed and worked through.

Members supported this proposal.

9. Organ Utilisation

9.1 Unit Clinical Leads in Utilisation update

C Williment presented an update on the Organ Utilisation Group (OUG) and the Organ Utilisation Programme (OUP) highlighting the recent achievements within the programme such as C Callaghan and Diana Garcia Saez who are the National Leads for Utilisation and the Clinical Leads in Utilisation scheme (CLU) scheme that has entered its second iteration. A business case will be submitted as soon as funding is obtained. A business case has been developed for the ARC. The discovery phase of the digital infrastructure has been initiated and C Williment thanked colleagues who have worked on that. The remit of the OUP is UK wide.

NHSBT is providing the secretariat support to the OUG which has been designed to deliver improvements within the transplantation services with particular focus on reducing inequity in equity of access and patient outcomes, supporting innovation and making the best use of the funding that is available. The remit of the OUG is in England only but are working very closely with the commissioners and health departments in all four countries. The OUG covers transplantation of organs from living and deceased donors, whereas the program just covers deceased donors and adult and paediatric services.

A stakeholder forum will take place to assist whatever comes out of the recommendations and that group will be meeting a few times up until the end of March.

In terms of progress to date, three meetings have taken place with the OUG, the online call for evidence closed on 25th October and will be sharing in further detail at the meeting on the 10th December. Seven site visits have been conducted and another three visits will be taking place in the coming months.

In terms of the workshop feedback that was held back in October it was identified that information sharing could be improved upon the retrieval side and with the strengths around donor characterisation and referral and assessment of patients. People were asked what challenges they are facing

in organ transplantation which identified access to resources, workforce commissioning etc.

More information and contacts for both the OUG and the OUP is available on the ODT website.

R Pararajasingham asked if when the site visits were conducted was this part of whether transplant centres met the NHS 2016 review of activity?
C Williment advised the site visits were based on access to centres what they felt are their strengths and weaknesses, opportunities and challenges and based on information gathering. C Williment is keen to ensure the recommendations from the OUG are delivered.

N Torpey highlighted one of the key vehicles for delivery will be the RSTP and is already putting in place things that will be needed but N Torpey would like to ensure that groups are not individually doing their own thing and would like to ensure coordination of that. C Williment agreed that going forward collaboration is very important and would want to prevent duplication of work.

C Callaghan presented an update on the CLU scheme whereby every unit was offered the opportunity to appoint a local CLU in each unit and have also appointed lead organ CLU's which Nick Inston has been appointed as lead kidney CLU. The funding for this will run out at the end of this financial year and colleagues are working hard to put forward a business case to NHSBT for longer term funding.

10 QUOD & PITHIA

10.1 PITHIA update

G Pettigrew advised that all centres now have access to the biopsy service and around a third and half of kidney offers over 60 have a PITHIA biopsy requested. The biopsy trial will stop in January 2022. It is likely the official final report from PITHIA will be presented in 2023.

G Pettigrew presented a MELODY study which has gained funding to take three groups of patients, the transplant population, patients who have autoimmune disease and blood cancer patients and the idea is that 12,000 patients will be tested from those who have had the third vaccine dose and will look at what proportion of those 12,000 patients have antibodies. Having that large number will mean that it will be possible to check the register to get some sort of link with what that means in terms of true protection from the disease.

G Pettigrew would like colleagues to promote the trial as widely as possible, through patient groups and through different aspects of the units. Transplant patients will be able to log into the website and provide consent through that. It is hoped the trial will begin early December and are keen to involve children in this study.

L Burnapp is happy to promulgate this through the BTS. R Ravanan added that if there is a link or flyer G Pettigrew would like included in the minutes to send this over to S Tomkings.

10.2 QUOD – KAG(21)20

J Hunter presented the biopsy audit results which was discussed at the previous KAG meeting.

The recommendation from the audit is to move from a 2mm biopsy to a 3mm biopsy. No objections were received from KAG to move to a 3mm biopsy.

Final approval should be from CARE. Once this is confirmed and the biopsy size is changed, R Baker emphasized that if any incidents regarding this takes place to complete an incident form.

11 Update review on KAG offer review schemes

Discussed at the last KAG meeting was the reinstating of the offer review schemes which are looking at individual organ offers where units have declined higher quality donors using the higher quality donor definition or recipients who are prioritized and when there is an organ decline or offer discard, than a clinician and in this case it will be Nick Inston will look at those and if he has some queries then he will be writing out to individual units. That process was paused over COVID and at the last KAG meeting there was a clear feeling from colleagues that they would like the scheme reintroduced. A letter will be sent out to every kidney unit informing them of the start date for when the offer review schemes will up and running again which is likely to be early/ mid December.

12 KAG Paediatric Sub-Group

12.1 Report from KAG Paediatric Sub-Group: 12th October 2021 – KAG(21)21

J Dudley presented an update from the last KAG PSG meeting held in October.

KAG PSG discussed the paediatric dialysis capacity issues and there is work in progress to try to increase the number of transplants which KAG PSG are very grateful for the support offered by this group, the clinical teams and the task and finish group. It was acknowledged that two to three units are still under strain.

A new supplementary report has been introduced to the standard reports to collate data on viruses. This is secondary to the implementation of the harmonisation program where we have aligned prescribing of immunosuppressive and anti-viral prescribing across all the 10 paediatric transplant units and in order to assess that, this supplementary report has been introduced to collect data on the immunosuppressive side effects as well as the viruses.

The group have addressed donor age for children and young people and 9 out of 10 centres will be considering donor offers up to the age of 60.

KAG PSG are very interested in progressing the work on declined offers in transplantation as 55 to 60% of organs are declined in children and young people, so there are pieces of work underway to assess that and the group will hopefully make some recommendations for that.

J Dudley is handing over to A Williams and this will be J Dudley's last KAG meeting. The formal hand over will be at the next KAG PSG meeting.

ACTION

L Burnapp asked although there are few of the non directed donors for children and young people some of the donors may be from an older age group that would be unacceptable in the paediatric community and L Burnapp asked J Dudley as part of the audit decline, to keep minded of those preferentially offered non directed donors after the matching run that are unmatched. L Burnapp feels it would be good to have an understanding of that from the paediatric side.

13 Pancreas Advisory Group

13.1 Report from Pancreas Advisory Group: 11th November 2021

S White reported from the PAG meeting which took place at the beginning of November where it was highlighted that a number of patients have sadly died on the waiting list waiting for simultaneous islet and kidney transplant (SIK).

PAG suggested looking into the waiting list during the COVID era to see whether delays have affected patients who have diabetes and end stage renal failure. S White asked members of KAG if they have noticed something similar within this group. **M Robb / R Curtis**

S White and R Ravanan have agreed to link the two statistics team leads at NHSBT for PAG and KAG to see if a joint paper could be produced for both advisory groups in the next 3-6 months.

14 Feedback from non-transplanting reps

J Stoves shared the minutes to the transplant leads in the non transplanting centres and will repeat the exercise once the minutes are available from this meeting.

Both J Stoves and L Karamadoukis are keen to be engaged in the non transplanting renal unit survey workforce which R Ravanan and L Burnapp will link up with them regarding this early next year.

J Stoves is keen to represent more in the OUG and to the regional collaboratives and regional networks with the RSTP initiative. N Torpey added that the RSTP includes all renal units and as the network develops, the key vehicle for driving this will be the regional networks which RTSP would hope to be represented at those meetings.

L Burnapp suggested it would be useful for J Stoves and L Karamadoukis to be included in the Living Kidney Donor Network.

15 Feedback from trainee reps

H Hendry confirmed a summary from the minutes of last meeting has been shared with colleagues but had nothing further to report.

16 Summary of CUSUM monitoring of outcomes following kidney transplantation – KAG(21)22

M Robb shared a summary of the CUSUM report from the last 5 months and advised that there have been four signals in kidney transplantation, two signals for graft failure at Cardiff and the Royal Free and investigations have been undertaken and no underlying issues were identified. There were two signals for patient mortality for adult deceased donor kidney transplantation and these were in Glasgow and St. Georges and these investigations are still outstanding. **M Robb**

In 2019 a question was raised whether CUSUMs could be looked at against the national rate which has been running in the background for around 18

ACTION

months now and are now reviewing this and would like a decision whether this should be continued.

The national data is not risk adjusted in the same way that the centre specific data is not. Discussion took place around risk adjusted monitoring as we do not want to punish centres with a liberal approach to listing and accepting.

G Jones asked if you are adjusting for a centre that there is the possibility that they could for example have continually low performance that would not necessarily trigger and they could be an outlier. M Robb advised that there is a baseline period which goes up 2016 at the moment, and that baseline level will not change over the next couple of years. In a few years time that will be updated therefore if a centre has had a bad period, that will be reflected later on down the line. R Ravanan also mentioned that outcomes are monitored in the funnel plots in the annual report and poor outcomes would be reflected there.

Members supported reverting back to centre based monitoring only.

17 Any Other Business

There were no further items of business.

17.1 HCV positive donor transplant – current centres – KAG(21)23

Outcomes from HCV positive donors were shared, and the group was asked what can be done to extend this offer to patients on each centres waiting list.

N Torpey advised Cambridge are not listing patients with HCV positive donors in mind as the assessment is more complicated in the current environment. Assuming resource restraints could be overcome this could be possible.

A Courtney advised it is working well in Belfast and have transplanted two from the same donor.

S Bond raised in table two under donor unsuitable virology, there are quite a lot of kidneys that were not used, is there a way of splitting out if they were RNA negative? The vast majority of donors will not have a PCR result as NHSBT do not have access to 24/7 virology PCR, therefore the current donor characterisation only tests for antibody status. If the potential donor identified very early and a PCR result is available that will be shared but it is currently not routine.

P Nagaraja added that the pathway is working well in Cardiff and have done 21 transplants with excellent function and SVR12. Only about half became viraemic and needed treatment.

C Snelgrove advised that Oxford have recently gone live with accepting HCV positive donors and noted that it was a long process particularly for those patients already listed to obtain the bloods and scans. Around 36% of patients are now listed. To enable this to happen, a small working group came up with a protocol and C Snelgrove sent patients letters with consent forms and information. For any new patients, they will be consented at clinic.

R Ravanan would be grateful if all units and those representing units could ask centres what could be done to encourage these donors to be used. **All members**

18 Date of next meeting:

TBA.

ACTION

19 FOR INFORMATION ONLY

19.1 Statistics and Clinical Studies Update – KAG(21)24

Noted for information.

19.2 Infant Donors Update – KAG(21)25

Noted for information.

19.3 Review of 2019 KOS – KAG(21)26

M Robb advised the one year outcomes have now been included, comparing two years prior to the new scheme with the first two years of the new scheme.

The graft survival is better at one year in the new scheme, but patient survival is poorer under the new scheme. The mortality rate has been run against the COVID registry which showed a high proportion of those deaths in the cohort for transplants under the new scheme were within 28 days of a positive SARS-CoV-2 test which is having a large effect on that figure.

R Ravanan advised a lot of work has taken place over the past few weeks specifically looking at vaccine efficacy and are looking at doing a joint analysis with NHSBT stats and UKASA (previously known as PHE) and hopefully the results from this will be available this year. Once the analysis is available it will be shared with all advisory groups. If required, a meeting will take place prior to Xmas to share this information with clinical leads of KAG.

19.4 Transplant Activity report: October 2021 – KAG(21)27

Noted for information.

19.5 QUOD statistics report – KAG(21)28

Noted for information.