

**NHS BLOOD AND TRANSPLANT
ORGAN AND TISSUE DONATION AND TRANSPLANTATION
MINUTES OF THE FORTY SECOND MEETING
OF THE KIDNEY ADVISORY GROUP
ON THURSDAY 7th JULY AT 173 - 177 Euston Road, London, NW1 2BJ
AND VIA MS TEAMS**

PRESENT:

Dr Rommel Ravanan	Chair & Assistant Medical Director for Transplant Medicine, NHSBT
Dr Emma Aitken	Glasgow Representative
Mr Atul Bagul	Leicester Representative
Ms Victoria Banwell	Surgical Trainee Representative
Dr Richard Baker	Assistant Medical Director for Governance, NHSBT
Ms Lydia Ball	Lead commissioner for specialised renal services, NHSE
Mr Adam Barlow	Leeds Representative
Dr Richard Battle	BSHI Representative
Mr Stephen Bond	Recipient Co-ordinator Representative
Ms Lisa Burnapp	Associate Medical Director - Living Donation and Transplantation, NHSBT
Mr Chris Callaghan	Associate Medical Director - Organ Utilisation, NHSBT
Ms Joanna Chalker	Regional Manager & SNOD Representative, NHSBT
Dr Andrew Connor	Plymouth Representative
Ms Aisling Courtney	Northern Ireland Representative
Dr Sarah Cross	QUOD National operational Coordinator
Ms Rebecca Curtis	Statistics & Clinical Research, NHSBT
Mr Abbas Ghazanfar	St George's Representative
Dr George Greenhall	Observer, NHSBT
Ms Heidy Hendra	Nephrology Trainee Representative
Mr James Hunter	Oxford Representative
Ms Dela Idowu	Patient Representative
Mr Nick Inston	Birmingham Representative & Lead CLU kidneys
Dr Gareth Jones	London Collaborative Clinical Lead & BTS Representative
Dr Katrin Jones	Newcastle Representative
Miss Amanda Knight	Nottingham Representative
Mr Makis Laftsidis	Portsmouth Representative
Professor Derek Manas	OTDT Medical Director
Dr Phillip Mason	Oxford & UK Kidney Association Representative
Mr Sanjay Mehra	Liverpool Representative
Mr Pramod Nagaraja	Cardiff Representative
Dr Jonathon Olsburgh	GSTT Representative
Mr Ravi Pararajasingham	Sheffield Representative
Mr Gavin Pettigrew	PITHIA Trial Representative
Dr Paul Phelan	Edinburgh Representative
Dr Tracey Rees	Chief Scientific Officer – OTDT
Dr Matthew Robb	Statistics & Clinical Research, NHSBT
Mr Debarata Roy	Coventry Representative
Mr Aamer Safdar	Lay Member Representative
Dr Cinzia Sammartino	Royal London Representative
Ms Susan Spence	Welsh Health Specialised Services
Dr John Stoves	Bradford Representative
Mr Nicholas Torpey	Addenbrookes & RSTP Representative
Dr Sam Turner	Bristol Representative
Mr David Van Dellen	Manchester Representative
Mr Alun Williams	KAG Paediatric Sub-group Chair
Mrs Claire Williment	Accountable Executive Organ Utilisation Programme & Legislation Implementation NHSBT

IN ATTENDANCE:

Ms Alicia Jakeman

Advisory Group Administrative Officer, NHSBT

APOLOGIES:

Mr John Asher, Atul Bagul, Ms Joanna Chalker, Mr Ian Currie, Mr Frank Dor, Ms Anushka Govias-Smith, Dr Lazarus Karamadoukis, Prof. Chris Watson, Ms Sarah Watson, Prof. Steve White, Mrs Julie Whitney

		ACTION
1	Declarations of interest in relation to the agenda There was one declaration of interest, declared by Rommel Ravanan. He owns shares in the company that produces Imlifidase, discussed under Any other business.	
2	Minutes of the meeting held on 05 April 2022 - KAG(M)(22)01	
2.1	Accuracy The previous minutes were agreed as a correct record, with one minor typing error under Item 4. to be corrected.	
2.2	Action points - KAG(AP)(22)01 3. Incidents for review: KAG Clinical Governance Report To be carried over to next meeting a F Dor not present. 4. Transplant MDT workforce survey H Hendra and V Banwell confirmed that they will start the data analysis in August in time for October KAG and will be shared with OTDT. This will start with kidneys first and will be rolled out to other Advisory Groups. R Ravanan invited feedback from attendees. G Jones advised that he found it quite hard. K Jones found it challenging to obtain the information from other colleagues but felt she must complete and was therefore concerned on the accuracy of the data. P Nagaraja found obtaining the information from surgical colleagues difficult. R Ravanan asked what analysis colleagues would like to see; - A Barlow requested the number of staff related to waiting list size or the number of transplants performed. To feed into recommendations by what NHSBT would deem safe staffing levels. D Manas reported that NHSBT does not fund transplants but needs to understand what the issues are. - R Baker asked what population is served and what are the number of staff and does registry have this data? (Will McKane will have this.) - L Burnapp suggested the complexity of case mix as well as numbers, non-resident donors, mixed society, maybe a complexity score created by business analyst. Between 1 and 3, how your workforce could be affected by this, rather than the number of people per patient, a professional group vs roles and responsibilities. Some units have more overseas donors but less numbers and undertake more antibody incompatible transplants. R Ravanan asked what data would be needed to come up with the complexity score. - J Stoves advised that Bradford used this mode for a business plan. The group discussed using 2019 data (calendar year) or average of 2017-2019 data, or alternatively June 2021 – June 2022. R Ravanan advised that NHSBT has data on recipients listed but no data on potential live donors. L Burnapp advised that she has diversity data in communities who have transplant opportunities out of their local area. - R Pararajasingham suggested to set a workforce per million population giving everybody equity to the surgical service and transplantation for renal failure patients. He noted a change in workforce since 2019.	RR/HH/VB

	<p>R Ravanan will work with H Hendra and V Banwell on the data analysis. R Battle advised that the BHSI local workforce survey data can be shared. R Ravanan asked that if the analysis was available, to be shared at October KAG.</p> <p>5. Organ Quality eForms update N Torpey will discuss offline.</p> <p>6. Audit of decline after arrival and options appraisal for future None of the 23 units use transport that is not IMT. Complete. Analysis of data will be presented in June 2023 KAG.</p>	RB
<p>2.3</p>	<p>Matters arising, not separately identified There were no matters arising, that had not been captured by previous minutes.</p>	
<p>3</p>	<p>Medical Director's Report</p>	
	<p>D Manas updated the group on new appointments; Associate Medical Directors (AMDs), congratulating them on their new roles; Lorna Marson is the new Associate Medical Director for R&D, R Baker is now the Assistant Medical Director for Governance, Sanjay Sinha is the surgical Lead for Governance, I Currie is now Associate Medical Director for Organ Retrieval. L Burnapp's job title has changed to Associate Medical Director - Living Donation and Transplantation. D Manas introduced L Burnapp, Associate Medical Director for Living Donation and Transplantation; she will bring other perspectives to the group and other areas of the organisation.</p> <ul style="list-style-type: none"> - Lesley Neil at Birmingham; is heading a National Histopathology program funded by NHS England as there is currently no national service. The retrieval service requires a histopathology to be provided. They have managed to secure funding from NHSE through the digital programme. There still needs to be a pathologist to lead this. In a year the aim is to have a national service to have histopathology within an hour of organ an being removed. G Jones is the national lead for collaboration. - Spending review; OTDT is funded through DoH and can't generate its' own money like the blood service and have been given flat funding for the next 3 years (no uplift) Therefore they are having to prioritise and engage with Clinicians, the Living donation digitisation project will continue but there is no confirmation that phases 2 and 3 will go ahead DCD Hearts is funded for the next year and A-NRP for Cambridge for next year only, decision being questioned. - Organ utilisation programme includes CLUs but not ARCs. OTDT Together has been successful in bringing all people together – test strategy soon. - CUSUMs; there are a few CUSUM triggers in centres, all have responded brilliantly, only one investigation remains open. - NHSBT are aware of workforce issues and are here to help. - Photography; There is a clear protocol on website. Use SNOD's Ipad or NHSBT phones must be used only. - Collaboratives; funding regional, renal networks have been set up with transplants included. Some networks are mature (London) some are not. Funding is through RCSs integrated systems. They plan to engage with funder, identify one RCS, to set up collaboratives. - G Jones questioned Histopathology issues. D Manas advised that the whole programme was split into two stages, the second stage, particularly liver, is posing the biggest problem. L Ball confirmed that NHSE meet with networks monthly ICSs, she will send her email address to D Manas to link in when required. 	LBa
<p>3.1</p>	<p>ODT Hub Update</p>	

	No update was given due to J Whitney's absence.	
4	OUG recommendations	
	<p>C Williment presented Key NHSBT initiatives, now only has 1.8 WTE within her team, rather than 13.</p> <ul style="list-style-type: none"> - CLUs; funding has been obtained for Q2, as late this was difficult for job planning, if people are not able to continue can they please let Claire no, although she is hoping they stay in their roles. - Assessment and Recovery Centres (ARCs); There are two arms, Physical ARC providing a national service - to provide equity of service & Devolved ARC - shared learning and best practice, working to common protocols etc. There is a need to pin down policies and protocols to establish a brand new service. R Baker reported a review in kidney is required as there is no evidence base currently. D Manas advised that a review of NORS is required as has been running for 12 years, with al machine perfusion and NRP review on how it is delivered in line with new technologies. - OUG; Shared new analyses that have been undertaken since last KAG; Analysis around socioeconomics and how that impacts on the decline rate on the waiting list and impact on waiting times using UK transplant registry postcodes. The group saw a variation, 35% in affluent achiever's category were transplanted within 1 year compared with 26% in the urban adversity category. (Deceased donation only). - Patient survey; The group received 260 responses from all four countries, answering a series of questions about care pathways. The results showed really high ratings except for the experience of moving between different parts of the healthcare system or when speaking to healthcare professionals. They also ran Patient focus groups within a different range of ethnicities. but it was very difficult to get anybody particularly black or Asian populations to come forward and speak. (That's not unique to transplantation.) The people that did come and speak were happy with their care but had concerns of a disjointed service and disparity of care and lack of psychological support. In fact, there were a lot of concerns about the lack of psychological support and social care support, and that has a very strong adverse impact and not just on patients, on their families, their relationships, their well-being. Some expressed that they had to fight to get the care that they needed and there were some very strong concerns raised about inequities in the system. <p>Although it is difficult to summarise key feedback from approximately 400 patient responses, from the survey, from patients and those that are delivering the transplant service, that inequity of access came across very strongly and that's access from the geographical areas, lifestyle, ethnicity and also ineffective access in terms of the resources that you can access from transplant teams. Disjointed commissioning causes frustration across the board and that access to data to support you in decision making, The report is written and will go through the Clinical Steering group in a week or so. There is a final meeting for sign off on Monday, with delays due to Ministers changing and inconsistencies in leadership which has been challenging. The recommendations have therefore not been finally cleared by ministers yet.</p> <p>The first thing in the report is the patient centred focus; the involvement, the choice, the information, the education along the entire care pathway.</p> <p>The second thing is around supporting operational infrastructure, having made a lot of improvements and learned a lot of lessons as a result of COVID.</p> <p>The third theme is workforce sustainability which is obviously very fragile. It seems to be a more fragile subset than some areas and came across as a very strong theme throughout.</p> <p>The next is improved data, to improve access to data to support informed decision making.</p>	

	<p>The next is the use of innovation and novel technologies, such as machine perfusion.</p> <p>The final recommendation is Strategic direction: Standardisation and strategic direction and leadership with national oversight.</p> <p>The report is written and will go through the Clinical Steering group in a week or so. There is a final meeting for sign off on Monday, with delays due to Ministers changing and inconsistencies in leadership which has been challenging. The recommendations have therefore not been finally cleared by ministers yet.</p> <p>R Ravanan thanked C Williment on behalf of KAG, OUG will shape the service of the future.</p> <p>A Safdar asked if there were any differences in ethnic groups getting involved pre and post pandemic in patient focus groups. C Williment advised that the concerns have remained the same, L Burnapp advised that she has sat on focus groups and felt that the message was that we need to do better. It isn't working for everybody. The medical teams don't relate to each other well and don't communicate with patients the same and NHSBT may be able to help with this. C Williment is keen to show that we have listened to and acted on what these group have said. D Idowu reported that black people feel if they have made recommendations, nothing has been done, and feels that they need to keep raising concerns to make change happen. D Manas raised the question of any potential unconscious bias in Clinicians, no one feels that they are disadvantaging patients of minority ethnic groups. How can this be changed and how can communities be supported better, D Idowu feels patients need to be listened to.</p> <p>N Torpey advises that OUG is running in parallel with other groups and that the DHSE report may say something different. Nick Powis chairs the OUG and is a Director in NHSE.</p> <p>M Laftsis is a Regional Director with the Royal College of Surgeons and offered to be the link for C Williment.</p> <p>C Williment will share her slides with group to go out with minutes.</p>	<p>CW</p>
<p>5.</p>	<p>Review of fast-track trigger thresholds - KAG(22)09</p>	
	<p>C Callaghan advised that the current trigger points for fast-track in the deceased donor policy were written nine years ago. A Fixed Term Working Group was established to review the Fast-Track process, to understand if the process could be improved and as concerns had been raised about staff resilience. C Callaghan reported that there was an options appraisal; 1. Do nothing, 2. A moderate change to Fast Track thresholds and number of centre declines for donor/quality reasons, to 7 declines for both DBD & DCD. The third option is to look at thresholds based on donor age, Cold Ischaemia Time and donor type, this would require major IT changes. The FTWGs suggestion was to go with option 2, with a further review at six months.</p> <p>M Robb advised that G Jones had raised some questions regarding the number of offers; the median number of fast-track offers is 6. G Jones questioned whether these kidneys were ever going to be accepted? He suggested removing these kidneys from the Fast-Track offering scheme.</p> <p>M Robb suggested it is difficult to identify a specific group/type of donor from which kidneys should not be offered through the fast-track scheme. N Torpey asked if there was data on the number of kidneys that centres didn't accept, similarly A Courtney asked what % of fast-track kidneys are actually transplanted. STATs can provide these numbers and also include them in routine monitoring of the scheme.</p> <p>C Callaghan advised that the National kidney offering scheme may not take into account all clinical variables that lead to declines, as the data is not collected by the registry. D Manas advised that with livers, the more the organs were offered the more organs were utilised. G Pettigrew felt that kidneys are</p>	

	<p>offered by Fast Track after they've declined by all centres. R Ravanan advised that this change should mean more kidneys go through the Kidney Offering Scheme.</p> <p>S Bond asked what patient representatives thought of the Fast-Track scheme; D Idowu and A Safdar agree it's positive, but A Safdar questions game playing. C Callaghan feels that this very small risk will be further reduced, and will be discussed with R Ravanan, M Robb & R Curtis out of the meeting and discuss if monitoring can include this. A Barlow feels that Fast Track centres will be disadvantaged.</p> <p>The Group agreed on option 2, recommendation accepted.</p> <p>This will be changed and reviewed at 6 and 12 months after implementation.</p>	<p>CC/RR/MR/RC</p>
<p>6.</p>	<p>QUOD update</p>	
	<p>R Baker provided an update, there was one general incident in 2021. There will be a change soon, moving up to a 3mm core biopsy imminently.</p>	
<p>7.</p>	<p>A2 donor kidneys for B recipients - KAG(22)10</p>	
	<p>L Burnapp presented the A2 donor kidneys for B recipients paper, updating on discussions within the FTWG, which was convened to consider the use of A2 living donor kidneys for the benefit of B recipients. The group met on 6th May 2022, L Burnapp asked members if there is an appetite to do this work. KAG is asked to consider questions to inform future direction of travel with this initiative.</p> <p>Two scenarios had been discussed, the numbers are low (eleven a year)</p> <ul style="list-style-type: none"> a) Offering of unmatched blood group A (A1 or 2 sub-type) non-directed altruistic donor (NDAD) kidneys in the UKLKSS to B recipients on the transplant list b) Utilisation of A kidneys within the UKLKSS matching runs for B recipients (with extended criteria options at recipient registration) <p>Would centres be willing to sub-type all NDADs +/- paired/pooled donors as currently not done routinely? Some centres might not have blood banks.</p> <p>N Torpey advised that Addenbrooke's reports A1 and not A1 only and only do transplants on patients with no antibodies. D Manas asked T Rees if the cost for the additional blood typing would be high, T Rees advised that costs would not be high but some centres use analysers that won't provide sub-types, therefore those centres will need to find where they could get sub typing done. Over 80% of centres agreed, with some concerns raised, the members agreed that the modelling work should be completed.</p>	
<p>8.</p>	<p>Live donor update - KAG(22)11</p>	
	<p>This paper provides an update on activities related to living donor kidney transplantation (LDKT). L Burnapp reported that latest statistics show that living donor transplantation (LDT) activity has made a consistent recovery, achieving 88% of pre-pandemic activity in the past year.</p> <p>L Burnapp reported that the aim is to report LDKT activity 30 days in arrears and asked members to ask their centres to submit living donor and recipient paperwork to ODT Hub information services within 7 days of living donor surgery to improve activity reporting. It is still taking up to 3 months to capture accurate and complete data.</p> <p>A better conversion rate is needed, late cancellations are impacting this but are getting nearer to 75% now, required to keep this scheme effective.</p> <p>L Burnapp detailed Figure 3.2.1: Number of non-proceeding transplants by centre, with classification, asking what could be avoided.</p> <p>Delayed transplants; data is needed to report to commissioners so that NHSBT may be able to help. 50% of transplants are happening after registration deadline for matching run, they won't be included in that matching run. The response rate from centres for the delayed survey has been low and there has been no response to surveys sent out from the January 2022</p>	

	<p>matching run. KAG representatives are asked to encourage timely response to survey monkey requests (via living donor coordinator and H&I leads) to improve completeness of data for non-proceeding and delayed transplants in the UKLKSS. This data helps to identify centre-specific constraints and inform discussion about support needed in individual centres. These recommendations were accepted.</p> <p>To address the increase of dialysis for children and young people, offering of unmatched non-directed altruistic kidney donors (NDADs) to paediatric recipients (as some weren't making matching run) was agreed for 1 year (4 MRs.) This has very little impact on the adult population. KAG was asked to consider whether or not the preferential offering of unmatched NDAD kidneys in the UKLKSS to paediatric recipients is continued. These recommendations were accepted.</p> <p>L Burnapp described a situation where a directed living donor kidney could not be transplanted into the intended recipient and needed to be offered to an alternative recipient. As NHSBT do not hold data for all living donors outside the UKLKSS prior to donation, section 4 of LDKT policy currently recommends local offering with a recipient selected by the transplant centre. A group internally reviewed this case to be able to better support colleagues as they didn't have donor information. (With existing NHSBT systems you can't create a partial donor record.) The proposal is that if a local donor is identified you ask a local/collaborative centre to identify a recipient, KAG was asked to consider addition to the LDKT policy in relation to the re-offering of directed living donor kidneys and approve the recommendation. These recommendations were accepted.</p> <p>L Burnapp highlighted the amendment to the Human Tissue Act with respect to travel for illegal transplantation. This data can be captured on arrival back to the UK centre for follow-up. Members were asked to ensure that clinical colleagues are aware of any illegal transplantation activity and that they continue to report suspected cases.</p> <p>All recommendations were accepted.</p>	
<p>8.1</p>	<p>Policy review of unmatched NDAD (Paediatric prioritisation)</p>	
	<p>Since this temporary change was introduced, there have been 6 unmatched NDADs, 2 of which were matches to paediatric recipients but only 1 offer was accepted for a paediatric.</p> <p>A Williams lobbied to keep this policy in place as it is not detrimental to the adult population due to the low numbers. There has only been one transplant, but it's a big impact on capacity within paediatric dialysis units just for one transplant.</p> <p>The group agreed that the policy should remain in place for the next four matching runs (one year of activity) and will be reviewed again after this.</p>	
<p>9.</p>	<p>Governance update</p>	
	<p>R Baker detailed two incidents, one of a patient coming back on the list, both unacceptable antigens were left on the list. IT have now resolved this with a new validation field.</p> <p>The second case was a patient transplanted with a kidney then developed a metastatic disease, the patient died. D Manas advised members to appeal to retrieval teams to open the kidney and look at the tumour.</p>	
<p>10.</p>	<p>KAG Paediatric sub-group update</p>	
	<p>A Williams provided a KAGPSG update, following on from previous discussion on dialysis capacity. He stressed that there is no statistical evidence that paediatric patients are disadvantaged although there is a feeling within the paediatric community.</p>	

	<p>Living donation activity is up, deceased transplant numbers are down, members are collecting dialysis numbers on a month by month basis, the paediatric dialysis numbers are stable.</p> <p>Waiting time does seem to be going up, now at 80 weeks, although this figure should be interpreted with caution as it is just a snapshot of waiting time at point in time. Waiting time to transplant numbers have not yet been analysed under the 2019 offering scheme.</p> <p>H Jones has post take analysis on the number of transplants that were not done, 21 were cancelled, 17 have now been done. Some families requesting postponement. Two were completed after patients became dialysis dependant, there has been one clinically urgent paediatric recipient receiving deceased donor transplant in the last year.</p>	
11.	Patient Representative/Lay Member update	
	<p>D Idowu advised that the living donor group meet weekly, creating a Black Living Donor choir. After their third session one member reported this was therapeutic as his mental health was suffering as a living donor. He hadn't been able to share this, other members of the group agreed they felt the same. This transformed the group. After living donation occurs there is a 6-week review then they aren't seen until 12 months later, they rely on this peer support. She questioned that they should be seen at a 3-month review. L Burnapp feels that they should be seen, maybe not 'clinically' as bloods, urine can be carried out when discharged to GP, but something else should be done. L Burnapp agrees an opportunity should be created for them within their own communities, working with Living kidney Charity – AGM/Steering Group in 2 weeks.</p> <p>D Manas agreed no psychological support with all organs. R Ramanan thanked her for bringing it to the group.</p>	
12.	PAG update	
	S White was not able to attend, papers have been attached. No points were raised.	
13.	CLU update	
	<p>N Inston shared slides from the CLU group, providing an update on the OUG, barriers to utilisation, asking surgeons to complete a survey. 96 surgeons completed the survey. Access to theatres, 24-hour histopathology, access to transplant ward bed were mostly raised and highlighted the challenges they are having.</p> <p>The scrutiny scheme of organs declined results were shared with the group, these are improving 100 HQ transplanted elsewhere, SCD high priority = 35, 9 HQ retrieved not transplanted. This is a very robust scheme. Current system is accept or decline, NORS is available to maximise organs, to optimise equitable access to an offer and what is an appropriate accept or decline. Some centres are only getting Fast Track offers. He is happy to look at Cold Ischaemic Time issues with Governance, as these should be recorded as a never event. The next steps, whilst waiting for the OUG report is to engage with CLUs, implement recommendations, identify challenges, provide updates on ongoing issues and report to KAG six-monthly.</p> <p>G Jones was surprised that capacity didn't come up. D Manas asked if the returned letters result in reflection from centres, as he felt that discussions with nephrologists and picking the phone up, has changed culture. D Manas would like to get this message out if there is evidence to support this. C Callaghan was thanked for his leadership and for his work on the offer review scheme.</p>	
14.	Feedback from non-transplanting reps	

	<p>J Stoves spoke with L Karamadoukis and Sapna Shah about how non-transplant centres can work collaboratively, also with the workforce survey. He highlighted that they are no different to other centres in having meetings to be attentive to aspects of workforce and commissioning alongside patient experience and quality improvement. They have RSTP AND a number of forums for their voices to be heard and to contribute to debate and renal service development. The collaboratives believe in the importance of support for staffing and workforce alongside agreements for standard setting and to discuss complex cases, high level communication. R Ramanan asked him to identify other members for a working group with leading members from a coordinator group as this group will define the survey. The report will be out in October, Sapna Shah is happy to review the first drafts of the survey.</p>	
15.	Feedback from trainee reps	
	H Hendra & V Banwell will meet soon now that the results are back from survey to analyse the data and share with trainee colleagues.	
16.	<p>Liver allocation and kidney impact - KAG(22)12</p> <p>This paper is a review of the revised ODT Hub Operations process for access to transplant for liver and kidney patients, the process was first changed on 5 May 2015 but changed again on 20 March 2018 due to the national liver offering scheme going live. The current process for adult DBD kidneys is: one kidney is reserved for liver patients only if one of the top three ranking recipients on the elective list require a kidney, kidney will become available for kidney patients after 60 minutes, or once it has been declined for the liver/kidney patient.</p> <p>Following a review, it was agreed at the May 2021 LAG that, subject to there not being high priority (Tier A) patients on the National Kidney Waiting List, a kidney from DCD donor should be reserved until the zonal and linked centres had declined the kidney. This change was implemented on 1 November 2021 and this paper also examines the DCD liver and kidney offering pathway for the first seven months.</p> <p>The group agreed to continue monitoring activity and reviewing the data to make sure no kidney transplant patients are disadvantaged.</p> <p>D Manas feels this policy needs to be looked at again after LAG in 2023.</p> <p>R Ramanan to discuss with D Thorburn outside of the meeting.</p>	RR
16.1	ACLF proposal	
	<p>LAG introduced a policy for liver allocation for acute on chronic liver failure (ACLF) patients. It's at a very early stage and LAG do not know if this is the right thing to do. D Thorburn and R Ramanan propose that anyone on the ALCF liver list should be removed from the kidney transplant list until they know that the process works. If they survive the liver transplant, they would then be listed for a kidney, no combined transplant. N Torpey advised that a patient that received a combined transplant had been on dialysis for 12 years, he thinks discussion should be had not prohibiting patients from getting a kidney.</p> <p>R Ramanan to feedback to D Thorburn outside of the meeting.</p>	RR
17.	AOB	
	<p>R Ramanan opened the discussion on Imlifidase, a new medication first in class drug, company secured license for use in Deceased donor transplantation. Final NICE guidance was released 3 weeks ago. NHSBT raise implications on how organs are allocated, if on drug, but if kidney isn't accepted what happens to the organ afterwards?</p> <p>To present as national outcome data, starting conversations so far. NICE recommendations are adopted by devolved nations separately. NICE guidance is not yet in place, maybe 20th July and then three months to implement. The clock then starts, Commissioners will adopt this so implement discussions</p>	

	<p>soon. R Baker stated, regarding the Governance point-of-view only short-term data available and raised concerns re. price if it would be released onto every unit. He suggests having a national expert panel; H&I experts as there are H&I concerns, only medically robust patients should be administered the drug.</p> <p>N Torpey shares concern of a substantive danger of poor outcomes, transplant community should decide how to implement this, nationally agreed criteria for eligibility, some centres have experience of incompatible transplants. Wrote document on behalf of BTS. How do we proceed from now to implement this, Patients within Tier A can be given one dose on day of transplant, facilitating transplant. G Jones feels that there is limited data and still rejects, later down the line.</p> <p>R Ramanan and L Ball have discussed whether this will be in every centre or selected centres. D Roy suggested checking at 24 hours to see if this has affected/improved antibody levels. Comparing levels after 24 hours, this has an implication on what happens to the organ. Time from administration to cross-match is 6 hours, improving CIT by another 6 hours, with the organ remaining in the centre, will give patients in that centre a higher chance of transplantation.</p> <p>Wales; P Nagaraja - it will be implemented in their centre, having to work on pathways. S Spence agreed it should be equitable access across the UK.</p> <p>Northern Ireland; A Courtney advised that NI are not obligated to follow NICE guidance, will use for a selective group of patients. H&I centre needs to do work in advance, rather than transplant centre.</p> <p>Scotland; P Phelan stated this has not been discussed widely – logistical challenges in Scotland due to wide geographical spread of patients. Have on call H&I service across two sites.</p> <p>NHSE; L Ball and P Mason reported that this will be implemented in 90 days from 20 July. A CRG has been de-established, previous members are willing to help. NHSE to set up a small implementation group to look at commissioning and clinical considerations for use of drug, to make available to patients. KAG would welcome a four-nation process. (Policy development takes a long time) 40% of pts didn't have antibody rejection.</p> <p>R Ramanan asked what support can KAG give to help write the rulebook for implementing this. L Ball to come back to Ramanan. KAG will form a FTWG with STATs & R Battle, to create four-nation clinical guidance.</p> <p>M Robb advised that centres were given the option to change donor age criteria, previously annually, now quarterly. Only one request was received from one centre, he asked members if they would like to we stick with quarterly or revert back to annually. Members agreed to revert back to annually.</p> <p>G Pettigrew advised that the PITHIA Trial Team are still having problems with centres returning data and the standard of data to NHSBT. It was noted that this remains an ongoing issue, required for the analysis of data for PITHIA. G Pettigrew will contact the relevant centres directly.</p> <p>R Battle advised that BSHI and BTS are reviewing antibodies in renal transplantation guidelines and would like a clinical reviewer from KAG, prior to the draft going through the BTS website for consultation. R Ramanan advised that if R Battle sends to him, he will send across to Clinicians.</p>	<p>LBa</p> <p>GP</p> <p>RB/RR</p>
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