NHS
Blood and Transplant

KAG(M)(25)01

NHS BLOOD AND TRANSPLANT
ORGAN AND TISSUE DONATION AND TRANSPLANTATION

MINUTES OF THE FIFTIETH MEETING OF THE KIDNEY ADVISORY GROUP ON WEDNESDAY 29th JANUARY 2025
09:00 - 13:00
via MS TEAMS

ATTENDEES:

Gareth Jones	**KAG Chair/London Collaborative Clinical Lead**
John Asher	Glasgow Representative
Richard Baker	National Clinical Governance Lead - NHSBT
Atul Bagul	Leicester Representative
Jenni Banks	Statistics & Clinical Research, NHSBT
Richard Battle	BHSI Representative and National H & I Manager
Kathryn Brady	Recipient Coordinator Representative
Raymond Braid	Programme Manager for NSD Commissioning
Susan Browne	NHS Wales Joint Commissioning Committee
Lisa Burnapp	AMD - Living Donation and Transplantation, NHSBT
Joanna Chalker	Regional Manager & SNOD Representative
Andrew Connor	Plymouth Representative
Aisling Courtney	Northern Ireland Representative
Ian Currie	AMD Retrieval, NHSBT
Hatty Douthwaite	Kings College London Representative
Abbas Ghazanfar	St George's Representative
Paul Harden	Oxford Representative
Nick Inston	Birmingham Representative & CLU Lead
Maria Jacobs	Statistics & Clinical Research, NHSBT
Rebeka Jenkins	Clinical Research Fellow, Statistics & Clinical Research, NHSBT
Gareth Jones	London Collaborative Clinical Lead & BTS Representative
Helen Jones	Paediatric KAG Chair & Evelina Childrens Hospital
Katy Jones	Newcastle Representative
Lazarus Karamadoukis	Dorchester Representative
Nicos Kessaris	Guy's Representative
Avneesh Kumar	Sheffield Representative
Katy Latham	H&I Representative, NHSBT
Miriam Manook	Surgical Trainee Representative
Derek Manas	Medical Director, OTDT, NHSBT
Sanjay Mehra	Liverpool Representative
Muir Morton	Manchester Representative
Zia Moinuddin	Manchester Representative
Pramod Nagaraja	Cardiff Representative
Laura Pairman	NHS Lothian/Recipient Coordinator Representative
Gavin Pettigrew	Chair of Research & Development Steering Group
Paul Phelan	Edinburgh Representative
AnnMarie Pritchard	NHS Wales Joint Commissioning Committee
Sam Richards	Statistics & Clinical Research, NHSBT
Matthew Robb	Statistics & Clinical Research, NHSBT
Carla Rosser	H&I Representative, NHSBT
Debabrata Roy	Coventry & Warwickshire Representative
Aamer Safdar	Lay Member
Sapna Shah	Kings College Hospital Representative
Adnan Sharif	University Hospitals Birmingham Representative
Sanjay Sinha	National Surgical Lead- Clinical Governance, NHSBT

Smeeta Sinha	National Clinical Director for Renal Services, NHSE
John Stoves	Bradford Representative
Rupesh Sutaria	Portsmouth Representative
Nicholas Torpey	Cambridge Representative
Samuel Turner	Bristol Representative
Madeleine Vernon	Leads Representative
Julie Whitney	Head of Service Delivery - Hub Operations, NHSBT

IN ATTENDANCE:

Liz Armstrong - Head of Transplant Development (minutes)

APOLOGIES:

Anthony Wrigley
Steve White
Melanie Wilkey (Welsh Commissioning)
David Van Dellen (Zia Moinuddin attending as Clinical Lead on DVD's behalf)
Cinzia Sammartino
Moira Straiton
Sarah Jane Plant

ITEM		ACTION
1.	Declarations of interest in relation to Agenda *Please note that it is the policy of NHSBT to publish all papers on the website unless the papers include patient identifiable information, preliminary or unconfirmed data, confidential and commercial information or will preclude publication in a peer-reviewed professional journal. Authors of such papers should indicate whether their paper falls into these categories.*	
	There were no declarations of interest.	
2.	**Minutes of the meeting held on 18th October 2024 - KAG(M)(24)03**	
2.1	**Accuracy**	
	The minutes were agreed as an accurate record.	
2.2	**Action Points - KAG(AP)(24)03**	
	Gareth Jones reviewed the Action points from the last meeting. Some action Points remain open: **AP1.4 Unit Waiting Time Analysis 03.07.2024** New definition of 'on dialysis' will appear in Annual Report July 2025 - Complete Changing methodology from using active waiting time only to earliest of start date on dialysis or active registration and include periods of suspension agreed by KAG, however Patient Advisory Group needs to be consulted to incorporate any preference. Therefore, both methodologies will be included in Annual Report 2025 - Ongoing Presentation of only centre un – adjusted analysis - Complete **AP2.5 Revised CUSUM Response Requirements 03.07.2024** Highlight only the failures or deaths for review that have taken place since the tabular CUSUM chart was last at zero - Complete **AP5 HTA B Forms/ Dashboard 18.10.2024** There are a number of forms still outstanding 50% of outstanding forms from transplant units and 50% from referring units. J Whitney to share centres with outstanding form returns at next KAG meeting. G Jones asked for support from the Networks with regards to outstanding forms from referring units - Ongoing	**J Whitney/ All**

	AP6 Paediatric Dialysis Capacity – Mitigation Options with KOS 18.10.2024 Alter HLA* age points in kidney offering scheme to give more prioritisation to paediatric patients for a fixed term of 18- 24 months (no extension beyond 24 months without OTDT SMT involvement) - Ongoing (testing for the change currently taking place, release estimated in Spring)	**J Whitney**
	AP7.6 KAG Approval for Minimum Dataset 18.10.2024 Members approved that the onset of graft function (immediate, delayed or primary non function) field to be mandatory and the number of rejection episodes filed should be amended to yes/no - Complete (request for IT change made)	
	AP8.7 CUSUM monitoring 18.10.2024 Expected mortality and graft failure rates will be updated to ensure CUSUM monitoring is relevant to current practice (adults) - Complete CUSUM monitoring report to be presented at KAG PSG - Complete Expected mortality and graft failure rates will be updated to ensure CUSUM monitoring is relevant to current practice (paeds) - Ongoing	**M Robb**
	AP9.14 CLU update 18.10.204 Recipient reasons for decline – Complete (agenda item 29.01.2025) National framework for organ decline meetings distributed to all CLUs for comment - Complete N Inston and H Jones to discuss paediatric offer declines offline - Complete	
2.3	**Matters arising, not separately identified:**	
	Nil identified	
3.	**Medical Director's Report**	
	D Manas welcomed GJ as newly appoint KAG chair and gave thanks to Rommel Ravanan outgoing KAG chair. Reminder to all KAG members that clinical initiatives and changes to offering and allocation need to be presented and agreed via KAG, it is not acceptable for Centre Director meetings or Core Group meetings to authorise changes. Urgent matters can be discussed with D Manas as Medical Director and KAG chair. Advisory Group meetings have been planned for 2025. The aim is to equally allocate meetings across 12 months as opposed to have meetings scheduled for Spring/ Autumn. There is a plan to review Terms of Reference for Advisory Groups in 2025 and the membership of the Advisory Groups, this review will then be presented back to the Advisory Groups for comment. A Ranasinge has been appointed as Chair of CTAG. C Rosser has been appointed as a Consultant Clinical Scientist to the joint CCS post and will be 3 days per week based in Southmead and 2 days NHSBT, primarily as the OTDT H & I Lead. D Garcia Saez stepped down from the National Clinical Lead for	

	Utilisation (cardiothoracic role). V Gerovasili has been appointed as the National Clinical Lead for Utilisation (cardiothoracic role) on an interim basis. N Inston has been appointed as the National Clinical Lead for Utilisation abdominal role) on an interim basis. RINTAG has now been disestablished and been replaced by the ROFG, co-chairs are E Lawson and G Pettigrew. The ROFG reports to the OTDT Research and Development steering group, co-chaired by R Ravanan and S Marwaha. L Barton has joined NHSBT as an OTDT Programme Manager supporting Organ Utilisation, primarily those recommendations assigned to NHSBT as lead organisation. A patient engagement group will be established in 2025. All Advisory Groups in the future will have 2 lay members and 2 patient representatives. Awaiting spending review decisions with regards to aNRP, DCD heart and CLUs. NHSBT would fund Lead CLUs at risk, if required. Matching and offering business case in part agreed and appointments will be made soon to enable more timely changes to IT systems. Assessment and Recovery Centres, awaiting spending review decision. Histopathology project continues and there are further discussions as to how and who would pay pathologists, if NHSBT were to pay this would imply that the service is commissioned by NHSBT and the service is not commissioned by NHSBT. Scanners used in the PITHIA trial will be used to support the project. A National Liver Offering Scheme face to face engagement meeting was held 23rd January 2025. The review is being led by D Thorburn. PPV focus groups and a survey will also contribute to the review and subsequent recommendations. An islet summit was held in December 2024. A commissioning summit was held in November 2024, recommendation 12 of the Organ Utilisation Group refers to commissioning frameworks and the relationship between NHSBT and commissioners. A Transplant Oversight Group has been established. A recent CUSUM meeting was held in Manchester face to face, all who participated found the meeting invaluable and a positive learning opportunity. There are currently 10 CUSUMS that a response is awaited and 11 CUSUMS moving towards closure, but clarification and additional information requested needs to be provided to progress. OUG work is progressing, NHSBT and the OTDT Clinical team are supporting several OUG recommendations including living liver	

	donation, ESiT, ERAS, ARCS, CLUs SCORE programme of work is in progress. Because of SCORE there will be work undertaken to look at transport flights and the rationalisation of flights EVLP lung project at Papworth with Wythenshawe and Harefield working towards projects 'going live' in 2025. Consent rates remain a challenge and a consent summit will take place in 2025. Continued discussion with regards to HHV-8, discussions are taking place with regards to obtaining HHV-8 status of the donor prior to transplantation.	
3.1	**ODT Hub Update**	
	J Chalker remined the group that suitability screening with regards to kidneys changed 12 months ago because of feedback from the centres undertaking screening for the UK was that the previous system was unsustainable. Screening now results in a screening call to the local renal centre close to the donor hospital. If the local centre is unsure about the suitability of a donor for kidney donation, a 2nd centre opinion maybe sought but is not mandated. Colleagues are reminded that the decision made during a screening as the local renal centre is on behalf of the UK and not their specific centre. Therefore, blood group should not be a reason for declining a kidney on screening and the centre is asked to consider what the UK response to risk would be. If the centre is unsure, they should declare this opinion and a second opinion would be sought. J Asher fedback that, in his opinion, the current screening process is working well and referred to a recent call whereby the SNOD was informed of some additional information that would be vital in regards to donor characterisation.	
3.2	**HTA B Forms/Dashboard**	
	J Whitney fedback that the return of HTA B forms was much improved and the backlog of outstanding forms is no longer a concern. HTA/ B Forms/ Dashboard can therefore be removed from KAG as a regular agenda item.	
3.3	**SCORE**	
	SCORe programme is progressing, awaiting final business case approval from NHSBT. SCORe programme team are engaging with individual transplant centres. Initial engagement with multi organ transplant centres as the consensus is that the impact of the SCORe programme may impact multi-organ transplant centres more than single organ transplant centres. The SCORe programme will aim to engage with renal units via the renal collaboratives, acknowledging that the impact of SCORe will be different for individual centres. Some further work is planned to consider fast track offering and the impact of fast track offering in planned offering window.	

	G Jones advised that he has found SCORe presentations helpful and encouraged the KAG membership to attend an event whenever possible. FAQs are in the process of being prepared following attendance at centres. J Whitney advised that the time frame for SCORe is an 18-month implementation period this is in part due to digital changes required and in recognition that transplant centres need to be prepared for the change. N Torpey advised that the SCORe engagement meeting have been useful at Addenbrookes Hospital and that 2 Board members had been useful (Head of Finance and Head of Planned Care). A question was raised as to how Transplant Units were going to be supported to have the correct resources in place to accommodate changes that the SCORe programme aimed to make and that NHS E needs to be fully engaged with the provider. S Sinha advised that transplant units need to escalate their concerns via the relevant risk registers, this has provided useful with regards to dialysis and has leveraged funding previously. Evidence of risk needs to be documented and then to be escalated to a regional and national level. There are currently no risks registered in relation to transplant currently.	
3.4	**CUSUM - KAG(25)10**	
	Summary of CUSUM monitoring of outcomes following kidney transplantation. **Conclusion** Over the twelve-month period since the last summary of the CUSUM monitoring there have been 22 signals in kidney transplantation centre-specific CUSUM reporting. Seventeen signals are still under investigation, at various stages. **Action** Centre representatives are asked to note the outstanding investigations within their centre and complete their investigation within the prescribed time frame of 4-6 weeks from notification, as outlined in NHSBT SOP5963 https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/31230/sop5963.pdf R Sutaria requested that learning from previous CUSUM signals are shared, G Jones agreed to put together a report with anonymised learning points. A Courtney noted a query regarding a recent CUSUM notification and the fact that a transplant had now functioned after a period of prolonged delayed graft function. Queries to be raised with M Robb and if required and the relevant report can be re-run to confirm if a CUSUM signal remains.	**All** **G Jones**
4.	**Remit of KAG & Forward Planning - KAG(25)01**	
	Remit of KAG & Forward Planning **Action**	

	Members of KAG are asked to: Note the remit of the committee and responsibility of its members Provide expressions of interest as a Deputy Chair Recommend areas for consideration of KAG within the remit of the advisory group and resources available Consider the meeting format of KAG (virtual vs face to face) and preferred locations. A Connor enquired as to whether there is a preference for the Deputy Chair to be a Surgeon as opposed to a Nephrologist, G Jones noted that the deputy being a surgeon maybe helpful. H Jones advised that the KAGPSG have 2 deputy chairs a Nephrologist and Surgeon and this is working effectively. Discussion with regards to the possibility of Hybrid meetings, G Jones noted that these meetings are costly to arrange in order to ensure the Hybrid option is effective and cost of an increased number of face to face meeting are significantly increased.	**All**
5.	**KOS Review & Update - KAG 25 (09)**	
	Summary The Kidney Offering Scheme, implemented on 11th September 2019, is largely meeting its objectives. Both DBD and DCD kidneys are being offered through the scheme, with 13.8% of kidneys being offered to a centre to transplant in a patient of the centre's choice. Overall, the national decline rate remained high at 61.5%, with D1 to R1 having the lowest decline rate of 48.5%. HLA match points remains tailored by age, with 73% of all transplants preformed in patients aged less than 18 at Level 1 or 2 (000, 100, 010, 110, 200, 210, 001, 101, 201). Highly sensitised patients (cRF≥85%) now have equivalent waiting times to those patients with a cRF<85%. Patients with a cRF of 100% still wait longer for a transplant, however this has significantly reduced compared to prior implementation of the 2019 KOS. Young adults now have a similar waiting time to patients aged under 18 years, however this time has increased following COVID-19. A change to the HLA*Age points is due to be implemented in spring 2025 to give more prioritisation to younger patients needing a better matched graft. R Battle enquired re low frequency HLA types and a group of patients that can rapidly achieve tier A status quicky when they are not sensitised. C Rosser advised that she had recently submitted an incident to the patient safety team on behalf of H&I laboratories to investigate a potential change in the allocation algorithm resulting in unsensitised patients receiving a matchability score of 10 and thereby being eligible for a Tier A offer. There is a concern from the H&I laboratories is that this is resulting in poorly HLA matched kidneys being offered to patients immediately upon activation. G Jones advised that there are plans in place to review the kidney offering scheme. The scheme is due to be reviewed as it has been in	

	place for 5 years and the KAG membership should advise as to what they would wish to the review of the scheme to incorporate.	
6.	**Waiting List Review - KAG(25)03**	
	Summary The number of recipients suspended on the transplant list has decreased from 3545 in March 2023 to 3510 in March 2024. Following agreement at KAG in October 2022, the IT request that was logged to restrict the number of waiting time points that can be accumulated while suspended, for recipients who are activate on the kidney transplant list prior to starting dialysis is currently in the testing phase and is expected to go live in spring 2025. **Action** To ensure adequate hygiene of the suspended list where the list truly reflects patients with a reversible, mitigatable or clinically defensible reasons for suspension and encourage regular centre level review of the suspended list. To evaluate whether long term suspensions are the only way of managing the patients, all centres are asked to: -Review their list of recipients who have been suspended. -Recipients who have been suspended for 5 years or more should be reviewed with a view to reactivation, removal, or providing clinical justification to KAG for continued suspension on the list, within 8 weeks of this meeting. -Review of progress will be undertaken at the June 2025 KAG meeting. Members of KAG are asked to consider the indications for suspension on the waiting list prior to activation and whether this requires further review. H Jones updated re discussions at KAGPSG and variations in practice with regards to the listing and the immediate suspension of patients. FTWG to be set up and the benefits of combining adult and paeds into the FTWG discussed and agreed. Expressions of interest to join the group from KAG to be sent to G Jones. M Robb advised of a previous discussion and advised that patients should only be registered as suspended prior to activation if registering for the living donor kidney scheme H Jones requested that paediatric patients to be also included in the review of recipients who have been suspended for 5 years or more.	**All** **All** **M Robb**
7.	**OU: AI Outcomes - KAG(25)03**	
	Project Title **A**ttitude to **R**isk in **T**ransplantation and **I**ncreasing **S**olid organ use by modifying risk Tolerance **(ARTIST)** **Background** A summary report from the Organ Utilisation Group outlined some of the variables that influence organ utilisation.[1] Significant variation exists	

	between transplant centres with regards to what organs they are willing to accept. Some of the variation relates to staffing, capacity, resources and/or infrastructure that are centre-specific. However, even *within* centres there is variation with regards to what organs are accepted and by whom. This likely relates to behavioural factors that influence how decisions are made by individuals. The human component of how individuals make decisions under risk and/or ambiguity (both transplant professionals and patients) is not well studied in the field of transplantation. Even with ample resource, there will be variation in decision making between and within transplant units[2] which contributes to inequity of access for patients. Understanding these factors is important in the wider discussion of organ utilisation. While there has been no specific research in this area within transplantation, behavioural scientists have been studying decision making under risk within the field of economics for decades. The aim of ARTIST is to bridge these two disciplines and study this question in the setting of organ donation and transplantation. Members of KAG are asked to be aware of the project and utilisation of their centre data. **Project aim** Review the literature regarding decision making under risk. Improve our understanding of how transplant professionals and patients handle decision making under risk when considering organ offers for transplantation, separating non-human from human factors. Study possible behaviour change interventions on human factors in order to: - Improve organ utilisation. - Reduce inequity of access to transplantation. The project is not just aimed at kidneys and A Sharif will engage with relevant Advisory Groups. G Jones also asked A Sharif to ensure necessary approvals via ROFG.	
8.	**Living Donation Update - KAG(25)04**	
	L Burnapp provided an update on activities related to living donor kidney transplantation (LDKT), including: • Activity and reporting • UK Living Kidney Sharing Schemes (UKLKSS) • Offering of unmatched non-directed altruistic donors to paediatric recipients • Requests for prioritisation for transplantation • Non-directed altruistic donor offers in Imlifidase eligible recipients **Activity and reporting** 2024/ 2025 activity is on target and activity has increased from the same period last year. L Burnapp thanked all centres of the reporting and confirmation of Living Donor Transplants. **Living Kidney Sharing Scheme (UKLKSS)** LivingPath digital transformation (Transition state 1) to underpin the UKLKSS has continued to embed and been positively received. Further	

	enhancements to simplify the complex (pre) matching run are due to be delivered prior to the July matching run. An interim workaround is in place to reduce the workload for clinical teams in accepting and declining potential offers. July and October 2024 matching runs identified higher numbers of transplants and the proportion of proceeding transplants has increased, with fewer early declines of offers. KAG members are asked to review their centre-specific data to consider ways to address non-proceeding transplants and work with their living donor coordinators and H&I representatives to improve the return of non-proceeding and delayed transplant surveys. NHSBT continues to collaborate with Universities of Glasgow (UoG) and Durham in the 'Kidney Algo Project to develop models for enhancing the matching algorithm for inclusion in transition state 2 of LivingPath (funding dependent). The European funded project (Euro- KEP) to build on the international collaborative work of European Network for Kidney Exchange Programmes (ENCKEP) held its first meeting Madrid on 22nd -23rd January. NHSBT and UoG represent the UK as Associate Partners. The first meeting of the KAG fixed time working group to explore options for international collaboration will be via MS Teams on Wednesday 9th April 3-4:30pm. Previous expressions of interest are noted and any others to join the group are welcome. Email lisa.burnapp@nhsbt.nhs.uk or Matthew.robb@nhsbt.nhs.uk. Teams' invitations to follow. **Offering of unmatched non- directed altruistic kidney donors to paediatric recipients.** Subject to KAG annual review and approval, preference has been given to paediatric recipients in offering non-directed donors (NDADs) unmatched in the UKLKSS since July 2021 to help address the increase in children waiting for a transplant. KAG members were asked to consider the continuation of this policy given the low number of matches and offers. A decision was made to continue the policy until the June 2025 meeting and then review in the context of other options to be presented to KAG about the use of unmatched NDAD kidneys **Requests for prioritisation for transplant (previous living donor or recipient).** As agreed by KAG, previous living donors in need of a transplant and recipients who miss out on a transplant during a UKLKSS exchange or direct donation because their living donor has donated, are entitled to consideration for prioritisation for transplant. This is embedded in the Living Donor Kidney Transplantation Policy (POL 274) and Living Donor Liver Transplant Policy (POL 402) accessed here, https://www.odt.nhs.uk/transplantation/tools-policies-andguidance/policies-and-guidance/ In July 2024, a new system to request prioritisation for transplant listing for living donors and/or recipients was introduced to streamline the process. One prioritisation request has been fulfilled through the new	

	process for a previous donor with end stage kidney disease (poorly controlled hypertension/poor adherence). KAG representatives are asked to note the new process to request prioritisation associated with recipients of living donor organs and previous living kidney donors and ensure that relevant members of their clinical teams are made aware of the process. **Non - directed altruistic donor (NDAD) offers for imlifidase eligible recipients** Recent clarification with NHS England regarding the option to accept offers of non-directed altruistic donors (NDADs) for Imlifidase eligible recipients. NHSE agreed to support recent offers associated with the January UK Living Kidney Sharing Scheme (UKLKSS) matching run (high priority recipients and end of chain offers) due to the ambiguity within the existing NICE guidance. NHSE are however seeking clarification from NICE as to whether NDAD donors are explicitly included within the policy, so that clarification for future transplant recipients can be provided. NHS E has confirmed that a policy proposition proposal will be needed to consider use of Imlifidase in patients receiving a kidney from a living donor other than NDAD offers, as use of Imlifidase is not recommended for living donation by NICE guideline TA809. Early discussion with commissioners is recommended if Imlifidase is planned for the recipienient of an NDAD offer. This is therefore work inprogress. Commissioners from the devolved nations also suggested early discussion to agree use of Imlifidase, prior to transplantation, under these circumstances. **ACTIONS** • Clinical teams are asked to liaise directly with their local commissioners / directly with the Renal Clinical Reference Group to seek clarity ahead of commencing any clinical planning for use of Imlifidase with NDAD offers, for eligible recipients • Please keep NHSBT informed via the LKDschemes@nhsbt.nhs.uk in box if any NDAD offer is received for an Imlifidase eligible recipient on the transplant list. Smeeta Sinha highlighted the importance of clinicians being involved in these discussions to ensure that the clinical perspective is appropriately reflected in decisions regarding the future use of imlifidase.	**All**
9.	**Patient Safety Update - KAG(25)05**	
	As of the 16th October 2024 the OTDT Clinical Governance team's name and job titles have changed. The change will be to simply change the term "Clinical Governance" for "Patient Safety" which continues to encompass donors, and donor families as well as recipients. September 2024 edition of Cautionary Tales is now available online: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/34504/cautionary-tales-september-2024.pdf	

	Please see link for new guidance on HHV8 and please report cases to the Patient Safety Team- OTDT NHSBT https://www.odt.nhs.uk/transplantation/tools-policies-and-guidance/policies-and-guidance/. Data is being collected with regards to prevalence of HHV – 8 and will be shared in due course. Group acknowledged support with HHV – 8 cases by Ines Ushiro- Lunb. Recent incident discussed and learning points shared as part of the Patient Safety report. Discussions with regards to the adaptation of the WHO surgical checklist for transplantation to support transplantation. Noted that there is some resistance to alternating the WHO surgical checklist or having a 2nd checklist. Membership shared examples of tool utilised to support checks prior to transplant operations commencing.	
10.	**KAG Paediatric Sub-Group Update**	
	No. of active children on the kidney only waiting list increasing currently 119 patients. Paediatric Living donation achieved its highest year in terms of transplants in 2021/2022 (102), number of living donation transplants have decreased year on year for the past 2 years. Beginning to see an increase in the utilisation if DCD kidneys for paediatric transplants. Downward trend in DBD paediatric kidney transplant noted over the past 5 years. Thank you to KAG for agreement to alter HLA* age points in kidney offering scheme to give more prioritisation to paediatric patients for a fixed term of 18- 24 months (no extension beyond 24 months without OTDT SMT involvement). H Jones reported on the KQuIP Paediatric Kidney Transplant Group: Declining Deceased Donor Offers (3D project.) Kidneys will not be declined for a paediatric recipient without discussion between at least a nephrologist and transplant surgeon, this is now mandated. A monthly questionnaire is completed by all centres for kidney offer declines., reasons for declines are explored and there is scrutiny regarding offers made. The aim of the project is to reduce unwarranted variations in declining offers. Some successful mutual aid noted between centres including support from GOSH to the Evelina Hospital during recent cyber-attack. Birmingham have provided support for a small complex Nottingham recipient. KAG PSG are trying to ensure trainees have opportunities within training to gain experience with regards to small and complex paed patients.	
11.	**Recipient Coordinator Update**	
	L Pairman advised that there were no issues that the recipient coordinators wished to be raised at KAG.	
12.	**Lay Member update**	
	No update.	

13.	**PAG Update**	
	Waiting list numbers rising for both pancreas and islet recipients. Changes in donor demographics is posing a challenge for islet recipients. Islet summit December 2024, recommendations are be published shortly.	
14.	**CLU Update**	
	N Inston presented Organ decline review 2024 (December 4th 2023-December 5th 2024.) Number of Highter Quality (HQ) Kidney Donors identified – 261 Number of Offers – 1533 Not actual HQ donors - 46 Actual HQ donors – 215 Noted that during 2024 50 (8%) cases whereby offer decline reason was classified as Recipient Refusal. Year on year increase since 2022. Noted that during 2024 82 (13.2%) cases whereby offer decline reason was classified as recipient no longer needs a kidney. Year on year increase since 2022. 37 Letters and queries sent to transplant units with donor history being the highest reason for decline. N Inston proposed that in future letters and queries to centres in future posed the question is this a missed opportunity'. 8 occasions whereby centre already transplanting was the reason for decline. Opportunities to collaboratives to provide mutual aid potentially to reduce some of these declines. Noted successful mutual aid collaboration between Birmingham and Coventry. Discussions with regards to whether AKI -3 should be a non-high-quality category and how well these kidneys function if transplanted. J Asher noted that some recipients may tolerate prolonged graft function more than others. N Inston advised work is planned via the Organ Utilisation Development Team to progress this work in more detail. N Inston confirmed that the review scheme includes paediatrics, no major concerns noted. N Inston will ensure formal paper to accompany slides are circulated to KAG membership.	**N Inston**
15.	**Feedback from Non-Transplanting Reps**	
	Nothing to report	
16.	**Feedback from Trainee Reps**	
	M Manook in attendance representing the Herrick Society. Society considering how trainees maybe attracted to careers in transplantation to support future workforce sustainability. Recent publication with regards to culture and transplantation has been of a concern for trainees. Surgical trainees are working alongside A Sharif considering	

	equality, delivery and inclusion.	
17	**Any Other Business:**	
17.1	**EMPIRIKAL Trial - KAG(25)06**	
	N Kessaris provided the background to the EMPIRIKAL Trial. Background: The EMPIRIKAL-2 study involves the ex vivo administration of the novel cytotopic complement inhibitor, Mirococept, to the donor kidney just before transplantation. It is a multicentre double-blind randomised controlled trial (RCT) that aims to identify a safe and effective dose of Mirococept for reducing delayed graft function in deceased-donor kidney transplantation. A safety run will initially be carried out at Guy's Hospital. A recent incident was discussed where the Mircocept was administered to the donor kidney however the transplant could not proceed due to recipient issues. The kidney was offered on and not subsequently allocated to another recipient due to ischaemic times. Although the above scenario rare and unlikely to be repeated KAG were asked to consider the action to be taken in the event of a similar occurrence. 3 options were considered. -1 Discard the treated organ. -2 Offer the kidney to another patient from the Guy's deceased donor list that has been deemed eligible during the initial screen and has been sent the PIS. -3 Kidney is offered to patients from centres that do not take part in the study. J Asher raised a concern that if the kidney is allocated to a tier A recipient as per POL 186/20 2.1 and is required to be reallocated the kidney should be offered back for any recipients also in Tier A. Otherwise, a tier A recipient may be denied a transplant. John's comment was acknowledged but the consensus was the likelihood was low (keep in perspective). J Whitney referred to the de fat study and the approach taken in that clinical trial and that we should mirror this approach in this study G Jones and other members of the KAG membership advised that a kidney can not be offered that has been treated with a medicinal product as part of a trial, to patients who are not consented for the trial. The feeling was that this was a rare event and the trial team had put in place mitigations to reduce the risk further. The majority of KAG membership agreed that during the safety run option 2 is the preferred option. Noted that following this incident some changes made regarding the administration of Microcept to mitigate further instances. Noted that ROFG approval is still required.	
17.2	Kidney Transplantation PREM - **KAG(25)07**	
	Development and testing of a novel Patient-Reported Experience Measure for kidney transplantation - update provided by R Jenkins. We aim to develop a PREM that is useful and practical for the kidney transplantation community. KAG membership are invited to feedback on	

	the proposed parameters, and specific content, of this novel PREM. Please contact the TransplantPREM@nhsbt.nhs.uk if you: • Have any comments on the proposed parameters of the novel PREM. • Would be interested in taking part in an interview to test the specific content of the PREM.	
18.	FOR INFORMATION:	
18.1	QUOD Report **- KAG(25)08**	
	AOB R Battle enquired as to the progress being made with regards to a review of the CRF calculator. J Whitney advised that work is underway including modelling and noted R Battle offer of support from BSHI. J Whitney will provide an update re progress at next KAG meeting.	**J Whitney**