NHS BLOOD AND TRANSPLANT
ORGAN AND TISSUE DONATION AND TRANSPLANTATION

MINUTES OFTHE FIFTY THIRD MEETING OF THE KIDNEY ADVISORY GROUP ON WEDNESDAY 11th FEBRUARY 2026
09:00 - 13:00
Via MS TEAMS

ATTENDEES

Gareth Jones	**KAG Chair**
John Asher	Glasgow Representative
Atul Bagul	KAG Deputy Chair/Leicester Representative
Catherine Boffa	Portsmouth Representative
Kathryn Brady	Recipient Coordinator, Leeds
Chloe Brown	Statistics & Clinical Research, NHSBT
Lisa Burnapp	AMD - Living Donation and Transplantation, NHSBT
Jo Chalker	Head of Service Delivery - ODT Hub, NHSBT
Andrew Conner	Plymouth Representative
Ian Currie	Associate Medical Director (Retrieval), NHSBT
Rachel Davison	Non-Transplanting Centre Representative
Nick Earl	Assistant Director for Transplantation, NHSBT
Jack Galliford	Bristol Representative
Ann Gath	Patient Partner
Abbas Ghazanfar	St George's Representative
Paul Harden	Oxford Representative
James Hunter	Kidney Clinical Lead - ARCs, NHSBT
Nick Inston	Lead CLU/Birmingham Representative
Claire Lish	Lay Member
Jorge Jesus-Silva	NHSE Representative
Helen Jones	KAGPSG Chair
Nicos Kessaris	Guy's Representative
Usman Khalid	Cardiff Representative
Derek Manas	Medical Director, OTDT, NHSBT
Miriam Manook	Surgical Trainee Representative
William McKane	Sheffield Representative
Sanjay Mehra	Liverpool Representative
Claire Mitchell	Patient Safety Manager, NHSBT
Ismail Mohamed	Royal London Representative
Emma Montgomery	Newcastle Representative
Belinda Otas	Patient Partner
Laura Pairman	Recipient Coordinator
Mysore Phanish	Non-Transplanting Centre Representative
Mia Poore	Statistics & Clinical Research, NHSBT
AnnMarie Pritchard	NHS Wales Joint Commissioning Committee
Sam Richards	Statistics & Clinical Research, NHSBT
Matthew Robb	Statistics & Clinical Research, NHSBT
Carla Rosser	OTDT H&I Lead, NHSBT
Avinash Sewpaul	Edinburgh Representative
Sapna Shah	BTS/King's Representative
Laura Stamp	Lead Nurse Recipient Coordinator, NHSBT
Jelena Stojanovic	Deputy Medical Rep. KAGPSG/GOSH Representative
Nick Torpey	Cambridge Representative/ BTS Vice President
Madeleine Vernon	Leeds Representative
Julie Whitney	Head of Service Delivery - ODT Hub, NHSBT
Anthony Wrigley	Lay Member

IN ATTENDANCE

Alicia Jakeman	Clinical & Support Services, NHSBT
Natasha O'Brien	Observer

APOLOGIES

Lydia Ball, Laura Barton, Marius Berman, Raymond Braid, Chris Callaghan, Aisling Courtney, Katrin Jones, Makis Laftsidis, Stephen O'Neill

ITEM		ACTION
1	Welcome and Apologies. Declarations of interest in relation to agenda and responsibilities of KAG members. *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 15th October 2025 - **KAG(M)(25)03**	
	2.1 Accuracy	
	The minutes were agreed as an accurate record of the last meeting.	
	2.2 Action points - **KAG(AP)(25)03**	
	Those Action Points from the last meeting not marked as complete will be discussed on the Agenda. AP1 Organ offers via text is on the Agenda. AP2 SCORE is on the Agenda. AP3 Environmental Sustainability in Transplantation (ESIT) Is complete. AP4 Follow up on suspended patients is on the Agenda. AP5 Unmatched NDADs for paediatric patients will be added to the KAG June 2026 Agenda. AP6 Feedback from Trainee Reps. is complete. AP7 Any other Business Leeds Exemption request is on the Agenda. M Robbs asked centres to complete the follow up form for Imlifidase treated patients. Update of the centre donor age criteria is complete.	
	2.3 Matters arising, not separately identified	
	There were no matters arising.	
	2.4 Key learning points	
	G Jones confirmed that Key Learning points will be disseminated to members after the meeting. He asked members to share these key points with Colleagues.	
	2.5 New KAG Members and Centre representation	
	G Jones asked new Members to KAG to introduce themselves to the Group. G Jones shared meeting attendance information with the Group detailing that some centres are well presented at the KAG meetings, with some centres less so. He asked members who are unable to attend future meeting dates to send a Centre Representative. It was noted that previous meetings have been scheduled during Scottish and Irish school holidays.	
	2.6 KAG future meeting format- **KAG(26)15**	

	G Jones presented a paper detailing the format of past and future KAG meetings. A Survey was sent to Colleagues, with 30 responses. G Jones shared the responses with the Group, with a preference to continue with both two online and one face-to-face KAG meeting per year. This format was agreed with a view to rotating the venue of the face to face KAG location each year, as long as the venue was easily accessible to all members and affordable.	
3	Medical Director's Report	
	D Manas provided an update to KAG members; Appointments Frances O'Callaghan has been appointed as the new NHSBT Chief Executive. He confirmed that she has a lot of experience in Transplantation. Nick Earl has been appointed as an Assistant Director for Transplantation Interviews for a new Assistant Director position for Strategy and Business development were successful. Doug Thornburn has commenced his new position as National Clinical Lead for Transplantation which has been extended for one year. Chris Callaghan has commenced his post as PAG Chair, Irum Amin is the new MCTAG Chair, Anna Reid is the new CTAG Chair, Jas Parmer is the New Patient Engagement Group Chair. Sern Lim has been recruited to the position of Lead for Collaboratives. Funding ARC Funding is in now in place for completion of the Pilot. The ARC Pilot Centres for Kidney have been agreed. SCORE has also been approved, with the priority focussed on matching and offering. The NRP Rollout, Sustainability Programme and DCD Programme are progressing. The Organ Utilisation Group is now closed. The Organ Utilisation Team are monitoring the ISOU recommendations; Workforce and Data will require further work. An Oversight Group has an arm entitled the National Transplant Clinical Panel, co-chaired by D Thornburn and D Manas, looking at quality monitoring, risk management and emerging concerns. The CT PACS Pilot was successful. The Formal NLOS Review has concluded, Ian Rowe is Chair of the Implementation Group. A Lung Pilot Scheme is starting on 16th February 2026. CUSUMs The Trust-Wide Organ Utilisation Strategy Group aim to strengthen CUSUM reviews, with members including all Chairs of the Advisory Groups. Consent A Consent Summit was held in late-2025 with several recommendations on aims to increase consent rates, as the rates of donor consent continue to fall. Outcomes from a recent Living Donation Futures meeting was discussed later on the Agenda.	
	3.1 Follow up form return rates	
	J Whitney advised that all follow-up form return rates have reduced significantly over the past few years, including lifelong follow-up forms, this is more noticeable with three-month forms. The return rates have been discussed previously in KAG meetings as they are part of the CUSUM Monitoring process. J Whitney and G Jones have been working with Centres to aim to increase the rates by utilising ODT	

	online rather than paper forms. Some Centres, including Referring Centres, report having no staff member to complete and return the forms. It was noted that ODT online is not available for Referring Centres. W McKane advised that he is not always aware of who to speak to within NHSBT regarding the data returns. J Whitney asked him to contact her for discussion outside of this meeting. She advised that other centres have similar issues where data cannot be extracted from their systems. M Phanish confirmed that St. Helier Centre utilises a company to come to their centre to complete their data returns. G Jones advised members that John Dark has asked for all Research follow-up forms to be returned as required for Outcome data for the SIGNET Trial. The Primary End-Point for Kidneys is a 12-month eGFR result from the recipient.	**W McKane/ J Whitney** **All**
	3.2 ODT Hub Update	
	J Whitney introduced J Chalker as the new Head of Service Delivery for ODT Hub, covering both Hub Operations and Information Services.	
	3.3 Organ offers via text - Centre responses	
	G Jones advised that following discussions at the last KAG meeting, he has not had a response from most Centres as to whether they can move from telephone calls to an organ offer via text. G Jones and J Whitney will share details on SMS Direct, phone divert, text divert and ringtones, recognising that the Wi-Fi and mobile phone signals could have an impact. J Whitney confirmed that if the centre do not respond to the text a phone-call is made as a back-up. J Whitney confirmed that NHSBT are moving to digital acceptance and decline for organ offers and that NHSBT have an escalation plan which includes these alternatives. Centres not using text notification will need to have a plan to change over in future, in preparation for digital acceptance and decline.	**G Jones/ J Whitney**
	3.4 Digital update	
	These issues were discussed under the previous agenda item.	
	3.5 SCORE	
	J Whitney shared a presentation with the Group with SCORE modelling ongoing one week per month. The impact of ARCs, as they come on board and organ arrival times at centres will be monitored. The presentation will be shared with members after the meeting. J Whitney asked all Members to nominate one person in their centre to complete a new survey to track Centre progress, to collect information from theatres, on arrival times, offering and assess your readiness for their centre to go live. QR codes are included in the SCORE Presentation and below: SCORE - self assessment link Renal and Pancreas transplant centre; Readiness (Self) Assessment for SCORE (Q1 2026)	**J Whitney (Complete)** **All**
	3.6 ARCs Programme: Kidney Workstream update - **KAG(26)01**	
	J Hunter spoke to the presentation, previously shared with Members. He confirmed that here are a number of steps that need to be completed before centres become active as a pilot, including the perfusion experience of a number of kidneys, both from a research or non-transplant perspective and a clinical point of view using the ex-vivo device before the Assessment and Recovery Centres (ARC) pilot can go live in that centre. He detailed the offering pathway, discussed in KAG previously. A kidney that has been declined by all centres through the Fast Track scheme can be accepted by the ARC consultant. Once processed at the ARC centre, the kidney will be offered out for transplant via the fast-track scheme.	

	The travel times from ARC Pilot Locations to Recipient Centres was shared with the committee. The cut-off times for travel is not yet fully agreed by the ARC steering committee but members asked that the suggested cut-off be the higher value of 4 hours travel, to improve access to ARC kidneys and allow equity for a greater number of centres. Centres were reminded that the initial pilot phase will be key, aiming for low-risk transplants and, if the pilot is successful, future travel times and limitations may be relaxed. All Centres can be an ARC Centre, if they fulfil the criteria, but they will need to be part of the fast-track scheme. A QR code can be scanned by Members to Opt-In. J Whitney will share the presentation after the meeting, asking each centre to nominate two Champions; a Coordinator and a Clinician. Centres were reminded that post ARC ischaemic time should be kept to a minimum and advised that patients able to be transplanted without the need for a formal crossmatch would be optimal, to improve speed of transplantation. Centres were also reminded that peripheral blood crossmatching would not be possible for ARC kidneys and any retrospective wet crossmatch would need to be performed on spleen/lymph nodes. Members were asked to vote on the below Offering Options: **Option 1: National FastTrack Offer (Self Policed Travel Restriction)** - where kidneys are offered nationally but centres are asked to limit potential travel when replying to an offer. **Option 2: FastTrack Offer Only to Centres Within Travel Radius (pre-defined) and allocated Using Matching Run Order** - where kidneys are offered via a general fast track within a 3 - 4 hour travel limit of the ARC centre and kidneys allocated according to the national matching run. **Option 3: Offer Only to Centres Within Travel Radius (pre-defined) and Allocated by Proximity to ARC (closest first) Preferred Option** - where kidneys are offered to centres within a 3-4 hour travel limit but allocated by distance from the ARC unit, with the nearest centre offered the kidney first and moving out by distance from teh ARC centre. The ARC Kidney Steering Group on 2 February 2026 Confirmed Option 2 as the preferred approach. Members unanimously agreed with Option 2, with a stipulation of a four-hour travel time window. Not all Centres were represented at the meeting.	**J Whitney /All**
	3.7 CUSUM Summary - **KAG(26)02**	
	M Robb shared the paper with members, comparing the outcomes of NHSBT analysis in 2025. In the 12-month period since the last CUSUM summary provided at KAG, there've been 24 signals in Kidney Transplantation Centres, 17 required investigation and 12 of those signals are still outstanding. In that meeting M Robb asked Centre Representatives to note the outstanding investigations within their centre and to 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 Centre representatives were also asked to acknowledge the requirement for timely three-month outcome form return, to avoid additional signals and unnecessary repetitive investigation when NHSBT receive late notifications of transplant outcomes.	**All**
4	H & I update - **KAG(26)03**	

	C Rosser provided an update, summarising the H&I/HLA related incidents related to kidney transplantation. There is no update on the Calculated Reaction Frequency (cRF) calculator. There was an NHSBT National Transplant Database (NTxD) failure on Friday 23rd January 2026, with no back-up system in place to provide a named recipient for an organ. She suggested downloading all active patients' data regularly. Members confirmed that they do this as good practice weekly/monthly. G Jones will include this with the Key Points from this meeting. J Whitney confirmed that the HLA type will be provided during a manual offer to centres if NTxD goes down. C Rosser confirmed that the spleen and lymph node will accompany the kidney to the Assessment and Recovery Centres (ARCs) but that peripheral blood from the donor will not be available for crossmatching.	**G Jones**
5	Statistics and Clinical Research	
	5.1 Waiting List Review/Follow up on long term suspended patients - **KAG(26)04**	
	S Richards presented the paper, detailing the characteristics of suspended recipients on the kidney transplant list. The number of recipients suspended on the transplant list has increased from 3290 in 2016 to 3510 in March 2024 to 3642 in March 2025. Following agreement at the KAG meeting in October 2022, the restriction to the number of waiting time points that can be accumulated while suspended, for recipients who were activated prior to starting dialysis, went live in February 2025. There is a large variation in the number of patients recorded as suspended across Centres with 36% of all recipients on the kidney only transplant list recorded as suspended at 31 December 2025, ranging from 20% in GOSH to 49% in Guy's. Patients suspended for more than 2 and 5 years was detailed by Centre. 759 patients were suspended for more than 2 years and 147 suspended for more than 5 years, with Manchester having the greatest number of patients suspended for over 5 years. Not all Centres with long-term suspensions were represented at the meeting. S Richards asked all members to ensure adequate hygiene of the suspended list where the list truly reflects patients with a reversible, mitigatable or clinically defensible reason for suspension. To encourage regular surgical and non-surgical centre level review of the suspended list to evaluate whether long term suspensions are the only way of managing the patient. NHSBT will provide centres with a list of patients who have been suspended for greater than 2 or 5 years to aide review. An update on this progress will be provided at the June 2026 KAG meeting.	**S Richards /All** **S Richards**
	5.2 Organ specific reports - 10-year data proposal - **KAG(26)05**	
	C Brown presented the paper detailing data on first adult kidney only deceased donor transplants performed in the UK between 1st April 2010 and 31st March 2014. Ten-year survival estimates are reported as of 22nd December 2025. The paper reports on two separate models; one for 10-year graft survival and one for 10-year patient survival, comparing survival rates among Transplant Centres. At 10-years post-transplant, the national death censored graft survival rate was 75% and the national patient survival rate was 70%. The funnel plots which show how consistent the centres survival rates are with the national rate showed the majority of centres fall within the	

	confidence limits and have survival rates in line with the national rate. Two centres lie outside the lower 95% confidence limits for patient survival and one centre for graft survival, indicating survival lower than the national rate. Members agreed that the 10-year survival data should be included in the NHSBT Organ Specific Annual Report. Data on Outcomes by both Referring Centre and Transplant Centre was suggested. The analysis for 10-year survival estimates following living donor kidney transplantation is to follow.	**C Brown**
	5.3 Tier A Kidney Offering Scheme simulations - **KAG(26)06**	
	C Brown presented the paper to members, summarising the characteristics of Tier A transplant recipients from the introduction of the scheme on 11th September 2019 and the update in the 10,000 donor pool and matchability score bandings on 20th February 2024. This was compared to the characteristics of the more recent Tier A transplant recipients, between 20th February 2024 and 31st December 2025. In the 53 months prior to the donor pool update, there were 911 Tier A transplants compared to 1026 in the 22 months since the change was implemented. Since the change, 83% of Tier A transplant recipients were matchability score of 10 compared with 44% prior to the change. The proportion of Tier A recipients who are 100% sensitised reduced from 35% prior to the change to 12% since the update. There has been an increase in the proportion of Tier A recipients who have received a transplant with less than 30 waiting time points from 2% to 10%. Between 20th February 2024 and 31st December 2025, there have been 281 transplants to Tier A patients with less than one year of waiting time points. All of these patients had a matchability score of 10 and only 24% of these recipients had a CRF of 95% or above. Simulation work continues within the NHSBT Statistics and Clinical Research Team. The simulations taken forward will be: Current scheme: Current Tier A definition: matchability score 10, cRF of 100% or a waiting time >7 years S1: Removing matchability score 10 from the Tier A definition S2a: Linking matchability score 10 with a cRF>=85% S2b: Linking matchability score 10 with a cRF>=95% S2c: Linking matchability score 10 with a cRF>=98% S3: Including level 3 HLA mismatches in the matchability score calculation and keeping the Tier A definition as per the current scheme. C Brown suggested setting up a Fixed Term Working Group (FTWG) to take this work forward. R Battle, N Torpey and J Asher volunteered to join the group.	**C Brown** **C Brown**
6	Living Donation - Offering of NDADs to Tier A - **KAG(26)07**	
	M Robb presented the paper to the Group, reviewing the activity of Non-directed Altruistic Donors (NDADs) and the proportion donating to Tier A of the kidney transplant list. Since 2012, Non-directed Altruistic Donors have been able to register for the UK Living Kidney Sharing Scheme matching runs. If they are matched in the scheme, they can start a chain of two or three transplants.	

	Before 2018 Non-directed Altruistic Donors had the choice of donating to a recipient on the UK transplant list or donating to the UK Living Kidney Sharing Scheme, since 2018 the default option has been to register in the UK Living Kidney Sharing Scheme. Since the update to the 10,000 deceased donor reference pool in February 2024 there has been an increase in the number of donors who donate to a Tier A recipient and a reduction in the number who donate to the UK Living Kidney Sharing Scheme. The paper compared the activity before and after the update in 2024 to consider whether this is still the best way to offer the kidneys. In 2023, the year before the donor pool update, there were seven donations (11%) to Tier A, 42 (67%) donors started a chain and 14 (22%) were unmatched. In total, there were 63 Non- Directed Altruistic Donors, resulting in 129 transplants, when including those as part of a transplant chain. In 2025, there were 65 Non- Directed Altruistic Donors. Twenty six (40%) donated to Tier A, 24 (37%) started a chain and 15 (23%) were unmatched. The total number of recipients benefitting from a transplant initiated by an NDAD (including as part of a transplant chain) was 105. In summary, since the update in the 10,000 deceased donor reference pool, there have been fewer donations to a transplant chain and more donations to Tier A recipients, resulting in a lower number of total transplants. However, the donations to Tier A recipients resulted in more highly sensitised recipients receiving a transplant. G Jones also suggested this issue may be resolved with realignment of TIER A recipients, as above. M Robb presented Options for members to vote on for preferred options in future offering of NDADs; **Option One** Continue to offer NDADs to Tier A recipients before including in UKLKSS matching runs **Option Two** NDADs are included in UKLKSS matching runs before offering to the transplant list (i.e. No matching with Tier A prior to the UKLKSS matching run) **Option 3** Offer NDADs to Tier A recipients before including in the UKLKSS for selected matching runs only (e.g.January and July runs). 12 members voted for Option three, two members voted for Option One. Two voting members abstained. It was therefore decided that January and July 2026 matching runs will remain the same, April and October 2026 matching runs will default to all NDADs going into the sharing scheme matching runs. This will run for twelve months prior to a review. Not all Centres representatives were present to vote.	**M Robb**
7	Commissioning Update	
	AM Pritchard advised of no update from Welsh Commissioning. J Jesus-Silva provided an update on behalf of Renal Services Clinical Reference Group; NHS England is reshaping their Service Specification to combine them into one renal replacement pathway to include dialysis and transplantation. The aim of this pathway is to ensure that commissioning is well supported, with alignment between Providers, Networks and Commissioners. NHS England are developing a working plan for 2026-2027 with the Transplant Community of Practice, which will be based over English Networks. The idea is to continue to support delivery and ensure that pathway	

	improvements are consistent. The Renal and Cardiac CRGs have completed reviews of BTS Transplant Guidelines, which will soon be published and disseminated. He advised that the Renal networks are keen to support members, asking that they raise any concerns or ideas with them. L Burnapp provided a summary of Commissioning conversations held during a recent Living Donation Futures meeting on 19th January 2026, with NHSBT's aim to support the expansion of living liver and living kidney donation in the future. Three of four nations Commissioning and Clinical representatives attended alongside donors and recipients. The group identified twelve priorities, consolidated into five areas; public awareness, promotion and engagement and consistent messaging around living donation, donor experience and support, Clinical pathways, capacity and capability and Data and digital transformation and commissioning, investment and system alignment. She advised that she will be emailing asking for Colleagues to ask for support for the workstreams to include wider engagement from across the community.	**All**
8	FTWG - Anatomically challenged patients - **KAG(26)08**	
	I Mohamed was not present at the meeting, this agenda item will be deferred to the next meeting.	**I Mohammed**
9	Kidney transplants with other organs - **KAG(26)09**	
	C Brown presented the data on 676 multi-organ transplants including a kidney, between 1st January 2021 and 31st December 2025. The process for multi-organ offering was summarised; the first kidney is offered to clinically urgent paediatric patients and patients in Tier A. If the second kidney is available, that will firstly be offered to Kidney/ bowel patients then Heart/Kidney and Lung/Kidney patients. The kidney is then offered to Tier A recipients, followed by liver/kidney patients, then pancreas/islet recipients needing a kidney and finally Tier B recipients. Over the five-year time period, multi organ transplants where a kidney was included accounted for 676 kidneys or 6% of all deceased donor kidney transplant activity. Kidney and pancreas was the most common transplant type each year and accounted for 592 kidney transplants or 88% of all multi organ transplants with a kidney.	
10	Intestinal allocation policy review - **KAG(26)10**	
	G Jones updated members on discussions with the Multivisceral Advisory Group on the thresholds for kidney inclusion as part of an intestinal graft. The current guidance for inclusion of a kidney transplant with an intestinal transplant is an eGFR of under 45ml/min. During discussion, it was suggested that the threshold for requiring a kidney transplant with an intestinal transplant should be reduced to 30ml/min and be brought into line with guidance for liver transplant (POL 195/7.) He asked members to vote on two options: 1) Endorse the lower threshold of eGFR 30ml/min for patients requiring a kidney with intestinal transplant, aligning with policy for liver. 2) Consider review of: a. Thresholds for all non-kidney transplants requiring a kidney transplant b. A prioritisation system for patients who develop ESKD while receiving another transplanted organ	

	G Jones asked members to take these recommendations to Colleagues and feedback.	**All**
11	Patient Safety Update - **KAG(26)11**	
	C Mitchell provided an update on behalf of R Baker, the paper was shared with members prior to the meeting. Learning was included from two incidents, with one incident detailed where no HTA form and donor blood group form was packed with a kidney when it arrived at the accepting centre. The kidney was declined for transplantation due to no forms being present. A further incident involved a transplant centre not informing Hub operations of an organ decline for 12 hours after the kidney had arrived in centre. The centre has now put actions in place to ensure that Hub Operations are informed as soon as possible following a decline. The kidney was eventually transplanted but after a prolonged period of total ischaemic time.	
12	KAG Paediatric Sub-Group Update	
	H Jones and J Stevanovic provided members with an update from the Paediatric Sub-Group, with nearly twelve months since a change in HLA and age point prioritisation for paediatric patients was introduced. Data analysis will start at the end of February, to analyse the impact on transplant and dialysis numbers. This will be bought to the June KAG Meeting. The Declined Deceased Donor (3D) Audit is ongoing. A Transplant Surgical Summit held after the last KAG meeting went well, with three working streams developed; one on Transplant complexity looking at the variation in paediatric transplants and comorbidities and how these children are managed. A Working Group looking at service disruption and what plans should be put in place there and a Workstream focussing on Surgical Workforce. Some smaller recipients are being listed onto the on-call list at London and Manchester Centres to provide some mutual aid to Nottingham and Birmingham centres whilst their Surgeons are doubling up and building up experience. The paediatric waiting list numbers have dropped again for another month, although transplant numbers have dropped at some centres.	**H Jones**
13	Recipient Coordinator Update	
	L Pairman advised that there was nothing to update Members.	
14	PAG Update	
	C Callaghan was not present at the meeting.	
15	CLU Update	
	N Inston provided an update to members, thanking C Callaghan for his hard work, having stepped down as AMD for Organ Utilisation. The vacancy of Lead Kidney CLU is open. A letter will be sent to local Kidney CLUs reinforcing the importance of monitoring declined donor offers. The KQuIP Paediatric Kidney Transplant group continue to investigate data on Deceased Donor offer declines. The organ review scheme and criteria on what is classified as a high quality decline will be led by the new Kidney CLU.	
16	Feedback from Non-Transplanting Reps.	

	M Phanish and R Davison were welcomed as new Non-Transplanting Centre Representatives. The email address for the Advisory Group Support Officers was shared, for communications.	
17	Feedback from Trainee Reps.	
	M Manook shared the Herrick Paediatric presentation with members prior to the meeting. The Trainees' feedback detailed that over 55% of Surgical Trainees don't have access to PED surgical training, one third would be interested in a Consultant post that offered paediatric transplantation and would be prepared to undertake twelve months' worth of training in paediatric transplantation. Members were asked their view on a national TPD; nearly three quarters thought that would be a good idea for transplant. M Manook advised members that she is stepping down from the Herrick Society having obtained a Consultant post.	
18	EMPIRIKAL Update	
	N Kessaris provided an update on the EMPIRAKAL Trial following previous discussions at KAG meetings on an issue of a kidney that was treated with the trial medication which then could not be implanted into the intended recipient, as the patient was deemed unstable. Members concluded that if a kidney was treated, it could not be transplanted into a patient that was not active in the trial. This risk has now been mitigated with the Research Operational Feasibility Group completing a material transfer agreement. In addition, it was agreed that any kidney that has been treated with placebo will not be offered out to a patient that is not in the trial. The trial team were asked to make sure that all mitigations put in place to avoid organ loss after treatment of the organ were reinforced in new centres entering the trial.	
19	Any Other Business	
	19.1 Change of registered blood group - **KAG(26)12**	
	G Jones provided updates following a group discussion held with a unit who wished to change a recipients registered blood group from AB to B due to the recipient having anti-A1 antibodies. The recommendations from the group were included in the paper.	
	19.2 Exemption panel request	
	G Jones provided an update on the outcome of an Exemption Panel Meeting. He asked all members to accurately record the kidney function and eGFR result post-transplant on follow-up forms at three months, six months and one year onwards. In addition, G Jones reminded centre representatives that a graft had to be registered as failed at 180 days, in order for a patient to retain their retrospective waiting time points. The panel's decision allowed the recipient to regain their previous waiting time, due to error in registration at the patients centre. Further discussion on the definition of a failed kidney transplant will be held outside of this meeting.	
Date of next Meeting: 10th June 2026, Lecture Theatre 4, 1st Floor, Queen Elizabeth Hospital Education Centre, Birmingham, B15 2TH		
	The date for the Autum KAG meeting will be rescheduled from Wednesday 7th October 2026 to an alternative day as it was noted that all 2026 meeting dates were scheduled for a Wednesday.	**G Jones (Complete)**
20	FOR INFORMATION	
	20.1 QUOD Report - **KAG(26)13**	

	20.2 Living Donor Kidney Transplantation Activity Update - **KAG(26)14**	
Organ and Tissue Donation and Transplantation Directorate		**February 2026**