

**NHS BLOOD AND TRANSPLANT
ORGAN DONATION & TRANSPLANTATION DIRECTORATE**

**MINUTES OF THE SIXTEENTH MEETING OF THE
KIDNEY ADVISORY GROUP HELD ON WEDNESDAY, 9 DECEMBER 2009
AT ODT, BRISTOL**

PRESENT:

Prof. Andrew Bradley	Chairman
Mr Niaz Ahmad	Representative for Newcastle & Leeds
Miss Laura Buist	Representative for Scotland
Ms Lisa Burnapp	Living Donor Scheme representative
Miss Sue Falvey	Director of Donor Care & Co-ordination, ODT
Dr Sue Fuggle	Scientific Adviser, ODT
Dr Andrea Harmer	BSHI representative
Mr Iain Harrison	IT Directorate, NHSBT
Dr Robert Higgins	Representative for Cambridge, Birmingham & Coventry
Mr Alex Hudson	Statistics & Clinical Audit, NHSBT
Mr Adel Ilham	Deputy for Dr R Moore, Representative for Wales
Mrs Rachel Johnson	Statistics & Clinical Audit, NHSBT
Mr Geoff Koffman	Representative for South Thames
Mr David Mayer	Clinical Lead for Organ Retrieval, NHSBT
Dr Philip Mason	Renal Association/Renal Registry representative
Ms Dawn McPake	Recipient Co-ordinator Representative
Mr Justin Morgan	Representative for Oxford, Bristol, Plymouth & Portsmouth
Prof. James Neuberger	Associate Medical Director, ODT
Dr Martin Raftery	Representative for North Thames
Mr Chris Rudge	Department of Health
Mr Badri Shrestha	Representative for Trent
Dr Jane Tizard	BAPN representative
Prof. Anthony Warrens	BTS representative
Mr Christopher Watson	Chairman, Pancreas Advisory Group
Mrs Ann Yates	Duty Office Manager, ODT

In attendance: Mrs Kathy Zalewska	Corporate Services Officer, ODT – Secretary
Miss Joanne Allen	Statistics & Clinical Audit, NHSBT (part meeting)
Miss Sally Rushton	Statistics & Clinical Audit, NHSBT

ACTION**APOLOGIES**

Apologies were received from Prof. Dave Collett, Mr John Connolly, Mr Abdul Hammad, Ms Sally Johnson, Dr Richard Moore and Mrs Karen Quinn.

Members noted that, due to a change of responsibilities within Statistics and Clinical Audit, Mr Alex Hudson would be taking over responsibility for KAG from Mrs Rachel Johnson.

- 1 DECLARATIONS OF INTEREST IN RELATION TO THE AGENDA – KAG(09)22**
- 1.1 Mr Watson, Miss Buist and Mr Morgan declared an interest in item 8 on the agenda.

2 MINUTES OF THE MEETING HELD ON 20 MAY 2009 – KAG(M)(09)1

2.1 The minutes of the meeting held on 20 May 2009 were agreed as a correct record.

2.2 Action points – KAG(AP)(09)2

2.2.1 **Item 1 – Renal transplantation in highly sensitised patients using left lateral lobe of liver with kidney transplant:** Mr Koffman reported that there are currently 2 patients registered on the study although no transplants have yet taken place. A copy of the protocol will be forwarded to Corporate Services at ODT for circulation.

G Koffman

Item 2 – Matters arising: not separately identified - Minute 3.3.1

Follow-up reporting of adverse events to living donors: Work is in hand to amend the forms for centres to use for follow-up reporting on living donors.

Item 3 – The transplantation of donated organs into non-UK EU residents: This item is ongoing. Refer to minute 3.5.

Item 4 – Three year review of deceased donor kidney allocation scheme: Work is ongoing to report to the next meeting.

Item 5 – Feasibility of priority allocation of kidneys to urgent paediatric patients: Refer to minute 17.1.

Item 6 – Biopsy of donor kidneys: There were concerns around the biopsy being undertaken at the time of donation rather than at the implanting centre as well as concerns around the need for informed consent for this procedure. Prof Bradley agreed to liaise with Prof Neuberger on how to take this forward as a prospective research project.

A Bradley

Item 7 – Impact of kidney/pancreas transplantation on kidney only patients: Refer to minute 17.2.

Item 8 – HTLV infection and transplantation: A revision of the MSBTO guidelines on transplantation is underway and Prof Warrens reported that SaBTO is likely to recommend anti-HTLV1/2 screening for organs and tissues. This is, however, subject to ratification by SaBTO.

Item 9 – Update on progress on the A₂ pilot in North Thames: Refer to minute 6.3.

2.3 Matters arising, not separately identified

2.3.1 **Minute 16.1.1:** In answer to a query on the mechanism for reporting of adverse events which may affect other recipients, Prof Neuberger confirmed that centres need to inform the ODT Duty Office immediately they are aware of an event. It is then the responsibility of the Duty Office to inform the appropriate centres of the situation.

3 ASSOCIATE MEDICAL DIRECTOR'S REPORT

3.1 NHSBT Update

- The IT implementation group met recently to identify IT projects required by the Advisory Groups and to develop a system whereby all IT requirements are assessed and prioritised with a commitment from NHSBT to work to a defined schedule of work. It is intended that this will help to resolve the issues with delays in implementing

changes requested by Advisory Groups. Details will be circulated formally to each Advisory Group meeting to allow members to review progress.

- NHSBT's responsibility for governance has increased since undertaking the employment of all donor transplant co-ordinators and the commissioning of retrieval teams. A review of governance arrangements for ODT is therefore underway with a proposal to revise the structures for clinical governance. The two main areas of focus will be adverse event reporting and tracking; together with monitoring of outcomes and feedback through the organisation. The formation of three sub-groups has been proposed to cover organ donation, retrieval and transplantation.
- New arrangements are in place to deal with graft outcome signals whereby when a signal is triggered NCG will be informed together with the relevant centre director and advisory group chair. If the response from the centre is deemed adequate then no further action will be taken; if an inadequate response or no response is received or if a second signal triggers within a defined period of time then NCG will launch a formal inquiry; in the case of renal transplantation NCG would act on behalf of the renal commissioners, keeping them fully informed of the situation.
- A mechanism has been developed for NHSBT to take formal responsibility for approval of selection and allocation policies generated through advisory groups. Advisory groups will remain central to advising NHSBT on selection and allocation together with proposals to measure the outcomes and regular audits. Legal representatives are currently reviewing NHSBT's policies on selection and allocation for robustness against a possible judicial review and compliance with current and proposed legislation.
- The NHSBT Board has established the Transplant Policy Review Committee to formally review and endorse all NHSBT policies/protocols relating to transplantation. This Committee will be led by two non-executive directors of NHSBT with representation from the advisory groups.

3.1.1 **Future arrangements for Advisory Groups – KAG(09)23**

3.1.1.1 Revised terms of reference for the solid organ advisory groups were received and accepted. These specify the minimal membership requirements to which groups may add if they wish. The tenure for the advisory group chairs is currently three years although current chairs have been asked to remain in place until 2010 in order to maintain continuity in light of the organisational changes currently taking place. One specific change to the terms of reference is the decision to remove patient representation from the advisory groups and replace with annual meetings with national and local patient support groups.

3.2 **Update on Organ Donation Taskforce (ODTF)**

- 3.2.1
- Clinical Leads for Organ Donation have been appointed for all level 1 hospitals and progress is being made on the establishment of Donation Committees within trusts.
 - A major advertising campaign for organ donation started on

2 November 2009.

- The first meeting of the Donation Ethics Committee is scheduled for early January 2010. Prof Neuberger will arrange to meet with the Chair to discuss how issues from advisory groups can be considered by this committee.
- The latest application of EOS went live in October together with the revised PDA tool and the DTC referral database. There are some connectivity problems which are being worked on currently. These new systems will ensure there is access to much more timely data at both a local and national level. The facility for H & I laboratories and virology laboratories to input results directly into the system is still in development.

An updated report on progress with the recommendations by the DH Programme Delivery Board can be accessed via the link below:

http://www.dh.gov.uk/en/Healthcare/Secondarycare/Transplantation/ODTPDB/DH_098585

3.3 Progress on the establishment of an organ retrieval service

3.3.1 Retrieval standards document – KAG(09)24

3.3.1.1 The agreed model for April 2010 onwards is based around the geographical location of retrieval centres. The model features abdominal retrieval teams based at the seven liver centres of Edinburgh, Newcastle, Leeds (+Manchester), Birmingham(+Cardiff), Cambridge, Royal Free (+ Oxford), and King's College Hospital; and cardiothoracic retrieval teams based at the six cardiothoracic centres of Glasgow, Newcastle, Manchester, Birmingham, Cambridge, and Harefield. Manchester, Cardiff and Oxford have been linked in with the liver centres as they can provide a pancreas team to join the liver team giving an opportunity for crossover training on retrieval of these organs. Although there are no plans to expand to eight teams a late bid from Plymouth is being considered in light of its geographical location.

Mr Koffman stated that the King's bid should have been a joint bid between King's liver and Guy's renal services. Mr Mayer confirmed that this had not been received as a joint bid and Mr Koffman would need to liaise with King's in order to modify the bid.

Mr Watson highlighted that pancreas transplant centres would be concerned that liver transplant centres are retrieving pancreata to an adequate standard and, as pancreata are offered nationally this could potentially be an issue.

With regard to non-heartbeating donation it was noted that if the local renal transplant centre wish to send someone to assist with retrieval they may do so. If the donor is a kidney-only donor then the local centre may retrieve but are under no obligation to do so; this would be the responsibility of the zonal retrieval team.

Mr Raftery queried an issue which had arisen with the new job description for donor transplant co-ordinators employed by NHSBT which is suggesting that DTCs undertake the role of perfusionists. Some DTCs are uncomfortable with this as it is something they have not been required to do previously. Mr Mayer confirmed that this is an issue

currently under consideration as, throughout the country, there have been different practices for perfusion. It is likely that historical precedence by area will be the deciding factor. When back-up arrangements come into force, however, this situation is likely to become confusing. DTCs are currently expected to carry out minimal perfusion and discussions are taking place with those co-ordinators who don't currently undertake this role.

Prof Bradley also commented that, since the transfer of donor transplant co-ordinators to NHSBT employment the role of the recipient transplant co-ordinator appears to have increased.

Members discussed whether both heartbeating (hb) and non-heartbeating (nhb) donor kidneys should be allocated using the same offering mechanism. NHSBT have been reviewing outcomes which indicate that nhb donor kidneys are equivalent to hb donor kidneys in terms of graft and patient survival and also in terms of EGFR at one year. Concerns were expressed over cold ischaemia time in relation to nhb donor kidneys and it was agreed that, following further analysis, the data would be circulated to members and discussed at the next KAG meeting.

R Johnson

3.3.2 **New arrangements for organ retrieval – KAG(09)25**

3.3.2.1

A paper detailing new monitoring and audit arrangements for organ retrieval was received for discussion. Members confirmed the definitions for primary non-function and primary dysfunction for kidney transplants. Dr Higgins commented that the definition of primary non-function would need to take account of patients transplanted pre-emptively. In addition, it was confirmed that duration of post transplant dialysis is recorded.

Members were also asked to advise of any absolute contraindications to kidney donation and agreed that the only active contraindications are active disseminated malignancy and advanced chronic renal failure. This information will help DTCs to avoid offering those organs which are universally unacceptable, particularly during the transition period with inexperienced DTCs and clinical leads for organ donation.

The reasons for non-retrieval and non-use of organs will continue to be monitored and Mr Koffman agreed to assist in the review and updating of the codes for reporting these reasons.

Discussions are taking place with representatives from the Royal College of Anaesthetists and the Intensive Care Society to move forward on the issue of donor management. One solution under consideration is to train up non-medical anaesthetic practitioners who are also trained in donor management who, in the fullness of time, would be able to fill that role.

3.3.3 **NHBD offering sequence – KAG(09)26**

3.3.3.1

The current offering principles for non-heartbeating kidney donors were received and members were asked whether any amendments are required to these principles. No changes were considered necessary at this time.

3.4 **Update on directed deceased donation**

3.4.1 A revised policy on the issue of directed deceased donation is still awaiting Ministerial approval; the delay is, in part, due to the differing legal frameworks across the four UK nations.

3.5 **Allocation of organs to non-UK EU residents: Independent report by Elisabeth Buggins**

3.5.1 Following publication of the report by Mrs Buggins an implementation group was established by the Department of Health (DH) to consider legislative issues and to advise ministers. The recommendations within the report have been accepted but, as yet, have not been implemented. The status quo therefore remains, with no change to the current practice with regard to EU or Group 2 patients. Once instructions are received on any change to current practice these will be notified to centres.

3.6 **Update on electronic offering system (EOS)**

3.6.1 The latest application of EOS went live in October and will be rolled out to all renal transplant centres by the end of the calendar year. Problems being experienced with accessing the system via laptops and hand-held devices are being investigated. The facility for H & I laboratories and virology laboratories to input results directly into the system is proving difficult but other options are being explored in order to extend EOS. The revised PDA tool also went live in October and is enabling DTCs and CLODs to have improved access to data. The referral database allows co-ordinators to understand factors and trends influencing consent rates.

3.7 **SaBTO H1N1 guidance – KAG(09)27**

3.7.1 Guidance from SaBTO on H1N1 in relation to organ donation was noted for information. Prof Neuberger emphasised the need to ensure that every potential donor who is H1N1 positive is offered. The final decision on whether to use organs from a donor who may have had H1N1 or from a centre where there was H1N1 rests with the implanting surgeon bearing in mind the risks/benefits involved. The International Transplantation Society guidelines on H1N1 can be viewed via the BTS website.

3.8 **Meeting with patient groups – national and local**

3.8.1 There will no longer be patient representation on advisory groups. This will be replaced by an annual meeting between each Advisory Group Chair, NHSBT representatives and representatives from national and local patient support groups. Members were asked to supply Corporate Services at NHSBT with details of local patient support groups for renal transplantation for a meeting scheduled for the end of January 2010.

**Centre
Reps.**

4 **SCIENTIFIC ADVISOR'S REPORT**

4.1 **The feasibility of the inclusion of DP typing for donors and recipients**

4.1.1 Resources for recipient HLA-DP typing, are contained within the proposal for commissioning of renal transplant and H & I services but this does not cover the cost of donor HLA typing for offering. It was

ACTION

recommended that if this proposal is to be introduced then Prof Bradley should write to the transplant centre directors to request that they support local funding for HLA-DP typing.

**A Bradley/
S Fuggle**

4.2 **The allocation of kidneys to HSP**

4.2.1 Dr Fuggle reminded members of previous discussions on the allocation of kidneys to highly sensitised patients. In January 2009 the method for classifying patients as highly sensitised was changed and based on a calculated antibody reaction frequency. This had increased the proportion of patients classified as highly sensitised from 10 to 19%. Currently, HSP are included in Tiers A-D for 000 mismatched kidneys.

If the antibody profile has been completely defined (ie residual sensitisation is 0%) or they are local, HSP are considered for Level 2 [0DR and 0/1B] mismatched kidneys. As the algorithm is currently programmed, HSP are not considered for kidneys with mismatch grades in Level 3 [0DR and 2B] or [1DR and 0/1B] and kidneys are not allocated to patients where the mismatch grade is in Level 4 [2B, 1DR] and [2DR]. Therefore HSP only have access to 0DR mismatched kidneys through the national pool.

A review to improve access to transplant for HSP was proposed because HLA antibody definition has improved and allocation of less well matched kidneys is less likely to result in a positive cross-match and reallocation. Furthermore, patients who are highly sensitised because of reactivity at class I could have a transplant mismatched at HLA-DR and are denied this currently. It was agreed that the review should be undertaken and should incorporate a review of long waiting patients to see if there any ways in which the allocation scheme could be modified to improve their access to transplant.

**S Fuggle/
A Hudson/
R Johnson/**

5 **STATISTICS AND CLINICAL AUDIT REPORT:**

5.1 **Conference presentations, current and future work – KAG(09)28**

5.1.1 Mrs Johnson reported on work currently being undertaken by statisticians at NHSBT, including conference presentations and publications as well as current and future work.

5.2 **Report from the Kidney & Pancreas Research Group – KAG(09)29**

5.2.1 Members received and noted the minutes of the June 2009 meeting of the Kidney and Pancreas Research Group. A further meeting was held at the end of November 2009 when discussion took place on applications for the use of data from the national database and on publications currently being worked up.

6 **KIDNEY ALLOCATION**

6.1 **Allocation of kidneys via the ‘unsuitable kidney’ scheme – KAG(09)30**

6.1.1 A paper was received for information on the allocation of kidneys via the ‘unsuitable kidney’ scheme. Members noted this as an example of a protocol which should be reworded as these kidneys are clearly not ‘unsuitable’ in all cases.

A Bradley

- 6.2 **Inclusion of predicted half life of donor/recipient combination as part of the offer information**
- 6.2.1 On behalf of Dr Newstead at Leeds, Prof Bradley raised the possibility that every time a donor offer is made for a particular recipient the predicted half life of the donor/recipient combination is included as part of the offer information. Following discussion it was agreed that this proposal would not be worth taking forward at this stage as it would deliver little value for a considerable amount of work. Prof Bradley agreed to respond to Dr Newstead accordingly.
- Prof Neuberger commented that the Liver Advisory Group is considering the concept of transplant benefit for new liver allocation protocols. This approach is based on life expectancy for individuals with a particular donor organ.
- A Bradley
- 6.3 **Proposal to modify the A₂ pilot in North Thames – KAG(09)31**
- 6.3.1 Following discussion at the last meeting on whether to continue the pilot in view of the success rate to date, Prof Warrens and Mrs Johnson submitted a proposal for modification of the allocation algorithm for blood group A₂ donor kidneys. This would involve blood group B patients on the study being given additional priority for heartbeating donor kidney allocation so that more transplants could be achieved to establish this practice as safe and effective. Investigation of the matching runs have indicated that allocating a bonus of 1500 points would be sufficient to ensure that a blood group B patient would be allocated the blood group A₂ kidney on the majority of occasions. Members were in agreement subject to Dr Higgins' suggestion that patients would only be allocated the bonus points if they had been waiting at least two years on the list. This would be implemented as soon as possible.
- R Johnson/
A Warrens
- 7 **UPDATE ON COMMISSIONING OF RENAL TRANSPLANT SERVICES AND H&I SERVICES FOR TRANSPLANTATION – KAG(09)32**
- 7.1 Members noted the latest version of the kidney transplantation (adult) recipient cost template which is based around a standard deceased donor adult transplant. Dr Harmer added that from an H & I perspective the template includes getting the patient on the list, maintaining the patient on the list and all the testing that takes place following the offer of a deceased donor organ to a specific patient. It does not, however, include typing the donor prior to retrieval. Prof Bradley agreed to highlight this omission to Julie Renfrew.
- Mr Koffman commented that as a significant number of kidney transplants are taking place from live donors then this should be taken into consideration as a separate costing exercise.
- A Bradley
- 8 **KIDNEY MACHINE PERFUSION TRIAL – KAG(09)33**
- 8.1 Earlier in 2009 NICE presented its appraisal of preservation methods for the storage of kidneys from deceased donors. This appraisal was based on two studies, one in the UK and one in Northern Europe, and

resulted in NICE declaring that both the traditional static cold storage method and machine perfusion were recommended for cold storage of kidneys. Their report was hampered by a lack of final data from the two studies although many members of the committee appeared to favour machine perfusion as the preferred method.

Mr Watson reported on a proposal for a UK national study on the preservation technique to be used for deceased donor kidneys prior to the appraisal review by NICE in August 2010. The protocol would be similar to the European study, with randomisation by the ODT Duty Office into treatment arms. There was general agreement that this would be a worthwhile study although there were some issues around funding. Centre representatives were asked to feedback to their centres and ensure they are happy to participate in the trial. Mr Watson agreed to develop the proposal further and circulate to centres.

Centre
Reps.
C Watson

9 ALTRUISTIC AND PAIRED KIDNEY DONATION

9.1 Report from the National Paired Donation Workshop – KAG(09)34

Mrs Johnson reported that a summary of current UK activity was presented at the National Paired Donation Workshop on 30 September. In addition, there was lengthy discussion on the paired donation process and suggestions were put forward to address current issues. The key outcomes from that meeting were:

- Explanatory leaflets for patients
- Changes to suspension rules
- Standardisation of cross-matching practices
- Two-week turnaround by laboratories on the initial crossmatch from the time of receipt of the matching results

A revised protocol has been circulated highlighting a number of important changes as from the January 2010 run. The most significant change to note is that all patients will be suspended from the paired/pooled list once a run is completed, irrespective of whether they are matched or not. Each patient listing will then need to be reviewed and re-activated if they are to be included in the next matching run. This is to ensure that all patients in each matching run are willing and fit enough to participate and are committed to the scheme.

To date there have been two successful three-way exchanges with a further two planned. Dr Higgins raised concerns regarding the priority given to exchange transplants with two exchanges which were set up six months ago still outstanding due to the postponement of transplant dates by one of the participating centres. One possible solution to this problem would be for one centre to accommodate two pairs in the exchange although this raises concerns around anonymity. It was agreed that Prof Bradley should write to directors of renal transplant centres stressing the need to give priority to setting an early date for these transplants.

A Bradley

10 LIVING KIDNEY DONOR FOLLOW-UP RATES – KAG(09)35

10.1 A paper showing follow-up form return rates for living kidney donors was received. Follow-up of these patients is variable with just 57% of up-to-

date donor assessments being reported for living donors donating between 2001 and 2007. It was recognised that these patients have an element of patient choice and can choose not to return for assessment, despite being sent reminders with alternative venues for follow-up, ie via their GP. It was, however, agreed that more effort should be made to follow-up on these donors. Prof Bradley would write to centre directors emphasising the need for completed returns and attaching the current data broken down by renal unit rather than by transplant centre.

**A Bradley/
R Johnson**

11 AUDIT OF THE KIDNEY POST-TRANPLANT SAMPLE MONITORING PROCESS

- 11.1 This paper reports the results of an audit from H & I Birmingham Specialist Patient Services in the kidney post-transplant sample monitoring process. The audit shows that the Birmingham laboratory received very few of the blood samples that it should have done according to the agreed laboratory protocol which is based in large part on the BSHI guidelines. The view of KAG was requested on whether such monitoring is important to ensure maximal graft and patient survival and should therefore be implemented or whether, if it adds nothing, it should be abandoned. Members agreed with Prof Bradley's viewpoint that routine monitoring for post-transplant alloantibodies, as recommended by BSHI, is of clinical importance and should not be abandoned. It was acknowledged that there is variability around the country in how the BSHI guidelines are implemented. Members noted that the guidelines are due to be reviewed in 2010 and it would be useful to revisit this when new guidelines are issued.

12 PRE-EMPTIVE KIDNEY TRANSPLANT RATES – KAG(09)36

- 12.1 A paper presenting information on pre-dialysis listing was received for information. There is still significant variation in pre-emptive listing rates between centres and it would appear that a few centres may be listing some patients too early. Centre representatives were asked to highlight the issue to the relevant centres and emphasise the need to adhere to the existing guidelines. The situation will be reviewed in 12 months' time. Members noted that the changes to the registration form to enable 'start of dialysis' to be recorded were still awaiting IT resources.

Centre Reps.

13 DONOR FACTORS INFLUENCING OUTCOME OF KIDNEY TRANSPLANTATION – KAG(09)37

- 13.1 A report determining donor factors predicting poor kidney transplant survival in the UK was received. A number of donor factors were identified as having a significant influence on post-transplant kidney survival including, donor age and history of hypertension. In addition, donor history of cardiovascular disease, weight, days in hospital prior to donation and administration of adrenaline influenced kidney transplant survival. Members welcomed the paper and agreed that this information could be used to develop a donor risk index. It was suggested that this analysis could inform use of marginal organs for dual transplantation. It was further suggested that renal function could be considered as an additional outcome measure.

**R Johnson/
C Watson**

14 STORAGE AND TRANSPORTATION OF KIDNEYS

- 14.1 On behalf of Mr Shrestha at Sheffield, Prof Bradley raised the question of the existence of a documented policy on the number of bags to be used for the storage and transportation of kidneys whilst awaiting transplantation. Members noted that both Eurotransplant and UNOS guidelines indicate the use of three separate sterile bags for this purpose.

Most centres use 2 bags currently and there is no specific policy within the UK on how many should be used. Miss Falvey reported that work is still ongoing on development of the EU Organ Directive which will specify quality standards throughout the EU so opinions from KAG on this should be directed towards these discussions. The clinical sub-group of the Retrieval Consultation Group will be discussing this, including variations in perfusion fluid. Prof Bradley agreed to respond to Mr Shrestha accordingly.

A Bradley**15 AGENDA ITEMS FOR RTSM ON 10 FEBRUARY 2010 – KAG(09)38**

- 15.1 The draft agenda for the Renal Transplant Services Meeting was received and noted. Members were asked to submit any further items for the agenda.

Item 9 on the agenda refers to an information sheet for recipients detailing the risk from different sorts of donors. Members were asked to submit any such existing documents to Corporate Services at ODT to help develop a model form.

16 REPORT FROM PANCREAS ADVISORY GROUP (23 OCTOBER 2009)

- 16.1 Mr Watson reported from the Pancreas Advisory Group meeting held on 23 October 2009. The number of pancreas transplants undertaken is down 20% on last year; there were 334 patients active on the transplant list as at 1 October 2009; the number of non-heartbeating donor transplants is increasing; and the waiting time for a pancreas transplant has increased. It was noted that as most of the pancreata used for the islet scheme are either from donors with a BMI of >30 and <40 or are pancreata offered for whole pancreas transplantation that were not accepted, this was not considered to be having a detrimental effect on the number of vascularised pancreas transplants undertaken.

Standard listing criteria for pancreas transplantation in the UK were agreed, together with the establishment of an appeals panel to consider exceptional cases where the registration does not meet the required criteria and which could respond within a specified time limit.

17 REPORT FROM THE KAG PAEDIATRIC SUB GROUP

Dr Tizard reported that at the meeting of the sub-group in November discussion had centred on two areas. The first was the variation between centres on organs being declined due to size with two centres in particular experiencing a problem with lack of surgical expertise for paediatric transplants. Offers of training with other centres were discussed together with the possibility of smaller patients being listed

elsewhere. Secondly, discussion took place on the factors influencing waiting time. Centres are to be asked to advise on their minimum matchgrade criteria and whether it needs to be reviewed.

17.1 **Protocol for clinically urgent patients – KAG(09)39**

17.1.1 At the last KAG meeting the priority allocation of kidneys to clinically urgent paediatric patients was agreed subject to the development of a formal protocol. This was submitted to KAG and endorsed with the caveat that regular monitoring of the scheme is undertaken to ensure that it is not abused by centres.

17.2 **Kidney allocation to paediatric patients - KAG(09)40**

17.2.1 The KAG paediatric sub-group requested agreement in principle to an adjustment to the points scoring system applied in Tier D to provide greater priority to favourably matched paediatric patients. Members gave their agreement in principle and it was agreed that Mrs Johnson would liaise as required to implement a change and report back at the next meeting.

R Johnson

18 **ANALYSIS OF SIMULTANEOUS LIVER/KIDNEY TRANSPLANTATION – KAG(09)41**

18.1 A proposal for selection criteria for simultaneous liver and kidney transplantation, which were accepted at a recent meeting of the Liver Advisory Group, was received for consideration. KAG members were asked to endorse the criteria within the proposal. Following discussion members were happy to give their agreement and requested that when patients are selected using these criteria a record should be made of which criteria are applicable to the patient in order to evaluate the programme. Prof Bradley agreed to respond on the decision of KAG to Dr Gimson, Chair of LAG.

A Bradley

19 **GOVERNANCE ISSUES**

19.1 **Non compliance with selection & allocation policies**

19.1.1 Prof Neuberger reported that as a consequence of the changes to the governance process referred to earlier in the meeting, there will be a closer analysis of incidents of non-compliance. There were no incidents of non-compliance to report at this time.

19.2 **Complaint re kidney offering**

19.2.1 Members noted a report of a complaint from a patient who had missed a kidney offer due to the DTC team using the patient's landline to try to contact her when she was away. Other contact numbers had been made available but not used. This complaint is being investigated by NHSBT.

20 **FOR INFORMATION ONLY**

20.1 **Update on renal patient consent scheme & living patient consent scheme – KAG(09)42**

20.1.1 The first report, on the renal patient consent scheme, showed that of the 5829 patients who were registered on the national list for a renal transplant, 92% have given consent for the use of their personal data.

The second report, on the living kidney donor patient consent scheme, showed that of the 611 patients who were registered on the national list for a living kidney donor transplant, 85% have given consent for the use of their personal data.

20.2 Transplant activity report: October 2009 – KAG(09)43

20.2.1 This report was noted for information.

20.3 The use of non-favourably matched grafts in paediatric patients – KAG(09)44

20.3.1 A report on the use of non-favourably matched grafts in paediatric patients between December 2008 and November 2009 was received for information.

20.4 Trends in patients joining the kidney transplant list – KAG(09)45

20.4.1 A paper summarising trends in patients joining the kidney transplant list since 2003/4 was received and noted.

21 ANY OTHER BUSINESS

21.1 There were no further items of business.

22 DATES OF 2010 MEETINGS

22.1 Wednesday 26 May 2010 at ODT, Bristol
Tuesday 7 December 2010 at ODT, Bristol