

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

**MINUTES OF THE FOURTEENTH MEETING OF THE  
KIDNEY ADVISORY GROUP**

**HELD ON WEDNESDAY, 26 NOVEMBER 2008  
IN CONFERENCE SUITE 2, ODT, BRISTOL**

<b>PRESENT:</b>	Professor Andrew Bradley	Chairman
	Mr Niaz Ahmad	Representative for Newcastle & Leeds
	Miss Laura Buist	Representative for Scotland
	Ms Lisa Burnapp	Living Donor Scheme Representative
	Professor Dave Collett	Director of Statistics & Audit, ODT
	Mr John Connolly	Representative for Northern Ireland
	Miss Sue Falvey	Director of Donor Care & Co-ordination, ODT
	Dr Sue Fuggle	Scientific Advisor, ODT
	Mr Abdul Hammad	Representative for Manchester & Liverpool
	Dr Andrea Harmer	BSHI Representative
	Dr Robert Higgins	Representative for Cambridge, Birmingham & Coventry
	Mrs Rachel Johnson	Principal Statistician, ODT
	Ms Sally Johnson	Director of Organ Donation & Transplantation, ODT
	Mr Geoff Koffman	Representative for South Thames
	Dr Philip Mason	Renal Association/Renal Registry Representative
	Mr David Mayer	Clinical Lead for Organ Retrieval, ODT
	Ms Dawn McPake	Recipient Transplant Co-ordinator
	Mr Justin Morgan	Representative for Oxford, Bristol, Plymouth & Portsmouth
	Dr Martin J Rafferty	Representative for North Thames ( <i>items 1 – 7</i> )
	Mr Chris Rudge	Department of Health
	Mr Badri Shrestha	Representative for Trent
	Dr Jane Tizard	BAPN Representative
	Mrs Ann Yates	Duty Office Manager, ODT
<b>In Attendance:</b>	Miss Joanne Allen	Senior Statistician, ODT
	Mr Iain Harrison	IT Directorate, ODT
	Dr Donal O'Donoghue	National Clinical Director for Kidney Care (item 2.3)
	Mrs Kathy Zalewska	Secretary, Corporate Services, ODT

**ACTION**

**APOLOGIES**

Apologies were received from Mrs Helen Lewis, Dr Richard Moore, Prof. James Neuberger, Mr Alex Stephen, Dr Anthony Warrens and Mr Chris Watson.

**1 DECLARATIONS OF INTEREST IN RELATION TO THE AGENDA –  
KAG(08)21**

1.1 There were no declarations of interest.

**2 MINUTES OF THE MEETING HELD ON 11 JUNE 2008 – KAG(M)(08)1**

2.1 The minutes of the previous meeting were accepted as a true and correct record.

2.2 **Action points – KAG(AP)(08)2**2.2.1 **Item 1 – Change to lower donor age limit for kidney/pancreas donation:**

Refer to minute 10.1 below.

**Item 2 – Analysis of patients joining the National Kidney Transplant List:**

Refer to minute 9.1.

**Item 3 – Renal transplantation in highly sensitised patients using left**

**lateral lobe of liver with kidney transplant:** Mr Koffman reported that two centres, King's and Guys, are participating in this pilot. Two patients have been identified, one of whom is on call, the other about to be placed on call. The procedure involves a lengthy agreement process and patient counselling. A mechanism for allocation has been agreed with the Duty Office and an update on progress on the pilot will be reported at the next KAG meeting.

**G Koffman**

**Item 4/5 – Commissioning of renal transplant services and H & I services for transplantation:** Refer to minute 2.3.**Item 6 – Minimum resolution for reporting donor and recipient HLA types:**

Refer to minute 4.1.

**Item 7 – Definition of highly sensitised patients:** Refer to minute 4.4.

**Item 8 – Two year report for 2006 kidney allocation scheme:** Work is in hand to consider whether the paediatric and adult data can be merged and split into age groups.

Further detail on the review to establish whether the number of patients sensitised to HLA-A has changed was discussed at minute 4.2 below.

The website content is being revised as a result of changes to NHSBT and information on the prioritisation of younger adults in the scheme will form part of this revision.

**Item 9 – Transfer of paediatric patients to the adult list:** Refer to minute 10.1 below.**Item 10 – CMV matching:** Refer to minute 8.1 for an analysis of the influence of CMV on patient and graft survival.

Miss Falvey reported that the most robust way of testing for EBV is to carry out EBV screening of all donors at the base laboratory, which would have financial implications for these laboratories. The alternative is to send serum samples for screening if it is known that the recipient is a paediatric patient. Dr Tizard commented that, from a paediatric point of view, screening for EBV should form part of the routine testing. Members agreed that donor EBV status is useful to know for all recipients and is crucial for paediatric recipients. The group needed to understand whether the reimbursement to hospitals for identifying potential donors includes provision for this test. Miss Falvey would follow this up and report to the next meeting.

**S Falvey**

**Item 11 – Update on paired and altruistic donation:** Refer to minute 4.**Item 12 – Allocation of extended criteria for kidneys for dual transplants:**

Analysis of the national database is taking place to inform future discussion on the use of dual grafts. A report is due to be submitted to the next meeting.

**R Johnson**

2.3 **Matters arising not separately identified**

2.3.1 **Minutes 3.2.1 & 3.3.1 - KAG(08)22:** Members noted the reply from Adrian Pollitt, Director of National Specialised Commissioning, to the request from KAG for consideration of a review of the commissioning and funding arrangements for histocompatibility and immunogenetics and for renal transplantation. Discussion had taken place between Dr Donal O'Donoghue, National Clinical Director for Kidney Care, and Mr Rudge, National Clinical Director for Transplantation at the DH, to take this issue forward.

Dr O'Donoghue attended the KAG meeting for this item to present a draft project plan on developing robust reference costs for kidney transplantation. A proposal had previously been successfully developed for kidney dialysis and it is

proposed to develop a project for kidney transplantation using a similar approach. The final report on kidney dialysis is due out shortly and it is anticipated that by 2010 there will be a mandatory tariff for dialysis using reference costs against returns from 2007/08. The proposal to undertake a similar exercise for kidney transplantation would need input from kidney transplant centres in England and it is proposed that the project group will include members from 19 Trusts with transplant centres in order to consider the risks and benefits involved. It is hoped that by 2011 robust costings should be available which are based on 2009/10 returns. It was noted that H & I services encompassed more than just renal services but could be considered as part of this process.

Following the Carter review on commissioning, ten specialised commissioning groups were set up in kidney services. It was recently agreed to formalise these commissioning groups and to give them Terms of Reference to develop consistent specifications and costings for financial reimbursement in a nationally co-ordinated process. It was noted that this process would currently only apply to England although there would be no problem with observers from the devolved administrations being involved. All types of transplantation (heartbeating, non-heartbeating, live) will need to be scoped and should be based on HRGs. Additionally, consideration will have to be given to developments such as antibody incompatible transplantation in order to ensure that these are not disadvantaged by the developments. The group will need to decide on whether the tariff should include the entire pathway prior to transplant as many patients are worked up and not transplanted. Dr Tizard emphasised the need for involvement from the paediatric transplant centres in the review.

The initial workshop for participating organisations is planned for January 2009. KAG strongly endorsed this proposal and an update from the workshop in January will be produced for the Renal Transplant Services Meeting on 12 February, 2009.

### **3 NHSBT UPDATE**

#### **3.1 Update on Organ Donation Taskforce**

3.1.1 The Programme Delivery Board met in June and September 2008 and is due to meet next in January 2009. Work on implementation of the 14 recommendations is ongoing and these have been broken down into individual projects which are the responsibility of either NHSBT, as the national organ donor organisation, or of the Department of Health in England and the devolved administrations in Scotland, Wales and N Ireland. Mr Rudge will be issuing a summary paper detailing progress to date on these projects within the next few days.

The need to control expectations in relation to this work was highlighted as the increase in donor numbers is not expected to happen immediately. In addition, work is ongoing on assessing how centres will cope with the increased workload, which is a much larger issue within the NHS in general, particularly in relation to the availability of ICU beds and theatres. The need to engage donor champions and develop clinical networks is crucial to this work.

#### **3.2 NHSBT structure /appointments**

3.2.1 The organ donor organisation (NHSBT) has established the Organ Donation and Transplantation Directorate (ODT) to replace UK Transplant and this directorate will carry out most of the activities under the UKT umbrella as well as the new responsibilities of the organ donor organisation as part of the Taskforce recommendations. Ms Sally Johnson was appointed as the Director of ODT in September and Prof. James Neuberger was recently appointed as Associate

Medical Director with a start date in January 2009 for one day per week, increasing to four days per week by March 2009. Mr Rudge will continue to provide clinical support until this time. Other appointments include Mr David Mayer to the role of Clinical Lead for Organ Retrieval and Dr Paul Murphy, Clinical Lead for Organ Donation, who took up the role in September. The appointment of three clinical advisors for the kidney, liver and cardiothoracic advisory groups had been put on hold until the above posts were filled and Prof. Neuberger will be meeting with the Advisory Group chairs to discuss how best to move forward with these roles. In addition, two DTC Regional Managers will be undertaking successive nine-month secondments to support the reconfiguration of the donor co-ordination services.

Prof. Bradley emphasised the importance of maintaining the crucial role of ODT in the collection and analysis of data on transplantation. Ms Sally Johnson reassured members that the maintenance of 'business as usual' for ODT is viewed as critical.

### 3.3 **Directed deceased donation – KAG(08)23**

3.3.1 The HTA and NHSBT are revisiting the issue of directed donation and have requested the views of the Advisory Groups on which patients listed on a national waiting list for transplant should be deemed to be of such significant priority that they would take priority over the wishes of the family to direct the organ to a relative. It was initially proposed that those patients identified as a 'highly sensitised' 000 mismatch should have priority over any request for directed deceased donation. The group was keen to support positive donation in the right circumstances and felt that, as there are other patients who wait as long as HSP patients then this would result in an arbitrary system of prioritisation. It was agreed therefore that it would be wrong to consider any group of kidney patients above a request for a directed deceased donation. Additionally, as most donations result in two kidneys this should provide for both a directed donation and for a patient on the kidney transplant list. It was highlighted that if the potential donor had already started down the path of becoming a living donor then this donation process should continue and be honoured where possible.

A letter was tabled from Mr Watson, surgeon at Cambridge, requesting that KAG consider a mechanism for prioritising a live donor for a kidney in the rare circumstance where renal function fails following donation. Mr Rudge highlighted just such a case where recovery of renal function is not anticipated and KAG members were asked for their view on whether, in these circumstances, the patient should be entitled to priority on the kidney transplant list. Mr Mayer stated that the Liver Advisory Group had agreed that a liver donor whose own liver fails within three months of the donation would receive priority on the liver transplant list. Following discussion it was agreed that a time limit would not be appropriate for kidneys but where a case of end stage renal failure is attributable to the episode of care itself then the patient should receive priority on the kidney transplant list. Priority should not be applied if the donor later develops renal disease or has the remaining kidney removed due to a tumour.

## 4 **SCIENTIFIC ADVISOR'S REPORT**

### 4.1 **Minimum resolution for reporting donor and recipient HLA types – KAG(08)24**

4.1.1 Dr Fuggle updated members on the level of compliance with the minimum resolution for reporting of donor and patient HLA types for the time period April to September 2008. One laboratory is still not achieving compliance routinely

## ACTION

S Fuggle/  
S Johnson/  
A Bradley

for recipients or for live donors despite being contacted in writing on two occasions. Dr Fuggle agreed to liaise with Prof. Bradley and Ms Sally Johnson on the options available to deal with this continued non-compliance.

The report will be circulated to Heads of H&I laboratories and the Directors of renal transplant centres as usual. This summary will be reported again in Spring 2009 and annually thereafter together with the HLA donor discrepancy monitoring report.

#### 4.2 **HLA-A sensitisation and access to transplantation – KAG(08)25**

4.2.1 An analysis was performed to determine whether patients with registered sensitisation to the HLA-A locus are disadvantaged by the change to the allocation scheme to allocate kidneys first to patients with a 000 HLA-A, B, DR mismatch grade and thereafter on the basis of HLA-B and –DR mismatch grades. Outcome data of the first two years of the 2006 allocation scheme was received where it was shown that there is no current evidence to suggest that those patients sensitised to HLA-A locus specificities are disadvantaged. In response to a query regarding the increased waiting times in Belfast, Dr Fuggle undertook to review the distribution of sensitisation on the Belfast transplant list.

S Fuggle

#### 4.3 **Definition of highly sensitised patients: Progress report – KAG(08)26**

4.3.1 At the previous KAG meeting agreement was given to a method of defining highly sensitised patients for deceased donor kidney allocation based on a calculated reaction frequency derived at ODT from unacceptable HLA antigens listed by the laboratory. This method is also used in the paired/pooled living donor scheme and the sharing scheme for sensitised pancreas patients.

The relevant changes have been made to the programming of the 2006 national kidney allocation algorithm and are being tested. The change will become active on 7<sup>th</sup> January 2009. Information will be sent to the Directors of all H&I laboratories and renal transplant centres describing the change. Early in December lists will be sent to each centre giving details of all their patients that will be classified as 'highly sensitised' and patients who change category. Standard waiting list reports available from ODT will be updated to reflect the new classification for HSP with effect from the end of January 2009.

This proposal is likely to increase access to transplant for highly sensitised patients and it was agreed that the effect of the new classification should be evaluated and shown to be acceptable before changes with regard to eligibility for less well matched kidneys for HSP are considered. One possible consequence of the change could be that highly sensitised adults could be prioritised over non-sensitised paediatric patients and this would need to be monitored.

#### 4.4 **HLA DP typing and organ allocation – KAG(08)27**

4.4.1 At the beginning of 2008 a letter was sent to the Directors of H&I laboratories and renal transplant centres advising that it was likely that HLA-DP would be required as part of the minimum HLA typing repertoire in 12-18 months time. Feedback from the laboratories has indicated that there would be resource implications in extending the repertoire to include HLA-DP. Dr Fuggle updated members on the monitoring of the proportion of patients on the transplant list with HLA-DP specificities and the impact of HLA-DP antibodies on reallocation of kidneys because of positive crossmatches.

Members discussed whether the minimum repertoire for the typing of donors and recipients should be expanded to include HLA-DP at present. It was noted that 10% of patients awaiting paired/pooled donation have HLA-DP antibodies and there was unanimous support for increasing the minimum repertoire to include testing for HLA-DP for donors for this group of patients. HLA-DP typing

for the entire recipient population would have huge resource implications and before making any recommendations it was agreed to undertake a consultation programme with the laboratories. In the meantime those laboratories that routinely type donors for DP should report this on the forms to UKT.

#### 4.5 **On call payments for H & I staff**

4.5.1 Dr Harmer tabled a paper outlining concerns for the future payment of out of hours work for staff working in H&I to support transplant units. The current local arrangements were due to run out this October but have been extended for an undefined period to allow negotiations to take place for out-of-hours arrangements. A case will be made for remuneration outside Agenda for Change on the basis of the critical importance of 24 hour testing to solid organ transplantation and the nature of these services being such that other arrangements are not suitable. It was noted that if the new arrangements are not commensurate with those previously worked then there is a risk that staff may withdraw from the voluntary on-call rota leaving transplantation services vulnerable. KAG members recognised the risks involved and emphasised the need for 24 hour H&I provision for renal transplantation. KAG would await the outcome of the current negotiations and stressed the importance of resolving this issue to a satisfactory conclusion to ensure that renal transplantation services are not affected.

### 5 **DIRECTOR OF STATISTICS AND AUDIT'S REPORT**

#### 5.1 **Conference presentations, current and future work – KAG(08)28**

5.1.1 A paper summarising the work of Statistics & Audit within ODT in relation to kidney transplantation was noted. Prof. Collett highlighted projects currently taking place including:

- Quarterly CUSUM analyses – updated to enable current performance to be compared with more recent outcomes than previously.
- The 'phasing in' process of the 2006 Kidney Allocation Scheme comes to an end in April 2009 when the scheme will operate in its intended form.
- Further analysis of the database on the incidence of malignancy in UK transplant recipients of kidneys, liver and cardiothoracic organs.

Various collaborative work is ongoing and a paper on paired donation has been accepted by Transplantation in the special conference edition due out in December.

Two abstracts on the allocation scheme and paired donation were presented at the International Congress of the Transplantation Society in August. A number of talks have also been given on paired and altruistic donation and on the kidney allocation scheme.

#### 5.2 **Report from the Kidney & Pancreas Research Group – KAG(08)29**

5.2.1 The research group had agreed to support four of the studies submitted for approval whilst one study on the evaluation of pancreas organ allocation for both whole pancreas and islet transplantation in the UK was not supported. This work is being undertaken by the Pancreas Allocation Working Party. Members also noted that the proposal to the National Institute of Health Research entitled 'Tailoring resources to maximise organ transplant outcomes in the UK', prepared by Prof. Bradley et al had not been accepted for funding. This is to be resubmitted for funding in March.

## 6 KIDNEY ALLOCATION SCHEME

### 6.1 **Accrual of waiting time points - KAG(08)30**

6.1.1 Waiting time is an influential factor in the 2006 Kidney Allocation Scheme and is currently determined from the date of first active listing for a graft, including any individual periods of suspension up to 90 days. When revised data collection arrangements are in place it is intended that waiting time will be based on dialysis time. It was agreed that until such time as dialysis start date is used in the definition of waiting time calculation should not exclude suspended time beyond 90 days in any period of suspension. It is anticipated that this change would affect about 15% of patients whose waiting time would increase, on average, by six months. Of those affected 5% (approximately 50 patients) would gain at least two years waiting time. Mrs Rachel Johnson will take this forward and implement the necessary changes.

R Johnson

### 6.2 **Allocation of non-heartbeating donor kidneys**

6.2.1 Members were asked to give consideration to whether a national organ allocation scheme for non-heartbeating donor kidneys should be developed in light of the rising numbers of this type of transplant. Members discussed the issues surrounding this proposal and felt that it was appropriate to move forward with this. It was noted that from a procurement viewpoint controlled non-heartbeating donation would fall within the remit of the national retrieval team. Those centres undertaking uncontrolled non-heartbeating donation would need to make local arrangements for these organs.

Some members expressed concerns about moving these organs around the country and highlighted the need to keep ischaemia times to a minimum. Mrs Rachel Johnson confirmed that plans are underway to formally analyse data on warm and cold ischaemic times and Mr Mayer added that work is also underway on defining start times for warm and cold ischaemia.

### 6.3 **Review of en bloc kidney activity & allocation scheme – KAG(08)31**

6.3.1 The current Kidney Allocation Scheme states that kidneys from donors aged four years and under will be retrieved and offered en bloc (but may be split if appropriate) whilst kidneys from donors aged five years and over will be retrieved and transplanted singly wherever possible. En bloc kidneys will be offered on a centre rather than patient basis to any centre wishing to receive offers of such kidneys. Members were asked to consider whether the current arrangements are still appropriate. Prof. Bradley agreed to write to Centre Directors with information on the scheme to allow a review to be undertaken of the centres wishing to accept these kidneys. Those interested centres need to put in place internal arrangements for allocating en bloc kidneys to suitable recipients.

A Bradley/  
A Yates

### 6.4 **Review of allocation scheme for 'unsuitable kidneys' – KAG(08)32**

6.4.1 A summary of all instances of kidneys being offered via the 'unsuitable kidney scheme' was received and members were asked to consider if the current protocol is still appropriate. Following discussion it was agreed that all centres should be contacted to confirm whether they are either happy to remain on the scheme or wish to join the scheme as appropriate.

A Bradley/  
A Yates

## 7 ALTRUISTIC AND PAIRED KIDNEY DONATION

### 7.1 **Update on altruistic and paired kidney donation – KAG(08)33**

7.1.1 An update on activity to date was received together with plans for altruistic and paired kidney donation for the future. Altruistic donation is progressing steadily and is relatively straightforward to facilitate. Paired donation matching runs have been carried out on a quarterly basis since April 2007. Prioritisation is

given to two-way exchanges, although three-way exchanges will be considered if there is no compromise to two-way exchanges. The potential for including 'non-straightforward' donors in the paired donation scheme was noted. The formulation of criteria for these donors has proved difficult and the decision is likely to be at the discretion of the donor's local transplant team.

Congratulations were extended to those involved with the work on domino paired donation and members endorsed the proposal to progress with domino (chain) paired donation with prioritisation of pairs who have waited longest on the paired donation scheme. Details on the implementation of this scheme will be circulated to Heads of Laboratories and Centre Directors in due course.

R Johnson/  
J Allen

## 7.2 **Implications of including pairs from outside the UK on the paired donation scheme**

7.2.1 KAG members were asked to consider a request for a couple from Greece to take part in the UK paired donation scheme. Following discussion it was felt that it was not appropriate, at this stage, to include on the scheme pairs from outside the UK. Mrs Rachel Johnson would respond to the clinician concerned.

R Johnson

## 7.3 **Protocol for the reallocation of living donor kidneys – KAG(08)34**

7.3.1 In both paired and altruistic living kidney donation there is the potential that a kidney is removed and sent for transplant in a recipient who is found not to be transplantable once their operation has commenced. Members were asked to consider a protocol for the reallocation in the context of both altruistic and paired kidney donation. In both cases the potential donor can opt for re-implantation or for an alternative recipient on the deceased donor list to be identified. If the latter is chosen KAG agreed that, in the interests of time, a patient at the same centre as the intended recipient should be identified for transplant. A (deceased/altruistic) donor matching run will be provided and patients should be considered for suitability in the priority order shown. A suitable recipient should be identified taking into consideration that the kidney will need to be accompanied by blood for crossmatching. Appropriate protocols will be put in place in due course.

R Johnson/  
S Fuggle/  
A Bradley

## 8 **THE INFLUENCE OF CMV MATCHING ON KIDNEY TRANSPLANT OUTCOME – KAG(08)35**

8.1 A paper examining evidence for the National Transplant Database about the possible benefits of matching donor and recipient on the basis of CMV status was noted. In this analysis there was no evidence of any significant benefit of considering donor-recipient CMV matching.

## 9 **TRENDS IN PATIENTS LISTED FOR KIDNEY TRANSPLANT – KAG(08)36**

9.1 Members received an update on the paper presented last year detailing transplants in patients listed for kidney transplant. It was noted that since 2003/04 the number of registrants to the UK active kidney only transplant list each year has increased markedly. This data will be reviewed and presented to KAG annually.

R Johnson

## 10 **REPORT FROM KAG PAEDIATRIC SUB-GROUP MEETING – KAG(08)37**

10.1 Dr Tizard summarised the discussions at the Paediatric Sub-Group of KAG held on 22 October 2008. The sub-group had endorsed the removal of the current lower donor age limit for kidney/pancreas donation with the proviso that the number of paediatric patients missing out on a kidney in Tiers D - E as a result of the increasing number of kidneys going to a kidney/pancreas patient should be closely monitored. Additionally the sub-group endorsed the decision that

patients should retain paediatric priority when moving from the paediatric transplant list to the adult transplant list at the age of 18 if they were first registered as a child, until such time as they are transplanted. Patients only need to have been active on the list at some point prior to turning 18. The scheme will be monitored to ensure that centres do not abuse the system by pre-emptively listing patients prior to the age of 18. It is anticipated that this change will take place from April 2009.

Surveys are planned on issues of variation in practice between paediatric centres to inform future work of the sub-group.

Prof. Bradley advised members of the case of a one year old in Bristol who has been on dialysis since birth. This patient needs a left kidney from a donor aged ten years or under due to complicated venous anatomy. Members supported the request for this child to be prioritised in the allocation sequence as a clinically urgent request and highlighted the need for a process to support this type of request. Dr Tizard confirmed that she will be contacting the newly appointed Associate Medical Director for ODT to confirm whether individual cases can be considered for priority allocation if and when they arise.

#### **11 REPORT FROM PANCREAS ADVISORY GROUP – KAG(08)38**

- 11.1 The minutes of the meeting of the Pancreas Advisory Group held on 17 October 2008 were noted. Mrs Rachel Johnson added that the kidney/pancreas transplantation summary previously reported to KAG will be produced for the next meeting in May 2009.

#### **12 OUTCOME REPORTING FOR HIGH RISK RECIPIENTS OF LIVING DONOR TRANSPLANTS – KAG(08)39**

- 12.1 Ms Burnapp submitted a paper for discussion on outcome reporting for living donor activity. In light of the concerns raised, assurances were given that all outcome analyses presented by ODT are adjusted for as many risk factors as possible.

#### **13 NON-COMPLIANCE REPORT**

- 13.1 There were no instances of non-compliance to report.

#### **14 PRESENTATION ON THE ELECTRONIC OFFERING SYSTEM**

- 14.1 Miss Falvey gave a brief overview of progress with the development and implementation of an electronic offering system (EOS) which forms part of Recommendation 9 of the Organ Donation Taskforce. The system is primarily for donor transplant co-ordinators (DTCs) to register a donor with the Duty Office, to update donor information and to start offering organs on an electronic basis. All functional testing and simulations were completed during July, August and September and a limited 'live' pilot commenced on 29 September. Following a review of the pilot the plan is that all DTC teams will be trained in the first half of 2009. In the longer term it is hoped to include additional functionalities and to incorporate this system with the PDA.

## ACTION

**15 AGENDA ITEMS FOR RENAL TRANSPLANT SERVICES MEETING  
– KAG(08)40**

- 15.1 The draft agenda for the annual RTSM on Thursday, 12 February 2009 was submitted for comment. It was agreed that an item on the antibody incompatible transplant registry would be added to the agenda and Dr Higgins would be asked to present this.

**Corporate  
Services**

**16 FOR INFORMATION ONLY**

**16.1 The use of non-favourably matched grafts in paediatric patients –  
KAG(08)41**

- 16.1.1 Members noted the annual monitoring report of these transplants.

**16.2 Transplant activity report: October 2008 – KAG(08)42**

- 16.2.1 The transplant activity report for October 2008 was noted for information.

**17 ANY OTHER BUSINESS**

- 17.1 Mr Rudge requested an update on progress on the A<sub>2</sub> pilot in the North Thames area. Dr Warrens would be asked to report on this at the next KAG meeting.

**Corporate  
Services**

**18 DATES OF 2009 MEETINGS**

- 18.1 The dates for the KAG 2009 meetings are:  
Wednesday 20 May 2009; and  
Wednesday 2 December 2009, both at ODT, Bristol.

**Organ Donation & Transplantation Directorate**

**December 2008**

Circulation:

Members

Directors of Renal Transplant Centres  
Directors of Paediatric Renal Transplant Centres  
Heads of H & I Laboratories

ODT Donor Transplant Co-ordinator  
Regional Managers  
ODT Briefing Group  
Members of ODT Patients' Forum  
UKTCA