

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

**MINUTES OF THE FIFTEENTH MEETING OF THE  
KIDNEY ADVISORY GROUP HELD ON WEDNESDAY, 20 MAY 2009  
AT THE ROYAL COLLEGE OF PATHOLOGISTS, LONDON**

**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
Prof. Dave Collett	Associate Director of Statistics & Clinical Audit, NHSBT
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
Mrs Rachel Johnson	Statistics & Clinical Audit, NHSBT
Mr Geoff Koffman	Representative for South Thames
Dr Philip Mason	Renal Association/Renal Registry 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 Alex Stephen	Patients' representative
Dr Jane Tizard	BAPN representative
Prof. Anthony Warrens	BTS representative
Mr Christopher Watson	Chairman, Pancreas Advisory Group
Mrs Ann Yates	Duty Office Manager, ODT

<b>In attendance:</b> Mrs Kathy Zalewska	Corporate Services Officer, ODT – Secretary
Miss Joanne Allen	Statistics & Clinical Audit, NHSBT
Mr Toyab Hussain	Statistics & Clinical Audit, NHSBT
Ms Bev Matthews	Director, NHS Kidney Care (item 6.1 only)

**ACTION****APOLOGIES**

Apologies were received from Mr John Connolly, Ms Sally Johnson, Mrs Helen Lewis, Mr David Mayer, Ms Dawn McPake, Mr Abdul Hammad, Dr Richard Moore, and Mr Badri Shrestha.

- 1 DECLARATIONS OF INTEREST IN RELATION TO THE AGENDA – KAG(09)1**
- 1.1 There were no declarations of interest in relation to the agenda.

**2 MINUTES OF THE MEETING HELD ON 26 NOVEMBER 2008 – KAG(M)(08)2**

**2.1 Accuracy**

2.1.1 The minutes of the meeting held on 26 November 2008 were agreed as a correct record.

**2.2 Action points – KAG(AP)(09)1**

**Item 1 – Renal transplantation in highly sensitised patients using left lateral lobe of liver with kidney transplant:** Mr Koffman reported that no transplants had, as yet, taken place on this pilot scheme. A copy of the protocol for the scheme would be forwarded to Corporate Services at ODT.

**G Koffman**

**Item 2 – EBV screening:** Miss Falvey reported that funding for EBV testing was not included in the reimbursement to hospitals for identifying potential donors but it was noted that further work is being carried out on the issue of reimbursement. This item also links with minute 14.1 below on HTLV screening.

**Item 3 – Allocation of extended criteria for kidneys for dual transplants:** This item will be reported to the autumn 2009 meeting of KAG.

**Item 4 – HLA DP typing and organ allocation:** Dr Fuggle reported that the consultation on the feasibility of the inclusion of DP typing for donors and recipients had been drafted and would be circulated to laboratories within the next few days.

**Item 5 – Accrual of waiting time points:** At the previous KAG meeting it was agreed that the definition of waiting time calculation should not exclude suspended time beyond 90 days in any period of suspension. This change was implemented and had resulted in an average extension to waiting time of 5 months over 1,000 patients. It was noted that until such time as revised data collection arrangements are in place dialysis start date cannot be used in the definition of waiting time.

**Item 6 – Review of en bloc kidney activity & allocation scheme:** Since the last meeting centres had been asked to confirm whether or not they wished to receive offers of deceased donor en bloc kidneys from donors aged 6 years or less. It was reiterated that this allocation scheme will only be used to identify the centre to which the organs will be offered and not the individual recipient.

**Item 7 – Review of allocation scheme for ‘unsuitable kidneys’:** A review of the ‘unsuitable kidney’ scheme took place at the last KAG meeting when consideration was given as to whether the current protocol is still appropriate. The allocation scheme for ‘unsuitable’ kidneys is utilised when a kidney from a deceased heartbeating donor has been offered and declined by five or more centres for the same clinical donor or organ related reason. All centres have been asked to confirm to the Duty Office whether they are either happy to remain on the scheme or wish to join the scheme, as appropriate.

**Item 8 – Update on altruistic and paired kidney donation:** Progress with the domino (chain) paired donation scheme is in hand.

**Item 9 – Protocol for the reallocation of living donor kidneys:** Clarification on this item is awaited from the HTA where a meeting is scheduled for 14 June 2009.

**Item 10 – Trends in patients listed for kidney transplant:** This item will be reported to the autumn 2009 meeting of KAG.

**Item 11 – Any other business – Progress on the A2 pilot in North Thames:** Refer to minute 15.1

2.3 **Matters arising: not separately identified:**

**Minute 3.3.1** – Prof Bradley updated the group on discussions which had taken place with a patient whose renal function had failed immediately following live kidney donation. As agreed at KAG the patient would be entitled to priority on the kidney transplant list for a deceased donor kidney. Following the meeting this decision was then extended, with the agreement of KAG members, to include priority for the first and also any subsequent renal transplants that are required.

Following discussions on this case the BTS Executive had suggested that follow-up reporting of adverse events to living donors should be mandatory and had recommended that NHSBT take on the role of co-ordinating this follow-up. Work would need to take place on how this proposal could be taken forward and centres advised to notify ODT of the need to capture this information. The ‘Kidney Living Donor Assessment Pre- and Post-Operative’ form would need to be amended.

R Johnson

**3 ASSOCIATE MEDICAL DIRECTOR’S REPORT**

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

The transfer of Donor Transplant Co-ordinators is continuing with six of the planned 12 teams now in place under NHSBT employment. The remaining six teams will be in place by the end of the financial year. Running parallel with this are further recruitment campaigns for DTCs together with work on commissioning training for the newly recruited co-ordinators.

Approximately 76 Clinical Leads for Organ Donation (formerly Donation Champions) have now been appointed and induction meetings have been held.

3.1.1 **Report on Donation Ethics Committee**

3.1.1.1 Work on the establishment of a UK-wide Donation Ethics Committee is ongoing. The Chair has been identified and advertisements for the committee members will be circulated during early June 2009.

3.1.2 **Programme Delivery Board**

- 3.1.2.1
- Monitoring activity will start in July and will be based on data from the Potential Donor Audit. The majority of Strategic Health Authorities are in the process of organising meetings to bring together trust management to discuss the ODTF recommendations and to agree action plans.
  - Queen’s Counsel has been consulted on the interpretation of the Mental Capacity Act and its Scottish equivalent in relation to organ donation. Draft guidance is being prepared in light of Counsel’s opinion although separate guidance will need to be issued for Scotland due to differences under Scottish law.

- A range of stakeholders have been consulted to identify methods of recognising organ donors.

The DH is looking to identify an individual to be Training Champion and work will then take place to identify support needs and funding mechanisms.

### 3.2 **Progress on the establishment of an organ retrieval service**

3.2.1 As from 1 April 2009 NHSBT took over responsibility for funding arrangements for the current retrieval teams for the financial year 2009/10 which remain essentially unchanged. Contracts are now signed and in place in many centres. The only other significant change this year is the introduction of a backup retrieval service whereby if the designated zonal team is unable to reach the donor within 3 hours of the intended start time the co-ordinators have been instructed to check whether the next closest available retrieval team is able to get there earlier.

From April 2010 the new organ retrieval service using multi-organ retrieval teams is due to be implemented. Different models of integrated cardiothoracic and abdominal teams have been considered as there are concerns around the uneven geographical distribution of centres and whether adequate cover would be available, particularly with the increase in non-heartbeating donors. It is anticipated that a decision will be made by Autumn 2009 in order to allow trusts to recruit the necessary personnel.

Prof Bradley emphasised the need for more engagement with centres to ensure that changes are communicated effectively. Miss Falvey highlighted the need for centres to report on operational issues around actual retrievals to allow these to be addressed and agreed to reissue the necessary form to centres. Members were also asked to notify Prof Bradley of specific issues on the new organ retrieval service which he would raise at a forthcoming meeting with Mr Mayer.

**S Falvey**

### 3.3 **Update on directed deceased donation**

3.3.1 The HTA, NHSBT and DH have revisited the issue of directed donation in order to produce a change of policy and have advised that directed donation can be considered but that all donation would still be unconditional. In addition, any recipients of directed donation must be on the list and suitable to receive a transplant.

Ministers are currently reviewing the proposal and it is anticipated that revised guidance will be published within the next two/three months. Standard operating procedures will then be developed for implementation and an advisory panel will be established to review unclear cases. A mechanism is being proposed within ODT whereby a clinician can receive advice on these cases.

### 3.4 **Blood sample testing**

3.4.1 An incident was reported to the ODT Clinical Governance and Monitoring Group where a patient was dialysing in a distant centre from the transplant centre. The blood sample was placed in a bottle labelled with another patient's details and the patient was registered with the wrong blood group for a period of two years. This error was

subsequently identified and raised as a governance issue and discussion took place on whether blood samples should be tested twice using two different samples in order to reduce the risk of this type of error. Some centres already operate this type of system for HLA typing recipient blood samples and it was recommended that, until formal guidelines to this effect are produced, then recipient blood group testing should be undertaken on two different samples whenever possible. This recommendation has subsequently been communicated to Directors of all transplant centres.

### 3.5 **Transmission of TB from non-heartbeating donor**

3.5.1 Miss Falvey advised of a further incident reported to the ODT Clinical Governance and Monitoring Group where two renal recipients from the same non-heartbeating donor were found to have TB post-transplant. Numerous investigations were carried out during the admission period and the donor had no clear risk factors associated with TB. Donation therefore proceeded. Both recipients are currently receiving treatment and the transplants are still functioning. An investigation was undertaken by the hospital and it was felt that all possible precautions had been taken to assess the donor for contraindications to organ donation. Due to the fact that 10% of cases produce false positive results then testing for everyone with TB potential was not felt to be practical. The transplant centre concerned had asked for the Advisory Groups to be made aware of this incident.

### 3.6 **Update on electronic offering system**

3.6.1 The first phase of the development of the electronic offering system (EOS) is ongoing with rollout to donor and recipient transplant co-ordinators during 2009 with a view to all DTCs using EOS by September 2009. Phase two will be to incorporate the revised PDA which co-ordinators will be able to complete on or off-line. In addition, a donor referral database is being developed which will capture all relevant information on potential donors referred for donation. It is planned that by October 2009 all donor transplant co-ordinators will have been issued with NHSBT laptops loaded with the new PDA and referral database. By the end of December 2009 all offering should be made via the EOS application. It was noted that IT are currently trying to resolve problems with connectivity for some donor transplant co-ordinators when using the EOS application. Future plans for EOS include the ability for H & I laboratories and virology laboratories to input results directly and a possible link with the NORIS system.

### 3.7 **The transplantation of donated organs into non-UK EU residents**

3.7.1 Members noted that Mrs Elisabeth Buggins, Chair of the former Organ Donation Taskforce, had been appointed by the Secretary of State for Health to examine policy and practice within the framework of European law on the use of organs from UK deceased donors in respect of the referral, acceptance and transplantation of non-UK EU residents. The findings of this report are expected to be reported during June 2009.

In response to a statement by Mr Stephen regarding people's disenchantment with organ donation following recent publicity on this issue, Prof Neuberger asked that members advise Mrs Buggins of any such instances.

Members expressed the view that UK organs should be offered preferentially to UK nationals and only to EU nationals if there are no UK nationals waiting.

Centres were encouraged to write to Mrs Buggins with their views on this issue.

It was highlighted that this type of situation tends to be an issue mainly with those countries where there is no reciprocal agreement, ie a non-EU country.

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

##### **4.1 HLA Donor discrepancy follow-up – KAG(09)4**

4.1.1 An overview of data for the last seven years on the donor HLA discrepancy follow-up scheme was submitted for consideration. The results of monitoring show that the level of discrepant donor HLA types reported to ODT has decreased over the years and is now very low.

##### **4.2 Minimum resolution for reporting donor and recipient HLA types – KAG(09)5**

4.2.1 A summary of compliance with reporting requirements for HLA types was received. The levels of compliance achieved in the six months October 2008 to March 2009 are similar to those achieved in the previously reported time period of April to September 2008. One laboratory is currently dealing with a backlog of reporting and it is anticipated that this will be completed by the end of July 2009. It was noted that the level of compliance for Glasgow is poor in this reporting period due to an IT problem which prevented the electronic submission of certain data. Work is taking place to resolve this problem.

This data will continue to be monitored and laboratories will be contacted if compliance is a problem.

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

##### **5.1 Revised arrangements for Statistics and Clinical Audit**

5.1.1 The ODT statistics and audit team have merged with the former NBS clinical audit team to create a new NHSBT-wide statistics and clinical audit function, headed by Prof Collett as Associate Director. This team will support a broad range of activities of NHSBT and the changes are not expected to impact on the service provided to the transplantation community.

##### **5.2 Conference presentations, current and future work – KAG(09)6**

5.2.1 A report was noted summarising current and future analyses of the national transplant database being undertaken by the Statistics & Audit Directorate at NHSBT and by external researchers. This includes work on quarterly CUSUM analyses; ongoing monitoring of the 2006 Kidney

Allocation Scheme; preliminary analyses of data on antibody incompatible transplantation; and monitoring of the paired donation scheme. Various collaborative work is also ongoing.

An update of analyses of outcome of patients transplanted overseas and returning to the UK for follow-up was noted for information. This will be reviewed by the Kidney and Pancreas Research Group. The lack of data due to those patients lost to follow up was noted and the need to register and report on these patients wherever possible was emphasised. Prof Bradley would write to centres, copying in H & I laboratories, regarding the retrospective registering and reporting of these patients.

A Bradley

### 5.3 **Report from the Kidney & Pancreas Research Group – KAG(09)7**

5.3.1 A report from the meetings of the Kidney and Pancreas Research Group in December 2008 and March 2009 was received and noted. The following study is to proceed: 'The provision of data to the UK Renal Registry on ethnicity of patients listed for kidney transplantation for a study on equity of access'. It was further agreed that kidney outcome data for patients recruited into the 'Identification of heart donors using biochemical probes study' and also the 'Donor optimisation audit' could be provided to the study co-ordinator. A re-written proposal to the NIHR on tailoring resources to maximise transplant outcomes has been re-written and submitted to NIHR by a consortium of investigators.

## 6 **UPDATE ON COMMISSIONING OF RENAL TRANSPLANT SERVICES AND H&I SERVICES FOR TRANSPLANTATION – KAG(09)8**

6.1 Ms Bev Matthews, Director of NHS Kidney Care joined the meeting to give an update on the project to develop robust reference costs for kidney transplantation. A project manager is working with all transplant centres to develop cost components to ensure consistency within this project. The aim is to move to a tariff during 2010/11. A separate workstream is also considering H & I services for transplantation. It was noted that many centres receive H & I services from NHSBT laboratories or the Anthony Nolan Trust and it is important that these organisations are represented in any consultation.

## 7 **THREE YEAR REVIEW OF DECEASED DONOR KIDNEY ALLOCATION SCHEME – KAG(09)9**

7.1 An extended report of the first three years of the 2006 national Kidney Allocation Scheme was provided for information. The scheme is now operating in its full sense with no phasing in place. Members noted that the impact of the scheme has been very positive in improving access to transplant for long-waiters, HLA homozygous patients and young adults, partly through relaxed HLA matching criteria while avoiding very poorly matched grafts. Additionally, variation in waiting times of patients across the adult kidney transplant centres is much reduced.

Whilst access has improved for difficult to match and ethnic minority patients, a degree of inequity remains and further measures may be needed to address this. Dr Fuggle proposed that consideration be given to those highly sensitised patients with rare HLA types being allowed access to more poorly matched kidneys in order to increase their access to transplantation and a report would be prepared for a future meeting.

**S Fuggle/  
R Johnson**

For future reporting, a breakdown of the reasons for each centre not using a kidney in the intended patient would be added to the report. Discussion took place on the current practice of listing within the arbitrary limit of six months of dialysis or of using EGFR. It was felt that this would be a good point to consider under equity of access and waiting lists at some point in the future.

**R Johnson**

## **8 ALTRUISTIC AND PAIRED KIDNEY DONATION**

### **8.1 Update on altruistic and paired kidney donation – KAG(09)10**

8.1.1 A summary of activity for paired and altruistic living kidney donation was submitted for members' information. By the end of April 2009 there had been 22 altruistic donor transplants and 26 paired donor transplants. In 2008 each programme contributed 1.5% of living kidney donor transplant activity.

Work on domino paired donation, whereby altruistic donor kidneys are used to start a chain of paired donation transplants resulting in a kidney finally being allocated to the deceased donor list, is unlikely to be implemented until 2010 due to other priorities within IT.

### **8.2 Issues and developments in paired donation – KAG(09)11**

8.2.1 A paper highlighting the issues and development in paired living kidney donation was received for discussion. Following an examination of the procedures a number of ways to improve the paired donation system have been identified. These include:

- changes to working practices in ODT
- identification of an individual within ODT to co-ordinate the ODT part of the process
- plans to identify a national clinical lead to support the paired donation scheme and to liaise closely with local living donor transplant co-ordinators involved in paired donation
- Collection of relevant clinical data together with the development of revised data collection forms
- In order to improve communication a national paired donation workshop has been arranged for Wednesday 30 September in London with participation by all relevant individuals.

The current algorithm is working well for 2-way exchanges although changes may need to be considered for 3-way exchanges due to the increase in complexity.

It was emphasised that:

- Donors and recipients should only be registered when full work-up is complete, with regular checks for those listed for a prolonged period.
- Any donors not likely to be universally acceptable (clinically) should

be notified to ODT with appropriate details to enable centres to be canvassed to see whether suitable recipients at their centre should be considered a potential match for the donor.

- Donor-recipient pairs included in a matching run must be fully prepared to proceed with a paired donor transplant.
- Any donor age and HLA matching criteria required must be detailed at the time of registration.
- All pairs in the match must be suspended at the same time.

Prof Neuberger requested members' views on a query from the Republic of Ireland about participating in the scheme. KAG had previously decided that it was not appropriate for a pair from outside the UK to be registered in the scheme as it was so new. However, with the geographical proximity of the Republic it was felt that, at this time, consideration should be given to this particular request. The HTA have been approached regarding any regulation that would prevent this possibility and have responded to the effect that there is nothing that would prohibit the inclusion of a pair from elsewhere, provided that they were assessed in accordance with HTA procedures. KAG members were happy to agree to this request, subject to the requirement stipulated by the HTA. Prof Neuberger agreed to advise the ROI of the decision.

J Neuberger

Prof Bradley commented on correspondence from Mr Ali Bakran from the Royal Liverpool University Hospital, questioning why, as part of the living kidney donation scheme the donor kidney travels rather than the recipient. Members agreed that if those involved are agreeable then there is no reason why this cannot take place and Prof Bradley would advise Mr Bakran accordingly.

A Bradley

## **9 UPDATE ON ANTIBODY INCOMPATIBLE TRANSPLANT REGISTRY – KAG(09)12**

- 9.1 Mrs Johnson summarised a presentation made to the Renal Association/BTS Annual Conference in April on preliminary analyses of the antibody incompatible transplant registry. ODT continues to rely on transplant centres to notify and report HLA incompatible transplants, while ABO incompatible transplants can generally be identified by routine data reporting to the national transplant database. Work on the registry is ongoing but the outcomes generally appear good with more detailed analyses possible as the cohorts grow.

## **10 FEASIBILITY OF PRIORITY ALLOCATION OF KIDNEYS TO URGENT PAEDIATRIC PATIENTS – KAG(09)13**

- 10.1 Members noted correspondence from Dr Tizard requesting agreement to a proposal for priority allocation of kidneys to paediatric patients in whom dialysis access was running out. This proposal would involve discussion on a case-by-case basis via the paediatric sub-group of KAG.

The proposal was agreed in principle with the caveat that a protocol should be developed to specify the procedure to be followed and who would be involved in the decision-making process on behalf of the

J Tizard

paediatric sub-group. Any decisions would be advised to the centre concerned which, in turn, would be responsible for advising ODT to ensure the patient is listed. There would be no requirement for KAG to endorse the prioritisation of individual patients under this proposal.

## 11 BIOPSY OF DONOR KIDNEYS

Prof Bradley raised the issue of centres having access to histology services in order to obtain biopsies pre-implantation. Many centres do not have access to 24-hour histology services and would have to extend cold ischaemia time in order to wait for a biopsy result. This procedure is increasingly becoming relevant in deciding how the kidneys are used and to whom they should be offered. It was suggested that a prospective research project on histology examination could be requested. This could then be correlated with outcomes. Prof Bradley agreed to look into how to take this forward.

A Bradley

## 12 REPORT FROM PANCREAS ADVISORY GROUP (3 APRIL 2009)

12.1 Mr Watson reported on key issues from the meeting of the Pancreas Advisory Group on 3 April. The number of patients listed for a pancreas transplant has continued to increase and whilst there was a small increase in pancreas donor numbers during 2008, transplant activity has remained consistent with that for the previous year. The proportion of patients on the active scheme has continued to fall following implementation of the sensitised scheme.

As from 1 August 2008 PAG introduced changes to the offering sequence whereby donors with a BMI of >30 and <40 would be offered first for islet transplantation.

A review of the first five months of the pancreas allocation scheme for sensitised patients revealed a decrease in the overall proportion of sensitised patients on the national pancreas transplant list from a quarter to a fifth of the list. Due to the influence of this scheme on activity the threshold for sensitisation was altered in November 2008 from a calculated reaction frequency of 30% to 75%.

A national scheme for the allocation of whole organs has been agreed and is planned to come into effect at the beginning of next year.

## 13 IMPACT OF KIDNEY/PANCREAS TRANSPLANTATION ON KIDNEY ONLY PATIENTS – KAG(09)14

13.1 A report was received on where the kidneys that were used in simultaneous pancreas/kidney transplants in the first three years of the 2006 kidney allocation scheme might otherwise have been allocated according to the national kidney matching run carried out at the time. The report indicated that had the kidney not been used as part of an SPK transplant then 18 kidneys would have been offered to 000 mismatched adult patients in the first year of the scheme and 12 kidneys would have been offered to favourably matched paediatric patients (Tier D). Mr Watson added that some patients would also have missed out on a kidney due to combined liver and kidney or heart and

kidney transplants.

There was some concern that favourably matched paediatric patients in Tier D were being disadvantaged by prioritising kidney/pancreas patients and it was suggested that data should be analysed on where the second kidney of the pair is being allocated in order to assess if this is to a paediatric patient or a highly sensitised adult, as may be the case in Tier D.

**J Allen**

## **14 HTLV INFECTION AND TRANSPLANTATION – KAG(09)15**

14.1 Correspondence from King's regarding the issue of HTLV testing of kidney donors and recipients was received for discussion. There is currently no national recommendation around HTLV testing and, due to the increased risk of complications to immune suppressed patients from HTLV1, the question was raised as to whether these patients should be listed for transplantation in light of the risks involved.

MSBTO previously issued an instruction that all organ donors should be tested for HTLV. This, however, proved to be difficult or impossible in some centres due to lack of funding for an out-of-hours screening service, or concern that the assay for screening is unreliable and has therefore not been implemented. It was noted that SaBTO is currently reviewing the recommendations for safety including the microbiological safety of organ donors.

Prof Warrens agreed to report the group's concerns to SaBTO and request guidance on testing for HTLV1 and for EBV in donors. If SaBTO recommends the screening of donors then further work can then take place on securing funding for a screening service.

**A Warrens**

## **15 UPDATE ON PROGRESS ON THE A<sub>2</sub> PILOT IN NORTH THAMES**

15.1 A paper giving an outline summary of the A<sub>2</sub> donor kidney allocation scheme in North Thames was tabled for information. In total 105 blood group B patients have been registered on the national list as suitable to receive an A<sub>2</sub> kidney. Of the 108 blood group A donors in North Thames since the inception of the pilot scheme there were 10 heartbeating donors with A<sub>2</sub> blood group. These resulted in 15 kidneys available for kidney-only transplant and of these 15, one was used in a blood group B patient whilst the remaining 14 were allocated to blood group A patients with higher rank on the matching run. From the five non-heartbeating donors with A<sub>2</sub> blood group, two were used in blood group B patients as selected by the designated donor centre.

Discussion took place on the merits of continuing the pilot in view of the rate of success to date. The pilot has taken a considerable amount of work to establish and an alternative may be to increase the number of patients being given the opportunity to take advantage of the scheme, which would involve changing the allocation priority. Mrs Johnson and Prof Warrens agreed to liaise on the most appropriate way to take this forward and report back to KAG.

**R Johnson/  
A Warrens**

## 16 GOVERNANCE ISSUES

### 16.1 Non compliance with selection and allocation policies

16.1.1 There is a need for a mechanism to allow a centre to report adverse events to NHSBT which may affect other recipients. Currently clinicians are not obliged to report these but the regulations of the forthcoming EU organ directive will make it mandatory to report adverse events and reactions. These events will be considered by the ODT Clinical Governance and Monitoring Group but this is dependent on centres informing ODT.

Prof Neuberger reported that a new classification system is to be introduced at ODT for instances of non-compliance, which will be circulated to centres when finalised.

It was also noted that a proposal has been submitted to the NHSBT Board to put in place a mechanism for the organisation to take formal responsibility for selection and allocation policies generated through Advisory Groups. The Board would endorse these policies as part of its responsibility under clinical governance arrangements.

### 16.2 CUSUM monitoring of kidney transplant outcomes – KAG(09)16

16.2.1 Slides describing the design and implementation of the monitoring scheme for 30 day graft and patient mortality following kidney transplantation were received and noted. Responses to signals from individual transplant centres are discussed in detail with the Chair of the Advisory Group and at meetings of the ODT Clinical Governance and Monitoring Group.

### 16.3 Centre comparisons of 20 year kidney transplant outcomes – KAG(09)17

16.3.1 A paper on long-term outcomes after kidney transplantation was received and noted.

### 16.4 Non-retrieval and non-use of organs – KAG(09)18

16.4.1 A paper giving reasons for non-retrieval and non-use of kidneys from deceased solid organ donors in 2008 was received for information. It was noted that the proportion of kidneys discarded appears to be increasing although it was recognised that this increase probably reflects changes in practice rather than poor practice.

## 17 FUTURE ARRANGEMENTS FOR ADVISORY GROUP PAPERS

17.1 In order to streamline the service provided to Advisory Groups, in the future all meeting papers will be circulated to members electronically for members to print or access via a laptop as appropriate.

**18 FOR INFORMATION ONLY**

**18.1 Update on patient consent scheme – KAG(09)19**

18.1.1 Members noted a report from Alison Gane, Information Manager at ODT, providing an update on the patient consent scheme in relation to patients registered for a renal transplant. As at 31 March 2009, 81% of patients have given consent for the use of their personal data by NHSBT. Outstanding consent for the remaining patients has been notified to centres and members were asked to ensure that this is followed up.

**18.2 Centre specific sensitisation data – KAG(09)20**

18.2.1 Members received and noted a report on centre specific sensitisation data for patients actively listed for transplant as at 4 March 2009.

**18.3 Transplant activity report: March 2009 – KAG(09)21**

18.3.1 The transplant activity report as at March 2009 was noted for information.

**19 ANY OTHER BUSINESS**

19.1 Prof Bradley reported on correspondence from the Chair of the Cardiothoracic Advisory Group requesting forbearance regarding requests to delay cross-clamping to best co-ordinate the donor and recipient procedure and minimise cardiac ischaemic time. It was noted that this issue is currently being considered as part of the work to establish a new organ retrieval service.

**20 DATE OF NEXT MEETING:**

20.1 *Post Meeting Note: the date of the next meeting has been rescheduled to **Wednesday 9 December 2009** at ODT, Bristol.*