Approved Minutes of RTAC Meeting held on Tuesday 8th December 2015, 9:00am – 3:00pm, Conference Room Level 1, Australian Red Cross Blood Service, 17 O’Riordan St, Alexandria, 2015.

Meeting Attendance Record

<table>
<thead>
<tr>
<th>REPRESENTATION</th>
<th>MEMBER</th>
<th>✓ =Present,@ = Apology</th>
</tr>
</thead>
<tbody>
<tr>
<td>VIC/TAS Representative &amp; Chair</td>
<td>A/Prof John Kanellis</td>
<td>✓</td>
</tr>
<tr>
<td>VIC/TAS Representative</td>
<td>Dr Peter Hughes</td>
<td>✓</td>
</tr>
<tr>
<td>NSW/ACT Representative</td>
<td>A/Prof Angela Webster</td>
<td>✓</td>
</tr>
<tr>
<td>NSW/ACT Representative</td>
<td>Dr Kate Wyburn</td>
<td>✓</td>
</tr>
<tr>
<td>Qld Representative</td>
<td>Dr Scott Campbell</td>
<td>✓</td>
</tr>
<tr>
<td>Qld Representative</td>
<td>Dr Tony Griffin</td>
<td>✓</td>
</tr>
<tr>
<td>SA/NT Representative</td>
<td>Prof Graeme Russ</td>
<td>✓</td>
</tr>
<tr>
<td>SA/NT Representative</td>
<td>A/Prof Toby Coates</td>
<td>✓</td>
</tr>
<tr>
<td>WA Representative</td>
<td>Dr Ashley Irish</td>
<td>@</td>
</tr>
<tr>
<td>WA Representative</td>
<td>Prof Lloyd d’Orsogna</td>
<td>✓</td>
</tr>
<tr>
<td>Renal Transplant Surgeon</td>
<td>Dr Christine Russell</td>
<td>@</td>
</tr>
<tr>
<td>AKX Medical Director</td>
<td>A/Prof Paolo Ferrari</td>
<td>✓</td>
</tr>
<tr>
<td>New Zealand</td>
<td>Dr Ian Dittmer*</td>
<td>✓</td>
</tr>
<tr>
<td>New Zealand</td>
<td>Dr Nicholas Cross</td>
<td>✓</td>
</tr>
<tr>
<td>Chair DNT Committee/ANZSN/KHA</td>
<td>(Acting chair - M Gallagher)</td>
<td>@</td>
</tr>
<tr>
<td>TSANZ - Representative</td>
<td>Prof Steve Chadban</td>
<td>@</td>
</tr>
<tr>
<td>APHIA</td>
<td>Ms Rhonda Holdsworth</td>
<td>✓</td>
</tr>
<tr>
<td>ATCA</td>
<td>Luke Datson</td>
<td>✓</td>
</tr>
<tr>
<td>Consumer Representative</td>
<td>(Currently Vacant)</td>
<td>@</td>
</tr>
<tr>
<td>Consumer/Community Rep</td>
<td>Mr Carl Pedersen</td>
<td>@</td>
</tr>
<tr>
<td>NOMS Manager</td>
<td>Prof Jeremy Chapman</td>
<td>@</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EX OFFICIO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NOMS Analyst</td>
<td>Ms. Jenni Wright</td>
<td>✓</td>
</tr>
<tr>
<td>DonateLife State Managers</td>
<td>Ms. Tina Coco</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>INVITED GUESTS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OTA National Medical Director</td>
<td>Dr Helen Opdam</td>
<td>✓</td>
</tr>
<tr>
<td>OTA Director Clinical Programs</td>
<td>Eva Mehakovic</td>
<td>✓</td>
</tr>
<tr>
<td>ARCBS – Lab Manager</td>
<td>Ms Narelle Watson</td>
<td>✓</td>
</tr>
<tr>
<td>Chair of Transplant Liaison Reference Group, Advisory Committee to the AOTA</td>
<td>A/Prof Josette Eris</td>
<td>✓</td>
</tr>
<tr>
<td>ARCBS – Software Development Manager</td>
<td>Chris Rankin</td>
<td>@</td>
</tr>
<tr>
<td>ARCBS – NOMS IS</td>
<td>Ms. Jenni Wright</td>
<td></td>
</tr>
<tr>
<td>SECRETARIAT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TSANZ Project Officer</td>
<td>Iman Ali</td>
<td>✓</td>
</tr>
</tbody>
</table>

*Teleconference 12.00 -1.00pm
1. Introduction and Welcome

J Kanellis welcomed members and invited guests, including the new ATCA rep, Luke Datson.

1.1. Attendees and Apologies

Apologies shown above were noted.

1.2. Declaration of COI related to current agenda

There were no declarations of conflict of interest with any agenda items.

2. Minutes and Actions

2.1. Confirmation of previous meeting minutes

Minutes from the meeting held on Tuesday 19th May 2015 were accepted (moved by K Wyburn and seconded by S Campbell). Out of session minutes of the teleconference held on 15 July 2015 were accepted (moved by A Webster and seconded by P Hughes).

2.2. Outstanding items and business arising from the minutes

a. Hep C List:

The meeting was informed that T Coco was not aware of her central role in communicating Hep C register patient list throughout the DonateLife network nationally. The meeting directed N Watson to circulate this list weekly to State DonateLife Managers in all the jurisdictions. T Coco will supply the necessary contact details to N Watson.

| Action 112 a |
| Supply contact details of all DonateLife State Managers to N Watson [T Coco] |

| Action 112 b |
| Send Hep C list weekly to all the DonateLife State Managers. [N Watson] |

| Action 112 c |
| Include this decision in the Register of Position Statements [I Ali] |

b. AKX Oversight Committee

The meeting noted that the OTA appointed “AKX Oversight Committee” reports to OTA and was therefore quite separate from RACOS, which was RTAC’s subcommittee with direct reporting obligations to RTAC. The Chair suggested that the OTA outfit would be rebadged as “AKX Strategic Governance Committee”.

| Action 151 |
| Ask OTA to consider renaming the OTA AKX Clinical Oversight Committee to the “AKX Strategic Governance Committee” [J Kanellis / Eva Mehakovic] |

c. Streamlining interstate offers of kidneys

The OTA National Medical Director said that some work was being done and a discussion paper will be tabled at a future meeting.

d. Letter to kidney transplant units - surgery times

This letter has not been finalised because of various considerations that need to be made. E.g. who is the letter addressed to? (CEO’s, State Departments of Health etc.); how will we be sure it is impactful? Etc. The letter should reflect that not all hospitals have surgery time issues and be constructive.
Action Item 148 – b to be retained.

**e. Appointment of a surgical rep in RACOS**
Christine Russell has been nominated by Living Donor Surgeons Subcommittee, a subsidiary body of the TSANZ Donor Surgeons and Donor Coordinators Advisory Committee, as a surgical rep on RACOS

3. **RTAC Governance**

3.1. **Changes to membership**
Luke Datson from SA is the new ATCA rep, replacing Julie Haynes. DNT have not yet confirmed their representative in RTAC (see item 3.3 below). The meeting noted the following invited guest to be included in RTAC meetings:

a. ARCB (NOMS Business Analyst): John Parshotamdas [TBC]
b. ARCBS (IT expert): Chris Rankin [TBC]
c. ARCBS (Information Services): Kate Wilson [TBC]

[An email from K Wilson to the Chair on 7 Apr 2016 advised that NOMS IS representation on RTAC would be Chris Rankin and Jenni Wright]

---

**Action 152**
Subject to confirmation update the meeting list and, if required, the terms of reference [I Ali]

3.2. **Subcommittees - Summary/TOR/ Resource needs.**
The meeting approved the following compositional changes to subcommittees:

a. Christine Russell appointed as the surgical rep in the AKX Clinical Oversight Subcommittee (RACOS)
b. Phil Clayton appointed as ANZDATA rep in the Histocompatibility Subcommittee.

The TOR of RACOS has been finalised and the Histocompatibility group was in the process of doing the same.

The meeting noted various other committees in which the chair and other members were involved which gives some insights into the breadth of their commitments outside of their core duties.

a. TLRG (OTA): John Kanellis and Josette Eris
b. OTA AKX Oversight Committee: John Kanellis
c. RTAC AKX Clinical Oversight Committee (RACOS): Peter Hughes
d. NOMS Strategic Governance Committee: John Kanellis and Paolo Ferrari, Rhonda Holdsworth
e. NOMS User Group (NUG): Rhonda Holdsworth, Narelle Watson, John Kanellis and Kate Wyburn
f. AOMS Working Group: Rhonda Holdsworth, John Kanellis and Narelle Watson
g. DNT (ANZSN): John Kanellis.

This list is not complete and J Kanellis promised to add more names of members involved with various committees.

---

**Action 153**
Add names of members involved with other committees and provide an update at the next meeting [J Kanellis]
3.3. Links with DNT/ANZSN
The Chair advised that Prof Mathew Jose who replaced Stephen May as DNT chair has resigned (acting chair is currently Martin Gallagher) and nonattendance of RTAC meeting by a DNT rep has weakened the governance link between ANZSN and RTAC. P Ferrari (as chair elect of ANZSN) explained that ANZSN governance structures were being reviewed, leading to more of a focus on the roles and responsibilities of its subcommittees. DNT is now called the Clinical Policy Advisory Committee (CPAC). The meeting felt that the link between the nephrologists and the kidney transplant community was necessary, however, the nature of relationship that the ANZSN wishes to foster with RTAC and how it wants to engage with RTAC is a matter for the ANZSN and the KHA. The Chair has been invited to attend ANZSN Council meeting, a task he felt should ordinarily be able to be undertaken by the DNT rep on RTAC, who is the link. The meeting endorsed the proposal of the Chair to seek information on the relationship between ANZSN and RTAC, including governance and communication protocols.

**Action 154**
Write a letter to ANZSN seeking information on the relationship between ANZSN and RTAC, including governance and communication protocols (this has been previously done via email prior to this RTAC meeting).

4. NOMS National Kidney Exchange /Audits
The Chair acknowledged the contribution of N Watson, J Wright and S Campbell in developing the new reporting framework. He went through tables 1-6 containing summary statistics, noting that the data was sourced from NOMS which needs to be reconciled with information captured by the EDR. It was agreed “Donor Risk” in Table 2 be rebadged as “High risk of infection”. The Chair cautioned that the word deviation in Table 4 is used somewhat loosely to define instances where allocation has not followed the normal pathway, although still acceptable. He invited members to review the structure of the tables to ensure that the dataset is robust, enabling meaningful conclusions to be drawn from them. A brief discussion followed on the cases which were already circulated and commented on by members.

**Action 141**
Modify wording in Table 2 to “High risk of infection”

4.3. State specific audits / other issues
Members reflected on jurisdictional issues. S Campbell reported that QLD continues to send blood group AB donor kidneys interstate given the paucity of AB recipients on the waiting list in Qld. L D’Orsogna explained that the incorrect application of local WA rules to an interstate recipient was the main reason behind not offering a national override to NSW on one occasion.

4.4 NOMS Analysis of Allocations 2014
J Wright presentation showed that cumulatively to 4 December 2015, NSW recorded a net inflow of kidneys (6), SA-NT (1) and VIC-TAS (8) whereas QLD, and WA experienced a net out flow of 2 and 13 kidneys respectively. Some discussion followed on the high rate of kidney outflows from WA, including their quality. A Iris said that WA endeavours to optimise transplantation outcome for potential recipients which requires a careful selection of donated organs. The meeting agreed to continue monitoring interstate balances.

5. NOMS Report
5.1. NOMS Current Status
J Kanellis alluded to the material appended to the meeting documents on the new process for managing systems change in NOMS. Many obsolete requests have been weeded out resulting in their shrinkage from around fifty to ten. R Holdsworth invited the meeting to suggest systems change now as requirement for the future state.
5.2 NOMS User Group
Inclusion of data for “survival matching” for audit and for potential near-future allocation considerations through “KDPI” and “ETPS” have been identified as two urgent requirements. The KDPI field should appear in the donor report but the mechanism through which a formula generates this value will need to be determined. It was noted that recipient data can be supplied by transplant units to the Lab for purposes of computing the EPTS recipient score. The EDR would hopefully generate the data for KDPI or KDRI which can then be entered by the Lab. Given that this body of work needs to be accomplished before May 2016, the meeting agreed that a working party be set up to:

a. Determine the source of data for calculating the KDPI

b. What specific data sets will be included

The Chair advised that VIC is calculating the KDPI retrospectively and using this in data in audits. It was decided that the Allocations Subcommittee prepare a proposal to consider a. and b. above in February for submission to OTA. S Campbell feared that in the event of a lengthy delay and the inadequacy of the national system, QLD may have to go alone and implement the KDPI manually.

Peter Hughes enquired what progress has been made to implement donor quality index. The chair explained that the first step is to build the fields in the software and model data based on different bands to determine how different algorithms will work. The issue was important but other priorities such as the AOMS and TSANZ Clinical Guidelines have impeded the progress. He will convene the meeting of the Allocations subcommittee to progress this and other matters.

**Action 155**
Convene The allocations Subcommittee to write a proposal for development of algorithm for KDPI, including the source of data and specific data sets for the calculation of the Index by May 2016 [J Kanellis]

5.3 AOMS
R Holdsworth provided a brief overview of the status of the NOMS modernisation project. Potential vendors have been culled from 9 to 5 who will be asked to tender which will close in May 2016.

6. Labs report
6.1 Laboratory Update
N Watson updated the Calculated PRA Analysis presented earlier in May 2014. Three different calculators (Fusion, UNOS and Canadian) were used including Class 1 and class 2 patients. The result showed no significant difference in the values generated by them. The analysis showed that when nPRA is compared to cPRA there is good correlation between the 3 calculations; variation in population donor pool was not significantly different. The expected shift in the number of highly sensitised patients is due to differences: inclusion of class 2 and increase sensitivity of CDC vs PRA.

The meeting noted that the exclusion threshold was different across jurisdiction with the MFI bonus set at 8000 in NSW and 2000 in QLD. It also noted that the proposed cPRA was the most transparent and fairest way of allocating kidneys and is likely to benefit difficult (highly sensitised) patients.

R Holdsworth advised that the Histocompatibility Subcommittee has considered the matter and has made the following recommendations:

a. To proceed with implementation of cPRA - a calculated cPRA based on Class I and Class II unacceptable antigens based on detection of antibodies by SAB.

b. The laboratories in each state to use the same cPRA calculator:
   - Same donor pool
   - Same rules
– All HLA antigens that are ‘unacceptable mismatches’ determined by detection by Luminex single antigen beads

c. Implementation date to be decided upon and the new process must go live in all the jurisdictions on the same day.

d. There will be ongoing monitoring of the national exchange (as part of monthly audit).

The meeting agreed to these proposals

<table>
<thead>
<tr>
<th>Action 120</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Document this in the Register for Position Statements [I Ali]</td>
</tr>
<tr>
<td>b. Update the Committee at the next meeting on the implementation of calculated cPRA based on Class I and Class II [N Watson]</td>
</tr>
</tbody>
</table>

7. Protocols/Guidelines

7.1 Live donor consent form (DNT request)

The Chair advised that DNT has for a number of years requested RTAC to implement a consent form to help promote follow up and track outcomes in living kidney donors. The consent is required to safeguard the information provided by patients to ANZDATA Registry. The meeting felt that jurisdictions already have a variety of consenting processes and imposing another consenting regimen was therefore unwarranted, given that the problem in collecting data stems primarily from a lack of willingness of the patients to oblige. The meeting instructed the Chair to write to Steve Macdonald advising him that RTAC sees little value in implementing the new consent form given that a consenting process currently exists in all jurisdictions although in different forms.

<table>
<thead>
<tr>
<th>Action 156</th>
</tr>
</thead>
<tbody>
<tr>
<td>Write to Steve MacDonald advising that RTAC does not support the need to implement another consenting process on top of existing consenting regimes in Australia. [J Kanellis]</td>
</tr>
</tbody>
</table>

7.2 Tumourectomised kidneys

A request by the Donor Surgeons Advisory Committee was made to consider a national protocol for this at RTAC. The discussion indicated that there was less and less use of this sort of donor kidney because of changes in Urological practice (e.g. partial nephrectomy). Also that the number of kidneys available for use in this manner was actually very small. The meeting decided that RTAC should not direct individual transplant units to utilise tumourectomised kidney as this is a matter for individual transplant units and their hospitals, dependent upon a number of factors such as the availability of surgical expertise, organ suitability and consenting recipient. The Chair will advise the DSDC AC accordingly.

<table>
<thead>
<tr>
<th>Action 157</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reply to the Chair of DSDC AC advising that utilisation of tumourectomised kidney is a matter for individual transplant units and that it would be inappropriate for RTAC to formulate a national protocol on this matter [J Kanellis].</td>
</tr>
</tbody>
</table>

7.3 Altruistic donor pathway

The Chair sought views of the committee on his draft letter outlining pathways for transplant units in assessing non-directed anonymous living kidney donors to be overseen by relevant transplant advisory committees in each jurisdiction. Some jurisdictions like WA and NSW have developed their own protocols in this regard and will not be changing their practice whereas other states agreed to go along with the recommendations. The Chair stressed that the document was not prescriptive, rather one that recommends a set of guiding principles for non-directed donors.
The Chair advised that a number of ethical guidelines and principles already exist and wondered whether there was a need to develop another one in regards to non-directed altruistic donors (e.g. NHMRC Ethical Guidelines, NSW Health Directive and Graeme Russ’s document dated 2003). The meeting agreed in principle to have a short document on guiding principles under RTAC’s banner and members agreed to consider how NSW and Graeme’s materials could be synthesised into a one page document.

**Action 132**

a. Write the letter incorporating points agreed to at the meeting and send it to jurisdictions [J Kanellis]
b. Review NSW Health Directive and the 2003 document supplied by Graeme and send suggestions to the Chair with a view to deciding the content of a similar document produced by RTAC [All]
c. Table draft protocol document at the next meeting [J Kanellis].

7.4 Donor Suitability/Biopsies to facilitate organ acceptance (TLRG)
The meeting heard that there was considerable variability in the practice of obtaining biopsies which potentially impedes the organ donation process. The meeting discussed whether guidelines describing instances where biopsies may be requested and agreed to produce a one-page document in the interest of facilitating the organ donation process. Some members however were of the view that biopsies are difficult to protocolise.

Members agreed to send their biopsy guidelines to J Eris who agreed to produce a one page document. OTA will assist in formatting the document

**Action 158**

Provide information on biopsy practices your jurisdiction to J Eris to enable her to produce a one-page guideline for consideration by the Committee at its next meeting.

7.5 NMHRC Ethical Guidelines
The OTA National Medical Director informed the Committee that the NHMRC-auspiced Expert Advisory Committee had finalised the document which will go to the Australian Health Ethics Committee in December. When approved, the Guidelines will be sent to the NHMRC Council for implementation, possibly in early 2016.

7.6 TSANZ Clinical Guidelines
The meeting noted the feedback provided by the Chair in respect of the submissions received during the targeted consultation process. Some discussion ensued on the relevance of 80% survival rule in an allocation setting based on matching quality of organs to recipients. OTA National Medical Director advised that the responses to submissions were being considered for inclusion in the next iteration of the document which will be finalised in January 2016 for release possibly in March 2016.

8. TSANZ Report
This matter was not discussed due to the absence of TSANZ President.

9. TLRG Report
G Russ represented the Chair at the last meeting of the TLRG which is chaired by J Eris. Issues covered included:

a. Update on the development of TSANZ Clinical Guidelines
b. Update on the current donation rates, with NSW showing a strong growth
c. NOMS modernisation / AOMS project

d. Reports of standing committees

e. National vigilance and surveillance system for reporting serious adverse events and reactions

f. Extended criteria donors

g. Review of the EDR

h. The upcoming Combined Donation and Transplantation Forum following the April ASM which will include presentations on organ perfusion technology, multi-organ transplantation and allocation systems.

10. OTA Report

The highlights of the National Medical Director’s presentation included:

a. Organ donation numbers – an increase in organ donations in the current year to October 2015 over the same period in the previous year, with NSW on target of achieving 17 donors per million population.

b. Change in ANZOD definitions of organ transplanted to bring them in line with international standard.

c. Development and implementation of a national vigilance and surveillance system for reporting of serious adverse events and reactions and tabling of a proposed framework for consideration of Australian Health Ministers Advisory Council (AHMAC) at their December meeting. This reporting does not replace existing jurisdictional monitoring and reporting processes for adverse events.

d. DonateLife “Thank You Day” was held to recognise organ donors on 22 November and ‘thank you’ cards have been developed to help recipients write to donor families when they choose to do so.

e. Streamlining the process for offering renal organs interstate is being considered and a discussion paper will be tabled for RTAC consideration in due course (refer to action 146 below).

11. NZ Report

N Cross provided a brief overview of renal transplant situation in NZ:

a. NZ organ donation rate although comparatively low has risen in the current year;

b. Collaboration with the AKX program;

c. The current organ donation practice and policy is being reviewed and its outcome will be reported to the Minister of Health in March.

The Chair pointed out that NZ renal transplant protocols have been appropriately integrated in the kidney chapter in the TSANZ Clinical Guidelines. Some discussion followed on the donor compensation policy in Australia which does not recompense self-employed donors. The meeting agreed that this matter should be brought to the attention of KHA, the advocacy group for kidney transplant, to eliminate the anomaly.

**Action 159**

Write to Ann Wilson pointing the current anomaly in donor compensation and requesting that the current policy be reconsidered so that all types of organ donors are treated equally and fairly [J Kanellis].

12. AKX

12.1 AKX Report
P Ferrari told the meeting that November 2015 was the 5th anniversary of the AKX Program, with 150 live-donor transplants facilitated to date. 6 transplants are likely to take place in the coming weeks. The proportion of patients matched in relation to the number of 281 registrants is 55% (transplanted 53%); this means that a patient who joins AKX has a 1 in 2 chance to be transplanted. The median cPRA of registered recipients is 82%. The 1-year graft survival in recipients of AKX kidneys is 98%, comparing well with the 97% 1-year graft survival in recipients of directed live donor kidney transplants.

Future enhancements include:

a. the expansion of the program to allow pairs from New Zealand to be added to the AKX pool
b. developing a report card to assist with tackling the issue of highly sensitised recipients, who have been in the AKX registry for a long time but remain unmatched
c. development of a policy framework to regulate inclusion of compatible pairs.

12.2 AKX NX Collaboration

P Ferrari informed the meeting that software changes will be required to match NZ pairs with Australian pairs and to that end a change request has been made to NOMS. The esky (chilly bin) used by NZ fits in the overhead compartment in commercial aircrafts and has been found to retain the right temperature during organ transportation. The challenge will be at the security and border control points. However, it was brought to the attention of the meeting that kidneys have been flown in from Noumea for transplanting in Australia without any known problems, although in this case the organ was unaccompanied and on a private plane. Each airport has its own protocols so arrangements have to be finalised with all of them. The meeting recognised that although good progress has been made in eliminating clinical barriers, a considerable amount of work is required to iron out the perceived administrative impediments to enable exchange of organs under AKX between Australia and NZ.

12.3 AKX Bowel Ca Screening.

P Ferrari explained that bowel cancer screening of the population as done in Australia is not feasible for NZ and since this test is mandatory under the AKX along with mammography and pap smear a modification of the AKX protocols was required so that asymptomatic NZ donors, assessed in accordance with NZ national bowel cancer screening guidelines, would be acceptable for enrolment in AKX. The meeting agreed to this proposition with the following wording change: “Screening for malignancy should be conducted in accordance with respective national guidelines”.

**Action 145**

Amend the AKX Program guidelines to accommodate different cancer screening practices in NZ and Australia in accordance with the decision of the Committee. [P Ferrari]

12.4 AKX Surgery Date Letter

No discussion was held on this matter

12.5. RACOS Report

P Hughes explained that the subcommittee has reviewed the outcome of the runs. A review is being undertaken on unmatched pairs and its result will be shared with RTAC. Inclusion of highly sensitised patients in match runs was discussed; there was a broad understanding that settings may be adjusted by eliminating authorised antigens in order to maximise outcome for this class of patients

13. Other Business

13.1 Media Policy

AKX program attempts to safeguard the privacy of donors and recipients, but authorities cannot stop them from going to the media direct. P Ferrari referred to a case where the media protocols were not adhered to and requested RTAC to remind transplant units of their obligations as spelled out in the Media Protocol. RTAC reemphasised the importance of observing media protocols and will through its
members request all transplant units and their hospitals to co-ordinate with OTA regarding organ donation and transplantation under the AKX program in the interest of safeguarding recipients and donors

13.2 Proposed Changes to Intestine/multivisceral allocation - SOP001/2015: Organ Allocation, Organ Rotation
This matter was discussed at the meeting of Liver and Intestinal Transplant Advisory Committee on 30 November where it was reported that RTAC had given in principle approval in respect to intestine and kidney offer. The chair requested that this matter be formally approved by the Committee. This was accepted on the understanding that it will follow the usual multi-organ transplant practice.

**Action 160**
Advise ATCA President (with a cc to Jonathon Fawcett, the Chair of LITAC) of RTAC’s decision in respect to Proposed Changes to Intestine/multivisceral allocation - SOP001/2015: Organ Allocation, Organ Rotation [J Kanellis]

13.3 Policy Register
TSANZ Project Officer explained that the purpose of the register was to retain corporate knowledge in one place and make the search for information easier. As many of the policies are included in the Consensus Statement (TSANZ Clinical Guidelines) they need to be appropriately cross referenced in the register. The Committee endorsed the register to be called Register of Position Statement (RPS) which will be updated after each meeting. S Campbell agreed to review the draft Register, it will then be tabled at the next meeting of RTAC for information and feedback. The register is presently for internal use of RTAC but could be placed in a public domain in future at the discretion of the Committee.

**Action 161**
Review the RTAC’s RPS and feedback comments to Project Officer for tabling at the next meeting [S Campbell]

13.4 AKX Program and orphaned kidney recipient overseas
J Eris explained that in accordance with the arrangement between NSW and New Caledonia kidney transplants of New Caledonian nationals are performed in NSW. She sought some clarification on what processes/protocols would be required to deal with an orphaned New Caledonian recipient under the AKX program. Enrolment of an orphan recipient from New Caledonia in the AKX program was accepted by the meeting provided the costs are born by the nationals of the recipient country. Australia would thus reciprocate by sending a kidney procured from Australian national to the new Caledonian orphaned recipient. J Eris pointed out that once in the AKX program the kidneys from New Caledonian residents could go to any jurisdictions in Australia and she asked whether members were comfortable with this eventuality. P Ferrari explained that the prospect of an orphan recipient entering the AKX Program has not been discussed but he alluded to previous discussion on this general matter. He did not see a problem of recipient orphan from Noumea entering the AKX program as long as the donor and recipient pay the costs. If they are matched and if another Australian pair in the same chain is disadvantaged, they would do a match run with all the Australian pairs and then do a match run with the overseas pair and if that generates a new chain then it was acceptable. If it generated a different combination with a new chain but disadvantaging an Australian pair then it would not be prioritised. The meeting concluded that an Australian kidney should be made available to an orphan new Caledonian recipient to compensate them for their donation to an Australian under the AKX program.

**Action 162**
Document AKX Program and orphaned kidney recipient overseas in the RTAC’s Register of Position Statements [I Ali]
14. Future Meetings
RTAC (Sydney face to face) 10 May 2016 – confirmed
RTAC (Sydney face to face) 6 December 2016 – confirmed (no longer 29 Nov as originally planned)
RTAC Allocations Subcommittee (24 February 2016)
The meeting noted that the RTAC get together to share information during the TSANZ ASM would be
difficult given absence of members and other commitments. Subcommittee working groups may have
an opportunity to get together. [Subsequently – 1. Members of the AOMS working group - JK, Rhonda
and Narelle - met to progress their RFT assessments (Sunday 10th April); there was also a special
meeting of OTA and the allocation subcommittee group to progress the survival matching concepts
and incorporation of KDPI into the donor information (Tuesday 12th April)].

Action 163
Make arrangements for a face-2-face meeting in February 2016 of the Allocations subcommittee