NHS BLOOD AND TRANSPLANT
ORGAN DONATION AND TRANSPLANTATION DIRECTORATE

THE NINETEENTH MEETING OF THE NATIONAL RETRIEVAL GROUP (NRG) WEDNESDAY 8TH NOVEMBER 2017 FROM 10:30 UNTIL 15:30 AT THE PARK CRESCENT CONFERENCE CENTRE, LONDON, W1W 5PN

MINUTES

Present:

Prof Rutger Ploeg	National Clinical Lead for Organ Retrieval **(Chair)**
Ms Karen Quinn	Assistant Director UK Commissioning, ODT (**Co-Chair)**
Mrs Liz Armstrong	Head of Service Development
Mr John Asher	Clinical Lead – Medical Informatics (ODT)
Ms Emma Billingham	Senior Commissioning Manager, ODT
Mr Chris Callaghan	National Clinical Lead for Abdominal Organ Utilisation, ODT
Mr John Casey	Pancreas Advisory Group Surgical Representative
Mr Ben Cole	Lead Nurse Service Delivery
Prof John Dark	Clinical Lead for Governance, ODT, NHSBT
Ms Melissa D'Mello	Independent Lay Member
Prof John Forsythe	Associate Medical Director – ODT, NHSBT
Mrs Victoria Fox	Independent Lay Member
Ms Victoria Gauden	National Quality Manager – ODT, NHSBT
Ms Kate Martin	Statistics and Clinical Studies, NHSBT
Ms Maria McGee	Deputising for Gabriel Oniscu – RINTAG Surgical Representative
Ms Debbie McGuckin	Senior Commissioning Manager, ODT, NHSBT
Ms Cecilia McIntyre	Retrieval & Transplant Project Lead Specialist
Mr Gavin Pettigrew	Consultant Transplant Surgeon, Addenbrooke's Hospital
Mr Jim Powell	Deputising for Prof Derek Manas, LAG Surgical Representative
Ms Laura Ramsay	Lead Nurse - Recipient Coordination
Mr John Stirling	NORS Workforce Transformation Programme Lead
Mr Mick Stokes	Deputising for Jacqueline Newby – ODT Duty Office
Mr Steven Tsui	Cardiothoracic Advisory Group Surgical Representative
Prof Chris Watson	Kidney Advisory Group Surgical representative
Mrs Claire Williment	Head of Transplant Development, ODT, NHSBT (part meeting)
Mr Colin Wilson	British Transplantation Society Surgical Representative

In Attendance:

Mr Tanveer Butt	Presenter, Freeman Hospital, Newcastle (part meeting)
Mr Asif Hasan	Presenter, Freeman Hospital, Newcastle (part meeting)
Mr B C Ramesh	Presenter, Freeman Hospital, Newcastle (part meeting)
Ms Debbie Sutton	Clinical and Support Services Manager, NHSBT
Mrs Kathy Zalewska	Clinical and Support Services Manager, NHSBT

Guest Observers:

Seon Hwaoh	Bioethics policy department action officer MoH, South Korea (visitor) (part meeting)
Jung Su Hong	KODA Co-ordinator, South Korea (visitor) (part meeting)

Apologies:

Mr Roberto Cacciola	Associate National Clinical Lead for Organ Retrieval
Prof Peter Friend	Bowel Advisory Group Surgical Representative
Prof Derek Manas	LAG Surgical Representative
Ms Jacqueline Newby	Head of Referral & Offering, ODT (Duty Office Representative)
Mr Gabriel Oniscu	RINTAG Surgical Representative
Ms Fiona Wellington	Head of Operations for Organ Donation (SN-OD representative)

Item No	TITLE	ACTION
1	**WELCOME AND DECLARATIONS OF INTEREST IN RELATION TO THE AGENDA – NRG(17)26**	
1.1	R Ploeg welcomed Seon Hwaoh and Jung Su Hong from South Korea to the meeting and introduced the membership. No declarations of interest were reported.	
2	**MINUTES OF THE RETRIEVAL GROUP MEETING HELD ON WEDNESDAY 12TH JULY 2017 – NRG(M)(17)2**	
2.1	**Accuracy** The minutes of the previous meeting were agreed as a correct record subject to the following minor amendments: **Minute 7.1** – amend final paragraph to read '……finalise the medical content……'	
2.2	**Action Points – NRG(AP)(17)3** • **AP1 Retrieval of Small Intestine & Bowel** Carried forward to the next meeting in the absence of P Friend. • **AP2 Clinical Governance – Pilot re Attaching Organ Images to Selected Kidney Offers** Refer to minute 7.2. • **AP3 Commissioning Performance Report** – Refer to minute 12.1. • **AP4 Service Development of NRP** The business case for NRP for livers has been approved in principle and is to be resubmitted in January with amendments/refinements. Once the business case has been approved it will be submitted to NRG for operational input. • **AP5 Length of Donation Process Requests for Delays** This work is being taken forward with O McGowan in discussion with SNODs/RMs to ensure a practicable solution. • **AP6 Use of Bank Blood and Donor Blood for Novel Technologies** Refer to minute 5.2. • **AP7 Electronic Quality Form Pilot – Working Group Results** Refer to minute 7.1. • **AP 8 Clinical Governance Report** Completed - CTAG Chair has written to cardiothoracic centres re the logistical and costing implications of cardiothoracic teams using the OCS machine. • **AP9 Abdominal Paediatric Retrieval** In hand • **AP10 NORS Team Dispatch** Refer to minute 5.4 • **AP11 Handover Tariff** Refer to minute 11.1 • **AP12 Team Mobilisation Heatmaps** Refer to minute 11.3 • **AP 13 Flight Policy** Action closed. Identification of non-profit organisations with access to free air transportation is unlikely now due to consolidation of existing providers.	

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2.3	**Matters Arising Not Separately Identified** There were no further matters arising.	
3	**ADVISORY GROUP PRIORITIES**	
3.1	**Multivisceral and Composite Tissue** No issues reported in the absence of the Chair.	
3.2	**Cardiothoracic** S Tsui reported the start of a pilot coding and recording the reasons for declining offers. Centres will collate this on a template and provide monthly returns to NHSBT The Grading of Donor Organ Pilot started in February 2017. To date, there has been a low return of completed grading forms, and this is being taken up with the teams in question. This may be due to perceived duplication with the HTA B form, which currently still needs to be completed. There was an incident in which, the internal defibrillator paddles brought by the CT NORS team did not fit the defibrillator at a donor hospital. Cardiothoracic retrieval teams have been asked to bring their own defibrillator to ensure teams are self-sufficient with equipment.	
3.3	**Kidney** C Watson stated that organs from small donors, i.e. under two years old, are currently offered to two specialist centres (Guys and St James). Pending further experience on transplanting neonatal (<1 month) kidneys, these centres will only accept organs from donors over 1 month old. If the donor is under one month old, there is no need to retrieve the kidneys.	
3.4	**Liver** J Powell updated members on major changes, which will be taking place in liver allocation. Offers are currently centre based, but from March 2018 will be offered on a named patient transplant benefit base. As a result of travelling longer distances outside of allocation zones, cold ischaemia time may lengthen and this is a concern to the liver community. Work is underway to address delays in the donation pathway and discussion took place on data collection on breakdown of ischaemia times, particularly in the multiple organ retrieval process. The inclusion of organ preservation practitioners within retrieval teams should help with delays experienced with paperwork. It was noted that recent changes to the lung allocation scheme have decreased the retrieval pathway by around 2 hours.	
3.5	**Pancreas** Following on from the discussion above, it was noted that islet labs had reported poor completion of the donor pancreas specific form in relation to retrieval timings. Damaged donor organs - the quality of the pancreas and the accompanying vessels must be assessed at the time of retrieval. Some vessels are unusable, resulting in 35% of retrieved pancreases not being used. There needs to be better communication between retrieval and transplant teams, and also liver and pancreatic teams. As pancreases can now be allocated for either solid organ or islet transplantation it was emphasised that the organ should be retrieved to the same high standard, as any other organ. There is	

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	an opportunity here to re-train and educate NORS teams with specific discussions at the Organ Retrieval Masterclass, Clinical Retrieval Forum and BTS Congress. Currently the small bowel is prioritised for retrieval over the pancreas, but PAG felt this should be kept under review in order to find a technique, which will enable both organs to be retrieved with sufficient vessels. R Ploeg asked J Casey to continue to liaise with the Chair of MCTAG on this issue.	**J Casey**
4	**UPDATE ON RESEARCH DEVELOPMENTS**	
4.1	**RINTAG** A LEAN event is being held in Cambridge on 23rd and 24th November to look at the application and approval process to minimise waste. A RINTAG stakeholder meeting is also taking place on 17th and 18th January 2018; more information on this will be circulated in due course. ***Post meeting note*:** This is now a one-day event taking place on 18th January 2018 only. The olfactory bulbs study is due to commence at St George's Hospital and is awaiting approval by NHSBT. The study is aimed at assessing the viability of olfactory cells post-retrieval. RINTAG has agreed the addition of consented non-proceeding donors to the study group subject to certain conditions. Consent in contra-indicated donors will be handled by the local team. Concerns were expressed over the impact on theatre times for these types of retrieval; M McGee agreed to highlight these concerns to RINTAG.	**M McGee**
4.2	**INOAR (Increasing the Number of Organs Available for Research) – NRG(17)27** There is currently a shortfall in the availability of, and demand for organs retrieved for research purposes. INOAR recommended that the Liverpool Research HTA Licence be extended to permit the removal of whole organs for research purposes. This will mean that all 41 hospitals currently covered by QUOD in England and Wales (HTA Act 2004) will no longer need additional local licencing arrangements for the removal of whole organs for research purposes; in Scotland under the Scottish HTA Act 2006 no special licence is required, which brings the total number of donor hospitals facilitating sample/whole organ research to 61. This proposal was supported by RINTAG and by the CPB, and will be submitted to SMT later this month. NRG members endorsed the proposal. This process should increase access to research for some organs, but while it is covered in the commissioning contract it will likely result in additional work for NORS teams. A framework will need to be developed to clarify details of the process including governance around the licence for traceability.	
4.3	**Service Development of NRP** Refer to minute 2.2 - AP4 above.	
4.4	**QUOD Report – NRG(17)28** Members receive this report for information only and noted that QUOD also take biopsies for service development and for the PITHIA trial. Training in punch biopsies is taking place for PITHIA in the new year at which time, QUOD will also change from trucut	

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	to punch biopsies in kidneys.	
5	**NHSBT UPDATE**	
5.1	**General Update and New Developments** J Forsythe introduced Laura Ramsay, as the new Lead Recipient Co-ordinator for NHSBT. • There has been a 7% increase in terms of donor and transplant numbers so far this year, and this is likely to impact on the retrieval teams and transplant centres. • Donor characterisation strategy - microbiological and H&I characterisation of donors, has now moved into the implementation phase. This is more problematic in some regions of England than in the UK as a whole, but improvements are being made. • A workshop aimed at streamlining the recipient consent process will be taking place next week. • New liver allocation process - lessons have been learnt from implementation of the lung allocation process and liver allocation will be piloted more vigorously as a result. The new lung allocation scheme has increased activity by 24%.	
5.2	**Use of Bank Blood and Donor Blood for Novel Technologies – NRG(17)29** Members noted the revised proposal for use of bank blood and donor blood for novel technologies. This had previously been endorsed by CTAG, but the terminology has since moved on and the wording needs to be finalised in order to be included within the NORS standards. The document would be forwarded to those involved for final approval, following which, it could be included within the standards.	**Clinical & Support Services**
5.3	**ODT Hub Update** M Stokes gave an update on the ODT Hub: • The new heart and lung allocation schemes have been delivered and safely implemented on new IT platforms. • Phased implementation of cardiothoracic offering into ODT Hub Operations to be completed in December. • A referral and assessment tool has been piloted across SNOD regions. • A registration list for liver centres has been built and demonstrated, as well as a multi-organ offering prototype using heart, lung and liver. • Rollout of the super-urgent liver list has started. • Release of an updated elective patient registration form and a new sequential update form to ODT Online in December 2017. • Changes to the liver registration pathway to begin in December 2017 with the launch of the new liver offering scheme in March/April 2018.	
5.4	**NORS Team Dispatch** This is now undertaken by the ODT Hub and M Stokes gave a demonstration of the new NORS calculator, which gives real time travel updates. Issues around retrieval are discussed with the commissioning team every two weeks, and the three hour travel time is still being monitored. It was suggested that M Stokes	

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	attend the next Clinical Retrieval Forum meeting to report on how far teams are travelling.	
5.5	**Request from NORS Teams to Retrieve Organs for Own Recipients – NRG(17)30** E Billingham outlined a paper on the impact of NORS centres asking to retrieve organs they have accepted rather than retrieval by the designated on-call team. Invariably, the reason for the request is in order to place the organ on machine perfusion. This change results in confusion and inefficiency, and impacts on the designated on-call team, as well as on the donor hospital theatre. It also goes against the principle of NORS, which was to separate the retrieval team from transplantation. Members were asked to comment on whether the principles outlined in the NORS standards were up to date or whether there should be any other circumstance when centres should be allowed to retrieve organs they have accepted. One specific area, which was highlighted, was when cardiothoracic teams need to gain experience in retrieving DCD hearts; it was agreed that these instances should be the subject of a formal request to RINTAG and NRG and should not impact on the agreed processes. Members felt that the NORS rules were clear and should be applied. There should be a good reason for not following the current process in a substantive way, and this should be notified to NRG. R Ploeg agreed to compose a letter reflecting the discussion, which would be sent to all retrieval teams using machine perfusion in order to find appropriate wording to include within the NORS standards.	**R Ploeg**
6	**DIGITAL PATHOLOGY**	
6.1	**Pithia Trial** G Pettigrew updated members on progress with the trial: • Twenty two centres will be involved in the trial, which is planned to start early next year. • There will be a four-month lead in to capture data on organ acceptance and offering. • Training of NORS surgeons to use the punch biopsy starts in January and will be carried out by the QUOD team. • An inaugural event with presentations about the trial was successfully held in October at the Royal College of Surgeons.	
7	**CLINICAL GOVERNANCE**	
7.1	**Electronic Quality Form Pilot – NRG(17)31** Members noted an updated report from J Asher detailing the changes incorporated from feedback received. Development work will begin in March 2018. Work is taking place to ensure that all variables in the existing dataset are mapped by a single variable in the new dataset so that the new data can continue to be compared with that already held within NTxD. It was suggested that the final deadline for comments, as regards clinical content, should be the beginning of December 2017, following which, a decision will be made on implementation by B Hume's team and SMT.	

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7.2	**Pilot Attaching Organ Images to Selected Kidney Offers** C Callaghan reported on plans to carry out a national pilot attaching organ images to selected kidney offers in order to evaluate organ quality, thereby increasing organ utilisation. If successful, this could also prove useful for both pancreases and livers. C Wilson referenced an iPad app, which delivers an imaging quality score for livers and agreed to liaise with C Callaghan on how this could fit in with work on the pilot, particularly as there were concerns that different organs may develop different imaging options. It was agreed that the national pilot should be restricted to kidneys at the moment in order to reduce the burden on SNODs and retrieval teams.	
7.3	**Contaminated Ice – NRG(17)32** A number of instances of contaminated ice in transport boxes were reported and found to be caused by positive cultures from the ice surrounding retrieved organs. J Dark reported on the background to these incidents and a recommendation that hospital ice machines are regularly cleaned. It was recommended that a letter be sent to all NORS team leads and transplant centre leads emphasising the need for regular cleaning, as best practice both for living and deceased donors. Each centre/team should develop a protocol with their local infection control team, which should include transport boxes and water heaters.	**J Dark**
7.4	**Clinical Governance Report – NRG(17)33** Members noted the Clinical Governance Overview report for November 2017. The following key messages arose from the reported incidents: • Retrieval incidents - organ damage where the organ is subsequently lost must be reported to the HTA. • Filming in theatre – the NHSBT policy is not concurrent with GMC guidelines, which allow filming without consent. However, NHSBT policy states that images can be used if anonymised, and then deleted once viewed. • CMV retesting – Some centres still re-test and need to consider when the testing took place if a discrepant result is received in order to take into account blood transfusions, which may have occurred. This is part of the donor characterisation review with one suggestion being that retesting takes place by a single laboratory, as soon as possible after donation. This is then seen as the confirmatory test.	
7.5	**Use of TOE in Cardiothoracic Retrieval – NRG(17)34** Issues arose around cardiothoracic transplant teams requesting a TOE be undertaken before accepting a donor heart. Pre-emptive use of TOE would mean a change to the NORS standards, and a letter to clinical leads to cardiothoracic transplant centres was noted, emphasising that centres may be required to make a judgement on whether or not to accept a heart based upon the information available without investigations such as TOE. The use of TOE, as part of the scout function, will be covered under the NORS Workforce Transformation programme and, in the meantime, a definition for the exceptional use of TOE will be agreed through NRG and CTAG.	**S Tsui**

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7.6	**Histopathology Update** J Dark presented a report on behalf of O McGowan on the process flows and request form for histopathology, which is designed to streamline the communication of histopathology results. Members asked that the paper be circulated asking for comments within 10 days, following which, the paper would be submitted to SMT in December 2017 for rollout in January 2018. It was noted that a letter had been drafted for circulation to cardiothoracic and liver centres emphasising that the final decision on the use of the organ lies with the transplant surgeon following a report on histopathology. In the longer term, the Royal College of Pathologists is also considering an on-call rota of specialist pathologists to provide advice.	**Clinical & Support Services**
7.7	**Organ Damage Report – NRG(17)35** K Martin reported on organ damage rates between 1 April 2016 and 30 September 2017. This report will be produced and presented to NRG on a bi-annual basis. Data is sent out to retrieval teams on a monthly basis with a request to feed back. There is a reluctance to share this data beyond the individual retrieval team without giving them the opportunity to comment. The complete report is only submitted to NRG. The question of whether to publish this data on the ODT website was discussed and the possibility of including it within a password protected section was suggested. At this stage there is concern that some of this damage is pre-mortem damage.	
7.8	**Terms of Reference – NRG(17)36** Following on from discussion on the frequency of NRG meetings, revisions were made to the NRG Terms of Reference and submitted to the group for comment. Further changes agreed included: • 'Lay member representative' to be amended to 'Independent Lay Member' • Remove Co-Chair position and replace with surgical Deputy Chair • Add a paragraph on the relationship between RINTAG and NRG. Membership to be reviewed by R Ploeg & J Forsythe.	**R Ploeg/J Forsythe**
8	**UPDATE ON CLINICAL DEVELOPMENTS**	
8.1	**DCD Heart Retrieval – NRG(17)37** S Tsui summarised a report submitted to CTAG in September on DCD heart activity from 1 February 2015 to 30 June 2017 at Harefield, Papworth and Manchester. During this time there were 42 DCD heart donors with 37 hearts transplanted successfully. In terms of commissioning, the business case for funding has been declined by the four DHs, but there is still interest from the remaining three cardiothoracic transplant centres.	
8.1.1	**Newcastle DCD Heart Protocol** B C Ramesh, T Butt and A Hasan joined the meeting to present a bid for Newcastle to start undertaking DCD heart retrieval. The infrastructure is in place and it is hoped to start the process early in 2018. The requirement to complete three DBD heart retrievals prior to commencing the DCD programme has been fulfilled. Funding for the DCD protocol has been secured for 17 cases, and OCS will be used. Papworth has agreed to proctor the first 3 DCD	

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	cases, which will involve non-complex regional retrievals. It was emphasised that if OCS is used, Newcastle must report back to NRG after 5 retrievals rather than after the 3 retrievals required for direct procurement. The consent form is in the process of being updated and training is planned for local SNODs/CLODs. The protocol is being presented to both NRG and RINTAG for endorsement. Newcastle representatives were asked to ensure that any planned media activity around DCD heart retrievals is linked with the communications team at NHSBT. In addition, if the approval process is extended then skills must continue to be maintained.	
8.2	**Update on Uterine Transplantation** It is proposed to undertake some 'dry runs' to check processes and surgical techniques for uterine retrieval. At the recent RINTAG meeting, the proposal was supported with specific consent for up to 5 cases when abdominal only NORS teams are mobilised and subject to uterine retrieval taking place post solid organ retrieval. There is provisional agreement from 3 SNOD regions (South East, London and South Central) to participate in the study. Clarification regarding the final protocol is awaited, as well as HTA licencing. NRG endorsed the proposal with the proviso that retrievals should only take place if Oxford is the on-call NORS team.	
9	**WORKFORCE TRANSFORMATION AND TRAINING**	
9.1	**Progress on Vanguard Project – NRG(17)38** J Stirling reported that simulations had taken place to test the viability and safety of a single scrub practitioner on multi-organ retrievals. There are 3 abdominal and 2 cardiothoracic teams involved in the project for which, an SOP has now been developed. Return rates for forms was initially low, but has now increased to over 80%. Some teams are not utilising the shared scrub practitioner due to concerns over safety or training. Thirty two vanguard retrievals have taken place, and work is ongoing to reduce the number of missed opportunities. The original 6-month duration for the project has now been extended to April 2018 in order to obtain sufficient data. It was agreed that a joint letter from R Ploeg and K Quinn, on behalf of the Workforce Transformation Project Board, should be sent to highlight the positive outcomes so far.	**R Ploeg/K Quinn**
9.2	**Update on Appointment of Organ Preservation Practitioners** Five abdominal teams have been appointed to this role; a further four are in the process of arranging to take on this function from SNODs by the end of March next year, and work is ongoing with the remaining team to achieve this deadline.	
9.3	**Organ Retrieval Masterclass 2017** The Masterclass will take place on 18th and 19th December 2017, and is designed as a combined surgical and perioperative workshop, which will also include a dedicated session on NRP. The Royal College of Surgeons continues to accredit the event.	
10	**NORS STANDARDS REVIEW**	

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10.1	R Ploeg thanked those who had been involved in the review of the NORS standards, which it was anticipated would be finalised at a meeting on 4th December 2017 for implementation, as soon as possible thereafter.	
11	**COMMISSIONING**	
11.1	**Handover Tariff** E Billingham reported that a proposal to fund up to four hours expenditure in addition to the existing handover tariff was to be submitted to SMT for approval. It was acknowledged that although there is a rationale to contracting teams for an additional four hours there may be times when it would be sensible to delay activating a team until the next team comes on duty.	
11.2	**Demand and Capacity** There are currently 7 abdominal and 3 cardiothoracic retrieval teams on call at any one time. If these teams are busy on more than 70% of days in 3 consecutive quarters a review will be triggered. One abdominal team has now triggered although overall abdominal teams are averaging around 50%. A mini review looking at reallocation of activity will take place next year and will take into account a number of aspects raised by the teams. The review process and findings will be reported via NRG. This will be raised at the forthcoming Clinical Retrieval Forum for discussion. It was recognised that due to increasing donation and transplantation numbers, the donation and transplantation community is taking on extra work borne out of success, and on occasion, teams are working above and beyond the norm .	E Billingham/K Quinn
11.3	**Impact of Zonal to Closest NORS Team First – NRG(17)39** K Martin presented a summary of the impact of the change in the retrieval team attendance sequence, which was implemented on 4th April 2016. Members noted: • Numbers of donor attendances have not increased notably since 2013/14. • The imbalance in activity between teams has changed over the years, but this is not solely due to the change in the retrieval team attendance sequence. Generally no difference overall either positively or negatively in changing from zonal allocation to closest team first. It was suggested that the heatmaps showing time of retrieval team mobilisation should be correlated with those for the donor pathway, as well as looking at numbers of donors alongside the number of donor attendances.	
12	**FOR INFORMATION**	
12.1	**Commissioning Performance Report – NRG(17)40** This report was received and noted.	
13	**ANY OTHER BUSINESS**	
13.1	C Williment informed members of her secondment within NHSBT to support the Department of Health consultation on opt-out in England and asked for advice on the best way to engage the	

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	NORS community. There will be a 12–week on-line public consultation together with the use of existing committees to run focused workshops. In parallel with this are one to one meetings, meetings with societies/organisations and deliberative events with regional collaboratives and other groups. The focus of the consultation is to support an individual's decision to opt out, together with the role of the family in this decision; BAME issues and the role of technology in organ donation and transplantation. Members suggested consulting with various NHSBT groups e.g. NRG, Clinical Retrieval Forum, Transplant Managers Forum, Advisory Group Chairs Committee and with individual NORS teams. R Ploeg and C Williment agreed to liaise outside of the meeting to decide on the best approach.	**R Ploeg/ C Williment**
13.2	**NORS Team Retrieval of Tissue** It was reported that there are potentially a number of tissues, which are retrieved in theatre by NORS teams, and are not covered by the EU Tissue and Cells Directive resulting in a licensing gap. Work is taking place with the HTA to work out a framework for those tissues not yet covered by the existing licence to be added to the NORS contract (hearts for valves, livers for hepatocytes, pancreas for islets, fascia for secondary tissues). From a licencing perspective, third party agreement can be added. Members expressed concern at the plan to include pancreas for islets as 'Tissue and Cells', and asked that the PAG Islet Steering Group be kept informed of any developments. Since the pancreas is currently allocated to both solid organ recipients and islet recipients placed on the same waiting list, a change towards pancreas for islets, as tissue would make a combined list impossible and cause a significant impact on allocation and transplantation.	
13.3	E Billingham advised that the tendering process for sterile retrieval packs would be starting soon. Once the specification has been finalised, it will be distributed to NRG members for comment.	
13.4	J Forsythe reported on the commencement of routine HEV testing, and on the trial of simultaneous offering of organs from high virological risk donors.	
14	**Dates of Future Meetings**	
14.1	• Wednesday, 18th April 2018 – Medical Society, London • Wednesday, 3rd October 2018 – Association of Anaesthetists, London	