NHS BLOOD AND TRANSPLANT
ORGAN DONATION AND TRANSPLANTATION DIRECTORATE
RESEARCH, INNOVATION AND NOVEL TECHNOLOGIES ADVISORY GROUP

MINUTES of the MEETING HELD ON 2 OCTOBER 2018
1st Floor, BJA Library, The Royal College of Anaesthetists, Churchill House, 35 Red Lion Square
London WC1R 4SG

Attendees:

Mr Gabriel Oniscu	GO	Chair
Mrs Liz Armstrong	LA	Lead Nurse, Service Development
Ms Hazel Bentall	HB	Lay Member
Prof John Dark	JD	National Clinical Lead – Governance – ODT
Prof Andrew Fisher	AF	NIHR BTRU
Prof John Forsythe	JF	Associate Medical Director, ODT, NHSBT
Prof Peter Friend	PF	Chair: Multi-Visceral & Composite Tissue Advisory Group
Ms Victoria Gauden	VG	National Quality Manager, ODT, NHSBT
Ms Fiona Hunt	FH	Specialist Practitioner in Organ Perfusion/Preservation
Dr Jennifer Mehew	JM	Statistical & Clinical Studies, NHSBT
Prof Elizabeth Murphy	EM	Lay Member
Dr Jayan Parameshwar	JP	Chair, Cardiothoracic Advisory Group
Prof Rutger Ploeg	RP	Chair, National Retrieval Group, Director of QUOD
Ms Karen Quinn	KQ	Assistant Director for Commissioning, ODT
Ms Sandrine Rendel	SR	QUOD National Operational Coordinator
Ms Maggie Stevens	MS	Specialist Nurse, Research & Service Delivery
Ms Hannah Tolley	HT	ODT Research & Project Manager
Dr Nick Watkins	NW	Assistant Director, Research & Development, NHSBT
Prof Chris Watson	CW	Chair, Kidney Advisory Group
Mrs Fiona Wellington	FW	Interim Assistant Director, Organ Donation & Transplantation
TITLE Michelle Willicombe	MW	BTS Representative

Apologies

John Casey	JC	Chair, Pancreas Advisory Group
Claire Williment	CW	Head of Transplant Development, ODT
Dale Gardiner	DG	National Clinical Lead, Organ Donation, NHSBT
Rachel Hilton	RH	Consultant Nephrologist, Guy's Hospital
John O'Grady	JOG	Chair, Liver Advisory Group
Michael Stokes	MS	Hub Operations Manager, ODT, NHSBT

In attendance

Heather Crocombe	HC	Clinical & Support Services, NHSBT

		Action
1.	**Welcome and Apologies**	

	GO welcomed everyone to the meeting and gave details of apologies – shown above	
2.	**Declarations of Interest in relation to the Agenda** *Please note that it is the policy of NHSBT to publish all papers on the website unless the papers include patient identifiable information, preliminary or unconfirmed data, confidential and commercial information or will preclude publication in a peer-reviewed professional Journal. Authors of such papers should indicate whether their paper falls into these categories.*	
3.	**Minutes of the Research, Innovation and Novel Technologies Advisory Group Meeting held on Friday 11 May 2018 RINTAG(M)(18)1** 3.1 Accuracy of Minutes Minutes of the previous meeting were reviewed and were deemed to be an accurate reflection of what was discussed at that meeting, except for the following: Front page: Elizabeth Murphy's title should be shown as Professor rather than Mrs. p.9, point 12. The sentence *Mobile perfusion units are all run by qualified perfusionists, static units not always* should be deleted p.9, point 13. The amount of the grant is shown as £900,000 over 3 years – grant should be shown as £1.7m over 3 years It appeared that HC had not circulated the most up to date version of RINTAG(M)(18)1 ahead of today's meeting. Check that the most up to date version has these changes made and recirculate. 3.2 Action Points from the Meeting All actions complete - nothing to add.	**HC** **HC** **HC** **HC**
4.	**Research Matrix – Current Status** **Revised Matrix (RINTAG(18)16) Hannah Tolley** The revised Matrix went live as at 31 August 2018. There was a delay in issuing the re-ranking due to a mistake that was noticed by the Research Team: • As per policy, any study that can transplant as the results of its research should be prioritised above all other studies for that organ type	

	• However, these criteria have no associated numerical score • Therefore, three studies with the same numerical score were given the same ranking even though only one stated that they will transplant from the research protocol Studies were re-ranked as a result of the Progress Reports sent out to Researchers in February 2018. Researchers submit reports biannually and the results of those reports are summarised and fuel the Ranking Matrix. Data took until June 2018 to process, at which time the re-ranking was decided. One researcher had asked that study outputs be incorporated into the ranking. RINTAG discussed this issue and felt that that adding outputs to the ranking matrix is based on guesswork and results are difficult to predict. A second consideration discussed was if the outputs of the previous studies should be considered when a researcher submits a new project application. RINTAG membership decided that there should be no changes to the current ranking scheme and the output of the studies should not be considered in the ranking. RP asked for the Start Date, Finish Date and Aim to be added to the ranking matrix. HT advised that she will add these categories. PF made the point that we need to ensure that projects which result in transplantation are not automatically put to the top of the list. Distribution of organs needs to happen fairly, regardless of the purpose of the study. AF raised the issue that if a project asks for an extension they lose ranking points simply because of that. This is particularly challenging for hearts and lungs where the number of organs available at the moment is small. RP asked what do we do with teams who are cherry picking – the centres who are only accepting organs during office hours, turning down over weekends etc. Can a study (for example) be deducted points for refusing organs? JF suggested that if you have declined a whole load of offers then you should go down the ranking. GO asked for suggestions as to how we capture all the data from each separate project that turns down organs (reasons for refusal, reasons for not responding until the next day, whether we can differentiate between refusing organs for a “good reason” or not and those centres who simply don’t respond). RINTAG agreed that the only	**HT**

	realistic way to gather this precise information is through Hub Operations Staff. The question was raised as to whether it should be made obligatory for all Centres to contact the Hub to explain their reasons for refusal? GO is happy to write to each researcher to explain that we would like to capture refusal information feedback retrospectively. We can add wording to the "offer" email to say, "if you are a refuser please complete this form and return it to us to explain the reason why". A pilot needs to be run for a month, with kidney projects, as they have the highest rate of refusal. For the pilot month we can give researchers the option of replying in a free text box, then categorise reasons at a later date. **Allocation of Research Organs located at a Transplant Centre (RINTAG(18)17) L Armstrong** RINTAG is asked to consider the proposal that the research allocation policy is amended so that when a liver is offered for research from a transplant centre and there is a liver research study based at that liver transplant centre, they are allocated the liver regardless of their scoring/ranking position. This paper was put together at the request of one centre. After discussion around the table, RINTAG membership agreed that we should carry on as we are and make no changes to the current allocation policy at present.	**LA/HT**
5.	**Research Activity – Statistics & Clinical Studies** **Consent RINTAG(18)18 J Mehew** This paper summarised how research consent/authorisation rates have changed over the last ten years in the UK. Rates were analysed for actual organ donors in the UK from 1 January 2009 to 31 July 2018. Key results: • Consent/authorisation rates for solid organ donors have generally increased from 83% in 2009 to 91% in the first 7 months of 2018 • England & Wales have had the highest consent rates over the past 4 years ranging from 91% to 98%. Northern Ireland has seen an overall increase in research consent rate since 2009, although it remains lower than the rest of the UK at 83% in the first 7 months of 2018 • The research rate for Scotland rose from 81% to 90% between 2015 and 2017 and was 88% for the first 7 months of 2018 • Kidneys (98%) and liver (97%) gained the highest rates of consent authorisation. Tissue has lower consent/authorisation rates than solid organs.	

Allocation Review RINTAG(18)19
J Mehew
Hub Operations translate their notes onto a spreadsheet and Stats then analyse that data. This paper shows results from 1 May – 30 June 2018.

Summary
Key results:

- 15% (123) of the total number of organs retrieved were not transplanted and were potentially available to use in research. Of those 123 organs that were not transplanted, 10 did not have consent for research, 88 were offered through the Scheme, 45 of which were used for research, 43 were disposed of despite having research consent
- 8 organs were not offered for research for reasons other than no research consent (SNOD advised to not offer on two, Hub Operations advised that three organs had been disposed of, three used for histopathology)
- 77% of offers made through the Scheme were made between 12pm and 12am
- When data from this paper was combined with the previous review data, there seemed to be a greater utilisation of organs between 3am and 3pm, spread across the week
- Research studies have stated in the past they have not always been able to facilitate an organ due to geographical location. The next allocation review paper (May 2019) will take this into account
- Long cold ischaemia times may occur due to the length of the offering process. Median time from the last offer for transplant to the organ being offered for research was 194 minutes
- Median number of responses per offer was 1
- No hearts and two lungs were offered during the review period. 55 kidneys, 18 livers and 10 pancreases were offered during the same period

Availability of Organs for Research RINTAG(18)20
J Mehew
Conclusions:

- Total number of organs retrieved and not transplanted has steadily increased over time. Proportion of these organs that has consent/authorisation for research has increased to 93% in 2018.

	• Utilised research organs were distributed across many studies – lower ranked studies still obtained organs **Research Team KPIs and monthly emails to researchers** **RINTAG(18)21 H Tolley** The ODT Research Team now collect data on research offers and acceptance rates. The following details are recorded for each offer: 1. Organ type 2. Donor number 3. Date of offer 4. Time of offer 5. Acceptance (Yes/No) 6. Destination (Study Number/Disposed) 7. Time of Day (CH/OCHWD/WE) (core hours, outside of core hours, weekend) Key data collected: • Many organs (on average 22 per month) offered through the national allocation scheme are disposed of • The likelihood of cardiothoracic organs becoming available through this route still very rare • More organs are accepted during core hours (Monday – Friday, 08:00 – 18:00) • 73% of research organs offered since May 2018 were offered overnight or during the weekend – and many of these were disposed of as researchers and tissue banks tend to work core hours • 23% acceptance rate of livers offered in June. Researchers contacted to ask why – reasons included: *Unavailability of study team, researchers busy, text from Hub Ops not waking team up, capacity, no funds for transportation of organ*	
6.	INOAR – *Increasing the number of Organs for Research* RINTAG(18)22 J Dark Background & Update on Progress The INOAR RINTAG Sub-Group was established to make recommendations on what more could be done to address the gap between the availability of and demand for organs for research purposes. The aims were two-fold: • To ensure that as many organs as possible are used for research • To ensure that a donor's family's wish to donate for research purposes where transplant is not an option is honoured wherever possible.	

Update

- The proposal was supported at RINTAG in 2017 and 2018
- The proposal was supported at CPB in late Oct 2017
- The proposal was supported in principle at SMT in 2017
- In parallel with the work in INOAR, the QUOD-EXPAND application to the MRC was successful (This project involves collecting the diabetic pancreas, hearts and lungs for a cell atlas based in Newcastle but available, like all QUOD samples, to a broad range of investigators.

Next Steps

- A paper research HTA A form has been developed which supplies all the information required by NHSBT for NTxD, and for the HTA. Information Services are happy to handle the paper Research HTA A form, but not in large numbers. The forthcoming 2019 Electronic HTA A form will have a research section and automated data collection, removing restrictions on what Information Services can handle. Retrieval will always be undertaken by a certified NORS Team who are fully cognisant of the various regulations and who are trained and competent to remove organs for research.
- Hub offering of organs for research (concern that a large increase in research rather than transplant activity might lead to difficulties)
- Consent for Research. To simplify consent process for SNODS on the ground
- Retrieval Pathway
- Continuation of Specific Consent

GO thanked both JD and EM for doing such a huge amount of work and for the time and commitment they have put into the INOAR Project.

After a lot of hard work by the ODT Research Team, with input from a range of individuals, many of these steps have been completed.
JF raised the question: Should there be SNOD or Regional Manager input within this group? JD advised that there is extensive SNOD input already.

Note: JD pointed out an error in the report - NHSBT Research Team should be ODT Research Team

LA presented a paper about the allocation of lungs to Study 59 (a specific consent lung study in Northern Ireland) once INOAR is implemented. Specific studies are due to become the exception to the rule once INOAR is introduced because they are very time-consuming to implement and usually have low consent rates. The

	suggestion was that due to large costs of transporting lungs allocated through the generic route to Belfast and the positive relationships between the Study team and the Northern Ireland SNOD team, lungs retrieved for research at the Royal Victoria Hospital in Belfast should stay in Belfast. RINTAG reviewed the proposal and decided that the optimal solution would be for the Northern Ireland SNODs to ring the researchers in Belfast if there was a potential donor for them; if the research team were then able to retrieve the lungs themselves they could access them via specific consent, and if they were not able to retrieve them, the lungs would be retrieved and offered under INOAR.	
7.	**Studies for Approval and Information** **H Tolley RINTAG(18)24(a) to (g)** Some RINTAG attendees are involved in some of the studies being discussed and would therefore leave the meeting at the appropriate point. **Heart Ex-Situ Normothermic Machine Perfusion RINTAG(18)25** Simon Messer came into RINTAG to present and talk through his proposed Trial protocol **Resuscitating the Donor Heart using Ex-Situ Normothermic Machine Perfusion (ES-NMP).** This protocol was authored by Simon Messer, Stephen Large, Pedro Catarino and Sarah Fielding. A Business Case was previously prepared for NHS England, unfortunately that wasn't accepted so the Project is still relying on charitable funds. S Messer had discussed with GO, RP and MMcG to ensure that this version of the Protocol, version 4.0, was appropriate. This is a very important study if the UK is to continue forging ahead in this field. GO question: *Has it been agreed that heart retrieval for the purpose of this study is treated as clinical retrieval?* SM answer: *The heart is to be removed in parallel with other organs and will not hinder the removal of those clinical organs.* NW question: *What is the timeframe for completion of the Study?* SM answer: *A year, and with a requirement of 10 hearts.* GO made the point that we should potentially expand the study to other hospitals besides SM's so that that target of 10 hearts within a calendar year is achievable.	

	GO said that on page 17 of the Protocol, the sequence of events needs to be clarified before the protocol is distributed. *SM left the meeting.* JD made the point that if a NORS team is present, approximately 50% of hearts/heart valves available for research are taken, percentage is substantially lower when no attending NORS team. PF: The potential gain here is huge. RINTAG supported this study unanimously. **New Proposals and Resubmissions** Ann Ogbemudia – Oxford – skin flaps and pancreases: No comments/objections Dan Doherty – Manchester - pancreases: No comments/objections Study 21 – resubmission – asking for an extension to December 2019. No comments or objections. Study 65: University of Edinburgh: requesting an extension in order that the required number of samples can be reached. No comments or objections. Study 66: Newcastle Blood and Transplant Research Unit (BTRU) – requesting an extension until the end of September 2020. No comments or objections. **Kidney Research UK/Fibrosis Network** It has become apparent that many organs which could be used are being disposed of (consented for research, targeted for research, not being utilised). RP suggested that QUOD as a group should have discussions with the Fibrosis Network to see if the fibrosis studies can be integrated rather than having a separate biobank and potentially have competing studies.	**RINTAG/Fibrosis Network**
8.	**Olfactory Bulb Transplantation - Update** A second successful procedure recently made it into theatre, however the patient's brain was too swollen to retrieve olfactory bulbs. Some families have refused consent completely; the team believes this is because abdominal/cardiothoracic organ donation is fine as it doesn't alter the appearance of the deceased, whereas an operation to the head or neck would. **Uterine Transplant - Update** MS has been awaiting a letter from the Finance Director confirming that there will be no cost implications to NHSBT.	

	There have been 46 cases worldwide, and the first live birth following DBD donation has happened in Brazil.	
9.	**Clinical Governance Update RINTAG(18)27 (Authors John Dark & Jeanette Foley)** Status – Confidential RINTAG were requested to note the findings within this report and respond to questions raised. **INC3390** Reporter had significant difficulties in registering with Hub Operations to start receiving research offers for declined organs. Reporter had not been added to distribution list for research offers despite completing appropriate forms. Contacted Hub Operations who added their contact details, reporter then started to receive offers. **INC3440** Lungs for research were placed in formalin so could not be accepted into study. It wasn't realised that the lungs were to be offered for research ahead of them being placed in formalin. No agreed process as to what solution research lungs should be placed in – unlike abdominal organs that are offered more frequently for research, CT centres are unaware of necessary fluids. **Requirement from NRG** In relation to 3440, RINTAG were asked to confirm that hearts and lungs should be placed in standard transport solution when being offered for research. Agreed by RINTAG Members. **Deep Dive** Reported Ongoing reports related to the use of NRP in relation to team mobilisation delays, requests for abdominal NRP when heart accepted by centre using DPP, lack of clarity over use of T-A NRP/NRP when centres differ in opinion on its use, multiple teams present for retrievals using T-A NRP/NRP, and delays in retrieval due to T-A NRP/NRP facilitation. Findings • Teams asked to mobilise specifically to use NRP rather than sending additional surgeon/technician alongside NORS Team • No clear documentation over agreements made in relation to when NRP is requested and DCD heart is accepted (ie. Limited awareness of previous agreement at DCD Hearts Steering Group that abdominal NRP takes priority over DCD hearts) • No clear protocol for DPP Learning RINTAG has confirmed the agreement that was made at last DCD Hearts Steering Group that if abdominal NRP is requested and a DCD heart is	

	accepted then abdominal NRP takes priority. DPP/NRP issues need to be explored to prevent transplantable DCD hearts not being retrieved. This will include the wider discussions over TA-NRP use. These points will be discussed at DCD Hearts Steering Group Meeting on 5 December 2018. Requirements • Insistence from the Recipient Centre that NRP is used for a liver retrieval • Awareness that abdominal NRP always takes precedence over heart DPP • Deployment of separate CT NORS team when OCS is used for a DBD donor	
	LUNCH	
10.	**Cell Line Discussion at NHSBT Care – Verbal Report** **N Watkins** Best practice in the field is to take specific consent. Discussion took place at the last RINTAG meeting on three options to manage consent for cell lines in ODT: 1. Specific consent 2. Generic consent – with information provided in the research information leaflet 3. ODT do not support research studies that intend to generate cell lines The stance from CARE is that specific consent should be sought from the donor families whose loved ones are donating material that will go on to be used for cell lines. Needs to be discussed on a case by case basis. **VG:** with regards to taking consent at the time of death, how much information would the family take in at that time? With regards to taking cells which are then utilised for cell lines 48 hours later and having to potentially obtain consent 48 hours after death, that will also pose problems. The explanation for donation of cells and creation of cell lines is so complex and requires the nursing staff to ask some in-depth and specialised questions. Consent required first for cells and additional specific consent sought afterwards for these projects. That specific consent only to be obtained from experienced research nurses rather than SNODS. **AF:** Producing immortalised cells is not the best course of action. Cells which have not been immortalised are always far better – primary cells yes, but no rationale for producing immortalised cell lines. **NW** advised that the sort of cells being retrieved for immortalisation can actually be purchased online. Rather than say that NHSBT doesn't support retrieval of cells for cell line creation at all, we must set out in what circumstances it would be supported. RINTAG to take back to NHSBT Care/ODT Care that whilst we are not closing the door on cell line donation at the moment, we favour a two-stage consent process.	

	The first stage is when the family consent to generic research as part of the consent/authorisation form, and the second stage is a few days later when a trained research nurse would call the family and take consent for creating immortalised cell lines. This is much like the consent for tissue donation process in NHSBT's Tissue and Eye Services. JF suggested that researchers should take the cell line immortalisation process far enough to ensure viability of the cells whilst waiting for the second stage of consent to take place, and then stop. If secondary consent is then refused, there needs to be a robust process in place to make sure the cells are disposed of. MS noted that the family may not have had a post-operative phone call from the SNOD before they get a call from a research nurse asking for cell line consent, so that could come as a surprise at a difficult time. FW noted that making this operational would require a lot of work.	
11.	**QUOD Report RINTAG(18)28** **S Rendel** SR presented QUOD Statistics for August 2018 Please refer to paper for details on Biopsy and Incident Metrics, Consent for QUOD Research and Actual QUOD Donors, QUOD Samples issued to Applications. Key Figures: • 3,368 donors • 59,281 samples in total • 31,713 blood samples • 7,361 urine samples • 8,330 kidney samples • 4,492 liver samples • 4,895 ureter samples • 2,490 spleen samples • 355,293 biobank items **QUOD Bronchioalveolar Lavage (BAL) and Cardiac Samples** The Cardiothoracic NORS teams are being trained to take heart and BAL samples for QUOD, and after the 8th October the only remaining team to be trained will be Birmingham. GO queried whether QUOD could take bile/bile duct samples. SR responded that it had been discussed previously and the QUOD team were unsure as to how to collect them, but these samples would be covered under their ethical approval.	

	It was noted that the UK Transplant Registry (UKTR) doesn't record any data on bile ducts, and that the Liver Advisory Group (LAG) would need to approve this idea if it progressed. It was also noted that researchers would need to specify where the bile was collected from and what segment of the duct is sampled. CW specified that the distal common bile duct would be the most preferable for the liver transplant surgeons and bile collection should be from the main bile duct rather than the gallbladder.	
12.	**DCD Hearts** **DCD Heart Working Group Update** The first DCD Hearts Working Group Meeting was held about 6 weeks ago. At the time of the meeting three centres were active. • Agreed governance for eg. how to sign people off • NHS England raised the subject of trying to get funding for mentoring. • TA-NRP protocol has been prepared and is going to NRG 3 October 2018 • DPP Protocol to be prepared • Scotland are likely to start their training soon • Great Ormond Street are not planning to do anything, due to lack of funding. The OCS machine does also not work for donors weighing less than 50kg due to the amount of blood needed to make it work. • Any issues with TA-NRP protocol should be directed through Marian Ryan • There is a perceived conflict between DPP and A-NRP – although both procedures were successfully and simultaneously carried out at Addenbrookes recently. • How to roll out TA-NRP? Previously controlled by Paul Murphy. Dale Gardiner wants to be involved in it now, so either DG or DH need to attend DCD Hearts Steering Group. Dan advised that he or Dale will be happy to attend. • Abdominal NRP always "trumps" abdominal DPP. JD asked if this is a definite rule. GO said that except in very unusual circumstances, this should be maintained but efforts should be made to develop a DPP-A-NRP protocol based on the recent Addenbrooke's experience. This should consider the utilisation of banked blood as well. Rajimeyer Venkateswaren has been asked to produce a DPP Protocol. Once prepared this Protocol needs to go to DCD Hearts Steering Group, to RINTAG then to SMT to be agreed and circulated to each Centre. It should also go to the NRG, but for information.	**JP** **JP** **HC to issue invitation**

13.	**Communication of Risk & Consent in Transplantation RINTAG(18)31 Maria Ibrahim** **Background** • Changing donor demographic has led to increasing use of "marginal" donors • Greater need for individual assessment of risks/benefits of transplant due to large variability in recipient and donor population • Perception that more "risky" transplants are taking place and continued evaluation of outcomes is required • How can we improve communicating this risk/benefit relationship to patients and clinicians? Work is going ahead on the development of an online tool (**Transplant Risk/Benefit Assessment and Communication (TRAC))** – aiming to be an online calculator and to be used by physicians when consenting patients in clinic, from the time of listing for transplantation to organ offer. This online tool will need to be registered as a medical device. NHSBT working closely with the Winton Centre at the University of Cambridge who are experts in communication. US already have a similar online tool to TRAC – NHSBT's data is as rich as the US data, so the hope is that we will produce something comparable. The second piece of this work will develop best practice consent videos. The group noted that the average reading age is 11 years old, which is why videos are a much better tool for communicating complex medical information than written patient information leaflets.	
14.	**NRP Service Evaluation Update** **Verbal report – G Oniscu** GO noted that a service evaluation of NRP with 100 DCD donors has been ongoing in Cambridge and Edinburgh, with more retrieval centres coming online. Oxford went live a few months ago and there has been renewed interest from all other liver/retrieval centres. A business case put together by NHSBT's Commissioning team is going to the Department of Health to fund NRP. KQ noted that funding for all centres cannot be guaranteed. **PF**: What will the situation be for those teams who are some way behind pioneering units regarding reimbursement of costs?	

	GO: at the moment reimbursement for consumables is available for all centres as part of the NHSBT service evaluation. **Edinburgh Training Package for NRP Service RINTAG(18)32** **Fiona Hunt** An educational and training package has been developed in Edinburgh headed up by FH, a Specialist Practitioner in Abdominal Organ Perfusion and Preservation. FH set out details of the role of a Specialist Practitioner in the following fields: Recruiting/developing a core team, designing/delivering education and training, establishing competencies, managing equipment, co-ordinating the service, developing a rota, reviewing the service). Once education and training is complete, Practical training Components are brought into play (one to one/group sessions, dry runs including all members, actual donor attendance – supervised) JD asked about cost. FH advised that the company who supply the pump have provided intensive training and given a lot of support, free of charge, however the costing of the training programme has not been calculated. KQ advised that a Band 7 has been funded for each centre which is going to take this on. RINTAG suggested that the cost of the training should be included in the costings as part of the Business plan.	
15.	**Update on NIHRIO Workplan and Progress** **A Fisher – Verbal Report** AF gave an update on NIHRIO Workplan progress. Two conference calls have taken place, one to advise everyone what the aim of NIHRIO is and proposed timescales, the second call to provide an update on what NIHRIO had achieved so far. It is hopeful that the refined search will be available for the experts in the next two weeks. The group will meet face to face in York on the 9th November, and the project should conclude in January 2019. GO noted that it is a huge amount of work.	
16.	**Utilisation of Organs for Research RINTAG(18)33** **J Forsythe**	

	The ODT SMT agreed at their May 2018 meeting that there should be a monetary recognition of the resources needed to set up research studies. A fee of £300 per study was agreed. RINTAG noted and supported this proposal.	
17.	**3rd RINTAG Winter Meeting** To take place as a one-day event on 16 January 2019. In future years will be held jointly with BTS as a two-day event. GO asked that if anyone has any items they want to see on the Agenda to let him know. **NHSBT Organ Perfusion Meeting** JF advised that this taking place on the 31st October. The aim is to see how we might set targets for a strategy in the future. The companies involved in this area will present in the morning, followed by questions from the Faculty Panel. Plenty of time will be given for discussion. At the end of it, we should have more of an idea how to move this forward.	
18.	**Any Other Business** None	
	Date of Next Meeting: To be agreed	**HC to circulate invitation**