NHS BLOOD AND TRANSPLANT
ORGAN DONATION AND TRANSPLANTATION DIRECTORATE

THE TWENTY-FOURTH MEETING OF THE RETRIEVAL ADVISORY GROUP (FORMERLY NATIONAL RETRIEVAL GROUP) ON TUESDAY 29 SEPTEMBER 2020 FROM 10:30 UNTIL 1:30PM VIA MICROSOFT TEAMS

MINUTES

Present:

Ian Currie **(Chair)**	UK Clinical Lead for Organ Retrieval
Elijah Ablorsu	NORS lead, Abdominal, Cardiff
Aimen Amer	NORS lead, Abdominal, Newcastle
John Asher	Clinical Lead – Medical Informatics, ODT. NHSBT
Marius Berman	Associate Clinical Lead for Organ Retrieval
Andrew Butler	NORS lead, Abdominal, Addenbrookes
John Casey	Chair, Pancreas Advisory Group, Edinburgh
Philip Curry	NORS lead, Cardiothoracic, Glasgow
Rebecca Curtis	Statistics and Clinical Studies, NHSBT
Vijay Dhakshina	NORS lead, Abdominal, Leeds
John Dark	Newcastle University
Melissa D'Mello	Lay representative
Bimbi Fernando	BTS representative
John Forsythe	Medical Director, OTDT, NHSBT
Peter Friend	Chair, Multi Visceral Tissue Advisory Group, Oxford
Victoria Gauden	National Quality Manager, ODT, NHSBT
Dale Gardiner	National CLOD, NHSBT
Dan Harvey	National Lead for Innovation & Research in Organ Donation, NHSBT
Rachel Hogg	Statistics and Clinical Studies, NHSBT
Michael Hope	Abdominal Recipient Coordinator Representative
John Isaac	Deputy Chair, Liver Advisory Group
Lesley Logan	NHS Scotland
Debbie Macklam	Senior Commissioning Manager, NHSBT
Derek Manas	Clinical Governance Lead
Olive McGowan	Clinical Governance
Cecilia McIntyre	Retrieval and Transplant Project Lead Specialist
Vipin Mehta	Representing NORS lead, Abdominal, Manchester
Hynek Mergental	NORS lead, Abdominal, Birmingham
Majid Mukadam	Representing NORS lead, CT Birmingham
Lisa Mumford	Head of OTDT Studies, NSHBT
Gabriel Oniscu	Chair, RINTAG
Gavin Pettigrew	NORS lead, Abdominal, Addenbrookes
Theodora Pissanou	NORS lead, Abdominal, Royal Free
Rutger Ploeg	QUOD
Richard Quigley	Cardiothoracic Recipient Coordinator Representative
Karen Quinn	Assistant Director, UK Commissioning, NHSBT
Isabel Quiroga	NORS lead, Abdominal, Oxford
Nicky Ramsay	Cardiothoracic Perioperative Representative
Rommel Ravanan	Chair, Kidney Advisory Group
Susan Richards	Interim Head of Operations – Organ Donation and Nursing
Mark Roberts	Head of Commissioning Development, ODT, NHSBT
Jaques Roderick	Statistics and Clinical Studies, NHSBT

Marian Ryan	NORS Workforce Transformation Project Lead, ODT Commissioning
Karthik Santhanakrishnan	Representing NORS lead, Abdominal, Manchester
Avinash Sewpaul	NORS lead, Abdominal, Edinburgh
Afshin Tavakoli	NORS lead, Abdominal, Manchester
Douglas Thorburn	Chair, Liver Advisory Group
Chris Watson	Joint Chair, Novel Technology Implementation Group
Julie Whitney	Head of Service Delivery, ODT Hub, NHSBT

In Attendance:

Ms Hannah Westoby	Clinical and Support Services, ODT, NHSBT **(Minutes)**
Ms Caroline Robinson	Clinical and Support Services Manager, ODT, NHSBT

		ACTION
2.	**WELCOME, INTRODUCTION & APOLOGIES**	
	Apologies were received from Ayesha Ali, Chris Callaghan, Catherine Coyle, Liz Armstrong, John Stirling, Lisa Hodgson, Jayan Parameshwar, Craig Wheelans, Colin Wilson, Bart Zych and Hector Vilca-Melendez. Thanks were extended to Melissa D'Mello and Vicky Fox for their long service to the Retrieval Advisory Group. Thanks were also extended to Rebecca Curtis for her sterling work underpinning retrieval with statistical rigour and for being a very helpful colleague. Welcomes were extended to Rachel Hogg who has taken over from Rebecca Curtis, to Mr Avinash Sewpaul, NORS lead, Edinburgh and Mr Pradeep Kaul, NORS lead, Papworth. *It was noted that some papers in the agenda for this meeting contain sensitive data and are not to be shared on the NHSBT website or otherwise. These are marked as confidential.* *No declarations of interest were reported.*	
2.1	**ACCURACY AND FOLLOW UP OF PREVIOUS MINUTES AND ACTION POINTS OF THE RETRIEVAL ADVISORY GROUP**	
2.1	Minutes – The Minutes of the last RAG meeting on 31/3/2020 were approved with no amendments.	
2.2	Action Points - The Action Points from the previous meeting were updated as follows:	
AP1	**Training** - e-learning module. C Wilson has informed IC that the completion date of planned changes to the abdominal module are uncertain and will remain so. Update at next RAG.	**Ongoing** **IC**
AP2	**Training and Registration:** The issue of competence for retrieval of tissue was raised as HTA are likely to check. HTA module is required to be completed every year by all retrieval surgeons. Surgeons to have annual reminders to complete HTA modules – reminder to go out from NHSBT. However, surgeons and NORS leads **remain responsible** for their own updates. T&R has been updated to reflect this.	**Ongoing** **IC/VG**

	Action; IC/VG to ensure reminder email goes out annually to NORS Leads to prompt annual HTA module completion by all retrieving surgeons in May 2021 and annually thereafter.	
AP3	**Uterine Transplant:** This is currently suspended due to covid. *I Quiroga/L Armstrong*	**Ongoing**
AP4	**Bile Sampling in Organ Donors:** Mr S Fahid (Leeds) has proposed an addition to QUOD, allowing the collecting of bile in DBD donors. Mr Fahid will present updated technique to RAG at next meeting. **Action;** I Currie will follow up with S Fahid after RAG meeting on 30/9/2020 and will report back at the next meeting.	**Ongoing** **IC**
AP5	**Remote Imaging:** MB and IC to present findings of project should circumstances permit the project to commence *Marius Berman/Ian Currie* Action; IC/MB to update at next RAG in 2021	**Ongoing** **MB/IC**
AP6	**Super Urgent Liver group:** Group to re-convene to progress/implement changes in donation/retrieval process when the liver recipient is super-urgently listed - *IC to arrange meeting*	**Ongoing** **IC**
AP7	**Governance** 1. Organ sharing when organ is currently maintained on warm perfusion device. DM to take forward with liver centres and LAG to formalise arrangements. 2. Anti-coagulated donor where delay arose as a result of decision to give factors and check bloods. DM will circulate outcome document to NORS teams. Discussion with liver teams and agreed that the centres and trust will have to fund the transport and a gentleman's agreement to share the organ and all units agreed. **Action: D Manas agreed to circulate document on anti-coagulated donor to RAG.**	**D Manas**
AP8	**Pancreas damage** IC/JC to discuss how pancreas retrieval could be better supported to minimise damage to grafts. Have agreed to set up a pancreas retrieval cadaver session related to NRP and DCD hearts that is being set up in Edinburgh – plan to record images for NORS learning materials plus written material to try to support teams.	**IC/JC**
AP9	**Retrieval Injury FTWU:** Finalise and implement the revised damage scale and retrieval CUSUM for organ damage – Agenda item for this RAG	**DM/RC et al**
AP10	**Training and registration** Send updated T&R document to all NORS leads after RAG meeting on 30/9/2020.	**IC/HW**
AP11	NORS standards – items discussed at RAG 30.03.20 1. Develop structured action plan should the diagnosis of pregnancy be made during donor surgery (IC) 2. Expand wording around delays in retrieval if CT recipient is complex (IC) 3. Data to explore adverse outcomes (excessive transfusion, premature termination of NRP, organ loss when aNRP is being used and lungs are being retrieved; Data collection to support this (MB/IC)	**Revisions of NORS guidelines (IC has updated) and production of draft additions to guidelines for RAG Oct 20**

	4. DG to circulate NODC paper which describes action plan if donor heart should re-start in DCD retrieval (DG); IC to prepare document for retrieval teams in this situation (IC) 5. "A" form signatures and delayed organ departure. IC and Melissa D'Mello to take forward and agree how this should be done (IC, MD'M) then to pass finalised approach to OMcG/DM 6. Late declines where WLST has already occurred; and equivalent/subsequent stages in DCD/DBD surgery; wording to change so that surgery/packing may continue until all organs declined for clinical use and permitted research (IC)	
4.	**OTDT MEDICAL DIRECTOR'S UPDATE** JF expressed thank you to the retrieval community represented on today's call and to the rest of the teams. We were able to continue transplantation for those who were most urgent on the transplant list during the COVID-19 pandemic, which showed incredible teamwork. • During July 2020 (across the whole of donation and transplantation), there were 128 donors and 318 transplants were performed. This was the busiest July in a decade. • 5 paediatric DCD hearts retrieved during this time – outstanding contribution to paediatric heart transplant • The latest COVID bulletin contained a link to help identify signs of a second COVID surge (https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/19870/covid-19-bulletin-22-24092020.pdf) • JF noted that some of the organ donations could be due to the rise in good feelings towards the NHS during the COVID outbreak but not to rely on this for the imminent second wave. • He also commented that the opt-out media coverage has made the public more aware	
5.	**Update from Advisory Group Chairs** • Multi-visceral • Cardiothoracic • Kidney • Liver • Pancreas	
6 **6.1**	**CLINICAL GOVERNANCE** OMcG advised members that RAG are to note the findings in the confidential report **(Paper 6)** and to discuss within teams. Some reports are still under investigation but have significant learning issues identified already. 4977 Lungs declined when ANRP was to be used, as lung recipient team wished to retrieve lungs prior to start of NRP. Still under investigation. Response was the circulation of the national DCD heart/lung retrieval protocol (+/- NRP) and re-iteration of the widespread acceptance of the protocol. 4791 A heart was returned to the body, but was later stated to be absent from the chest during a post-mortem examination.	

	Family very upset by this. Although there is no reason to suppose the heart was not returned to the body, there was no contemporaneous documentation. **The surgeon who removes an organ which is not ultimately for retrieval must replace it in the body and must record this.** A letter was circulated. Discussion as to the underlying possibilities - heart could be distant from where it would normally be, post retrieval. Have to remove heart first to do this safely for lungs. No evidence of wrong-doing but the documentation aspect is essential. 4641 Paediatric kidneys retrieved. Ureter cut very short. Awareness that paediatric kidneys (donor <20kg) should be **retrieved with a cuff of bladder** to facilitate implant.	
	Action; Abdominal NORS leads are requested to highlight this with retrieving surgeons.	**Abdominal NORS Leads**
	…….	
6.2	D Manas made RAG aware that **failure to go through standard governance portal** (NHSBT OTDT website) when submitting clinical governance reports made follow up of such matters much more difficult. **Please use portal.**	
	……..	
6.3	**Organ photography** is strongly supported in communicating organ quality to recipient centres. A photograph in the above situation would have been invaluable for planning, and for later learning. Anonymised imaging is supported for all organs. Occasionally there is a lack of understanding that photography is approved. Recommended views for kidney and pancreas have been authorised by KAG and PAG.	
	Action – OMcG to circulate SNODs as regards NHSBT support for anonymised organ photography.	**OMcG**
	Action - IC to ask KAG and PAG to provide brief documentation as regards recommended views, for circulation to NORS teams	**IC**
6.4	**Small bowel and pancreas offering** A clinical governance event occurred when pancreas was accepted in the same donor where small bowel was later accepted and retrieved. A small bowel donor cannot also be a pancreas donor. It is likely that the Hub documentation does not include detail in this situation, therefore Hub staff were not aware that a pancreas offer would have to be withdrawn if the small bowel is actually retrieved.	
	Action – IC/JW to agree an amendment to HUB documentation such that the above scenario is managed	**IC/JW**

	appropriately, whether small bowel is offered and accepted or whether later declined.	
7. **7.1** **7.2**	**RETRIEVAL DAMAGE** Organ Damage report RC thanked IC for his kind words at the beginning of the meeting. RC highlighted the main points from the organ damage report and stated that each of the retrieval teams would have received information each month on damage and this would have been discussed at the NORS contract review meetings. Section 1 – Analysis of 1 April 2016 to 31 March 2020. Newcastle and Glasgow had particularly low rates of organ damage and they are to be commended for this. Kings had a difficult year last year but now have decreasing damage rates especially for pancreas. **Actions to take; D Manas and I Currie to discuss proposal to meet with all NORS leads on a six-monthly basis to discuss the damage rates and how to improve these.** **Updated Retrieval Team Information form** RC and IC introduced the proposed changes to the RTI form which were compiled by the organ damage fixed term working group, and drew attention to section 3 on the form *(NB, this example form is draft only - not to be used).* The changes were suggested better to reflect the relative levels of organ injury. 0. No effect/No damage. Damage is not relevant if it is decided not to use the organ 1. Mild effect. Damage present but organ can be repaired for transplant 2. Moderate Effect. Damage significant and may contribute with other factors to a decision not to use the organ. 3. Severe Effect. Damage is severe and would be sufficient in isolation to result in decline for clinical transplantation. The organ could have been used if no damage was present. RC informed members that there will be a similar change made to the HTA-B forms. In addition, a modification has been added to reflect retrieval of the heart : 1 - No, 2 - Yes for heart tx, 3 - yes, for tissue. Timelines for introduction of upgrades are uncertain but early 2021 is planned. Communications will go out when this is to happen. These changes will improve the quality of injury data and will be used to produce CUSUMs. Acknowledgement was made of the considerable volume of work John Asher had undertaken in past years relating to data collection and organ injury grading.	 **DM/IC**

	Thanks were extended to the working group: Isabel Quiroga, Derek Manas, Ian Currie, Mark Roberts, Marius Berman, Rachel Johnson and Chris Callaghan. There will be further amendments made to the RTI form in future, these are more extensive and require a larger amount of IT work. The RAG membership will be involved in such upgrades.	
7.3	**Retrieval damage CUSUM (verbal)** The changes to the organ damage wording on the HTA-B form will enable future production of damage CUSUMs. If an organ is marked as severely damaged this will be an event. A national baseline will be derived, after which team CUSUMs will be constructed.	
8 **8.1**	**NRP** **UK Funding of NRP Business Case** D Macklam advised members that a response has not been received from DHSC at this stage, however, Scotland, Wales and Northern Ireland have all come back with a positive response.	
8.2	**ANRP Steering Group** The ANRP Steering Group is a new endeavour to re-invigorate NRP for potential implementation. Chris Watson is the Chair. Part of the remit is to review and refresh the business case to go forward to the DHSC. It was noted that the invite letters have gone out for this group and the first meeting is set to be in early November. CW will be reporting back at the next RAG meeting.	
9. **9.1**	**Research and Development** **QUOD update** RP advised that Sandrine Rendel had moved onto another post and that Sarah Cross has taken over. He extended thanks to Liz Armstrong, Clare Denison and Maggie Stevenson for their help in resuming QUOD at the end of July after the pause in operations. He also extended thanks to NORS teams. The restart will take place in Scotland in October.	
9.2	**PITHIA Update** PITHIA is currently suspended and advice at the moment is that it won't restart till March 2021.	
9.3	**Transplant and Research Development Delivery; Team Update** VG advised that the INOAR go-live date has been moved to 13 January 2021, allowing approximately 8 weeks of training for the operational teams including the Specialist Nurses for Organ Donation along with HUB operations. Details will be sent round to NORS teams in due course. Project team scheduled in November.	**VG to circulate INOAR details prior to launch**

	Consideration was given to going live earlier but the pressure on operations of COVID and level of change impacted this. D Manas advised that in April 2020, SMT agreed the establishment of a working group to explore options and identify strategies to ensure that there is an out-of-hours access to a sustainable and cost-effective histopathology service to support organ donation and transplantation. A steering group has been established and met in July 2020 to identify options for consideration and hoping to come back with solutions by the end of December 2020. It will be reported back at the next RAG meeting in March 2021.	**D Manas to report on Histopath Group findings at RAG in Spring 2021.**
10.	**Blue light Group update** M Roberts advised that the DfT has asked them for more detailed analysis of blue light usage. This has been worked on with a small group of IT staff within NHSBT, which is establishing how the data can be collected and analysed on a weekly basis from transport providers. A draft analysis document will be produced by end of 2020. Once this has all been completed it is hoped to have a meeting with DfT and to report back at the next RAG meeting in March 2021.	**MR to produce draft analysis document.**
11.	**Masterclass** IQ advised that the virtual masterclass will be on 16, 17 and 18 December 2020 (later revised to 14-16th Dec). As it will be done virtually there is an opportunity to expand the programme and less restrictive in the number of delegates that can sign up. The programme will be supported by the Royal College of Physicians (Edinburgh) providing the technology and will be able to include live plenary sessions, recorded sessions and break-out rooms. There will be more sessions including some on novel technologies. Details will be circulated to teams in due course on how to sign up. The programme is currently being finalised along with the costings for the masterclass. **Thanks were extended to Isabel Quiroga and Rutger Ploeg in implementing the programme for this event.**	
12.	**National DCD heart program – update** The DCD heart retrieval programme started on 7th September 2020, and one transplant has taken place so far, and the recipient is recovering well.	
13.	**Outcomes in abdominal NRP with and without cardiothoracic retrieval (please note this information is confidential)** CW presented the Cambridge experience of NRP when a cardiothoracic team attends. Of 119 NRP cases, 68 occurred without a cardiothoracic team and 51 with a cardiothoracic team recovering either lung or heart or both. Non-cardiothoracic donors were a median 17 years older, and more likely to be non-traumatic deaths. The NRP process used a median 2 units (IQR 1 to 4) of blood when abdominal alone, 6 units (IQR 4 to 8) when a thoracic team attended. Early liver function was poorer with 18% early allograft	

	dysfunction when a thoracic team attended and 11% when no thoracic team attended (Olthoff criteria). These data confirm that despite the substantial expansion in transplantable organs which novel technologies bring, there are significant challenges for combined retrievals. The future is novel technology for cardiothoracic and abdominal teams, and teams need to make it work.	
14.	**Donor Statin Study (papers were circulated)** This Study has been previously approved at CTAG Hearts (28 September 2020). **Please note this information is confidential.** Members viewed a presentation by J Dark (being shown at all Advisory Groups), outlining the SIGNET Study, envisaged to start in April 2021 for a period of 4 years. Donor family consent will be required for donation and research. All potential recipients will receive information about the study, with a description of the potential benefits - there will be no perceived risk so no consent will be required by recipients. No additional data or samples are required from recipients. This will be the largest donation intervention study in the world. The following were confirmed: • Simvastatin 80mg given as a single dose is a safe drug to use with no measurable amount transferred to the recipient. The delay between consent and retrieval is usually around 24 hours, so by the time the organ has been flushed and on ice, essentially no drug will be present • A mechanistic study will be submitted for funding in November which is going to look at the time between brain death and administration. The effectiveness of the drug will also be examined in donors with hyperinflammatory features • The research teams were heavily involved in the study design, together with the Clinical Trials Unit, and funding has also been achieved for the SNODs through the NIHR • Biopsies for the mechanistic study will go via the QUOD route • In addition, the study will be examining organ utilisation As this Study will last for 4 years, JD confirmed that he would be happy for donors to take part in parallel studies (eg. PITHIA study), and there will be no problem with co-recruitment.	
15.	**Human Tissue (Scotland) (Authorisation) Act 2019: implication for teams retrieving in Scotland (opt-out legislation 2021)** L Logan presented updates regarding opt out as introduced in the Human Tissue Authorisation (Scotland) Act 2019. Opt out legislation will be implemented early in 2021. The training will take place for Scottish teams during November 2020 until 1 March 2021. As any UK team may retrieve in Scotland, all UK	**All NORS team members to complete online learning for opt-out in Scotland prior to end March 2021.**

	NORS team members to complete the online training. Opt-out Implementation date: 26 March 2021.	**IC/L Logan to circulate online web address when available.**
16. **16.1** **16.2** **16.3**	**Workforce sustainability group (confidential reports)** Interim report. IC outlined the setup of the workforce sustainability group after national meetings amongst the abdominal and cardiothoracic retrieval community's workforce planning and sustainability meetings in 2019. The meetings highlighted differences in working practice across the units and the common strengths and weaknesses seen in different services. Two surveys were completed, one for perioperative staff only and the second for all staff groups. Very high return rate of surveys. Survey 2019; Perioperative Staff. A number of reassuring findings, including staff very likely to stay in the job in the next 3 years, despite perceptions of dissatisfaction and turnover. Survey 2020: All Staff. These were circulated before Covid-19. Feedback was generally positive, although comments were made about long waits in hospitals, no food on arrival, lack of predictable workload, long distance travelling with regular exposure to unfamiliar environments in the donor hospital during unsocial hours. IC encouraged members to read through the surveys at their leisure and to share with own teams. There was a short discussion that followed, and it was suggested that a short survey could be produced now to ask teams on how they feel at the present time with the 2nd wave of Covid imminent. A 2nd survey was discussed to assess effects of COVID. DG mentioned that he was planning on writing to Organ Donation Committees to gather information on how best to approach the issues of food availability at donor hospitals for teams amongst other issues.	**DManas/IC to discuss 2nd survey.** **DG and IC to discuss possible letter to Organ Donation Committees.**
17. **17.1**	**A form update** Although it is proposed to have electronic A forms in the fullness of time, a number of patient safety issues have been identified which require updates to the paper forms as an interim measure. PDFs of the modified A forms were circulated with the meeting papers.	

	Forms capture whether biopsies were taken, and if so what type of biopsy. Also whether NRP or other machine perfusion was used. Time of kidney removed from body as an omission was noted by JA. RR noted that adding this in may cause further delay. CW asked if some older preservation solutions should be removed and newer ones, such as IGL 1, added.	
17.2	**Signatures and delayed departure – mitigation** It has now been irrevocably accepted that a NORS team member may sign for the surgeon to expedite organ departure. The surgeon remains responsible for the content of the A forms and should ensure that the content is correct before directing the team member to sign.	
18.	**Recommended actions if heart re-starts during DCD retrieval** IC introduced the item and thanked DG and NODC for their input. It was noted that heart restarting in DCD organ retrieval is extremely rare. It has only occurred in the setting of DCD lung retrieval. It could theoretically occur if an abdominal aortic clamp has not been applied correctly in NRP donors. (In TANRP it would occur routinely but only after division of all arch vessels) IC to update document according to comments received from the group via email (re crash-call an anaesthetist in this setting, and the NORS team to stand back and wait for the ICU/anaesthetist to manage patient). May need to ask for coroners'/Fiscals' view. Share the document as best practice within NORS teams once agreed.	
19.	**Recommended actions if pregnancy is diagnosed during retrieval** IC and DG prepared the document and confirmed that it had not gone to any advisory group at this point. It has been agreed to take the paper to NODC for further discussion. If there are any comments please send them to DG and IC.	
20.	**Super urgent liver group – progress update:** JW; Expecting implementation in next few weeks. For now, if undue time is passing due to offering when super-urgent is waiting, then escalate on a case by case basis with the regional manager. Safety nets in process whilst this work is completed.	
21. **21.1**	**Pathway intelligence group (confidential data)** Pathway timings IC introduced the item. Group comprised SNODs, CLODs and a few surgeons to look at what is happening in the donation/retrieval pathway, and why we are transplanting complex liver recipients at night for example. Data presented and shared runs up to start of offering. The data will need to be extracted further to look at post-offering timings. This will be further discussed further at the next Retrieval Advisory Group in March 2021.	

21.2	FICE –When cardiothoracic organs are offered, the pathway is longer. One of the particular issues is the availability of echocardiography in various units so it was discussed at CTAG Hearts on 28/9/2020 and ideally should try and obtain a transthoracic echo. FICE (Focussed Intensive Care Echo) could be used to assess the heart in ITU. National committee that monitors and accredits the training for FICE. FICE is widely available in the ITU community and may help with cardiac assessment, but it is not the same as TTE. Antonio Rubino (regional CLOD) is working on this and will keep the group updated – for Agenda, RAG, March 2021.	
22.	**SherpaPak:** Not covered in the meeting due to time constraints.	
23.	**Imaging at retrieval – CT** Not covered in the meeting due to time constraints.	
24.	**NHSBT fellow update -** Not covered in the meeting due to time constraints.	
25.	**Moment of Honour** IC advised that at donor surgery that there may be a moment of silence and thanks to the donor. Some members of the retrieval team are very uncomfortable during this moment and have asked if this can be an optional, after retrieval surgery and not before. It relates to the very different roles and tasks that donation staff (SNOD, ITU) and retrieval staff (surgical team) are required to perform. The moment of honour originated in the donation team. DG mentioned that this is a topic for discussion at the next congress meeting. There are strong feelings both ways on this. What is clear, if there is to be a moment of honour, is that team members who do not wish to participate must not feel 'judged' for declining to do so, nor should they find themselves part of it by default. It was suggested that RAG members could email DG/IC to share their opinions.	
26.	**IT report for information**	
27	**AOB**	
28.	**Date of Next Meeting:** Tuesday 30 March 2021, 9.30am – 2.30pm via Microsoft teams Tuesday 28 September 2021, 10.30am – 3pm	