NHS BLOOD AND TRANSPLANT
ORGAN AND TISSUE DONATION AND TRANSPLANTATION DIRECTORATE

THE TWENTY-NINTH MEETING OF THE MULTI-VISCERAL AND COMPOSITE TISSUE ADVISORY GROUP MEETING
AT 10:30 AM ON THURSDAY 5 DECEMBER 2024
VIA MICROSOFT TEAMS

Present

Andrew Butler	**Chair MCTAG /** Cambridge University Hospitals
Philip Allan	Oxford Intestinal Transplant Centre
Richard Baker	Associate Medical Director – Governance, NHSBT
Carly Bambridge	Clinical Nurse Specialist, Paediatric Intestinal Transplant, King's College Hospital
Sarah Brown	Consultant Physician, Kings College Hospital
Gemma Brewin	BSHI Rep
Emilio Canovai	Oxford Transplant Centre
Kim Corbey	Recipient Co-ordinator, Oxford
Miriam Cortes Cerisuelo	Consultant Transplant Surgeon, King's College Hospital
Tim Court	Lay Member, MCTAG
Samantha Duncan	Recipient Co-Ordinator Rep, Addenbrookes
Girish Gupte	Consultant Paediatric Hepatologist, Birmingham
Susan Hill	Paediatric Gastroenterologist / BSPGHAN
Jonathan Hind	King's College Hospital
Maria Jacobs	Statistics and Clinical Research, NHSBT
Simon Kay	Composite Tissue Rep, Leeds Hand Transplant UK
Derek Manas	OTDT Medical Director, NHSBT
Isabel Quiroga	Oxford Intestinal Transplant Centre
Charlotte Rutter	Cambridge University Hospitals NHS Foundation Trust / BAPEN
Tahir Shah	Consultant Transplant Physician, QEH, Birmingham
Rhiannon Taylor	Statistics and Clinical Research, NHSBT
Hector Vilca Melendez	Consultant Liver & Intestinal Transplant Surgeon, Birmingham
Sarah Watson	NHS England
Julie Whitney	Head of Service Delivery, OTDT Hub, NHSBT

In attendance

Caroline Robinson	Advisory Group Support, NHSBT (Minutes)

Item		Action
1	**Welcome and Apologies**	
	• A Butler welcomed all to the meeting. • Apologies were received from Ayesha Ali, Varuna Aluvihare, Marius Berman, Suzi Browne, Chris Callaghan, Gordon Crowe, Ian Currie, Khalid Sharif, Sanjay Sinha, Craig Wheelans, Anthony Wrigley	
2.	**Declaration of interest in relation to the agenda**	
	• There were no declarations of interest at the meeting. • The agenda, Minutes and papers from this meeting will be added to www.odt.nhs.uk Authors of any papers that should not go on this website should identify these as soon as possible.	
3.	**Minutes and Action Points of the MCTAG meeting held on 5 June 2024**	

3.1	Accuracy - **MCTAG(M)(24)01** – No changes are recorded for the Minutes of the last meeting on 5 June 2024 which are now approved.	
3.2	Action Points - **MCTAG(AP)(24)01**	
3.2.1 AP1	Governance – A trial re estimation tools to compare estimated and actual donor weights was discussed at the last meeting. Transfer of CT images across the UK was highlighted and is also being discussed in CTAG. D Manas to discuss this with W Akhtar (who has been developing this for CTAG) and a working group will be set up next year and L Ellis-Morgan.	**ONGOING D Manas**
3.2.2 AP2	Patient survival after intestinal transplantation - It was previously agreed a decision was needed on minimum criteria for data collection from all centres on patients who return to PN post-transplant to determine irreversibility to ensure all patients are captured by the proposal. All 4 centres agree definition of graft failure is 1 explant being re-listed for re-transplant if there is irreversible graft dysfunction, explant or listing for re-transplant will be the option where there are medical reasons or immunological reasons or patient factors that prevent this from happening. No time period for this was decided. Agreed that A Butler will work with P Allen to write a policy document for this.	**ONGOING A Butler / P Allan**
3.2.3 AP3	M&F Proposal – Potential funding for film (Transplant TV) – E Canovai, C Bambridge, S Hill and L Hogg will form a working group alongside D Manas to explore working with Transplant TV to create videos for intestinal transplant. Examples of work that is available can be found at TTV Homepage - Transplant TV	**ONGOING D Manas / E Canovai / C Bambridge / S Hill / L Hogg**
3.2.4 AP4	Potential funding for film (Transplant TV) – Educational information – It was agreed that this would be an annual event and inclusion of both adult and paediatric patient stories is important. It was also agreed to include upper limb transplantation in this work.	**ONGOING D Manas / E Canovai / C Bambridge / S Hill / L Hogg**
3.2.5 AP5	Clinical Governance **–** There is lack of clarity of how rectus fascia or an abdominal wall transplant is recorded on the HTA A form or whether an additional box should be added to the form. R Baker will chase the recording of rectus fascia on the HTA A form with I Currie and M Berman. If change is agreed this will be a manual change initially.	**ONGOING R Baker**
3.2.6 AP6	Summary from Statistics and Clinical Research – It was agreed that A Butler would attend the PREM group formed at NHSBT	**ONGOING A Butler**
3.2.7 AP7	Performance report of the National Bowel Allocation Scheme (NBAS) – FOEDUS - The status of Group One patients referred from the EU now that the UK is no longer a member is still unclear and decisions have to be made on a case-by-case basis. Treatment is based on residency and if a patient is in the UK as a non-resident they have to be treated as an emergency. Where there are special circumstances, an appeal would have to be made to prioritise our patients across the whole of Europe. D Manas would need to go to other countries and seek agreement and support for this. S Watson also to respond to D Manas on this issue.	**ONGOING D Manas / S Watson**
3.2.8 AP8	Discussion re: potential changes to allocation policy – A separate working group is discussing any changes and will report to the next MCTAG meeting.	**ONGOING A Butler**
3.2.9 AP9	Summary from Statistics and Clinical Research - The meeting agreed that ethnic minorities information and geographical inequality/proximity to the transplant centre and its effect on access to transplant should be included in the report. Agreed that	**ONGOING S Duncan / K Corbey / R Taylor**

	S Duncan and K Corbey will work on this with R Taylor and the disparity in regions will be discussed outside the meeting.	
3.2.10 AP10	Patient Survival after Intestinal Transplantation – potential further subdivisions in future reports (malignancy v. non malignancy) - The previous meeting noted the fall in survival beyond 5 years and it was agreed more information on what has been included in the calculations is needed. A paper will be presented at the Spring MCTAG meeting.	**ONGOING R Taylor / M Jacobs**
3.2.11 AP11	Limb Transplantation – *See Item 10.2*	**COMPLETE**
3.2.12 AP12	Forward with NRP in DCD Donors. Developing a Strategy and Actions - Paediatric units need to align with an NRP unit. DCD needs to be removed as a contraindication so it can align with adult NRP. A Working Group will be formed to decide how to proceed and a change control will be needed. **ACTION: Birmingham to find person to chair with G Gupte helping initially.**	**ONGOING G Gupte**
3.2.13 AP13	Access to Super Urgent Liver Transplants Post Intestinal Transplantation – A Fixed Term Working Group is exploring this and has now met twice). The next meeting will be in January.	**COMPLETE**
3.2.14 AP14	Potential Routine Inclusion of Contrast Enhanced CT scan in Donor Characterisation **-** The issue of having to move patients from ITU to take the CT scan was raised. *See Item 16*	**COMPLETE**
3.2.15 AP15	Discussion Relating to Data Set for UK Reporting – *See Item 17*	**COMPLETE**
3.2.16 AP16	Quality of Life Working Group: data collection – *See Item 18.1*	**COMPLETE**
3.2.17 AP17	Adequacy of Psychological Support for Patients Undergoing MV Transplantation – *See Item 20*	**COMPLETE**
3.2.18 AP18	Multicentre Collaborative Studies and Research – *See Item 21*	**COMPLETE**
3.3	Matters Arising – NAD	
4.	**Web information on intestinal and multi-visceral transplantation on the new NHSBT website for patients - https://www.nhsbt.nhs.uk/organ-transplantation/**	
	This work to ensure there is web information on intestinal and multi-visceral transplantation on the NHSBT website is ongoing with C Callaghan. The information is consistent with other organ groups and has been forwarded for consideration. To date it has been set up from the adult patient perspective, but this now needs paediatric input as well. **ACTION: C Callaghan to pass around for MCTAG members to comment**	**C Callaghan**
5.	**Medical Director's Report 2:15**	
5.1	D Manas gave an update on recent developments: New appointments – • Gareth Jones has now taken over from R Ravanan as KAG Chair. • A Ranasinghe becomes the new Chair of CTAG Hearts. • Following David Briggs' retirement there will be a new appointment for H&I. • There will be a new Lead CLU following D Garcia-Saez' decision to step down. V Gerovasili has agreed to be interim lead CLU. R & D -	**A Butler**

	• This group replaces RINTAG has now had its first meeting. Any studies to go forward need to go the Operational Feasibility Group. An Environmental Sustainability Group chaired by Matt Wellberry-Smith links into the Advisory Groups and their Chairs. **ACTION: MCTAG member needed for this group** Finance - • Funding for several projects have been requested from DHSE. These include a request to have DCD Hearts and NRP included in sustainable funding. • CLU funding comes to an end in the middle of next year. N Inston will take over leadership of the programme from C Callaghan. • The £IM funding for NRP has now been been allocated. This is for education and cannot be used for staffing. Most centres should have received some of this money to help develop their services. • Histopathology - The interim plan is nearly finalised, and this will help to fund pathologists. Other Developments - • NLOS review – this is progressing. A stakeholder meeting will be held on 23 January 2025. **ACTION: MCTAG representation is needed at this event**. • OUG recommendations – although this is not funded, the work on the 12 recommendations is being done by the Medical Director's' team. A Transplant Oversight Group (TOG) has been set up to look proactively at outcomes and more engagement is planned with centres. • EVLP has started at Papworth as a service evaluation. • The ARCs proposal has been put forward and a decision re: funding is expected in April. • ISOU – Groups covering trust engagement, H&I, ARCs and patient engagement will report soon. • The Renal Collaborative will meet on Monday 9 December in London. A Liver Collaborative meeting will also be established. • The PAG Islet Summit will meet on Tuesday 10 December. This follows the King's lab being down for a year highlighting some of the issues there are with islet isolation. • Consent – this remains problematic at around 61%. A summit will take place in March to try and understand why this is and how it can be improved. • HHV8 – SaBTO has agreed to continue screening. About 2000 donors have been screened with 7 transmissions mostly through the liver. More resource has been requested to support I Ushiro-Lumb in this work.	
5.2	SCORE **MCTAG(24)09** – J Whitney gave an update on the SCORE programme and information about the programme was circulated prior to the meeting. Current issues in the programme include: • Fast as possible model removes all planning in the system. • No oversight of activity results in deployment of resources being reactive rather than planned.	

	• No predictability in the system results in delays, particularly at retrieval. • Complex implant surgery takes place out of hours. • Decisions on organ offers take place in the middle of the night and these decisions are often reversed during the day. SCORE aims to introduce certainty and greater sustainability into the service. The planned workstreams include: • Donation window – a move to daytime offering of organs • NORS Model Workstream – A PAW is proposed to improved predictability of retrieval times, reduced travel times are likely through better allocation of resources and fewer delays in accessing theatres is anticipated; current data indicates there are more delays in the daytime. The modelling is based on one retrieval per night. • Transplant Centres – Daytime offering should result in improved decision making and organ acceptances. There should be increased certainty that organs will arrive in the daytime and transplants will take place at optimal times for surgeons and recipients. • Support Services – There should be increased time to plan and support resources. Increased certainty also ensures improved access to labs. Centres need to consider: • Offering and arrival windows of 08:00-13:00 and 13:00-15:00 • How offers will be managed and surgical/medical input into this. • How theatre access will be managed and whether this can improve wasted holding of a theatre. Centres may wish to consider an audit and whether machine perfusion can help. Inclusion of regional networks in this is suggested. Roadshows are planned at each transplant centre and multi-visceral teams are asked to attend these along with trust management. A clinical person will work within the Hub to help with this workload and particularly with ensuring PACs images reach recipient centres in daytime. The digital workstream is also now underway. **ACTION: MCTAG rep required to join this and other workstreams.** It was agreed that the work will be much appreciated especially by donor families. It was suggested that drivers and condensing driving time needs to be considered to reach the new timescales and use of commercial flights could perhaps be an option. Queries about SCORE can be sent to SCORE@nhsbt.nhs.uk	
6.	**Clinical Governance Report for MCTAG – MCTAG(24)10**	
	This paper was circulated prior to the meeting. The following items were highlighted: • The Clinical Governance Team has now been re-named 'Patient Safety'. • There are around 50 incidents per month, but there is nothing specific to bring up for this meeting. • A link to 'Cautionary Tales' which came out in September can be found in the paper.	
6.1	Traceability of rectus fascia flowchart – *See also Item 3.2.5*	**R Baker**

	ACTION: R Baker will report back on this at a future meeting.	
7.	**OTDT Hub Update**	
	Centres are asked to request planes for retrieval with caution where possible due to unavailability of both pilots and flights.	
8.	**Summary from Statistics and Clinical Research – MCTAG(24)11**	
	• The annual report was published this Summer. • A new NHSBT fellow will be working on NRP utilisation.	
8.1	Follow-up form return rates **– MCTAG(24)12** – The paper circulated shows return rates for forms issued between 1 October 2019 and 30 September 2024 for both adult and paediatric deceased donor intestinal transplants in the UK. Adults: • Between 1 October 2024 to 30 September 2024 overall form return rate for the 1-year follow form was 100%. • Overall return rate for the lifetime follow-up forms (≥ 2 years) was 98%. Paediatrics: • For paediatric patients, overall form return rate for the 1-year form was 78%. • Overall form return rate for lifetime follow up forms was 84%. • Overall transplant record form return rate was 43% with 20% return rate at King's. Centres are asked to ensure follow-up is up-to-date to enable accurate monitoring of intestine transplantation.	
8.2	Potential infographics for bowel transplants to see on website – **MCTAG(24)13** – These infographics were circulated prior to the meeting and will be updated annually. All information is from the organ specific reports, the annual report and intestinal transplantation and focuses on adults as this is what happens in other organs. • It was noted that it would be good to include paediatric transplants in future infographics to ensure patients and their families have as much information as possible. • This is currently in draft and following approval by MCTAG will be published online. • It does not include malignant v. non-malignant as this is currently only presented in post-transplant survival. • It was suggested that the word 'elective' is changed to 'waiting list' but it was noted this could cause confusion as patients may also be on the super urgent intestinal list. • It was stressed that consistency with other organ infographics was desirable, but changing the details to include other information would be possible.	
9.	**Update on Current Situation Relating to Composite Tissue Transplants**	
9.1	Uterine Transplantation – I Quiroga gave an update: • This collaboration between Imperial College and Oxford has a living and deceased programme. The first transplant took place in February 2023 and since then, there have been 3 more deceased DBD transplants in Sept 2023, January 2024 and June 2024. • Campath and tacrolimus mycophenolate are used. No steroids are used. There is a change in	

	immunosuppression at 3 months as Mycophenolate MMF is teratogenic. Patients are on azathioprine during pregnancy. • To date there have been no failures. There has been one mild rejection. There has been DSA conversion on one patient not associated with rejection on any biopsy. One patient has a viral infection of the cervix with an, as yet, unknown pathogen. There has been one miscarriage early in the pregnancy and 2 failed embryo transfers. • One pregnancy is ongoing. • Some women originally on the programme have since opted for surrogacy. There are 9 patients now waiting. The main barrier to listing is IVF as progress depends on local funding of only one cycle, Embryos also need to be suitable for transplant. If a patient has no uterus or there is uterine infertility, there is no funding. • Many women have contacted the charity Womb Transplant UK offering to be living donors and talks are ongoing to move forward with this. • The Midlands is now included as a retrieval area with South Central. • Surgical availability is an issue, and it can be difficult to negotiate delays with donors. These cases need to be escalated to the on-call manager so that a manual change can be negotiated. **ACTION: A Wrigley to be asked to contribute to a piece of work regarding funding (transplants, IVF and surrogacy)**	**A Butler/ A Wrigley**
9.2	Limb Transplantation – **MCTAG(24)19** – S Kay gave the following update: • To date, there have been no Hand and Upper Limb Transplants (HAUL) in 2024. Clinics and MDTs, along with aftercare of transplanted patients, continues routinely as does recruitment of new patients. • In 2025 there will be 7 patients awaiting transplantation across the whole UK. • It is hoped a new plastic surgeon (Mr David Leonard) will join the team. He gained his experience at the Transplantation Biology Research Center in Boston, USA. • Clinics include rehabilitation of physicians and prosthetists to ensure all options are exhausted prior to transplantation. • Recruitment of donors is problematic. Aside from poor physical or immunological mismatch and consent issues, hands can also be regarded as evidence if a donor is victim of assault. Bilateral transplantation also requires 4 surgical teams. • Consent particularly is a concern. Feedback states that a key issue is the disfiguring nature of the donation (despite prosthetic replacement of limbs). It is also perceived that this donation is not 'life saving' in the same way organ donation is as prothesis is perhaps viewed as a good alternative. The message to donor families should be the 'life-changing' nature donation has as limb amputation can be so devastating. • Waiting times are lengthy as indicated in the paper circulated. The Leeds unit has good relationships with	

	centres in Lyon and Philadelphia where waits are considerably less at around 4 months. The hope is that waiting times in the UK can be similarly reduced. • MCTAG members were recommended to listen to podcasts produced at Leeds regarding upper limb transplants called 'In Safe Hands' and to cascade this information to other team members. Podcasts are available from the usual podcast outlets and on the following link **https://podfollow.com/in-safe-hands** **ACTION: DMM to invite SK to the Consent Summit planned for March 2025.**	**D Manas/ S Kay**
9.3	Update on Current Situation Relating to Composite Tissue Transplants - An update on Sentinel skin flaps - In H Giele's absence this was not discussed.	
10.	**Moving Forward with NRP in DCD Donors. Developing a Strategy and Actions**	
	See Item 3.2.12	
11.	**Potential Bowel Donors – MCTAG(24)15**	
	This paper was circulated prior to the meeting. Since 1 November 2021, potential DBD donors aged <60 years and weighing <90 kg are considered for bowel donation. Potential bowel donors were defined as DBD donors who donated at least one solid organ for the purpose of transplantation, who met the criteria and whose family gave consent for bowel donation. Results are shown in the paper. It was noted: • Ideal donors are <50kg • Virology issues (EBV and CMV) are a major reason for decline which differs from other organs. • The reduction in DBD offers and increase in DCD is impacting both paediatric liver and bowel donation. Less brain stem testing and increased neuro testing alongside ICU issues has an impact on offers. • Paediatric offers in the last year were particularly poor with minimal offers. At King's 4 children have died on the waiting list (2 in the last month) quite often needing a multi-visceral transplant in the weight range of 8-12 kg. • It was suggested that doing reductions in the donor at the time of retrieval might minimise cold ischaemia time. However, these grafts often don't work well in children.	
12.	**National Bowel Allocation**	
12.1	Performance Report of the National Bowel Offering Scheme – **MCTAG(24)16** – This paper was circulated prior to the meeting. The move away from DBD to more DCD donors will affect the figures that are recorded. This trend is likely to continue and therefore a smaller pool of DBD organs is likely in future. New neurological testing criteria are coming through, and it is hoped these will address some of the red flags that have come up. While the trend is worrying there may be some reversal by this time next year.	
12.2	Discussion re: potential changes to allocation policy – A fixed term working group, chaired by R Ravanan will look at allocation policy. R Ravanan will be in contact re participation of MCTAG members and a report will follow at the next MCTAG meeting.	
12.3	Threshold for Kidney Allocation – The current threshold for kidney allocation is 45 ml per minute from eGFR perspective which is higher	

	than for any other combination of organs. Gareth Jones, the new Chair of the Kidney Advisory Group (KAG) will be part of the discussions around the changes to the allocation policy outlined in Item 12.2. It is suggested that MCTAG aligns with liver to reduce the eGFR to 30 ml per minute. MCTAG members are asked to consider representing the centres' interests on the fixed term working group.	
12.4	Access to Super Urgent Liver Transplants Post Intestinal Transplantation – There will be another meeting in January to discuss this issue and a report at the next MCTAG meeting.	
13.	**Paediatric transplantation**	
13.1	Paediatric offering - **MCTAG(24)20 –** Results are shown in the paper circulated with the Minutes. Although there are no statistically significant differences apparent in the demographics of patients registered at the 2 paediatric centres in the last 18 months, patients registered at King's appeared as named patients on less matching runs that those at Birmingham and so there were less patient offers. The result is that the median waiting time to transplant for patients registered over a 5-year period was longer at King's than at Birmingham with a cumulative incidence estimate of 17% of patients at King's transplanted at 1-year post-registration compared with 65% at Birmingham. There appears to be a difference in electing to go for or having to elect to go for an isolated liver rather than a liver and bowel to resolve a situation for a child short-term. However, this then impacts on the way data is interpreted. It was agreed that the centres would look at their different practices and that at the next meeting survivals and those who died would be examined in more detail.	
13.2	Impact of Synnovis on transplantation – C Bambridge stated that after a decision was made to stop the programme temporarily at King's due to problems with blood transfusion, Birmingham offered to help and the two centres became one big team. The shared drive from NHSBT was very user friendly and easy to access and a pathway was set up if an offer came in. Although there were no transplants and no offers, both teams learned a lot and there was a more homogenous approach to dealing with patients.	
13.3	Update on Publicity Campaign re: Paediatric Transplants	
	Not discussed	
14.	**Group 2 Bowel Transplants – MCTAG(24)17**	
	There are no transplants to report	
15.	**Potential Routine Inclusion of Contrast Enhanced CT Scan in Donor Characterisation**	
	In M Berman's absence, A Butler stated that he was keen to push forward in having this included in the core data set for bowel donors as being able to see the arterial anatomy in a donor is critical. A working group is looking at the use of CTs but there is concern about this becoming a mandatory requirement particularly as many smaller hospitals don't have access to this technology. A request on assessment or on point of offering may be a better possibility. **ACTION: J Whitney and R Baker will discuss with D Manas**	**J Whitney/ R Baker/ D Manas**
16.	**Discussion Relating to Data Set for UK Reporting**	
	Prior to L Sharkey's departure a new data set to be collected was agreed and put into an excel spreadsheet which has been trialled over the last year with transplants at Cambridge. S Duncan has	

	since gone through the data to identify any issues that need addressing. This will then go back to R Taylor to make the changes. Work on this will continue and it is felt it has been a very valuable exercise.	
17.	**Update from Working Groups**	
17.1	Quality of Life Working Group: data collection – *See Items 17.1.1 and 17.1.2 below*	
17.1.1	Adults – Permissions for a form previously used have now been given and this will now be rolled out across adult groups.	
17.1.2	Paediatrics – The above form also covers paediatric centres as well as teenage transition patients allowing them to access PNIQ and to ensure seamless transition across the ages. However, smaller children are not doing so well due to a large turnover of psychologists at King's meaning there is no consistent person to help. A psychologist from Birmingham may be able to help with this.	
18.	**Intestinal transplantation for patients with Neuroendocrine Tumours – MCTAG(24)18**	
	A presentation by E Canovai is circulated with these Minutes. A working group will be formed to report to the next meeting.	
19.	**Feedback from Liver Advisory Group Meeting**	
	V Aluvihare was not present at the meeting. A Butler reported there was nothing specific for MCTAG included in the LAG meeting other than access to SU listing which will be discussed further at the next MCTAG meeting	
20.	**Adequacy of Psychological Support for Patients Undergoing MV Transplantation**	
	A useful meeting has taken place with psychiatric services at Addenbrookes. A single psychiatrist is involved in all assessments. A retrospective review of all patients is needed to define what is wanted. Liaison will take place with psychologists at Oxford to identify issues that will be of help. Work is ongoing.	
21.	**Multi-centre Collaborative Studies and Research**	
	In G Gupte's absence, it was agreed A Butler would liaise with him post-meeting	**G Gupte/ A Butler**
22.	**Items from the meeting for cascade to teams**	
	A Butler highlighted the following issues from the meeting: • DCD NRP component – Due to concerns about access to paediatric grafts, a fixed term working group will take this issue forward. • Education resources – Work with Transplant TV for both adults and paediatric recipients is ongoing and will now include limb transplants as well. Access to information already available in podcast form will be included. • Quality of life - work in this area is moving forward. • Psychology post-transplant – an in depth assessment for psychology needs for patients post-transplant is needed. • Very small bowels – An adhoc agreement with LAG is needed for prioritization for patients until the DCD NRP is available. **ACTION: A Butler to engage with T Grammatikopoulos and the Paediatric sub-group in January.**	**A Butler**
23.	**Any Other Business**	

23.1	FOEDUS – *See Item 3.2.7*	
24.	**Dates of meetings for 2025** • 2 July 2025 – Face to face meeting - venue to be confirmed. • 9 December 2025 – via Microsoft Teams.	