

**NHS BLOOD AND TRANSPLANT
ORGAN DONATION AND TRANSPLANTATION DIRECTORATE**

**THE FORTY SEVENTH MEETING OF THE PANCREAS ADVISORY GROUP (PAG) &
THE TWENTY THIRD MEETING OF THE PAG-ISLET STEERING GROUP
THURSDAY 9 OCTOBER 2025
1030-1600**

THE WESLEY HOTEL AND CONFERENCE VENUE, LONDON, NW1 2EZ

Present:

Steven White	PAG Chair
John Casey	PAG-ISG Chair & Deputy Medical Director – NHSBT
Anand Muthusamy	WLRTC & Hammersmith Representative
Arash Akbarzad-Yousefi	BSHI (H&I) representative
Carla Rosser	OTDT H&I Lead
Chris Callaghan	NHSBT Associate Medical Director, Organ Utilisation
Claire Counter	NHSBT Statistician, Statistics and Clinical Research
Colin Wilson	Newcastle Transplant Centre Representative
Denise Bennett	Newcastle Islet Transplant Co-ordinator
Doruk Elker	Cardiff Transplant Centre Representative
Edward Sharples	Oxford Transplant Centre Representative
Gail Defries	Addenbrookes Recipient Co-ordinator Representative
Georgios Papadakis	Guys Transplant Centre Representative
James Shaw	UK Islet Transplant Consortium
Jenni Banks	NHSBT Statistician, Statistics and Clinical Research
Julie Whitney	NHSBT Head of Service Delivery – ODT Hub Operations
Kirsty Duncan	Edinburgh Islet Cell Transplant Coordinator
Mr Giuffrida representing Zia Moinuddin	Manchester Transplant Centre Representative
Miranda Coles	Kings – Islet Transplant Coordinator
Paul Johnson	Oxford Director Islet Isolation and Transplant Programmes
Sarah Watson	NHS England Highly Specialised Services
Shaminie Shanmugaranjan	NHSBT Statistician, Statistics and Clinical Research
Vicky Prior	Edinburgh Recipient Coordinator
Yee Cheah	KCH Transplant Centre Representative

In Attendance:	
Lawna Pugh	NHSBT Advisory Group Administration Officer
Misha Leigh Thompson	Admin Assistant, Medical Director and Group Support
Rory Brown	Guest – Manchester University - Feasibility Study
Apologies	

	<p><u>New appointments</u> - J Casey provided an update:</p> <ul style="list-style-type: none"> • J Casey has been appointed as Deputy Medical Director in a clinical capacity and R Ravanan will cover R&D issues. • PAG - Thanks to S White for 5 yrs of service as PAG chair with C Callaghan taking on the role. Thanks to C Counter for 9yrs of statistical support which put pancreas data on the map. • NHSBT CEO and Deputy - Following the recent resignations of the CEO and Deputy CEO from NHSBT, the interim CEO will be Caroline Walker. Gail Mifflin will be interim Deputy. • SCORE - K Quinn has been appointed as Accountable Executive • Assistant Director for Transplantation – a new appointment will be advertised. • MCTAG chair – Irum Amin has been appointed. • Collaborative lead is Ben Stutchfield. <p><u>Developments in NHSBT:</u></p> <ul style="list-style-type: none"> • Terms of Reference - a review of memberships and deputies for all Advisory Groups. • Patient Engagement Lead – J Parmer has been appointed as the Associate Medical Director for this group along with new patient partners. • ARCS – the application for the pilot scheme is under review with outcomes by the end Oct 2025. • SCORE – roll out is expected by Autumn 2026. • Organ Utilisation group – expected outcomes are due November 2025, NHSBT will update as and when. <p>S Watson added that D Thorburn is the National clinical lead from NHSE and will work with NHSBT to discuss priorities. An oversight group has been set up with D Manas leading the Strategy group. The priorities will be shared with all Advisory Group chairs.</p>	
<p>4.</p>	<p>Sustainability and Certainty in Organ Retrieval (SCORE)</p>	
	<p>PAG/ISG(25)19 - This paper was circulated prior to the meeting and J Whitney provided an update:</p> <ul style="list-style-type: none"> • There is now investment committee funding to go through for the full Business Case. • The operational data collection model is complete – thanks to all involved. • Transplant centres are encouraged to look at local plans in their own centre. • NORS teams have been sent a letter outlining the impact of SCORE on contract values. This will be discussed at a future RAG meeting. • SCORE is too large to pilot therefore a shadow modelling approach to assess impact of changes will be used. In talking through PAW (Planned Arrival Window) with transplant centres, logistics were investigated and times when the kidney and pancreas were arriving and trying to achieve the best times. These requested times may vary slightly than the actual planned organ arrival time the wider spread of accepting centres with most organs arriving between 0600 – 1000 hrs. Also, additional modelling for SN~ODs, transport and H&I impacts have been investigated. • There is a reduction in flights of 11% in the shadow period, although ischemic time for pancreas and islets have not been included. • Digital bedding in period for the new offering system to work is ongoing - will keep the group updated. • J Whitney will focus on transformation change in ODT Hub for the next 2 years, a fixed term cover for substantive role will be advertised in due course. <p>Further discussion took place on how a pancreas will be offered to Islet laboratories if 2 donors were in the South. Suggestions were to follow the patient so transport after isolation is minimised where it is possible to do so. The following points were noted:</p>	


	<p>The SCORE survey has shown what stage each centre is at. A centralised clinical decision within Hub Ops will be by a Senior Nurse who will be recruited early 2026, although this is around planning, so organ allocation will be upskilled.</p> <p>ACTION: J Whitney to organise calls to talk to the lab managers regarding the above.</p>	<p>J Whitney</p>
<p>5.</p>	<p>Governance (PAG & PAGISG)</p>	
<p>5.1</p>	<p>Incidents for Review: Patient Safety Report (formerly Clinical Governance) report - PAG/ISG(25)01 - This paper was circulated prior to the meeting</p> <p>Further discussion took place around waiting times with the following points noted:</p> <ul style="list-style-type: none"> • Manchester stated that their patients are waiting between 3-5 years. Many are legacy patients so this number will reduce. The hybrid system between referring centre and Manchester is not working so this will be revised. • All centres see patients regularly from 3 monthly reviews to 2 years. • C Counter added that a regular report on long waiting patients is generated every 6 months and suggested a new PAG summary of this report. • C Wilson asked if centres should move patients from pancreas waiting lists to kidney waiting lists. J Shaw added there are other options with high quality diabetes management. • J Casey/S White explained that consent is being reviewed along with utilisation. NRP will also improve utilisation, but waiting lists need to be kept under review. Draft papers for recommended changes have been submitted to DHSE, although it takes time to implement. • A Muthusamy noted that DCD NRP is not often used, so universal NRP will help waiting lists. <p>S White asked if the group should increase the DCD donor age limit to 60 years.</p> <p>It was agreed that data/evidence of increasing the age needs to be shown prior to deciding.</p> <p>ACTION: S Shanmugaranjan to have a new PAG summary of the regular report on long waiting patients.</p> <p>ACTION: S Shanmugaranjan to collect data on DCD donors up to 60 years of age for the next meeting.</p>	<p>S Shanmugara njan S Shanmugara njan</p>
<p>5.2</p>	<p>Summary of CUSUM Monitoring following Pancreas Transplantation - PAG/ISG(25)02 - This paper was circulated prior to the meeting, and C Counter provided an update:</p> <p>There has been 1 CUSUM signal and the centre is to investigate.</p>	
<p>5.3</p>	<p>Annual Utilisation Report</p> <p>Due to the absence of D van Dellen there was no report at the meeting.</p>	
<p>5.3.1</p>	<p>Girth measurements - PAG/ISG(25)03 - This paper was circulated prior to the meeting, and C Counter presented the data:</p> <p>The group requested additional data for: Abdominal girth where the pancreas was accepted but not transplanted data and if girth to height ratio makes a difference.</p> <p>ACTION: S Shanmugaranjan to include girth to height ratio and where pancreas was accepted and not transplanted data in an update of the paper.</p>	

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5.4	Update Solid Organ Pancreas Clinical Leads in Utilisation Due to the absence of D van Dellen there was no report at the meeting.	
5.5	Update on High Quality Organ Offer Declines Due to the absence of D van Dellen there was no report at the meeting.	
5.6	DCD Working Group – simulations update - PAG/ISG(25)04 - This paper was circulated prior to the meeting and C Counter provided an update: The paper summarised outcomes from simulations where the DCD travel time points were amended. Further discussion around which simulation was preferred highlighted that it was the ranking of the centre that was taken into consideration and not the specific travel times. NRP will enable additional travel times and there is a need to be mindful of both solid organ transplantation and islet isolation. PAG & PAGISG Agreed Simulation 2 (S2) As current scheme, but for DCD donors, whole pancreas patients at the two transplant centres closest to the donor hospital receive 10,000 travel points and patients at the third closest centre receive 5,000 points. ACTION: S Shanmugaranjan to take forward change to offering scheme policy to implement change in DCD travel time points as per simulation 2.	S Shanmugara njan
6.	Pancreas Transplant Activity	
6.1	Fast Track Scheme Review - PAG/ISG(25)05 - This paper was circulated prior to the meeting and C Counter presented the data: More granular data was requested for the number of DCD pancreas for isolation that were offered as a fast track. However, these numbers are very small and not straight forward – it was decided to continue to present that data in the same format.	
6.2	Transplant List & Transplant Activity – PAG/ISG(25)06 - This paper was circulated prior to the meeting and C Counter presented the data adding it was the lowest number of transplants since the year of COVID in 2020/21.	
6.3	Transplant Outcomes – PAG/ISG(25)07 - This paper was circulated prior to the meeting and C Counter presented the data: J Shaw noted the superb SPK (simultaneous pancreas and kidney) and PTA (Pancreas after kidney) results, although outcomes for kidneys should be better.	
7.	Islet Transplantation	
7.1	Islet Transplant Summit and Fixed Term Working Group - J Casey provided an update: <ul style="list-style-type: none"> • A further meeting is being organised to move forward quickly. • Main issue is the substitute for the COBE which is out for commission. • The Prism device has arrived in Edinburgh with an isolation completed. The initial feedback is positive. • The priority is to look at the laboratory service provision and move toward a 24/7 commissioned service for pancreas isolation. 	

	<ul style="list-style-type: none"> NHSE has a capital allocation to tap into and by 2026/27 it is hopeful to have 1 machine in each laboratory and a second machine by 2027/28. Centres to put forward expressions of interests and include auto transplanting centres for this PRISIM device. S Watson (NHSE) added that J Palmer will have an open meeting with clinical leads. <p>ACTION: S Watson to include Scotland in the meeting invitations.</p>	<p>S Watson</p>
<p>7.2</p>	<p>Update from each Centre:</p> <ul style="list-style-type: none"> Kings –2 allogeneic islet patients listed, 2 patients have undergone transplantation through the Vertex FORWARD stem cell derived islet transplantation clinical trial, 9 patients have undergone total pancreatectomy and autologous islet transplantation (another one planned for Oct), 12 patients being assessed for allogeneic transplantation (5 islet alone, 6 islet after kidney, 1 SIK) and 10 patients being assessed for total pancreatectomy and islet auto transplantation. Oxford – 15 patients on the national waiting list (6 ITA/IAK and 9 SIK). They have undertaken 4 islet allotransplants this year and continue to undertake 1 elective TPIAT (Total Pancreatectomy and Islet Auto transplantation) each month. Manchester - 25 patients on the waiting list, 17 SIK and 8 islets patients. Limited availability of isolation lab. Newcastle – 4 active patients, 2 transplants in the current finance year and ongoing Vertex trial. Diabetes centre is now on site at Freemans. Timing is more important than the yield and if there is a new criteria waiting longer is acceptable. Edinburgh –There have been 16 transplants in 2025 with 8 priority patients (x 5 SIK, x 10 ITA, x 1 Auto). Calendar referral x 17 patients with 12 under assessment. Waiting list currently is 12 ITA/IAK and 12 SIK (Simultaneous Islet and Kidney transplant). Smaller islet yields, with some patients have been waiting up to a year for a second transplant. The centre get offers but ability to isolate restricted due to lab unavailability. There is an increase of DCD donors. <p>It was requested by London centres if PAG can support joint working to facilitate an SIK and top-up islet alone transplant at different centres. S White/J Casey explained the Summit will work through the processes and Business case; aftercare expertise also needs to be worked through.</p>	
<p>7.3</p>	<p>Report from the PAG Islet Steering Group – PAG/ISG(M)(25)01 – The Minutes were circulated prior to the meeting and J Casey provided an update:</p> <p>No comments were noted other than to amend the PAG.ISG Minutes as noted in item 2.2 of these minutes.</p>	
<p>7.4</p>	<p>Islet Transplant Activity & Outcome - PAG/ISG(25)08 - This paper was circulated prior to the meeting and J Banks presented the data with the summary results shown in the paper:</p> <p>No comments were noted.</p>	
<p>7.5</p>	<p>Research Organs – PAG/ISG(25)08 - This paper was circulated prior to the meeting and C Counter presented the data:</p> <p>J Shaw asked to extend chronic pancreatitis organs for research, the QUOD tissue bank is restricted to diabetes only.</p> <p>ACTION: J Shaw to contact R Ramanan to discuss.</p> <p>P Johnson shared that a damaged pancreas was offered out for research by Hub Ops and Oxford had to wait 3 hours for collection, when they believed the policy stated that the isolation laboratory could keep it for research.</p>	<p>J Shaw</p>

	ACTION: J Whitney will clarify this process with Hub Ops – there is a written document or share the video again.	J Whitney
7.6	Update to Patient Selection policy and Supplementary Registration form – PAG/ISG(25)08 - This paper was circulated prior to the meeting and J Shaw provided an update: J Shaw was pleased to have the new criteria for islet transplantation and suggested to share with NICE (National Institute for Health and Care Excellence) as they are not aware.	
8.	Islet Isolation Outcomes	
8.1	Report of Islet Isolation Sub-Group Meeting - P Johnson provided an update: <ul style="list-style-type: none"> Laboratory managers and Auto Islet centres met. Contamination of laboratory has been resolved - thanks to those laboratories that covered. Enzyme use is available and being tested for a document update. Issue with lead times – P Johnson will share. PRISIM experiments, design and DCD clarification are in the last minutes. J Casey added the number of staff reduces to run islet isolation using the PRISIM. Once tested, laboratories need to include this in their budgets as well as consumables as these are expensive, at around £10k per use. Edinburgh are reporting the licence issue and will modify to obtain this. ACTION: P Johnson to share lead times	P Johnson
8.2	Islet Isolation Statistics - PAG/ISG(25)11 - This paper was circulated prior to the meeting and J Banks presented the data: The following points were noted: Is it possible to see the difference between SIK and ITA isolations as they have different release criteria - It is not possible to have two definitions of “met release criteria” within the paper, but it was agreed to change the wording of the footnote on Figure 1 as “released under licence” is not an appropriate phrase. ACTION: S Shanmugaranjan to change the wording “released under licence” in figure 1 in collaboration with R Spiers.	S Shanmugaranjan
9.	Standard Listing Criteria:	
9.1	Summary Data - PAG/ISG(25)12 - This paper was circulated prior to the meeting and C Counter presented the data: No comments were noted.	
9.2	Identify new criteria for registrations - P Johnson/J Shaw provided an update: This item is pre-dated by the new criteria so the approach can be modified.	
9.3	Islet transplant listing exemptions request and outcome of previous applications to appeals panel – PAG/ISG(25)13 - This paper was circulated prior to the meeting and J Casey presented the data: No comments were noted.	
10.	Clinical adoption of advanced therapies for diabetes – J Casey provided an update:	

	<p>The Vertex studies are moving forward and there have been discussions around how to incorporate work to ensure delivery to patients is in an efficient and fair manner. There are existing infrastructures and databases. Working with or alongside other groups (UKITC/R&D) is being taken to SMT (Senior Management Team) to discuss how this can be done</p> <p>ACTION: S Watson to include the Advanced Therapies team to the meeting.</p>	<p>S Watson</p>
<p>11.</p>	<p>Blood group O recipients in tier A - V Prior provided an update:</p> <p>The offering of organs to Tier A based on matchability score and then waiting time allows those patients who are difficult to match to have priority. Those patients in Tier A with a low match score (e.g. SPK patients who have been waiting a long time and moved into Tier A) will appear lower on the matching run than other Tier A recipients and so may continue to wait even longer for an offer.</p> <p>C Counter shared data from the end June 25 which highlights this. Of 29 patients in Tier A of the pancreas offering scheme, over 80% are due to long waiting time alone and 50% of all the patients in Tier A have a waiting time of 4 years or longer. 90% of those in Tier A due to waiting time alone are blood group O patients.</p> <p>It is important to note that if there are two patients in Tier A who need a kidney and match with a donor, both kidneys will go to those patients, which wouldn't leave a kidney to go with the pancreas for the patients in Tier A of the Pancreas Offering Scheme.</p> <p>Since the change in matchability score banding in 2024 some Tier A patients in the Kidney Offering Scheme are getting transplanted more quickly than expected because they have a higher matchability score but a shorter waiting time. KAG are looking into this with a possible change and SW will email the KAG chair.</p> <p>ACTION: C Rosser will raise impact of this on the pancreas offering scheme at KAG. S Shanmugaranjan will investigate the issue further.</p>	<p>C Rosser/S Shanmugaranjan</p>
<p>12.</p>	<p>Report from UK ITC and the UKITC Research Steering Group (including update of MRC-QUOD extension) – J Shaw provided an update:</p> <p>A request for this group to use QUOD tissue as there are 150 tissue samples available.</p>	
<p>13.</p>	<p>The Effect Perioperative Glycaemic Control in Pancreas Transplant Recipients: A Feasibility Study - PAG/ISG(25)14/14a - These papers were circulated prior to the meeting which R Brown presented:</p> <p>Support is requested to go ahead with this study. Continuous glucose monitoring will be utilised as support for clinical staff in conjunction with central blood glucose monitoring.</p> <p>PAG/PAGISG ALL AGREED TO SUPPORT THE STUDY</p> <p>ACTION: QR code shared for feedback from all centres.</p> 	<p>All</p>
<p>14.</p>	<p>Update on islet data applications – C Counter provided an update: No comments were noted.</p>	

15.	Recipient Coordinator Updates – V Prior/G Defries shared there were no updates.	
16.	Any Other Business	
17.	FOR INFORMATION ONLY	
17.1	Summary from Statistics & Clinical Research	
17.2	Transplant Activity Report	
17.3	QUOD Report	
18.	Future Meeting Dates: EPITA Igls 25-27 January 2026 BTS – 3 -6 March 2026 PAGISG – 19 March 2026 (Virtual) PAG – 28 April 2026 (Virtual) PAG/PAGISG Joint – 30 September 2026 (Face to face) Pancreas Forum – Oxford – date TBC	