

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

**THE MINUTES OF THE FORTY EIGHTH MEETING
OF THE PANCREAS ADVISORY GROUP
AT 10:30AM ON 28 APRIL 2026
VIA MICROSOFT TEAMS**

Attendees:

Chris Callaghan	PAG Chair
John Casey	Chair of PAGISG and Deputy Medical Director NHSBT
Adam McLean	Co-centre rep – WLRTC Tx
Aileen Feeney	Lay Member Rep
Anand Muthusamy	Co-centre rep – WLRTC Tx
Andrew Madden	Lay Member Rep
Andrew Sutherland	Centre rep – Edinburgh Tx
Argiris Asderakis	Centre rep – Cardiff Tx
Arthi Anand	BShI (H&I) rep
Carla Rosser	H&I Lead – OTDT
Colin Wilson	Centre rep – Newcastle Tx
Doruk Elker	Centre rep – Cardiff Tx
Edward Sharples	Centre rep – Oxford Tx
Elijah Ablorsu	BTS representative, Cardiff
Gail Defries	Recipient Coordinator rep – Cambridge
Gareth Jones	KAG Chair
Georgios Padakis	Centre rep – Guy's Tx
Irum Amin	MCTAG Chair
James Shaw	UK Islet Transplant Consortium rep
Joanna Chalker	Head of Service Delivery – OTDT
Kate Dreyer	OTDT Leadership Team Representative
Kimberley Gahagan	Patient Partner
Laura Stamp	Lead Nurse Recipient Coordinator
Neil Russell	Centre rep – Cambridge Tx
Paul Johnson	Member representing Islet Isolation centres
Raymond Braid	NSD Scotland
Rhiannon Wallis	Stats – NHSBT
Sarah Watson	Highly Specialised Services – NHS England
Shaminie Shanmugaranjan	Stats and Clinical Research – NHSBT
Sian Emmett	Patient Partner
Simon Knight	Lead Pancreas CLU
Victoria Ker	Lead Nurse Representative
Victoria Prior	Recipient Coordinator rep – Edinburgh

Yee Cheah	King's College Hospital – Diabetologist
Zia Moinuddin	Centre rep – Manchester Tx

In Attendance:

Lawna Pugh	Advisory Group Support Officer – Minutes
Jas Parmar	AMD Patient Engagement, NHSBT – Guest
Nick Earl	Assistant Director – Transplantation – Guest

	WELCOME, INTRODUCTIONS, APOLOGIES, ANNOUNCEMENTS AND THANKS C Callaghan welcomed everyone to the meeting and extended sincere thanks to S White (previous PAG chair) and C Counter (Stats) for their valuable contribution to the group. Apologies were received from S Sinha, L Birtles and L Irvine.	
1.	Declarations of interest in relation to Agenda: No declarations were noted.	
	<i>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.</i>	
2.	Minutes:	Action
2.1	Accuracy Minutes of the joint PAG/ISG meeting held on 9 October 2025 were approved as accurate.	
2.2	PAG Action Points PAG(AP)(25)02 – the following actions were discussed: AP1 – Referral patterns Concerns that there are unacceptable variations in referral patterns for pancreas and/or islet transplantation. A lack of data around referral patterns has made this difficult to progress. ACTION: C Callaghan to contact R Ravanan (given his experience in database analyses) to discuss the data around referral patterns for both islets and pancreas transplantation, with support from J Casey, S Watson and P Johnson. AP4 – Research Organs ACTION: J Shaw to arrange a meeting with R Ravanan - marked as ongoing.	C Callaghan J Shaw
2.3	Matters Arising, not separately identified C Callaghan provided an overview of the current situation for pancreas transplantation. There has been a 30% drop in transplants over the last 5-6 years which requires investigation. A Pancreas Summit is scheduled for 30 th June 2026 with the aim to look at all the areas/pathways and bring solutions which can be implemented promptly.	

	The Islet Summit which took place in December 2024 is now looking at delivering the recommendations for islet isolation and transplantation. Papers should now include lay summaries to help improve engagement with the lay members and patient partners – all are keen to support and share experience from a patient perspective. All submitted papers must have a lay summary at the start.	
2.4	PAG Terms of Reference and membership – (paper PAG(26)01 was circulated prior to the meeting). C Callaghan shared the document with the following points noted: Lay members and patient partners as voting members were discussed and supported. To ensure meetings are quorate there needs to be 1 lay member/patient partner and 50% of centre representatives in attendance. It was agreed that when there are clinical decisions, lay members and patient representatives can abstain from voting. ACTION: C Callaghan • Add a clause around abstentions for lay members and patient partners on voting on clinical decisions as they wish • Add a clause around the necessary numbers to be quorate • Discuss with D Manas removing representation from the Dept of Health (not needed as the 4 Commissioners around the UK are represented) • Circulate ToR to J Casey to confirm ToR and members from PAGISG	C Callaghan
2.5	New PAG members C Callaghan welcomed new members to the group, especially lay members and patient partners; their input will be invaluable. K Gahagan shared her experience receiving a pancreas and is keen to support and collaborate with the group. The focus from this perspective is on equity of access and share the lived experience to inform discussion and decisions.	
2.6	Update from Associate Medical Director for Patient Engagement J Parmar provided some background of his new role and the new patient groups. Some of the aims of this group is to provide a voice on new and existing policies, act as subject matter experts for service improvement, participate in co-production to design, and to deliver and evaluate health services. The group's core mission is better, clearer information and feedback on lay summaries and website development. The membership includes Co-Chair, Deputy Chair (L Stamp), Patient partners from each solid organ advisory group, the transplant development leadership team, 2 OTDT Lay members and other patient, public professional representatives. Also, he is leading on updating and revising the patient-facing website (https://www.nhsbt.nhs.uk/organ-transplantation/). This requires regular review by subject matter experts. ACTION: C Callaghan to add 'Patient website' to the autumn PAG agenda for discussion around review of content for pancreas transplantation.	C Callaghan / L Pugh

2.7	Deputy PAG Chair – expressions of interest C Callaghan requested that if any Centre leads are interested to please send him an email. Although this role is not remunerated there is information in the ToR for reference. A formal email will be circulated. ACTION: C Callaghan to email existing pancreas transplant centre reps for expressions of interest.	C Callaghan
3.	Medical Director's Report - J Casey provided an update and welcomed C Callaghan as the new PAG chair. • New CEO NHSBT, F O'Callaghan • R Ramanan has been appointed as the Chief Medical Officer for NHSBT. Expressions of interest has been circulated for an interim role for deputy R&D • N Earl is the new AD for Transplant Operations. • New Advisory Group Chairs – I Amin of MCTAG • J Parmar AMD for Patient Engagement • Pancreas Summit in June 2026 to tackle challenges in transplantation • The ARC pilot is moving forward with funding approved and potential subsequent ARCs. • SCORE is looking at some of the challenges and hoping to start spring of 2027. • NRP is being rolled out and should be completed by spring of 2027. There are some challenges in the DCD heart retrieval workforce. • Organ donation joint working group have released 8 recommendations. There are some challenges with a high percentage of DCD donors and low consent rates, which are high priorities. • The Transplant Oversight Group and NTCP (National Transplant Clinical Panel) are working on their ToR (circulated prior to the meeting) and how to work together to deliver the ISOU (Implementation Steering (Group) for Organ Utilisation) recommendations. • ERAS (Enhanced Recovery After Surgery), environmental sustainability, and living donor liver transplant programmes, are moving forward and in progress.	
4.	Data Review	
4.1	NPOS (National Pancreas Offering scheme) review - paper PAG(26)02 was circulated prior to the meeting). S Shanmugaranjan presented slides for the detailed data in the paper: Trends in pancreases and islet activity in the most recently reported period compared to 10 years ago were presented. This has shown a drop by approx. 34%, and the waiting lists increased by approx. 60%. C Callaghan clarified that the Pancreas Summit is where solutions to the data would be addressed. The aim of today is to ensure that sufficient data are available and have been rigorously assessed. Further discussion took place with the following points noted: • Reduction in the rate of retrievals needs more investigation but could possibly be the look/feel of the pancreas rather than criteria or new technology like NRP.	

	- Highly sensitised patients were put into Tier A kidney offering scheme to give better access which reduced waiting times. - Oxford shared that utilisation from DCD donors falls to half due to more conservative acceptance. Those organs accepted and not retrieved has increased which needs investigating at what stage and why they are being declined by centres, as this increases cold ischemia times. - Better photographs at retrieval may help surgeons make more informed decisions. - Those patients who die whilst on referral lists or during workups are not being accounted for in the data, which C Callaghan is aware of. - Discussion around possible benefits of back-dating waiting times for those patients on dialysis with diabetes. Not included in the current scheme as this may disadvantage ITA/PAK/PTA patients who are not on dialysis. - Outcomes after NRP for DCD pancreas transplantation are good but appear no different from non-NRP outcomes. Awaiting publication of S White's work. - Data on losing pancreases due to aberrant liver arterial anatomy would be useful. Wording on this has been agreed previously with LAG. ACTION: S Shanmugaranjan to try to obtain data on discarded pancreases due to aberrant liver arterial anatomy ACTION: C Callaghan to contact chair of LAG with these data for discussion - A concern was raised about both kidneys going to kidney-only patients, and what happens to those pancreases. Oxford commented that those pancreases are offered as PTA or islet but often there are no antibody-compatible PTA/ITA patients on the list. Often these are good donors who are not eligible for named-patient islets because age <25 + BMI <25. These donors are offered to pancreases and islets through the Pancreas Fast Track Scheme. ACTION: S Shanmugaranjan to obtain data on pancreases offered for PTA/ITA because both kidneys have been accepted for kidney-only patients.	S Shanmugaranjan / C Callaghan S Shanmugaranjan
4.2	NPOS Tier A and long waiting patients - (paper PAG(26)03 was circulated prior to the meeting). S Shanmugaranjan presented the paper: <u>LAY SUMMARY</u> <i>A new priority tier (Tier A) was introduced into the NPOS Scheme in 2019. Tier A prioritises patients within the offering scheme if they are difficult to match with a donor, highly sensitised or have been waiting a long time for a transplant. It was highlighted that a greater number of blood group O and easy to match patients were waiting a long time in Tier A. The paper aims to quantify this issue that was raised.</i> C Callaghan gave thanks to RTC representatives for raising this issue early on. The following points were noted: - Cambridge is not getting named offers for blood group O until they become Tier A patients and likely waiting 2-3 yrs and therefore disadvantaged. - These issues are most likely due to increased overall waiting times (change to donor demographics etc) and issues with organ offering pathways (NPOS and NKOS Tier A changes) and organ utilisation patterns ACTION: S Shanmugaranjan/C Callaghan to gather further data and compare wait times by blood group and compare recipient characteristics by Tier. These issues will also be addressed directly via the Pancreas Summit	S Shanmugaranjan / C Callaghan

4.3	DCD donor age criteria - (paper PAG(26)034 was circulated prior to the meeting). R Wallis presented the paper: <u>LAY SUMMARY</u> <i>Currently the upper donor age limit for pancreas donation from donors after circulatory death (DCD) is 55 years. This paper looks at what the benefits may be if this age limit was increased to 60 years. This was done by estimating the potential number of additional donations that the group of DCD donors aged between 56 and 60 years may provide. PAG are asked to consider if the upper age limit for DCD whole pancreas donors should be changed.</i> Further discussion took place with the following points noted: • Should DBD criteria also be changed? No strong support to increase this age limit. • If we change criteria nationally, then centres need to examine their 'autodecline' criteria • At a previous joint PAG and PAGISG meeting the islet centres were keen to go up to DCD donor age of 60 with the use of NRP. C Callaghan noted that PAG are not mandating usage of organs from older DCD donors but are allowing these organs to be offered - centres must make their own organ utilisation decisions based on individual donor-recipient factors. NRP cannot be mandated by PAG, though national funding for this has been approved and is increasing. Outcome data for pancreas transplantation are very similar between DCD and DBD donors with no evidence that age impacts outcomes differently between different donor types, though increasing donor age is a risk factor for worse outcomes. It is proposed to increase the upper donor age limit of DCD up to the same level as DBD donors to 60yrs. The data can be reviewed after 2-3 years. Overall support for this proposal. Islet colleagues also support it. If islet isolation centres wish to decline DCD donor offers between 55-60 years if NRP isn't available, then that is their prerogative to do so. <u>Consensus from all centres agreed to increase the age limit for DCD pancreas donors (whole pancreas and islets) to 60 years.</u> ACTION: J Chalker to feedback how to implement these changes and timescales.	J Chalker
5.	SCORE – J Chalker provided an update: The latest rounds of modelling data are due to be shared with a potential 'go live' date in spring of 2027.	
6.	Governance and Utilisation	
6.1	Incidents for Review: PAG Patient Safety (Clinical Governance) Report – (paper PAG(26)05 was circulated prior to the meeting): No comments were noted.	

6.2	Summary of CUSUM Monitoring following Pancreas Transplantation – (paper PAG(26)05 was circulated prior to the meeting). S Shanmugaranjan provided an update: The data allows a comparison for centre specific data and performance against national average. There have been no signals in the last quarter Dec 25 – March 26. The June 2025 signal has not closed off yet. Further discussion took place around the number of CUSUMS previously. These signals are not punitive and are an early warning. The following points were noted: • Islet CUSUMs are not currently available as the numbers are low. PAGISG are looking into this. • CUSUM triggers set for national data, not centre-level data. The pancreas CUSUM document mentions centre-level data; this needs to be changed. • CUSUM trigger level is re-examined every 2 years. If we are asking centres to accept organs from older donors, we may need to be more flexible with CUSUM triggers. ○ ACTION: S Shanmugaranjan to check CUSUM paper and change as needed ○ ACTION: C Callaghan to consider the issue of relaxing CUSUM triggers at the Pancreas Summit • June 2025 CUSUM is still open due to the accuracy of data needs to be clarified. ○ ACTION: C Callaghan to write to the relevant centre for an update.	S Shanmugaranjan C Callaghan C Callaghan
6.3	Pancreas Damage and Quality - (paper PAG(26)07 was circulated prior to the meeting). R Wallis provided an update: LAY SUMMARY <i>This paper reports on pancreas damage in 2025. There were 243 donor pancreases accepted for a whole pancreas transplant. Of these organs, 18% had a grade of surgical damage reported. Over half (56%) of the damaged pancreases had moderate or severe damage and were not transplanted. There were 16 pancreases that were not inspected for damage. PAG members are reminded of procedure to report damage incidents.</i> Further discussion took place around the difficulties removing a pancreas, especially from DCD donors. En bloc versus in situ split may be a factor. ACTION: S Knight to speak with S Shanmugaranjan to see if there is a difference in pancreas damage when retrieved en bloc versus split in-situ. If these data are recorded, to be presented at the Pancreas Summit.	S Knight / S Shanmugaranjan
6.4	Pancreas Utilisation – Lead CLU Report - S Knight provided an update: The Offer Review Scheme (ORS) produces a report which looks at offers that have been declined that meet high-quality donor criteria. Missed opportunities are identified and letters to centres are written. Normally receives 4-5 offers per week. This is to be extended to islet offers, in time. HQD criteria is to change slightly for pancreases.	

	<u>Possible solutions for improving organ utilisation:</u> Education/improved consistency between centres, avoiding late declines, review Tier A kidney offering pathways where pancreases are high quality. Those accepted but not retrieved is more difficult to understand with limited data. Either late recipient issues leading to the decline, organs declined on visualisation by the retrieval team before they've been removed from the donor, or perhaps centres changing their minds due to handover of surgeons who may have different risk appetites. Those retrieved but not transplanted main concerns are around quality of the organ. Possibly solutions are to transport all explanted organs to implanting centre for inspection, 2nd on-call rota for second pair of eyes and feedback to retrieval teams regarding damage. Further discussion took place with the following points noted: • High quality photographs are essential and gives an audit trail. • To know in advance the quality of the organ means it can be offered on to nearest centre if declined and shorten cold ischemic time. • CT scanning of donors is being discussed within the utilisation group. • Comms to advise local centre that all pancreases should be inspected by the implanting centre.	
6.5	DCD Working Group – simulations - update provided by A Sutherland and S Shanmugaranjan: This has previously been agreed at PAG. Due to resource with database developers this has not yet started with no known timescales. With limited resource it takes time to change offering scheme and pathways. ACTION: S Shanmugaranjan to collate the changes required to NPOS at present ACTION: C Callaghan to work with J Casey and D Manas to find out where PAG are in the queue of prioritisation to make these changes.	S Shanmugaran jan / C Callaghan
7.	Pancreas Transplant Activity	
7.1	Transplant List & Transplant Activity - (paper PAG(26)08 was circulated prior to the meeting). R Wallis provided an update: LAY SUMMARY <i>This paper summarises the pancreas and islet waiting lists, donation and transplantation in the UK. In 2025, 376 people were waiting for a pancreas or islet transplant, the highest number seen in the past decade. A total of 153 pancreas and islet transplants took place in 2025, which was an increase from 2024 but lower than the number of transplants before 2020. Of the 153 pancreas and islet transplants in 2025, 41% were from deceased after cardiac death (DCD) donors. This was a 75% increase in DCD donor pancreas transplants from the previous year. In 2025, 84%, of the pancreas and islet waiting list were waiting for a kidney and pancreas transplant. Simultaneous kidney and pancreas transplants were the most common type of transplant, representing 75% of all pancreas and islet transplants in 2025.</i>	

7.2	Transplant Outcomes - (paper PAG(26)09 was circulated prior to the meeting). S Shanmugaranjan provided an update: LAY SUMMARY <i>This paper summarises pancreas graft survival, kidney graft survival, and patient survival following pancreas transplants performed in the UK in recent years. After simultaneous pancreas and kidney (SPK) transplants carried out in 2023–2024, about 90% of pancreas grafts were functioning one year after the transplant. This was similar in the previous two years, and similar for transplants with organs from donors after brain death (DBD) or donors after circulatory death (DCD). One year after SPK transplants, 95–99% of kidney grafts were functioning, regardless of the donor type or time period. One year after SPK transplants, 96% of patients were alive, this was similar for both donor types and time periods.</i> ACTION: S Shanmugaranjan to include kidney eGFR at one year for those that have kidneys transplanted (SPK). SIK outcomes are included in papers for ISG and to share with PAG.	S Shanmugaranjan
7.3	Fast Track Scheme review - (paper PAG(26)10 was circulated prior to the meeting). S Shanmugaranjan provided an update: LAY SUMMARY <i>The Pancreas Fast Track Offering Scheme (FTS) was introduced on 1 December 2010, with multiple changes made to the scheme since it started. The purpose of the scheme is to use organs which have been retrieved from the donor but without an offer accepted for transplantation prior to fast tracking. The paper presents data to monitor the number of organs offered and transplanted through the fast-track scheme, as well as reasons for the fast-track offers being triggered. In 2025, 140 pancreas donors led to an offer being made through the fast-track scheme. Of these offered organs, 35 (25%) were used for a pancreas or islet transplant. This was slightly higher than in the previous year. The main reason that triggered fast track offers was a previous offer for the organ being declined after the retrieval of the organ had started.</i> It was commented that it would be very useful to see more detailed breakdown of data around reasons for offer decline, and the outcomes of those organs that were transplanted. ACTION: S Shanmugaranjan to ask J Mehew to see what data are available on offer declines triggering the fast-tracked offer, and if CLUs or centres can have access to this. Post-transplant outcomes of pancreases transplanted through the FTS to be included in future papers.	S Shanmugaranjan
8.	Recipient Coordinator Updates No updates currently.	
9.	Islet Transplantation	
9.1	Report from the PAG Islet Steering Group – J Casey provided an overview:	

	The Islet Steering Group was originally set up as a short-term task force under the Pancreas Advisory Group when islet transplantation was first commissioned, over time it became clear that the complexity of islet transplantation required a standing forum for more detailed discussion. ISG therefore functions as a PAG subgroup, working very closely together, focusing on the operational and specialist issues that can then be fed back to PAG. ISG meeting format focuses primarily on clinical aspects of islet transplantation, supported by high-quality UK data that is internationally recognised. Meetings review changing patterns of clinical activity, particularly the growth of SIK transplantation and the increasing number of patients on the islet waiting list, while continually recognising the important risk–benefit issue that, as with SPK, if an islet transplant does not proceed, the kidney transplant does not happen either. The group also discusses laboratory activity in detail, including the practical challenges of delivering islet isolation to an extremely high standard, and maintains strong links with ongoing research, with updates and forward planning presented through the UKITC, chaired by J Shaw. Key current issues are: • Purification of islets – COBE 2991 machine which is obsolete and not supported. Looking at alternatives and using the PRISIM machine and roll out to other centres. • Edinburgh COBE machine is broken, and the lab cannot currently isolate – Oxford and King's are taking on the additional work. • Islet summit – looking at how to take the output/recommendations forward, in particular staffing and support of clinical islet programmes in the UK. • UKITC and ISG viewpoint of emerging stem cell technologies. In particular the trial led by Vertex with embryonic stem cell derived islets and how the group can be part of this.	
9.2	King's and Guy's proposed SIK service – (paper PAG(26)11 was circulated prior to the meeting). G Papadakis provided an overview: <u>Summary</u> <i>Simultaneous islet-kidney (SIK) transplant is increasingly common in the UK, and early UK experience suggests that this is a viable transplant option for selected patients with type 1 diabetes (T1D) and end-stage renal disease (ESRD). However, current UK services are limited to just four units, with none in London or the southeast of England. This suggests inequity of geographical access. After detailed discussions between the King's College Hospital (KCH) islet transplant unit, and the Guy's Hospital (GH) kidney and pancreas transplant unit, we propose a joint KCH-GH SIK service, with transplants taking place at GH.</i> Further discussions took place with the following points noted: Feedback from all centres were provided and all agreed support of this planned service. NHSE acknowledged the comments advising that once all information is collated by King's and Guy's, these will be submitted to TOG and Trust governance pathways. ACTION: G Papadakis and King's and Guy's colleagues to submit the required documents to NHSE and TOG when ready	G Papadakis

10.	Any Other Business No comment was noted.	
11.	Key points from today's meeting for cascade to centres – to be circulated in the Minutes There has been a 30% drop in pancreas transplants over the last 5-6 years, with a corresponding increase in the waiting list, which requires investigation and action. A Pancreas Summit is scheduled for 30th June 2026 at King's College London, Waterloo Campus, London, with the aim of looking at all relevant areas/pathways and identify solutions which can be implemented promptly. Invitations have been sent to centre representatives, and they will determine attendance from each centre. The following were key points from the PAG meeting: - All units should note that papers submitted to PAG must now include lay summaries at the start; this will help to improve engagement with lay members and patient partners. PAG will review the content on the pancreas pages of the patient-facing NHSBT website, and this will be discussed at the next PAG meeting. - PAG and PAGISG terms of reference and membership are being reviewed. - The Chair of PAG, Chris Callaghan, asked for expressions of interest for the post of Deputy PAG Chair from existing pancreas centre reps. - Data on the last 4 years of the National Pancreas Offering Scheme were reviewed. Although some aspects of pancreas offering have shown an improvement (such as access to transplantation by highly sensitised patients), there are many aspects which require modifications. All centres are encouraged to read paper PAG(26)02 which was circulated prior to the meeting. In particular, the number of pancreas offers has reduced, as have some aspects of pancreas organ utilisation. DBD donors have dropped significantly, and DCD donors have increased. Changes to the National Kidney Offering Scheme around the definition of Tier A patients have also altered the availability of kidneys for SPK and SIK transplantation – reviews are currently being undertaken by the Kidney Advisory Group which will address these issues. - Given the above, PAG discussed increasing the upper age limit of DCD donors to be in line with DBD donors (an increase from 55 years to 60 years). An analysis was presented which suggested that more transplants would likely be performed if this change was made. PAG supported this change, and this has already been supported by colleagues in PAGISG. UK evidence suggests that pancreas transplant outcomes from DBD and DCD donors are broadly equivalent. Given the rise in the number of DCD donors in the UK, and imminent changes to DCD donor age criteria, centres are asked to consider their own donor criteria and consider offers on an individual basis.	

	- The COBE machine in the Edinburgh islet isolation lab is not functioning at present, and the lab cannot currently isolate. The Oxford and King's labs have taken on the additional work. Many thanks to King's and Oxford colleagues, and to Edinburgh colleagues who are working to get a new machine up and running. - G Papadakis discussed the proposal to start SIK transplants at Guy's Hospital. This joint King's-Guy's programme was supported by PAG and has previously been supported at PAGISG. Centres are encouraged to disseminate these notes. Please contact NHSBT if you have further questions or issues arising from them.	
12.	FOR INFORMATION ONLY – (papers PAG(26)13–20 was circulated prior to the meeting).	
12.1	Summary from Statistics & Clinical Research	
12.2	Transplant Activity Report	
12.3	QUOD Report	
12.4	ToR for Transplant Oversight Group	
12.5	Islet Isolation outcomes	
12.6	Islet Transplant Activity outcomes	
12.7	Annual NPOS review	
12.8	KAG(26)09 - Multi-organ transplants	
12.9	KAG(26)06 - Kidney Offering Scheme Tier A simulations	
	Future Meeting Dates: Pancreas Forum – 15 July 2026 (Oxford) NHSBT Pancreas Summit – 30th June 2026 (venue now confirmed as King's College London, Waterloo Campus, London) Joint PAG-PAGISG – 30 September 2026 Meliá White House (Hyde + St James room) Albany Street, Regent's Park, London, NW1 3UP	