NHS BLOOD AND TRANSPLANT
ORGAN DONATION AND TRANSPLANTATION DIRECTORATE

THE THIRTY- SEVENTH MEETING OF THE RETRIEVAL ADVISORY GROUP (RAG)

0930 – 1600 hrs
THURSDAY 14 MAY 2026

MINUTES

ATTENDEES:		
Marius	Berman	Chair - Retrieval Advisory Group
Chris	Johnston	Deputy Chair – Retrieval Advisory Group
Elijah	Ablorsu	NORS Lead - abdominal - Cardiff
Alba	Bueno	Guest
Aimen	Amer	NORS Lead - abdominal - Newcastle
David	Bartlett	NORS Lead - abdominal - Birmingham
Sarah	Beale	Senior Commissioning Manager, NHSBT
Emma	Billingham	Head of Commissioning, NHSBT
Carlo	Cerasa	NORS Lead - Royal Free
Ian	Currie	AMD Retrieval, NHSBT
Nick	Earl	Assistant Director – Transplantation, NHSBT
Victoria	Gauden	National Quality Manager, OTDT
Rachel	Hogg	Statistics and Clinical Research, NHSBT
Michael	Hope	Abdominal Recipient Co-ordinator Rep
Pradeep	Kaul	NORS Lead - CT - Papworth
Liz	Armstrong - representative E Lawson	Head of Transplant Development, NHSBT
Debbie	Macklam	Head of Service Development, OTDT
Derek	Manas	Medical Director, OTDT, NHSBT
Olive	McGowan	Chief Nurse
Cecelia	McIntyre	Retrieval and Transplant Project Lead Specialist
Helen	McManus - representative S Halcrow	Professional Development Specialist Nurse
Mia	Poore	Stats - NHSBT
Liz	Middlehurst	Head of Operations and Development
Jas	Parmar	CTAG Lungs Chair
Gavin	Pettigrew	NORS Lead - abdominal - Addenbrookes
Steve	Potter	Lay member
David	Quinn	NORS CT Lead - Birmingham
Isabel	Quiroga	NORS Lead - abdominal - Oxford
Mylvaganam	Jeyakanthan	NORS CT - Newcastle
Aaron	Ranasinghe	CTAG Hearts Chair
Afshin	Tavakoli – representative C Wong	NORS Lead - abdominal - Manchester
Daniel	White	CT Recipient Co-ordinator
Bart	Zych	NORS Lead - CT - Harefield

IN ATTENDANCE:

Lawna Pugh	Advisory Group Support, NHSBT(Minutes)
Caroline Robinson	Advisory Group Support, NHSBT

		ACTION
1.	**WELCOME, INTRODUCTIONS, APOLOGIES, ANNOUNCEMENTS AND THANKS**	
1.1	M Berman (Chair) welcomed everyone to the meeting. Apologies were received from: Aaron Ranasinghe, Afshin Tavakoli, Arya Prakash, Cara Murdoch, Cathy Miller, Chris Callaghan, Shamik Ghosh, Julie Whitney, Sarah Plant, Sarah Whittingham and BC Ramesh.	
2.	**DECLARATIONS OF INTEREST**	
	No declarations of interest were reported.	
3.	**MINUTES, ACTION POINTS AND MATTERS ARISING FROM 14 MAY 2025**	
3.1	Accuracy – **RAG(M)(25)02** – The Minutes of the last RAG meeting on 19 November 2025 were approved apart from one name to be added to the previous minutes – D Macklam.	
3.2	Action Points – all actions were completed or on this agenda.	
3.3	Matters Arising – No issues were raised	
3.4	Terms of Reference – paper **(RAG(26)01)** was circulated prior to the meeting: All Advisory groups have ToR and RAG is under review - **ACTION:** M Berman and C Johnston to make the following amendments: • Tenure to be agreed • NHSBT commissioning member • To include lay members • NHSBT Quality assurance and clinical governance • Include reporting to MHRA • Include Associate Medical Director OTDT (J Parmar). D Manas representative • To include ODT HUB representation • Include Assistant Medical Director – J Casey • Remove Advisory group chair • Discuss with J Parmar patient partners • Circulate ToR to members for feedback to M Berman and C Johnston	M Berman/C Johnston
3.5	Mandatory NORS Lead requirements The tenure requirement is 3 yrs and to review at 2 yrs. Attendance is mandatory for RAG for each centre to send a representative. All NORS leads must engage with the Master Classes and there may be an update that CT NORS surgeons attend day 3 of the Master Class where machine perfusion is discussed. This could be a way to engage very experienced	

	surgeons as a refresher, like an appraisal process which D Manas suggested take place every 6 months. **ACTION:** M Berman/Ian Currie/C Johnston to implement appraisal process and meet with NORS leads every 6 months. Update document and recirculate.	M Berman/Ian Currie/C Johnston

4.	**Medical Director's Report -** D Manas provided an update:
	
	• New CEO NHSBT, F O'Callaghan
	• K Quinn AD Commissioning retires the end June 2026
	• N Earl is the new AD for Transplant Operations
	• R Ravanan has been appointed as the Chief Medical Officer for NHSBT
	• J Casey is the Medical Director deputy
	• New Advisory group Chairs:
	  o I Amin for MCTAG
	  o C Callaghan for PAG
	  o J Parmar AMD for Patient Engagement
	  o A Reed for CTAG Lungs
	• The ARC pilot funding is approved with potential subsequent ARCs. If proven successful a new business case will be submitted.
	• 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
	• 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 ISUO (Implementation Steering (Group) for Organ Utilisation) recommendations. Chaired by D Manas and D Thornburgh who are looking at risk and emerging concerns and will escalate if required. Cusum monitor will continue.
	• CT scanning to progress with D Manas oversight
	• Paediatric transplantation a proctor scheme to be organised
	• Histopathology out of hours service is progressing slowly – NHSE commission this service.
	• The Islet programme will close if a new machine is not available as the existing COBE machine has stopped working.
	HHV8 testing will continue inhouse for another 1 year with donor and recipient testing – a letter will be circulated.	

5.	**COMMISSIONED SERVICE UPDATES**	
5.1	E Billingham provided an update announcing that M Roberts (Commissioning Manger) has retired and S Beale has successfully been appointed to the role. Teams are asked to stock up on Retrieval packs as there are discussion with the current provider regarding the contract.	

	Mobilisation Key Principles in the mobilisation paper are around times, breaks, flights, DCD heart teams. There is working progress around documents when travelling as there is a Border clamp. A reminder to staff to take passport and travel documentation including Ireland as fines to aviation occur and will be added to contract. A summary of details will be circulated. When mobilising occurs with potential travel to Europe, please inform Hub Ops of any issues regarding documents especially with NRP as this is more challenging. **ACTION:** D Macklam to share the guidelines for NRP mobilisation. It was noted by E Ablorsu there are issues on travel rights when mobilising the team. To discuss further with D Macklam and L Middlehurst. **ACTION:** E Billingham to discuss with IMT and 247 aviation. **ACTION:** D Manas to raise the issue at the Irish transplant service meeting.	D Macklam EA/DM/LM E Billingham D Manas
5.2	**Perfusion fluid tender update** In abdominal, UW was not available and there was only one provider. To avoid this in CT, two providers are used. Therefore, the global solution will be a generic one that supports multiple providers	
6.	**SERVICE DEVELOPMENT**	
6.1	Paediatric Cardiac Business Case Workstream- D Macklam provided an update: update: The business case has OTDT SMT approval, and the next stage is to finalise funding options. The machine is not CE marked which is due to one component. the business case will be submitted with this caveat in the next few months.	
6.2	ARC pilot update – D Manas provided an overview (slides **(RAG(26)12)** circulated with the minutes): The remit is to utilise the declined organs and improve equity of access across the county. On 16th February, the Royal Papworth Hospital officially opened its doors as an ARC Lung pilot site. Newcastle is following next, and due to go live shortly (for lung also). The Liver pilot is planned to go live on 1 June 2026, with Royal Free, King's, and Addenbrookes first live sites. Planning is underway for Kidney go live (July/August 2026 Funding has been approved for Proof of concept (on a time-limited basis). There have been 9 expressions of interest received from centers. Due to no lungs so far going through ARCS the criteria may change. If the organ is not utilised, rather than discard if will go through an ARC. DCD lungs with NRP must go to ARC prior to Utilisation. There are 3 people auditing including a clinician. Low activity will be closely monitored.	

6.3	Change lung offering **-** V Gerovasili and S Mason provided an overview (slides **(RAG(26)13)** circulated with the minutes): The ask from RAG is to support instigating change in the policy of lung offering. Six months of data was reviewed for lungs not consented and/or offered. Of 46 cases there were 7 consent and no offers. Systematic missed opportunity in lung utilisation and the images does not support this decline. Suggestions on slide to RAG. Support: 1. Removal of major consolidation from Policy 188 – to be discussed at CTAG Lung 2. If concerns utilise screening calls to support SNODs in decision making **Further discussion took place with the following points noted:** This will increase retrieval but will also increase the number of transplants. Imagine will help decision making, although it is up to the transplant surgeon to decide. Gather numbers of activity for sign off at SMT to evaluate costs and include the pathway of organs for research. This can then be presented at ODT Care in 2 weeks. **ACTION:** V Gerovasili S Mason to gather data for ODT Care. ALL AGREED TO PROCEED	V Gerovasili/S Mason
6.4	Portable Refrigeration System – M Berman provided an update: There is a need for all centres to agree on a joint system. Assessing with A Ranasinghe to support with the HOPE machine this enable much longer travel with organ. Share finding with centres and loop in IMT as soon as possible if there is a change. **ACTION:** M Berman and A Ranasinghe looking into an agreed national system for hearts.	M Berman/A Ranasinghe
6.5	Computed tomography Imaging **ACTION:** D Manas and M Berman will follow up with T Billyard regarding this item.	D Manas/M Berman
6.6	Consent form pilot **–** S Halcrow provided an overview – papers **(RAG(26)02a,b,c)** was circulated prior to the meeting: The consent form is under revision and looking at feedback due to the complexity of consent. Confidence in using the form will iron out any difficult conversations. Over halfway of pilot and notice that the conversations more streamlined. MASH forms are next step to be reviewed with the hope of a more intuitive form for tissues.	

6.7	DCD assessment – L Middlehurst provided an overview - paper **(RAG(26)03)** was circulated prior to the meeting: The summary is in the paper. At previous RAG it was discussed to reduce those non-proceeding donors due to PTA. With concerns of less mobilisations for DCD the pre and post assessment forms were looked at and the number of times those families were not approached due to PTA and there were no changes in the data. Looking at this data monthly over the last 5 yrs, around 68-73% was the correct decision. No data provided changes this prediction rate and all with the same outcome.	
7.	**PATIENT SAFETY**	
7.1	Patient Safety Report - K McNally provided an update - paper **(RAG(26)04)** was circulated prior to the meeting: There were 2 incidents reported 1 where blood volumes were discussed further with the following points noted: As there are multiple protocols including the NORS standards these need to be aligned so SNODs have an idea of the requirement. Comms have been sent to Directors of local blood banks and updated in the documents. SNODs will send comms to local blood banks at the donor hosp.	
7.2	**Debrief updates – ANRP and CT retrieval** – S Beale provided an update: 5 CT and ANRP debriefs held covering 10 cases 8 National ANRP debriefs held covering 12 cases Attendance remains challenging and has decreased over the last 12 months, encouraging teams to join. Learning from patient safety debrief - letter shared with NORS leads in Feb 2026 Following a recent debrief of a complicated multiorgan NRP retrieval which involved both abdominal and cardiothoracic NORS teams, we wanted to share some learning with the retrieval community. The specific incident related to perfusion difficulties during NRP which took approximately ten minutes to recognise and correct. The learning points were: • Teams should be more familiar with the existing NRP protocols (https://www.odt.nhs.uk/retrieval/policies-and-nors-reports/) • In particular, attention should be paid to the aortic vent cannula at the point when NRP commences. Any blood loss through the vent cannula should prompt an immediate instruction to stop NRP; the presumption being the aortic clamp is misplaced. • The vascular clamps used for retrieval should come from the abdominal pack to avoid later changes when the CT team leaves. • The above two issues should be addressed at the preoperative briefing. • Communication between CT and abdominal teams is an important component affecting outcomes.	

	• NORS team members are welcome to attend the monthly cardiothoracic with NRP retrievals debriefs, chaired by I Currie and M Berman. These are good opportunities to share learning points.	
7.3	Surgical count at retrieval – C McIntyre provided an update: An issue has been identified regarding the availability of donor hospital staff to assist NORS teams with surgical counts during retrieval procedures. Due to workforce challenges in donor hospitals, NORS teams are at times allocated a junior member of the team who does not have the competency to undertake a count or a team member who does not feel competent or safe to undertake a count with a set of instruments with which they are not familiar. It is suggested as best practice, during the team brief the arrangements for the surgical count should be discussed and agreed. Given the various NORS teams arrangements, if donor hospital staff are unable to perform the count, the NORS team must undertake and manage the count themselves. The donor hospital staff should be informed that a count has been completed so the outcome can be recorded. **All NORS team members must be supportive and understanding to allow the count to be.** **ACTION:** C McIntyre to formalise the process. **ACTION:** C McIntyre, M Berman, C Johnston send comms to NORS teams of the process.	C McIntyre C McIntyre/M Berman/C Johnston
8.	**SUSTAINABILITY AND CERTAINTY IN ORGAN RETRIEVAL (SCORE)** – S Beale provided an update: Modelling is currently underway and is expected to continue for approximately one year, with one week per month dedicated to covering all scenarios. This work is hosted on the SCORE website, where centre-specific data, including organ arrival times, is available. The next step is to progress the development of the full business case over the summer period. In parallel, the digital offering platform will continue to be developed as a top-level priority, as it needs to be fully embedded before go-live. Specialist Nurses in Organ Donation (SNODs) will also begin discussions with local donor theatre teams to support awareness and preparation for the upcoming changes.	
8.1	NORS contract - E Billingham provided an update: A communication has been sent to all abdominal teams, and several meetings have already taken place. Teams have been encouraged to share any concerns and to make contact directly to ensure their feedback is captured and considered.	
8.2	Local NORS collaborative forum – C McIntyre provide an update:	

	The recommendation from SCORE was to establish local NORS collaboratives that would meet twice a year. Positive feedback has been received from teams so far, and meetings are being scheduled, with updates also shared through clinical review meetings. There remains a significant amount of work to ensure the right people are involved, particularly given the frequency of management changes. One suggestion is to introduce joint monthly meetings involving each team and NHSBT. E Billingham has offered to attend these sessions on request to discuss NORS contract requirements and provide further clarity. In addition, the National NORS Clinical Forum meets annually and is chaired by C Johnston and E Billingham. This forum provides an opportunity to share best practice and support collaborative problem solving across teams.	
9.	**ORGAN DAMAGE**	
9.1	Organ Damage Report **-** R Hogg shared the paper - paper **(RAG(26)05)** was circulated prior to the meeting: There is 1 outstanding B form. Any severe damage gets supported to the Patient Safety team. The data is only surgical damage which much lower than anywhere else in Europe - well done to all teams. **ACTION:** R Hogg to consider adding DCD Heart to team comparisons and present at autumn RAG.	R Hogg
9.2	Nephrectomy timings – R Hogg shared the paper - paper **(RAG(26)06)** was circulated prior to the meeting: There were concerns from the community by donor type and organs retrieved. A cap of 120 mins was set for times to nephrectomy. As there were not enough follow up forms to collate this data it will be presented at the next RAG. This will feed into KPIs of NORS contract. Further discussion took place with the following points noted: • Time taken to remove organ has no evidence of impact to other organs. • Heart guidelines are in place • D Manas stated this cannot be set as a KPI only as a guideline • Warm ischemic times can impact outcomes • Cambridge policy standard is within 45 mins, and this is achieved **ACTION:** R Hogg to gather further data for hepatectomy and nephrectomy timings per centre and present at autumn RAG.	R Hogg
10.	CUSUM report **-** R Hogg shared the paper - paper **(RAG(26)07)** was circulated prior to the meeting: There have been no signals since last meeting, with one previous signal outstanding.	
11.	A-NRP STEERING GROUP – I Currie provided an update - slides **(RAG(26)16)** circulated with the minutes:	

	No meeting since Sept 2025 year due to the Chair C Watson stepping down. A depth of gratitude to what he has achieved. The next meet is July 2026. There is lots of BAU plus CT retrieval base line changes which will be taken forward for risk adjustment. The numbers in the paper are provisional, correct ones will be in the NORS report: DCD and NRP from 2019/20 – 2025/6 sharply increased utilisation with same no of attendances. With a 22% increase for liver transplants.	
11.1	A-NRP roll out **-** D Macklam shared the paper - paper **(RAG(26)08)** was circulated prior to the meeting: The aim is to fully commission this service by April 2027 and happy to support any blockages teams are presented with. Cases are increasing, supported by funding that has enabled 8 of 10 teams to be signed off; however, many are not yet increasing delivery of ANRP due to ongoing challenges with workforce capacity and equipment. Although ANRP is now incorporated into the contract and rota commitments, delivery is constrained by difficulties in training, including limited mentorship capacity and the need to establish a sustainable workforce model.	
11.2	Update on Paediatric abdominal A-NRP **–** A Bueno provided an overview - paper **(RAG(26)14)** circulated with the minutes: There is a broad agreement to progress Paediatric A-NRP. The focus of practical implementation has started with discussions with all teams. Technically it is possible, as the machine can be adapted for paediatrics and discussion around logistics. Proposal of 3 stages implementation which requires support: Operationally, perfusion workforce, equipment, sustainable fund, mentorship and pathways. This will be looked at nationally and a business case is required to prove the concept – a working group will be set up. M Berman suggested to work with T-NRP colleagues which is used for neonatal in other countries.	
12.	**DCD HEARTS**	
12.1	Cardiac Retrieval Service Development Group **-** D Macklam shared the paper - paper **(RAG(26)09)** was circulated prior to the meeting: There is an increase in ECMO usage. Improved transplantation and 60% of donors are now DCD donors. For Paediatrics funding remains charitable to support on a local basis while a national business case is being developed. Now there is base line funding the remit is working toward sustainability of the service. The group have now re-named as CRSDG and will look at how to stabilise the service and bring in paediatrics. Additional elements/**actions**:	

	• Donor age is capped at 50yrs – CTAG raised whether age can be increased to 60yrs. Data has been modelled. This was deferred to the DCD Heart Stabilisation Group for detailed review of the data and discussion. • Potential DCD hearts missed by only having one DCD heart team on the rota. The impact of adding a second team is being considered. • Criteria for training has been developed to support sign off of DCD heart surgeons and perfusion specialists. A case was highlighted where a maternal cardiac death occurred and a foetal heartbeat was present at 8 weeks gestation. Within UK guidance this highlights a gap and the guidelines need to be reviewed and changed. **ACTION:** M Berman, I Currie, D Manas to discuss with D Gardiner, O McGowen and J Chalker who have these guidelines specifically around ethical advice.	M Berman, I Currie, D Manas
12.2	DCD Heart retrieval service stabilisation workstream – I Currie provided an update: The workstream commenced 18 months ago to equally distribute the workload as this doubled Papworth's workload. There are 3 legs to the journey as the team travel with the organ to recipient. An 11-hr rest period was added with no impact on DCD retrievals. A 4th team joined rota (Newcastle) who are being proctored by Papworth with signing off in progress. There are some gaps in rota cover, so the service is still not stable especially if unexpected issues arise. Offline looking at surgeons being renumerated for performing extra work/new technologies etc.	
12.3	<u>Consideration of a second DCD heart team</u> **–** S Beale provided an update - paper **(RAG(26)10)** was circulated prior to the meeting: Numbers have increased with more demands on teams and length of time is longer. Issue with multiple mobilisations, consent and teams time out. Some of these are up to 46 hours due to flights or no team availability. An extra team can potentially create benefits more local to donor and reduce costs by 50%. Options being considered are do nothing or look at 2 current teams (recommendation) or train all 6 teams to make service more robust. These will be presented at SMT. <u>Further discussion took place with the following points noted:</u> • Consent loses 1 organ per month • Volumes will grow per centre per year • This will make the service sustainable as it's based on 1 surgeon and if not available the teams not available. • Option 3 is good if the age bracket changes • Impact assessment for heart/lungs • Financially the same apart from training. • No abdominal organs have been lost • Number of staff at retrieval is lean when retrieving both heart and lungs – 2 surgeons are difficult especially using ANRP etc.	

	• Manchester workforce is an issue with team on the ground. Would like to attend next meet 3 June to address this • Link with finance and business managers to discuss • Modelling when both teams are on rest period	
12.4	Impact of 11-hour rest **–** I Currie provided an update: To date, there is little evidence that the 11-hour rest period has led to missed DCD heart retrievals. However, some risk of missed opportunities due to non-availability remains. Monitoring continues, with findings reported via the DCD Heart Stabilisation Group and the Cardiac Retrieval Service Development Group. Centres are encouraged to retrieve DCD hearts directly using OCS to reduce deployment times and build experience. Uptake has been minimal since January 2026, largely due to staffing constraints.	
12.5	DCD heart training and registration – M Berman provided an update: **ACTION:** M Berman and I Currie will look at the options for signing off this process and finalise how to register machine perfusionists and operators.	M Berman/I Currie
12.6	European DCD Paediatric heart retrieval **–** E Lawson provided an update: No updates were noted from colleagues.	
12.7	Clinical update DCD Paediatric – L Kenny provided an update – Slides **(RAG(26)15)** circulated with the minutes: The HOPE programme is now fully operational under an MHRA blanket humanitarian waiver. To date 10 HOPE transplants have been completed (4 DCD and 6 DBD) with an additional 9 screening calls in the last 18 months. Protocols have been finalised and now include very small donors. All children on the waiting lists are being offered DCD and DBD hearts. Postoperative outcomes have been excellent with all cases demonstrating normal function at 30 and 60 days post- transplant. The programme remains entirely charity-funded and reliant on a volunteer workforce, meaning it is operating with extremely limited resources. Great Ormond Street have completed their paperwork and can retrieve DBD and DCDs hearts.	
13.	**CRITICAL UPDATES**	
	ACTION: An updated National NRP protocol will be shared by I Currie.	I Currie
14.	**NORS CLINICAL LEADS FORUM** The next meeting is due to be arranged and if there are any suggested agenda topics, please email C Johnston or E Billingham.	All

15	**EDUCATION**	
15.1	Masterclass Update – virtual and cadaveric **–** C Johnston provided an update: The general feedback is good and extended to 3 days to include machine perfusion. There are recordings available and there is lots of interest from trainees. The next meeting for the organisers is in June and any suggestions are welcome, please pass this onto trainees. Suggestions noted are: • Non operative skills (pregnancy or challenging scenarios) role play • Paediatric retrieval • Include a hybrid element • Log in or a session for established colleagues	
15.2	Learnpro retrieval video library - I Currie provided an update: This library is restricted to NORs teams only due to the sensitive nature of the material. The Masterclass content is not included within the library, as it is not equivalent to attending the session and receiving formal certification. However, colleagues are encouraged to contribute practical resources to the library, such as guidance on packing an icebox or preparing tray layouts.	
15.3	UK NORS textbook – C McIntyre provided an update: Colleagues agreed that a Retrieval textbook would be a useful quick reference guide. **ACTION:** Item to be discussed at June Masterclass organisers meeting.	C McIntyre
16.	**TA-NRP –** M Berman provided an update: A minimum of five cases is required for the study to proceed. As no patients have been recruited over the past year, the study has yet to commence.	
17.	**RESEARCH**	
17.1	Study 173 Investigation of human immune modulation to prevent transplant rejection, autoimmunity and inflammation" – E Lawson provided an update: Oxford will go live in October 2026 and will take additional blood samples and tissue samples, lymph, spleen, bowel, spinal tissue, tonsil and biopsies of nasal mucosa, either from DBD or DCD retrievals. Trainees will be mobilised with no impact to the retrieval teams. The samples will be taken from surgeons from Oxford who are competent NORS surgeons, they will attend in addition to the retrieving Abdo NORS Teams.	

	The expansion on the lung trial has received positive feedback again with no impact to teams.	
17.2	Update on mOrgan – E Lawson provided an update: Due to no update currently, keep on the agenda for the autumn meeting.	
18.	**ANY OTHER BUSINESS**	
18.1	Items for next RAG agenda: **ACTION:** • All to send suggestions for the next meeting. • J Parmar shared that BAL samples are low – can teams please take to every retrieval for QUOD bank.	
19.	**KEY POINTS FROM TODAY'S MEETING FOR CASCADE TO CENTRES**	
20.	**FOR INFORMATION ONLY**	
20.1	QUOD Data and Governance Update – **RAG(25)11** - This paper of QUOD statistics in October 2025 was circulated prior to the meeting.	
23.4	Date of the next meeting Thursday 22 October – via Microsoft Teams	