



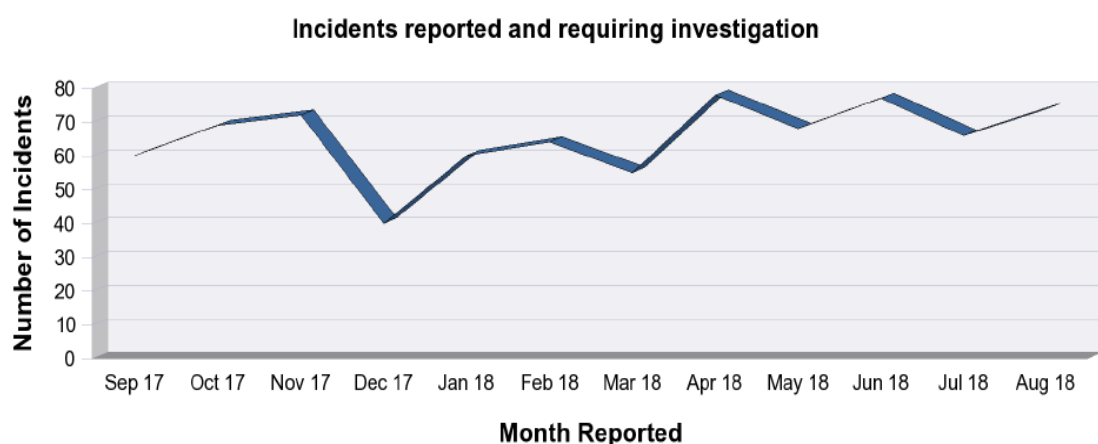
**PAG Advisory Group
ODT Clinical Governance Report**

1. Status – Confidential

2. Action Requested

PAG are requested to note the findings within this report and respond to questions raised below

3. Data



4. Learning from reports

Below is a summary of the findings and learning from key clinical governance reports submitted to ODT or investigation completed between 1st April 2018 – 31st October 2018:

Date reported: 18th April

Reference: INC 3173

What was reported
That pancreas was not transplanted due to anatomy of kidney that went as part of SPK. Concerns raised that kidney without anatomy problems should have given a part of the SPK rather than the one provisionally requested at time of offering.
Findings investigation
The offering had been completed correctly as agreed previously by the advisory groups that the highest ranking person would always receive the left kidney even if the organ had altered anatomy, size or even damaged. The right kidney could be requested but would require the other centre to agree and would be required due to a major clinical need.
Learning

This has been raised with both kidney and pancreas advisory groups for their awareness.

Date reported: 25th October 2018

Reference: INC 3593

What was reported
Islet isolation process from the pancreas was abandoned due to the poor condition of the pancreas as a result of donor trauma.
Findings investigation
Concerns that the condition of the pancreas did not reflect what had been documented on the HTA A form. Following review of the HTA A Form and discussion with John Dark it was agreed the description of the trauma was sufficient.
Learning
Highlight with PAG that concerns were raised around isolation laboratories being busy when accepting a pancreas which might not have been right for isolation due to its condition following trauma. This resulted in concerns that the laboratory might not be able to accept another healthy pancreas for isolation whilst they assessed the organ.

5. Summary from National Lead for Clinical Governance

In addition to these specific Incidents, a few other issues which have occurred during the past 6 months have some useful learning.

One was around photos of organs. There is clear guidance from ODT ([Guidance and Principles – Donor Organ Photographs](#)), with an emphasis on the benefit to the recipient being a priority. That guidance also stresses the importance of either encryption (for instance, though WhatstApp), or use of an nhs.net email address, and complete deletion of all the information once the clinical need has been met.

One Incident surrounded poor packaging of vessels which accompanied the pancreas, and the requirements for such packaging has been emphasised in a letter to all NORS teams from the National Lead for Organ Retrieval.

Finally, the occasional inability of surgeons to ligate the bile duct in a pancreas retrieval continues to surface from time to time. A pancreas, and in one instance, all of the abdominal organs, were lost because of contamination

6. Requirement from PAG

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