NHS BLOOD AND TRANSPLANT

ORGAN DONATION AND TRANSPLANTATION DIRECTORATE

BOWEL ADVISORY GROUP

SUMMARY FROM STATISTICS AND CLINICAL STUDIES

INTRODUCTION

1 This paper provides an update from Statistics and Clinical Studies and summarises current and future work.

UPDATE FROM STATISTICS AND CLINICAL STUDIES

2 The third Annual Report on Intestinal Transplantation was produced by NHSBT and circulated to intestinal transplant centres for review in September 2016 (deadline for responses and planned publication date is 10th October 2016). The report covers 10 years of intestinal transplant data, from 1 April 2006. Reports for all organs are available from *http://www.odt.nhs.uk/uk-transplant-registry/organ-specific-reports*.

3 Work has been done to improve the contents of the Annual Report on Intestinal Transplantation. This year's report includes risk-adjusted survival rates post-transplantation and post-registration based on a small number of risk factors identified from national and international studies. There is more work to be done to identify risk factors for intestinal transplant patients which is reliant on the continued provision of high quality data to the UK Transplant Registry.

CURRENT AND FUTURE WORK

4 Statistical support is being provided to the Small Adults Working Group of the Bowel Advisory Group (BAG). The Group is due to meet on 18th October to agree a plan for analysis and action.

5 Work has continued internally to correct errors identified in intestinal transplant data and to avoid new errors happening in future. When a centre accepts donor organs/tissues for an intestinal transplant the Duty Office require information on exactly what has been retrieved from the donor and what has been transplanted. This information, which is usually provided by the recipient coordinator over the phone, needs to be received in a timely fashion as they are required to close the donor record within 72 hours for several reasons, including waiting list management. Recently, a handful of cases have been identified where this verbal communication has been incorrect. The error is usually related to whether the donor stomach or abdominal wall was transplanted or in fact retrieved and disposed of. Due to the nature of the UK Transplant Registry, this sort of issue causes problems that are time consuming to fix. Since this issue has been identified, the Duty Office have conducted refresher training to ensure duty officers ask more explicitly what has and has not been used. The next course of action is to highlight to the recipient coordinators the importance of this information being correct and ask them for feedback on any barriers that might lead to this kind of error occurring in future. Statistics and Clinical Studies will monitor this and let the BAG know if this issue continues.

ACTION

6 Members are asked to highlight to recipient coordinators the importance of correctly communicating this information over the phone to the Duty Office when asked.

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Statistics and Clinical Studies **September 2016**