NHS Blood and Transplant

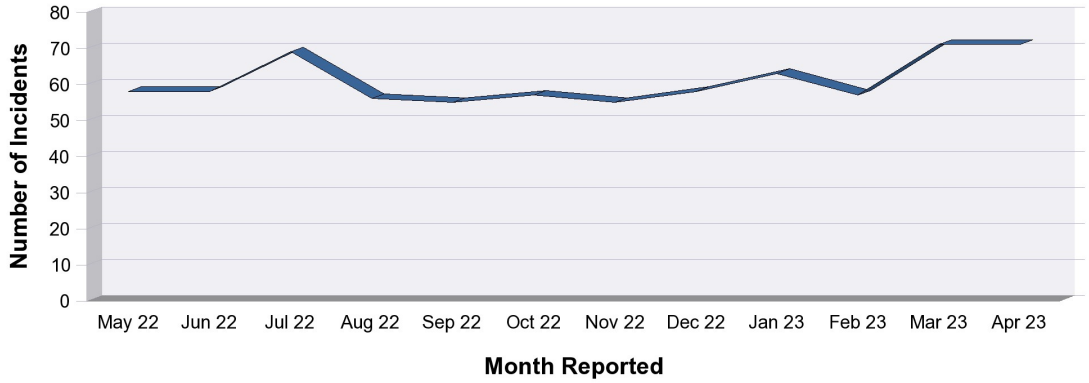
Pancreas Advisory Group
ODT Clinical Governance Report November 2023

1. Status – Confidential

2. Action Requested

PAG are requested to note the findings within this report.

3. Data



4.Learning from reports

Date reported: 06/03/23
Reference INC 6880 and 6879

What was reported
Reported that the pancreas was not tied off at the bile duct on arrival at the transplant centre. Following assessment, as there was no contamination of the pancreas, a decision was made to transplant with antibiotic and anti-fungal cover for the recipient.
Investigation findings
This was reviewed by the abdominal NORS team Lead Surgeon, and they have confirmed that the bile duct was tied and fixed at retrieval and provided images.
Learning
Although it is not clear what happened in this case, it is known that several similar incidents have been reported; in some cases, the pancreas has been contaminated and therefore not transplanted. These have been discussed with NHSBT Associate Medical Director - Organ Retrieval, National Surgical Lead – Clinical Governance and the Chair of

PAG. Following this, communication has been sent to the NORS retrieval teams (April 2023) requesting that the process of “bile duct suture ligation on the pancreas at retrieval” is commenced.

Date reported: 11/06/23, 14/06/23 and 30/06/23
Reference INC 7116/ INC 7124/ INC 7174

What was reported
Several cases have been reported in relation to gastric staples failure.
Investigation findings
Following review by the National Organ Retrieval Teams (NORS) learning was identified around surgical technique which was highlighted with NHSBT UK Retrieval Lead. It was also identified that some of the organs were transplanted, and some were not due to suspected or actual contamination.
Learning
The learning regarding surgical technique will be shared at the autumn Retrieval Advisory Group meeting for wider awareness for all retrieval teams.

Date reported: 15/09/23 and 27/07/23
Reference INC 7249 and INC 7360

What was reported
No isolation laboratory available nationally
Investigation findings
On-going issues with lack of isolation laboratories availability for islet isolation. This is due to multiple factors; contamination of Laboratory A, Laboratory B unable to work additional hours due to staff contractual review and staff sickness at Laboratory C. This is regularly being reviewed by a group including - Head of Service Delivery - ODT Hub, Chair of Islet Advisory Group, QA, ODT Statistics and OTDT Medical Director in which they look at rotas for laboratory cover. Offers are still made to transplant centres for them to assess the suitability of an organ. At the time of writing, it has been confirmed that organs have been declined due to unsuitability rather than lack of isolation laboratory, however, as offers are continual this may have changed since the writing of this report.
Learning
Sharing report for wider awareness.

5.Trends noted

Some recent cases have highlighted a requirement to share NHSBT Organ Donation Management Team On-Call Contact Details: Any questions or concerns transplant colleagues have regarding proceeding donors/cases can be directed in the first instance to NHSBTs Organ Donation Management Team On call. They will then be able to liaise with the staff directly involved and escalate to NHSBT Directors on Call if required. They can be directly contacted 24hrs a day via a pager 07623512222.

6.Requirement from PAG

Note findings in report. PSIG have been requested to discuss the differences in CIT criteria for islet isolation.

Author

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