NHS
Blood and Transplant

Pancreas Transplant Summit

Report and Recommendations

October 2026



Executive Summary

The Pancreas Transplant Summit, held on 30 June 2026 at King's College London, convened the UK's pancreas transplant community to address a sustained decline in solid organ pancreas (SOP) transplant activity and rising waiting list pressures. Over the past decade, SOP transplant numbers have fallen by almost 30%, while the waiting list has grown by 70%, with median waiting times increasing from 364 days to 598 days and exceeding 1,000 days for blood group O recipients. The underlying reasons for this are likely to be multi-factorial, complex, and inter-related.

The summit brought together transplant surgeons, nephrologists, diabetologists, NHS Blood and Transplant (NHSBT) leaders, Commissioners, statisticians, islet transplant specialists, organ retrieval experts, and patient representatives. The morning plenary reviewed current data on donation trends, retrieval quality, offering pathways, organ utilisation, and emerging beta-cell replacement therapies. Afternoon breakout groups developed practical solutions, later synthesised into a set of national recommendations.

Key issues identified included the following:

- Declining deceased donor numbers, reduced neurological death testing, and falling consent/authorisation rates
- Increasing reliance on donation after circulatory death (DCD) donors, though with lower pancreas utilisation
- Variation between centres in organ utilisation practices
- Issues within the National Pancreas Offering Scheme (NPOS), including interactions with the National Kidney Offering Scheme (NKOS)
- Workforce fragility, limited succession planning, and concerns about risk aversion driven by governance (e.g., cumulative sum (CUSUM) triggers)
- Insufficient collaboration between SOP and islet transplant programmes, despite evolving beta-cell therapies
- Gaps in data quality, granularity, and linkage to wider diabetes datasets

The following recommendations were made:

1. Review and modify the NPOS and other relevant schemes
2. Increase the utilisation of offered pancreases by 20%

3. Reduce centre variation in offer acceptance and transplantation rates
4. Improve training in pancreas retrieval to minimise damage and increase utilisation
5. Positive collaboration between SOP transplant centres, and with islet transplant centres
6. Ensure that better data are available to guide optimal clinical decision-making
7. Improve the pancreas transplant workforce
8. More support of patients
9. Prepare for future developments in pancreas transplantation and beta-cell replacement

Timelines for implementation, with estimated resource requirements, were identified. Completion of the above recommendations will be overseen by the Pancreas Advisory Group (PAG), with input from members of the wider organ donation and transplant communities as needed.

Summit Overview

Over the last 10 years, the number of SOP transplants performed annually in the UK has dropped by 25-30%, and the number of patients on the UK pancreas transplant waiting list has risen by 70%. The Pancreas Summit was held on 30 June 2026 at King's College London, and the aims of the summit were to gather the SOP transplant community to identify and define the underlying reasons for the fall in SOP transplantation in the UK, to formulate reasonable actions to reverse this trend, and to improve outcomes for patients waiting for a pancreas transplant.

The objectives of the meeting were to:

- Increase SOP transplant activity
- Improve SOP organ utilisation
- Enhance our understanding of the broader landscape of beta-cell replacement therapies in the UK and provide a roadmap for future improvements

These objectives will be achieved by:

- Identifying barriers and actionable solutions to increase SOP transplant activity to pre-2019 levels
- Reviewing current evidence and establishing a consensus
- Developing system-level policies and operational changes
- Understanding how to strengthen collaboration between centres and disciplines
- Establishing a commitment to improve accountability

The meeting was divided into three sessions, with a plenary morning session to review current data and set the scene, breakout sessions in the afternoon to identify solutions to the issues identified, and a final plenary session to report back to attendees and determine next steps (Appendix 1).

It was agreed prior to the summit that the output of the meeting would be a report with recommendations for PAG, NHSBT, and the wider donation and transplant communities to take forwards. Completion of recommendations will be overseen by PAG, with input from members of the above communities as needed.

Attendees

The summit was organised by NHSBT, and the organising Chairs of the event were:

- Chris Callaghan, Consultant Transplant Surgeon, Guy's Hospital, and Chair of PAG
- John Casey, Consultant Transplant Surgeon, Royal Infirmary of Edinburgh, Chair of PAG Islet Steering Group, and Organ and Tissue Donation and Transplantation (OTDT) Deputy Medical Director, NHSBT
- Derek Manas, Consultant Transplant Surgeon, Freeman Hospital, and OTDT Medical Director, NHSBT

To ensure a thorough discussion, and to reflect the diversity within the SOP transplant community, representatives from many different backgrounds were invited to attend. SOP transplant centres were asked to invite their multi-disciplinary team and managers. Attendees included:

- NHS Commissioners, including those from devolved governments
- Recipient transplant co-ordinators
- NHSBT representatives, including from the organ donation community and the Pancreas Clinical Lead for Organ Utilisation (CLU)
- Consultant transplant surgeons
- Consultant nephrologists
- Consultant diabetologists
- PAG lay member representatives
- PAG patient representative
- NHSBT statisticians
- Representatives of the islet transplant community
- Representatives of the histocompatibility and immunogenetics community
- Transplant centre manager

All SOP transplant units in the UK were represented, and an observer from the Republic of Ireland national SOP transplant unit was also present. Patient and lay members were present throughout the meeting, ensuring that their perspectives informed the discussions.

Context and Data

Pancreases are donated for the purposes of transplantation into patients living with severe complications from diabetes, to re-establish their own insulin secretion and reduce the risk of diabetes-related co-morbidities in future. Patients waiting for a SOP transplant can receive a whole pancreas by itself, or with a kidney from the same deceased donor (simultaneous pancreas-kidney (SPK) transplantation). Alternatively, a donated pancreas may undergo a process to purify insulin-producing cells that are then transplanted as an islet transplant, either by itself, or with a kidney from the same deceased donor (simultaneous islet-kidney (SIK) transplantation). Patients waiting for an SOP transplant or an islet transplant are on the same national waiting list. There are eight SOP transplant units in the UK (Edinburgh, Newcastle, Manchester, Oxford, Cambridge, Cardiff, Guy's Hospital (London), and Hammersmith Hospital (London)).

There are significant challenges for SOP transplantation in the UK, with falling numbers of pancreas transplants and increasing waiting lists. The underlying reasons for this are likely to be multi-factorial, complex, and inter-related. These changes have happened in the context of wider changes, e.g., improvements in diabetes technology, workforce resilience issues, and other organ donation and transplantation trends. NHSBT have addressed some of these issues in previous meetings and processes, including the Organ Donation Joint Working Group (ODJWG) (2026) and the Islet Transplant Summit (2024).

Pancreas Transplantation (Shaminie Shanmugaranjan, NHSBT Statistician)

Over the last 10 years, the number of pancreas and islet transplants has dropped by almost 30%, whilst the waiting list has increased by almost 70% (Figure 1).

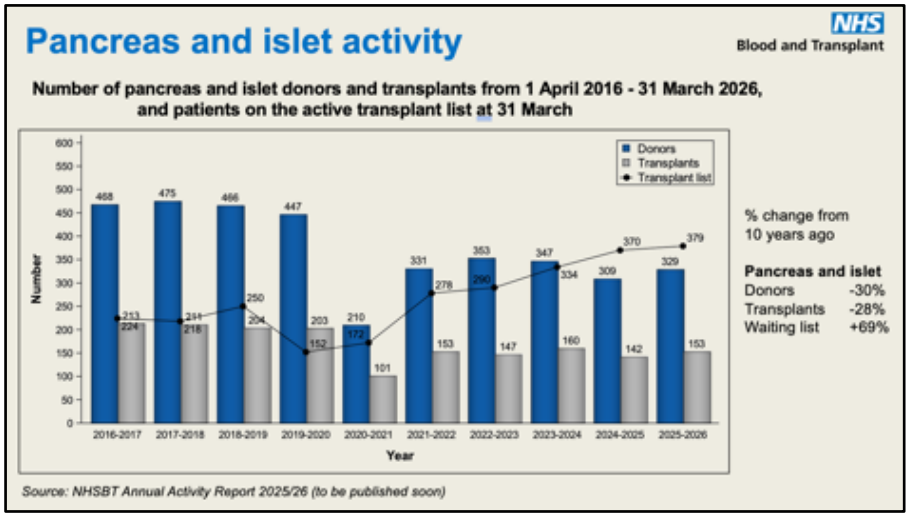


Figure 1: Pancreas and islet donors, transplants and patients on the waiting list 2016-2026

The overwhelming majority of pancreases transplanted are SOP transplants (80-85%) rather than islet transplants. That proportion has stayed constant over the last 10 years. The proportion of SOP transplants from DCD donors has increased from 25% to 41%. The median waiting time to SOP transplantation (of those that reach transplantation) has increased from 364 days between 2015-2019 to 598 days between 2020-2024. Blood group O recipients waited a median of 1028 days in the latter period. For those patients that were registered on the SOP transplant waiting list between 2022-2023, just 44% had been transplanted three years later and 23% had been removed from the list or had died. Five years after a first SPK transplant, average pancreas graft survivals are approximately 85%, kidney graft survivals are approximately 92%, with patient survivals of 91%.

Deceased Donor Organ Donation (Helen Buglass, Regional Clinical Lead for Organ Donation)

Deceased donation activity in the UK has been static or falling for the last 5-6 years, with an increasing number of controlled DCD donors (Figure 2).

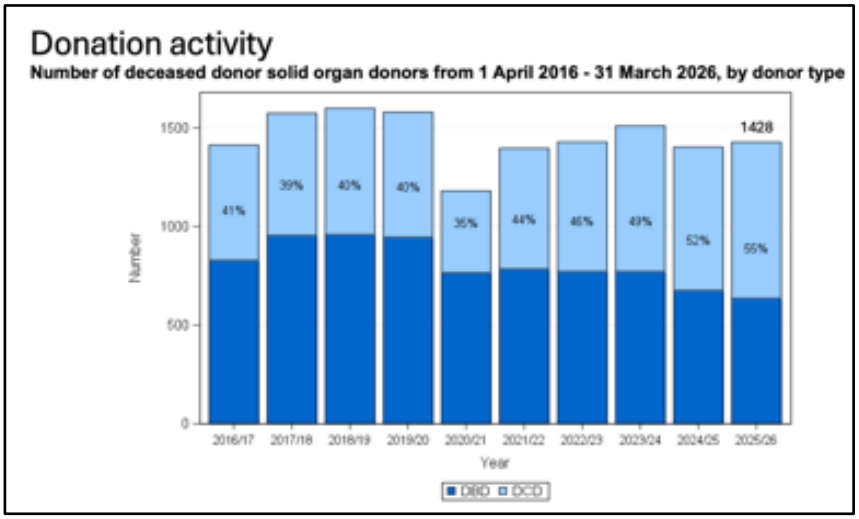


Figure 2: Deceased donation activity in the UK, by donor type, 2016-2026

The reasons for the increase in DCD over DBD donations are multifactorial, including that the neurological death testing rate has dropped progressively, especially over the last 2-3 years (Figure 3), and the consent/authorisation rate has dropped to 57%.

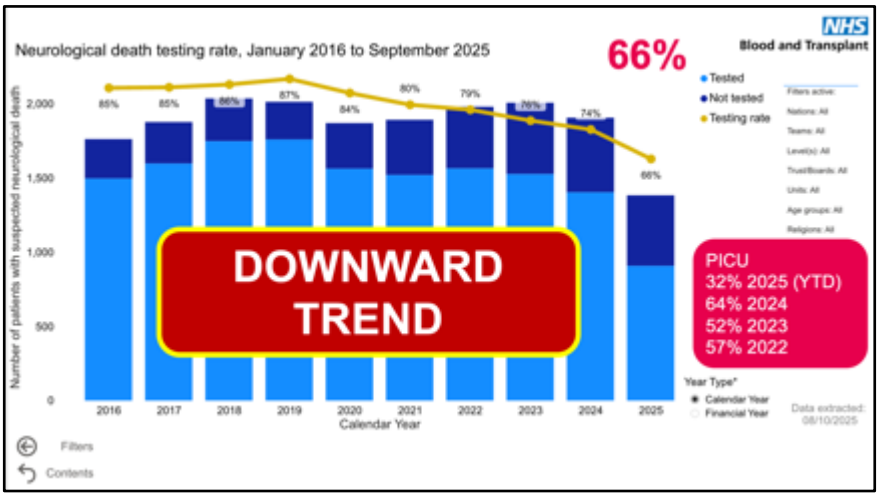


Figure 3: Neurological death testing rate in the UK, 2016-2025

The age of UK deceased donors has stayed stable, with approximately 40% being aged under 50 years. These challenges have been recognised by the organ donation community, and ten high-level actions are being taken forward as part of the ODJWG report (Figure 4). Other developments to improve organ donation rates include an updated code of practice for the diagnosis and confirmation of death. Increasing consent/authorisation rates and neurological death testing is a priority for NHSBT and the organ donation community.

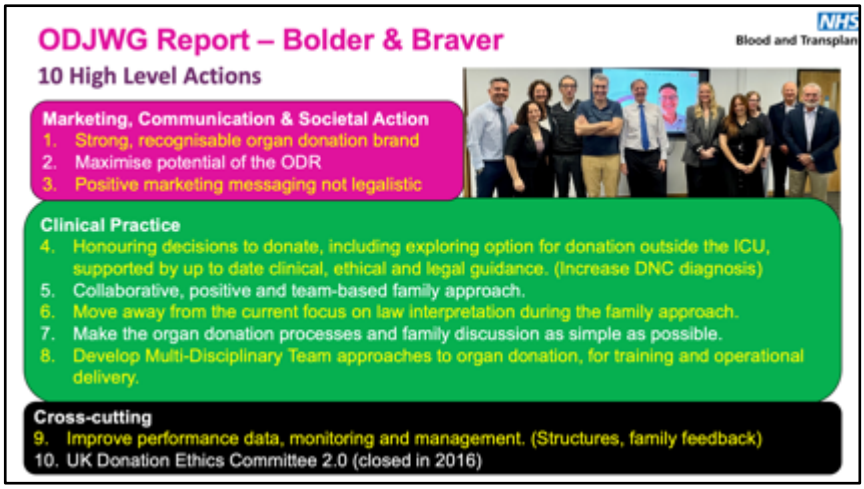


Figure 4: High-level actions from the ODJWG Report (2026)

Pancreas Retrieval (Marius Berman, Chair, Retrieval Advisory Group)

The educational activities underpinning the National Organ Retrieval Service (NORS) were described, including the three-day NORS Virtual Masterclass and the two-day Cadaveric Retrieval Masterclass. There are annual reports on NORS activities, and numerous team metrics, including utilisation rates and organ damage rates. NORS is underpinned by a strong commitment to clinical governance and patient safety, and CUSUM processes are used to

detect signals regarding organ loss due to retrieval surgical damage (NHSBT policy document MPD1791/1). Reported pancreas damage rates from DBD donors are similar to livers and kidneys, whilst severe pancreas damage rates from DCD donors are higher (Figure 5). For pancreases retrieved from DCD donors, there was no difference in damage rates between NRP and non-NRP retrievals between July 2024 and December 2025.

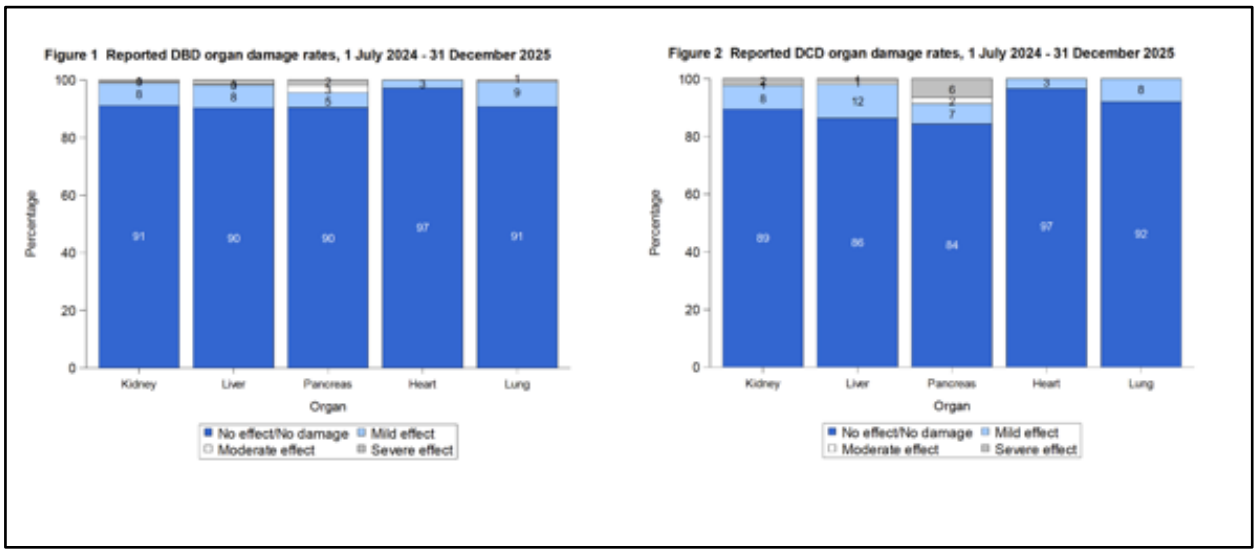


Figure 5: Organ damage rates for DBD and DCD donors, July 2024 – December 2025

Pancreas Offering Pathways (Shaminie Shanmugaranjan and Chris Callaghan)

Changes to the NPOS were described (Figure 6). Major updates occurred in 2019, when deemed consent laws were introduced in England, and increases in deceased organ donation were projected.

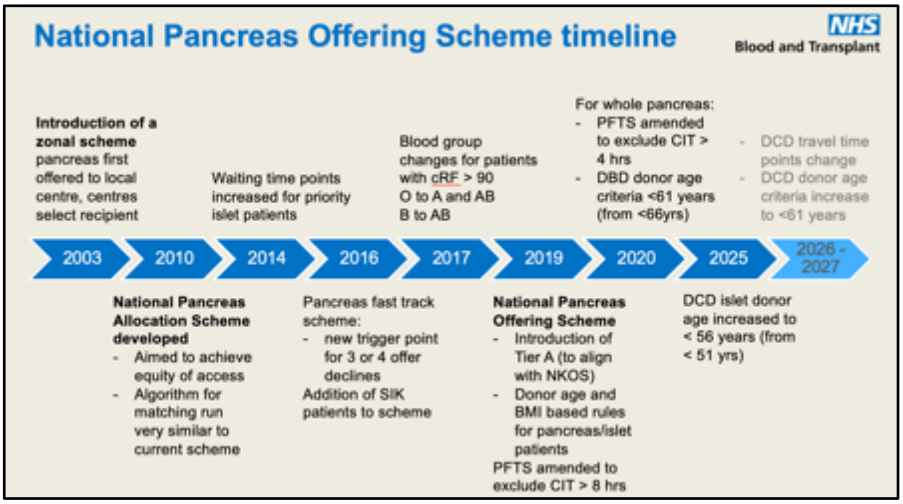
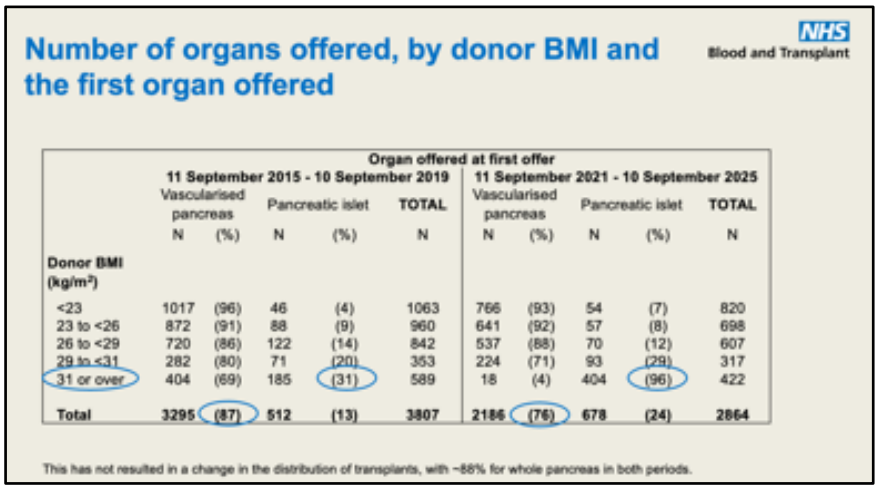


Figure 6: Changes to the NPOS

Since 2019, the number of first offers to SOP patients has decreased, whilst the number of first offers to islet patients has increased (Figure 7). More detail has been provided in the recent PAG paper (26)02, including an analysis of all offers, where the same trend is seen.



Number of organs offered, by donor BMI and the first organ offered

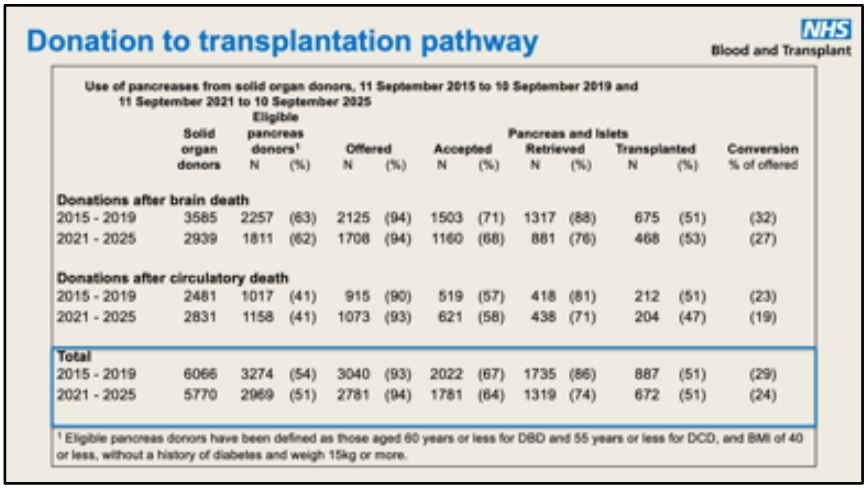
NHS Blood and Transplant

	Organ offered at first offer									
	11 September 2015 - 10 September 2019					11 September 2021 - 10 September 2025				
	Vascularised pancreas		Pancreatic islet		TOTAL	Vascularised pancreas		Pancreatic islet		TOTAL
	N	(%)	N	(%)	N	N	(%)	N	(%)	N
Donor BMI (kg/m²)										
<23	1017	(96)	46	(4)	1063	766	(93)	54	(7)	820
23 to <26	872	(91)	88	(9)	960	641	(92)	57	(8)	698
26 to <29	720	(86)	122	(14)	842	537	(88)	70	(12)	607
29 to <31	282	(80)	71	(20)	353	224	(71)	93	(29)	317
31 or over	404	(69)	185	(31)	589	18	(4)	404	(96)	422
Total	**3295**	**(87)**	**512**	**(13)**	**3807**	**2186**	**(76)**	**678**	**(24)**	**2864**

This has not resulted in a change in the distribution of transplants, with ~88% for whole pancreas in both periods.

Figure 7: First offers for SOP and islet transplantation before and after 2019 NPOS

The number of donors eligible for pancreas donation has dropped since 2021, especially from DBD donors. The proportion of pancreases retrieved from eligible pancreas donors has decreased for both DBD and DCD donors, with a lower overall conversion rate (Figure 8).



Donation to transplantation pathway

NHS Blood and Transplant

Use of pancreases from solid organ donors, 11 September 2015 to 10 September 2019 and 11 September 2021 to 10 September 2025

	Solid organ donors	Eligible pancreas donors[1]		Pancreas and islets Offered		Accepted		Retrieved		Transplanted		Conversion
		N	(%)	N	(%)	N	(%)	N	(%)	N	(%)	% of offered
Donations after brain death												
2015 - 2019	3585	2257	(63)	2125	(94)	1503	(71)	1317	(88)	675	(51)	(32)
2021 - 2025	2939	1811	(62)	1708	(94)	1160	(68)	881	(76)	468	(53)	(27)
Donations after circulatory death												
2015 - 2019	2481	1017	(41)	915	(90)	519	(57)	418	(81)	212	(51)	(23)
2021 - 2025	2831	1158	(41)	1073	(93)	621	(58)	438	(71)	204	(47)	(19)
Total												
2015 - 2019	6066	3274	(54)	3040	(93)	2022	(67)	1735	(86)	887	(51)	(29)
2021 - 2025	5770	2969	(51)	2781	(94)	1781	(64)	1319	(74)	672	(51)	(24)

[1] Eligible pancreas donors have been defined as those aged 60 years or less for DBD and 55 years or less for DCD, and BMI of 40 or less, without a history of diabetes and weigh 15kg or more.

Figure 8: Changes to the pancreas donation to transplantation pathway since 2019

The proportion of extremely high-quality donors where the pancreas was not retrieved has increased since new NKOS/NPOS Tier A definitions were introduced in February 2024 (Figure 9). It was noted that waiting times for a pancreas transplant are broadly equivalent to a kidney-only transplant. There is an especially prolonged pancreas waiting time for blood group O patients. The Kidney Advisory Group (KAG) has recently approved changes to the definitions

of Tier A, which is expected to reduce the number of eligible pancreas donors where both kidneys are offered to Tier A kidney-only patients.

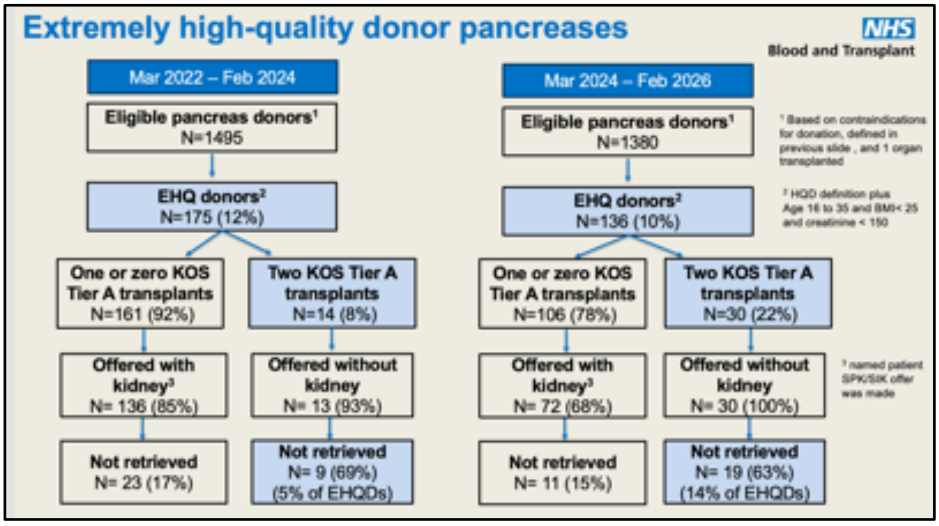


Figure 9: Non-retrieval of pancreases from extremely high-quality donors since February 2019

Overview of Pancreas Organ Utilisation (Simon Knight, Lead Pancreas CLU)

In 2024/25, 26.2% of offered pancreases from DBD donors were transplanted, compared to 12.4% of offered DCD donor pancreases. This differential organ utilisation rate is a particular concern given the increase in the number of DCD donors and the decrease in DBD donors. More data are shown in the NHSBT Annual Organ Utilisation Report. A growing proportion of pancreases are accepted but not retrieved. There is variation in offer decline rates of DCD donor pancreases between units, and this may lead to prolonged waiting times in units with a higher-than-average offer decline rate (Figure 10).

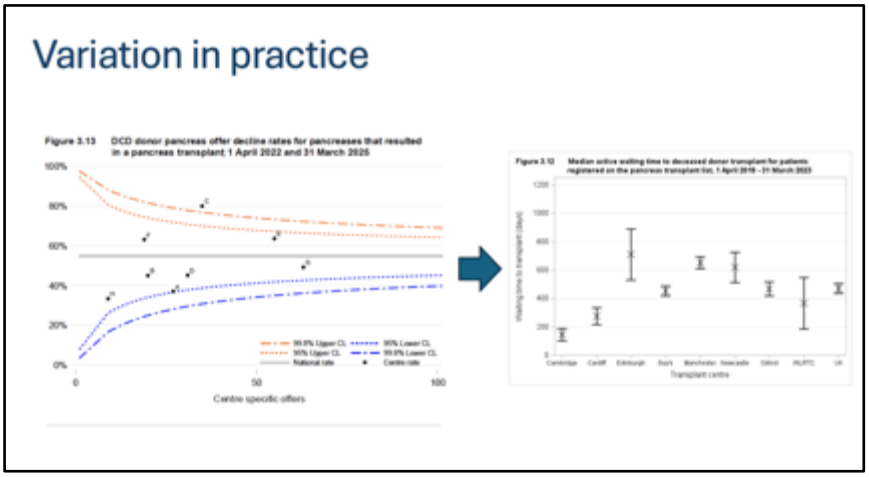


Figure 10: Variation in DCD pancreas offer decline rate and centre waiting time

Further details were presented on pancreases from young, slim donors where both kidneys are allocated to Tier A kidney-only patients and where the pancreas was not retrieved due to the lack of suitable recipients on the pancreas transplant alone waiting list and islet centres had declined due to low body mass index (BMI). Most SOP offers are declined due to concerns about donor history or BMI and subsequent risk of post-transplant pancreatitis, though the risk factors for this are poorly defined. Possible solutions for these issues were discussed, as was the need for balancing earlier versus later offer declines. Firm evidence is needed to help reduce unnecessary organ offer declines and reduce variation between centres.

Collaborative Working and the Beta-Cell Replacement Model (John Casey and Gareth Jones, Chair of the Kidney Advisory Group)

The complexity of beta-cell replacement therapeutic options was discussed, including recent French data from the KAIAK group on the apparent benefits of islet-after-kidney transplantation. The Edinburgh model of an integrated beta-cell replacement unit was described, with a recent increase in referrals for SIK transplantation. The aims, goals and regional structures of NHSBT Collaboratives were described. The importance of joint discussions on beta-cell replacement therapies was recognised, particularly as stem cell therapies become increasingly relevant. Participants agreed that collaboration between pancreas and islet transplant communities will be essential as these therapies evolve.

Summary from the Morning Session

Key themes emerging from the discussion included improving organ utilisation, reducing unwarranted variation in clinical practice, reviewing donor and recipient selection criteria, strengthening oversight of organ offer decline decisions, reviewing and modifying the NPOS, promoting collaboration between SOP and islet units, and ensuring future planning incorporates advances in beta-cell replacement therapies. These areas were identified as priorities for reversing the decline in UK pancreas transplantation and improving outcomes for patients awaiting transplantation.

Recommendations

Attendees were pre-assigned to breakout rooms and facilitators received briefing notes (Appendix 2). Recommendations were expected to be realistic and achievable. Outputs of each group were collated and discussed by facilitators in the final plenary session. These outputs have been summarised below as recommendations, with actions and recommended owners. Other stakeholders will be involved in this process as required.

Where relevant, measurable targets and timelines have been included. A full resource and feasibility assessment has not been undertaken, but significant resource implications are noted where they are especially pertinent.

1. Review and modify the NPOS and other relevant schemes

This will be achieved through:

- Convening a PAG fixed-term working group to examine the NPOS and to consider overarching issues of equity of access, changes in organ donation and transplantation, offering pathway efficiency, improved organ utilisation, optimising patient outcomes from listing, and operational feasibility (PAG)
- Examining specific issues, including (but not limited to) the balance between SOP and islet offering, effect of patient blood group on waiting time, effect of the Tier A NKOS on pancreas offering, possible introduction of dialysis waiting time points, and the definition of Tier A NPOS (PAG, KAG, NHSBT)
- Ensuring the appropriate administrative, statistical and information technology resources are available to support these processes with the timely implementation of any agreed offering scheme changes (NHSBT)

The above will be completed and implemented within 18 months.

2. Increase the utilisation of offered pancreases by 20%

This will be achieved through:

- Dissemination of the existing UK evidence-base on outcomes of DCD donor pancreas transplants, with education of implanting centres (PAG, Pancreas CLUs)
- Discussions to identify significant unanswered questions with registry analyses to address these, e.g., impact of normothermic regional perfusion on DCD pancreas outcomes, identifying risk factors for adverse post-transplant outcomes (Pancreas CLUs, PAG)
- Reviewing and improving pancreas Offer Review Schemes (Pancreas CLUs)

- Analysing reasons for pancreases accepted but then not retrieved, with specific and measurable actions to reduce this practice (Pancreas CLUs, PAG, NHSBT)

The above will be completed and implemented within 12 months.

3. Reduce centre variation in offer acceptance and transplantation rates

This will be achieved through:

- Understanding the reasons behind existing variation between centres and determining if this variation is warranted or unwarranted (Pancreas CLUs)
- Developing objective pancreas assessment criteria with linked utilisation recommendations (Pancreas CLUs, PAG)
- Ensuring that each SOP transplant centre has a local escalation plan for offer declines due to lack of resources (Pancreas CLUs, PAG, NHS Trusts)
- Developing recommended standards in organ utilisation, e.g., time from pancreas arrival at an implanting centre to inspection, encouraging dual consultant offer acceptance/decline decisions (Pancreas CLUs, PAG)
- Focussing the above organ utilisation improvement practices on centres with long-term lower organ utilisation rates, e.g., those outside 95% confidence intervals on offer decline funnel plots (Pancreas CLUs, PAG, NHS Trusts)

The above will be achieved within 24 months.

4. Improve training in pancreas retrieval to minimise damage and increase utilisation

This will be achieved through:

- Further development of training and support packages for NORS surgeons on pancreas and blood vessel retrieval, especially from DCD donors (NHSBT, Pancreas CLUs, PAG, RAG)
- Development of structured pancreas assessment tools for use by NORS teams (Pancreas CLUs, NHSBT, RAG)
- Improved guidance on pancreas photos at organ retrieval with subsequent assessments of photo quality (Pancreas CLUs, NHSBT, RAG)
- Ongoing monitoring of CUSUM damage rates to focus improvement practices on NORS teams with adverse pancreas damage rates (RAG, PAG)

The above will be achieved within 12 months.

5. Positive collaboration between SOP transplant centres, and with islet transplant centres

This will be achieved through:

- Setting up NHSBT Transplant Collaboratives in pancreas transplantation, with the aim of promoting best practice and considering shared patient pathways (NHSBT)
- Ensuring that SOP and islet transplant centres have referral pathways and joint team meetings in place to enable patients to have appropriate access to the breadth of beta-cell replacement options (PAG)

The above will be achieved within 18 months.

6. Ensure that better data are available to guide optimal clinical decision-making

This will be achieved through:

- Improving the evidence-base on pancreas utilisation and transplantation (e.g., the implications of offer declines, analyses of deaths on the waiting list), and supporting transplant surgeons to maintain knowledge of that evidence (Pancreas CLUs, NHSBT)
- Improving the collection and analysis of data on pancreas retrieval time-points and logistical issues at donor centres after pancreas retrieval (PAG, NHSBT)
- Setting up a fixed-term working group to re-examine pancreas and islet data captured in the UK Transplant Registry, including the use of diabetes technology, pre- and post-transplant glycaemic control, and linkage to other national datasets (PAG, NHSBT)

The above will be achieved within 24 months.

7. Improve the pancreas transplant workforce

This will be achieved through:

- Asking SOP transplant centres to have clear succession planning in place for key members of the pancreas transplant workforce (PAG, Commissioners, NHS Trusts)
- Raising the profile of pancreas transplantation and highlight current workforce challenges to professional societies, Royal Colleges, NHS Trusts, and other relevant organisations (PAG, NHSBT, Commissioners, Royal Colleges)
- Re-examining the CUSUM process to ensure that the risks of offer decline and changing donor demographics are recognised (PAG, NHSBT)
- Further education of specialist nurses in organ donation on the importance of pancreas ischaemic times (PAG, NHSBT)
- Supporting high volume SOP transplant centres to develop Fellowships in pancreas transplantation (PAG, NHS Trusts, Royal Colleges)
- Highlighting issues in pancreas transplantation to NHS Commissioners and asking for their support (PAG, NHSBT, Commissioners)

The above will be achieved within 24 months.

8. More support of patients

This will be achieved through:

- Asking SOP transplant centres to update their patient information and clinical guidance to ensure that they are informed about current issues in UK pancreas transplantation (PAG, NHS Trusts)
- Greater involvement of patient representatives in Advisory Group decision-making (PAG, NHSBT)
- Updating and expanding patient information available on the NHSBT website (PAG, NHSBT)

The above will be achieved within 12 months.

9. Prepare for future developments in pancreas transplantation and beta-cell replacement

This will be achieved through:

- Considering the impact of changes associated with the Sustainability and Certainty in Organ REtrieval (SCORE) programme and emerging machine perfusion technologies (PAG)
- Increased emphasis on measuring outcomes after SIK transplantation (PAG)
- Setting up a fixed-term working group to examine emerging beta-cell replacement therapies and ensure that structures are in place to enable rapid development of these treatments in the UK (PAG, NHSBT)

The above will be achieved within 24 months.

These recommendations will be taken forward by PAG and NHSBT, with the involvement and support of other key stakeholders. Together, these recommendations are expected to increase SOP transplantation to pre-2019 numbers within three years.

Authors and Acknowledgements

This report was prepared by Chris Callaghan, Chair of PAG, with input and advice from Richard Baker, Marius Berman, Helen Buglass, John Casey, Ian Currie, Dale Gardiner, Nicholas Inston, Gareth Jones, Simon Knight, Derek Manas, Vicky Salem, Shaminie Shanmugaranjan, Laura Stamp, and Andrew Sutherland.

Thank you to everyone who contributed to the Summit, this report, and to all those who are dedicated to improving the outcomes of those waiting for SOP transplantation in the UK.

Appendices

Appendix 1: Pancreas Summit Programme

Pancreas Summit 2026 – Programme

Tuesday 30th June 2026, Franklin-Wilkins Building, King's College London Waterloo Campus,

- 0930-1000: Tea and coffee

Plenary session (Chair, C Callaghan) – Issues in UK pancreas transplantation

- 1000-1005: Welcome (D Manas)
- 1005-1020: Setting the scene and the aims for the day (C Callaghan)
- 1020-1035: SOP transplantation in the UK and international comparisons (S Shanmugaranjan)
- 1035-1050: Deceased donation in the UK (NHSBT stats / H Buglass)
- 1050-1105: Pancreas retrieval in the UK (NHSBT stats / M Berman)
- 1105-1120: Pancreas offering pathways in the UK (S Shanmugaranjan / C Callaghan)
- 1120-1135: Overview of pancreas OU (NHSBT stats / S Knight)
- 1135-1150: Collaborative working and the beta-cell replacement unit model (J Casey / G Jones)
- 1150-1200: Summary and next steps (C Callaghan)
- 1200-1220: Wider discussions and views from attendees
- 1220-1300 Lunch

Breakout sessions (pre-assigned rooms / attendees) – Solutions for UK pancreas transplantation

- 1300-1430
    - Organ retrieval (facilitator, M Berman)
    - Organ offering pathways (facilitators, C Callaghan and G Jones)
    - Organ utilisation (facilitators, S Knight and N Inston)
    - Workforce, support, and Collaboratives (facilitators, D Manas and L Stamp)
    - Developments in beta-cell replacement therapies (facilitators, J Casey and V Salem)

- 1430-1500: Afternoon tea

Plenary session (Chair, D Manas) – Putting it all together

- 1500-1550: Feedback, discussion and synthesis (C Callaghan and J Casey)
- 1550-1615: Summary and thanks (D Manas)

Appendix 2: Briefing Notes for Facilitators

Pancreas Summit 2026 – Breakout sessions briefing document

Tuesday 30th June 2026, Franklin-Wilkins Building, King's College London Waterloo Campus,

The morning sessions will identify issues in UK pancreas transplantation; the aim of the afternoon sessions is to identify potential solutions (and actions) to resolve those issues. The final report from the Summit will collate, edit and synthesise notes from the afternoon sessions.

- Outputs from each breakout group should ideally follow the format found in the table on the final page of this document. This format may not fit all the issues identified – alter / re-name as needed.
- Please use the flipcharts provided – pictures will be taken of these to synthesise outputs at the end.

1300-1430 Breakout sessions (pre-assigned attendees) – Solutions for UK pancreas transplantation

Discussions are expected to be fluid, but suggestions for discussion points are outlined below

- **Organ donation and retrieval (facilitator, M Berman)**
  - How can rates of pancreas damage at retrieval be reduced? En bloc retrieval?
  - How can we avoid discarding pancreases due to aberrant hepatic arterial anatomy?
  - How can we optimise organ imaging at retrieval?
  - Can we improve pancreas assessment at retrieval?
  - How can we optimise vessel procurement for pancreas transplantation?
  - Will the increasing use of NRP in DCD pancreas transplantation change practice?

- **Organ offering pathways (facilitators, C Callaghan and G Jones)**
  - Are changes need to the current NPOS (and/or other schemes, e.g., NKOS)?
  - Is a FTWG on pancreas offering needed?
  - If so, what should be the key areas of focus?
  - What should be the new NPOS outcome metrics?
  - How can organ offering pathways (e.g., PFTS) be refined and improved?

- **Organ utilisation (facilitators, S Knight and N Inston)**
  - How can rates of organ utilisation be improved, especially for DCD donors?

- Should centres remove ‘automatic’ offer declines?
- How will SCORE influence OU?
- Would a standardised pancreas assessment tool at transplanting centres be of benefit?
- How can SOP centres and islet centres work more closely together to improve OU?

- **Workforce, support, and Collaboratives (facilitators, D Manas and L Stamp)**
  - How can UK pancreas transplant workforces be improved and supported?
  - How can Pancreas Collaboratives improve patient outcomes?
  - Do pancreas CUSUMs need to change to enable acceptance of higher risk donors?
  - Would post-CCT Fellowships in pancreas transplant surgery be of benefit?
  - How should pancreas units enact succession planning?

- **Developments in beta-cell replacement therapies (facilitators, J Casey and V Salem)**
  - Do we have truly collaborative working models in UK pancreas transplantation?
  - How do we prepare ourselves for future beta-cell replacement therapies?
  - Are we collecting enough pre- and post-transplant data (e.g., around diabetes technologies)?
  - What is the role of NHSBT in future cell therapies for diabetes?

NHS Blood and Transplant

Suggested format for outputs from each breakout session group

Area of focus	Identified barrier(s)	Likely root cause(s)	Proposed actions(s)	Suggested 'owner(s)'
- e.g., improved organ utilisation	- e.g., sub-optimal communication between NORS and implanting teams, and between implanting teams around pancreas usability	- e.g., lack of a standardised approach to pancreas quality assessment	- e.g., develop an accepted proforma for assessing pancreas quality	- e.g., PAG and NORS teams, with pancreas transplant centres
- e.g., improved NPOS/NKOS	- e.g., too many usable pancreases not being offered out with a kidney	- e.g., imbalance in the number of kidneys going to kidney-only patients	- e.g., work with KAG to reconsider the number of patients in Tier A	- e.g., PAG and KAG
- e.g., workforce support and governance	- e.g., concerns about risk aversion due to potential CUSUM	- e.g., CUSUMs reflect past practice and not current issues (older donors, more DCDs, more comorbid recipients with longer waiting times)	- e.g., ensure that any CUSUM triggers or visits appropriately consider donor/recipient factors	- e.g., PAG and NHSBT

The above are examples only and may or may not be relevant to each discussion.