

Cautionary Tales

Sharing learning from events across the organ donation and transplantation pathway

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We are all aware that the current pressures on the NHS are widespread; you only need to switch the TV on or read the paper to see a new headline. These times of intense pressure are when it becomes clear if processes are effective, culture is safe, and staff feel able to raise concerns.

When people are busy, systems overloaded and pressured, safety can be compromised. People revert to what is quick, easy, and familiar. In particular, people may be delayed in raising concerns which may impact timely and prompt action.

We are seeing a slow trend of cases being reported whereby people have seen or been involved in situations where they had concerns. To note none had an impact on patient safety. These have included:

- Questions around the accuracy of donor information
- Appropriateness of location for handover
- Behaviour of staff members

Rather than raising the concerns in a timely fashion, reports were submitted later and then resolved in retrospect. We encourage people to raise concerns promptly as it can allay concerns and potentially avoid patient harm. A report can then be submitted to allow things to be reviewed for future.

This issue highlights a potentially deeper concern as to why people are not identifying their concerns at the time. Is it that people are busy, and raising concerns takes more precious time, which is a concern in itself. Or is it a deeper cultural issue that people don't feel that they are in a safe space. Culture is a difficult thing to explore, but this is something that we will be monitoring to see if it represents a wider issue. Whilst the increase in donation and transplantation rates is an important focus, it is also vital to ensure that this increase is built on a foundation of safety and trust.



The weather...

Weather in the UK is often a topic of discussion, and this year is no different. In fact, Cornwall and County Down recorded their wettest January on record!

Due to the national nature of organ donation and transplantation, we cannot avoid the impact of weather. National Organ Retrieval Service Teams travel long distances to donor hospitals, and organs are often flown between countries.

In two recent cases, the weather had an impact on the transport of an organ. In both cases the organ was being flown from the donor hospital area to the recipient centre with the aim of reducing travel times. It was over a period of severe weather and as such the planes required de-icing. Whilst there was clear communication around this need with those involved, delays in the organ leaving occurred.

These cases involved different airports and different teams. What was identified is that whilst airports do work closely with us to support the pathway, the process of de-icing a plane is not simple or quick. It can only be completed a short time prior to the flight as otherwise the plane will ice over again, and so the timing is crucial. This is also in the context of all other flight activity including commercial aviation.



Learning point

If poor weather is expected, early clear communication with all parties is vital to set expectations

If weather is predicted to worsen or be severe, consideration should be made to increase expected travel times to allow for the unpredictability of the pathway.

Historic Systems

Across the NHS there are various systems in use where manual 'workarounds' have been developed as the need has increased but the technology has not kept up. This can be the case in organ allocation as allocation algorithms become more complex.

In a recent case, a question was raised around a patient's registration. Following in-depth review between NHSBT and the recipient centre it was identified that certain information was not accurate or omitted.

What was highlighted was that certain information was automatically transferred onto the recipient registration, however, a manual workaround had been put into place years previously to collect outstanding data. Following changes in the offering scheme the information needed for appropriate allocation had then increased and the manual workaround had not been 'updated' to include this new information.

This example illustrates that if manual workarounds are implemented and managed appropriately, they can be effective for short-term fixes whilst a longer-term solution is identified. However, if manual workarounds become historic, they not only become a risk in terms of being forgotten, but they also add a burden onto staff when systems should be designed to support them.

These workarounds had never been reviewed as they were simply seen as something that was done. However, once the case was reviewed in detail, there was significant learning not only for the centre that raised, but others. The method of registration was changed, the workaround removed and the system future proofed for any subsequent changes in dataset.

Learning point



Manual workarounds can be effective short-term if implemented safely
Where historic systems are used, they should be reviewed as other processes around them develop to ensure they connect effectively
It is good practice to review manual workarounds regularly to ensure they are effective, and to explore longer-term strategies. It is acknowledged that within the NHS this can take time, but issues with workarounds will likely appear and lead to risks if relied on for prolonged periods.

Good news stories

Patients and donor families should always be our driver. And that said, its sometimes important to reiterate the impact of what we do, so thought it would be good to share the good news story of a patient who received a double-lung transplant and was discharged just prior to the birth of his baby girl:



<https://www.bbc.co.uk/news/articles/cljkde32kdeo>

Reference

1. Met Office (February 2026) How much rain have we had so far? Available at: <https://www.metoffice.gov.uk/blog/2026/how-much-rain-have-we-had-in-february-and-winter>

Anyone can raise a patient safety concern in relation to the organ donation and transplantation pathway via the online reporting form:

<https://www.odt.nhs.uk/odt-structures-and-standards/governance-and-quality/tell-us-about-an-incident/>

All reports received are reviewed by the ODT Patient Safety Team and the person who completed the form responded to with any findings and, where appropriate learning to strengthen the process. These reports also enable wider trending to highlight any processes or concerns that may need a more detailed or wider review. The Patient Safety Team endeavour to respond to all reports within 90 days, often sooner, but if you are ever concerned you haven't had a reply, please contact

PatientSafety.OTDT@nhsbt.nhs.uk

If you have any feedback or suggestions regarding Cautionary Tales or Learning from Excellence, please let us know via email:

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