



Highlight Report -TP Specialist Interest Group (SIG): September 2026

Key Updates

TP SIG Leadership

Samantha Bonney has stepped up as the new TP SIG chair, following Danny Gaskin interim term. Pedro Valle Vallines will continue to support Sam as the existing co-chair. The news was formally announced in Glasgow during the 2026 BBTS Annual Conference.

Bloodlines Contributions

Recent and upcoming articles continue to showcase the breadth of TP practice across the UK and internationally, the latest articles endorsed by the TP SIG included in Bloodlines 157 are attached to this document below. TP SIG members are encouraged to submit articles, including collaborative or externally authored pieces.

Transfusion Practitioner SIG Session at BBTS 2026: Chair's reflection.

The Transfusion Practitioner Specialist Interest Group (TP SIG) session at BBTS 2026 was a huge success. We were delighted to be given the opportunity to hold the session in the main auditorium, which provided a fantastic setting for our speakers and audience and helped create an excellent atmosphere throughout. The session was very well attended, and we await the formal conference feedback and attendance figures.

Maternity transfusion safety

This year, the TP SIG chose to focus on maternity transfusion safety and the delivery of anti-D prophylaxis. Maternity care has received significant national attention in recent years, with reviews including the Ockenden Review and the more recent Amos Review highlighting the devastating consequences that failures in maternity care can have for women, babies and their families. These reviews have also reinforced the importance of effective communication, learning from incidents and strong multidisciplinary working.



Transfusion teams have an important role throughout the maternity pathway, including antenatal blood group and antibody screening, foetomaternal haemorrhage quantification, supporting the management of obstetric haemorrhage and ensuring the appropriate use of anti-D immunoglobulin.

Anti-D prophylaxis represents one of the major successes of modern transfusion medicine. However, haemovigilance learning continues to identify opportunities to improve practice, including incidents involving omitted or delayed administration, knowledge gaps, IT-related issues and the challenges associated with evolving pathways such as cell-free foetal DNA testing.

Our session therefore brought together speakers from different professional backgrounds to consider these issues from both laboratory and clinical perspectives and, importantly, to explore how multidisciplinary working can reduce risk and strengthen maternity transfusion safety.

Our speakers

We were delighted to welcome:

- Dr Eithar Babikir, IMT-2, Royal Liverpool University Hospitals
- Sue Pope, Senior Sister – Kent Ward, Medway NHS Foundation Trust
- Bronagh O'Neill, Area Haemovigilance Practitioner, Southern Health & Social Care Trust

Together, the speakers brought valuable perspectives from medicine, nursing and haemovigilance, generating an engaging discussion around the practical challenges of delivering safe anti-D prophylaxis and the opportunities to improve communication, knowledge and practice across professional boundaries.

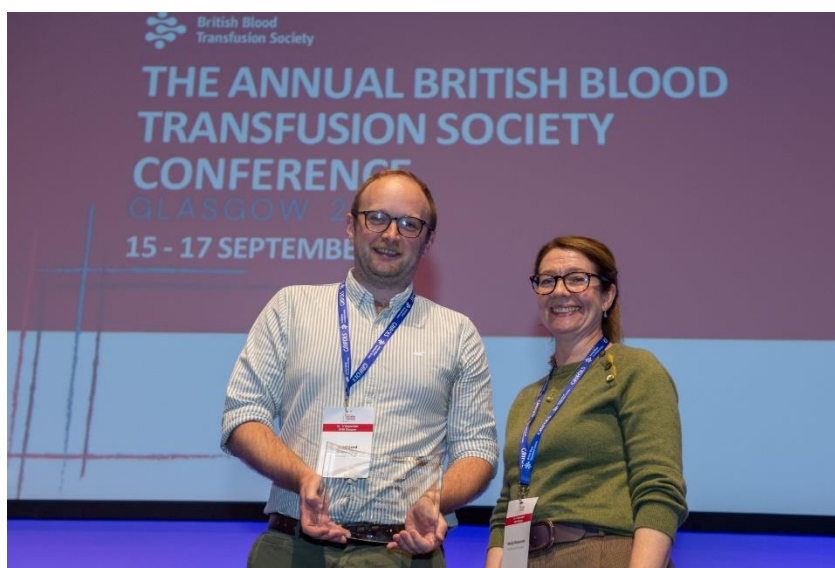
The session was chaired by Danny Gaskin, Chair of the TP SIG, alongside Pedro Valle Vallines, Deputy Chair of the TP SIG.

TP SIG Award

Another highlight of the session was the presentation of the annual TP SIG Award. It was brilliant to welcome Wendy McSporran, last year's award recipient, back to the stage to present the award to this year's recipient, Stuart Lord, Lead Transfusion Practitioner at Gloucestershire Hospitals NHS Foundation Trust.



Having the previous year's recipient return to present the award was a fitting way to recognise the contribution and achievements of Transfusion Practitioners and to continue building the sense of community that sits at the heart of the SIG.



Stuart Lord (2026 TP Award Winner) with Wendy McSporran (2025 TP Award Winner).

SIG leadership handover

The session also marked an important moment for the future of the TP SIG, with Danny Gaskin formally handing over the Chair to Sam Bonney, Lead Transfusion Practitioner at Mersey and West Lancashire Teaching Hospitals NHS Trust.

Danny had served as interim Chair for the previous year while the group recruited a new Chair. Throughout that period, a key principle had been that the SIG should ultimately be led by a Transfusion Practitioner – someone with first-hand understanding of the challenges, priorities and professional interests of TPs.

It was therefore a great pleasure to formally hand over the reins to Sam at BBTS 2026. Her appointment provides an exciting opportunity to build on the work of the past year and take the SIG forward under the leadership of a practising Transfusion Practitioner.



The handover also provided an opportunity to thank the wider TP community for their support over the past year and everyone who has contributed to the SIG, supported its sessions and helped shape its continued development.

Looking forward

Overall, the BBTS 2026 TP SIG session provided a fantastic opportunity to bring together colleagues from across transfusion and maternity care around an important patient safety issue. The combination of an excellent multidisciplinary speaker panel, strong attendance, an engaged audience, recognition of achievement through the TP SIG Award and the formal handover to a new Chair made it a particularly memorable session.

We look forward to reviewing the formal delegate feedback and attendance figures and to seeing the TP SIG continue to develop under Sam's leadership.

TP Role Development

National TP Framework

The Professional Development Framework for Transfusion Practitioners and the Supportive and Assistive Workforce can now be accessed via <https://nbtcup.targeted.agency/news/2026/professional-development-framework-now-available>

Next Meeting Dates

- 7th December 2026
- March 2027

PRE-HOSPITAL PRE-TRANSFUSION SAMPLES – SURVEY REPORT



Transfusion Practitioners SIG
British Blood Transfusion Society



Dr Karen Mead
Former Chair of BBTS
TP SIG and Specialist
Transfusion Practitioner,
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Dr Reuben Cooper,
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The authors would like to thank to Fionnuala Walker, Senior Haemovigilance Practitioner, Belfast Health and Social Care Trust for providing information regarding the PHPT sample process used within Northern Ireland.

Executive Summary:

To ensure stocks of emergency blood remain available for all, measures must be taken to limit the use of group O red cells and to switch to group-specific blood as soon as practically possible and safe to do so. A survey circulated to the Transfusion Practitioner (TP) and Air Ambulance (AA) communities revealed that pre-hospital pre-transfusion samples (PHPT) are not taken by the majority of AA crews. Where samples are taken, the estimated number of patients bled pre-transfusion varies from <10-80%. Upon arrival to the emergency department (ED), there is often confusion and misunderstanding regarding whether the sample can be accepted and sent to the transfusion laboratory, collectively resulting in very few PHPT samples being processed within England. The outcome of this is sustained avoidable and unnecessary use of emergency group O red cells in major haemorrhage situations.

This report summarises feedback from both the AA crews and the TPs regarding current practice, reviews perceived barriers to taking and accepting PHPT samples and finishes with some proposed next steps - exploring how systems could be developed to allow universal acceptance of PHPT samples within England, therefore helping to preserve and protect our precious stock of group O red cells.

Introduction:

During recent times of unprecedented, prolonged blood shortages, the

transfusion community have placed huge efforts into exploring potential ways to avoid and reduce red cell transfusion. The use of group O as emergency stock makes it particularly precious and can result in significant quantities being transfused to individuals in major haemorrhage situations where transfusion laboratory staff are unable to switch to group specific blood for a variety of reasons. One such situation presents when a critically ill patient is transfused by a pre-hospital team, without a pre-transfusion sample being taken. The lab may subsequently be unable to obtain a clean group from a post-transfusion sample and there may not be an historical group available for this patient within the Trust laboratory system. This inevitably results in the transfusion of group O red cells for the duration of the major haemorrhage management and may extend beyond this period for a considerable time, potentially for the

entire acute admission.

During July-August 2025, a survey was circulated to all TPs and AA Medical Directors within the UK on behalf of the British Blood Transfusion Society Transfusion Practitioners Special Interest Group (BBTS TP SIG). The objectives were to gain an oversight of how many AAs currently take PHPT samples and an understanding of acceptance criteria for these samples within hospital transfusion laboratories. It was hoped the data would identify an opportunity to encourage and support universal acceptance of PHPT samples in England - similar to that within Northern Ireland. The ultimate aim would be to reduce the amount of emergency group O red cells transfused to this group of patients by enabling transfusion laboratory staff to promptly switch to group specific stock following patient arrival into the hospital ED.



▲ Figure 1: Survey highlights

8/14 Air Ambulances didn't have a protocol for PHPT samples

Why not?

Need never identified
NHSBT discussions
Multiple destinations
Samples taken but not used

Willingness?

50:50
Currently developing protocol
Established service withdrawn
Is the need identified?

Concerns?

Lack of universal acceptance
Difficulty / time
Cognitive overload / may forget
Errors / Needlestick injuries

Responses from the Air Ambulance Charities:

A total of 14 responses were received from the 21 AA charities across the UK which represented a 67% return rate. Responses revealed that 6/14 (43%) AAs have a protocol to take PHPT samples, with the estimated number of patients to have samples taken ranging from <10%-80%. Two of these AA charities reported that their samples were accepted in all hospitals they transport patients to. The other 4 charities reported that samples were not universally accepted, but with no explanation from hospitals for the variation. Furthermore, they reported lack of certainty and differing opinion from clinical staff, even within the same hospital, as to whether these samples would be accepted by the transfusion laboratory staff or not.

The remaining 8 AA charities do not have a protocol to take PHPT samples for a variety of reasons including never being asked to do so; not considered necessary following discussions with NHSBT; a need to transport patients to differing hospitals which have varying sample acceptance criteria; and the additional time required on scene to take a sample. Of note – one charity was in the process of developing a protocol for PHPT sample collection, and another had previously taken samples but stopped when their major trauma centre (MTC) and other local hospitals would not process them.

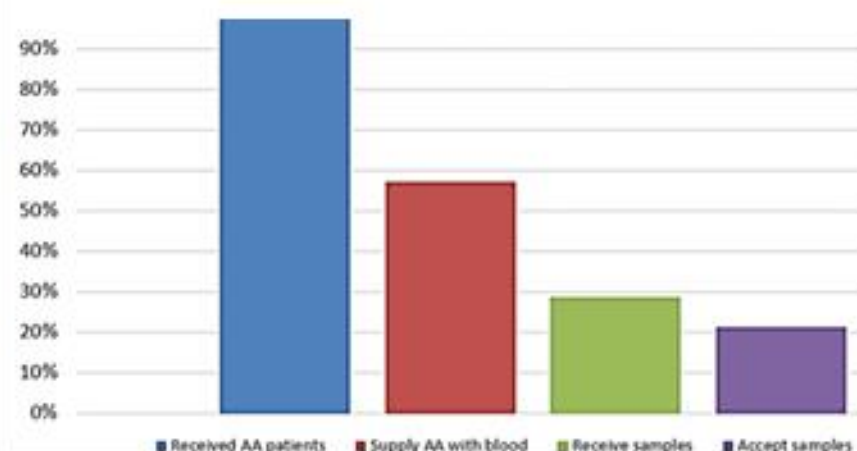
Of the 8 charities that do not have a protocol to take PHPT samples, 50% said

they would be willing to support this in the future and 50% said they wouldn't. Reasons for the lack of support included time required and difficulty in taking samples; potential need to carry and use differing request forms and/or sample tubes; risk of error and needlestick injury; having done so in the past but samples weren't used; and transfusion colleagues reportedly happy to deal with mixed field post-transfusion samples. However, one noted that if the blood provider asked for PHPT samples to be taken, they would not refuse. Perceived barriers to PHPT sample collection were largely around lack of universal acceptance of samples by the clinical and laboratory teams; concerns about forgetting to take or being unable to take the sample; and cognitive overload.

Responses from the Transfusion Practitioners:

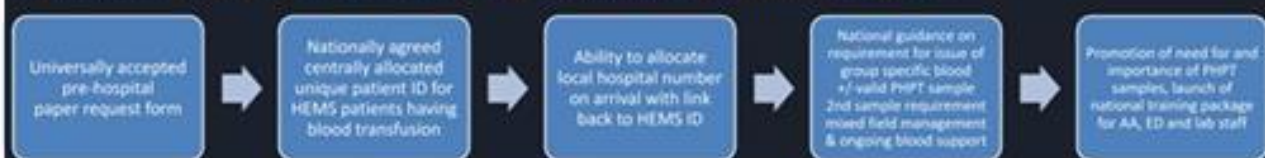
A total of 32 responses were received from TPs in different Trusts. Collectively, these Trusts named each of the 21 UK AAs as being their local AA. A total of 14 major trauma centres (MTCs) responded, resulting in 46% of all MTCs in England being represented. All 14 MTCs confirmed they received patients from their local AA, with 8 MTCs also supplying their local AA with blood components.

Of the 32 Trusts that responded, 25 confirmed they received AA patients but only 6 reported they receive and accept PHPT samples from the AA crew, with 4 of those also being the Trust that supply their local AA with blood components (and potentially also supplying pre-allocated patient identification (ID)



▲ Figure 2: Major trauma centre feedback

Consideration for development of a national system within England:



packs). Most Trusts informed that their local AA did not take PHPT samples, or the TPs were unsure if samples were taken as their transfusion laboratories had never knowingly received any.

When asked about the sample acceptance policy for PHPT samples, most Trusts confirmed they would reject these samples if received, with BSH guidance regarding the need for a unique hospital number (in the absence of an NHS number) being the main reason. Although these PHPT samples are labelled with a unique numerical identifier, it is not usually compatible/acceptable within the receiving hospital system. Other reasons for sample reject included not being electronically labelled and not being in the required sample tube or accompanied with a request form from their own Trust. Further comments related to the need for two clean (non-mixed field) samples prior to the issue of blood with the requirement for these to be taken and labelled independent of each other; and the belief that a pre-hospital sample is not required because a sample will be taken on arrival in ED. However, there were several hospitals who expressed an interest in receiving and accepting PHPT samples and one mentioned that these samples could potentially be processed as a concessionary release under the auspices of a precious sample. Two Trusts questioned whether the clinical staff in ED may take the decision to dispose

of any PHPT samples received without consultation or discussion with the laboratory staff. One Trust informed they previously accepted these samples, but the AA crew stopped taking them as they were not accepted elsewhere.

Proposed next steps:

The survey demonstrated an overall willingness and support for PHPT samples to be taken by AA crews and processed within hospital transfusion laboratories but also highlighted several obstacles that would need to be addressed and overcome in order for this initiative to proceed.

The biggest difficulty is resoundingly related to the use of core patient ID, particularly the pre-allocation of a unique number by the hospital issuing blood or the HEMS team, combined with concerns/constraints regarding acceptance of this in Trusts independent of where the ID was created. This has been overcome in Northern Ireland* (NI) where universal acceptance of PHPT samples has been in place for several years within all five Health and Social Care Trusts (although most patients are taken to Belfast Trust, the regional trauma centre). The NI AA crew carry one box containing two units of group O negative red cells which can only be transfused to one patient. On scene, a designated practitioner will label the sample tube with a unique HEMS number in the address field of

the tube and then sign, date and time the tube before keeping it securely on their person. Upon arrival in ED, the hospital will allocate patient ID (either a known or unknown patient registration) and the designated AA crew member will then complete the sample labelling using the information directly from the patient ID band. They are not permitted to hand the sample over to any ED staff until sample and request form are both fully labelled and ready to be sent to the lab. Consideration should be made for the possibility of a similar system within England requiring generation and issue of a universally accepted HEMS request form or this could be taken one step further with a HEMS ID being generated and regulated centrally - perhaps via NMSBT?

A review of the current BSH guidelines should be carried out with consideration for a specific pre-hospital transfusion guideline or for incorporation of PHPT sample requirements within current guidelines - particularly with regards to sample taking and labelling requirements, including consideration for 'precious sample' status and concession for handwritten samples where electronic sample labelling is a requirement within the Trust. Further consideration is required for the issue of blood components following a mixed field result - to include clarification around the two-sample requirement. It appears that individual Trusts have differing



General support to accept PHPT samples if aligned with national guidelines / policy

acceptance criteria relating to this with feedback from the survey indicating that two 'clean' groups without mixed field would be required within some Trusts for the switch to group-specific blood. Conversely, other Trusts would be happy for one 'clean' PHPT sample (+/- historical group on system) and a subsequent independently taken post-transfusion sample from ED - with acceptance of the mixed field result in the post-transfusion sample as long as the original group can be confirmed alongside the transfused group. In addition, a response from one of the AA teams indicated that their local laboratory staff were 'happy to deal with mixed-field samples' and two TPs indicated that their first patient sample would be taken in ED - which potentially would produce a mixed field result. It is unclear from the survey how blood provision would be managed in this situation but presumably it would result in the continued transfusion of group O red cells, particularly if there is no historical blood group recorded for the patient.

A further improvement recommendation would be to ensure that all staff involved with AA crews and PHPT samples are

aware of the Trust sample acceptance policy and ensure all PHPT samples arriving in any ED are automatically sent to the transfusion lab. There is currently a risk that PHPT samples which could/ would be processed by transfusion staff are not making their way to the laboratory because clinical staff within ED are disposing of them into clinical waste without realising there may be separate acceptance criteria for these samples.

Conclusion:

Over recent years, NHS Blood and Transplant has faced sustained ongoing challenges to meet and maintain the desired stock levels for group O red cells within England. These survey findings present an opportunity to review and improve current PHPT sample taking and acceptance processes. Alongside other collective efforts currently being requested of and undertaken by the transfusion community and clinical teams, these changes could contribute towards the much-needed reduction in avoidable and unnecessary use of group O red cells, therefore helping to preserve and protect this precious resource.

BLOOD, BRAINS & BANTER: THE STORY OF NORTHERN IRELAND'S HAEMOVIGILANCE TEAM



Denise McKeown
Regional Haemovigilance Co-ordinator/ Manager of BHSC
Haemovigilance Team
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Transfusion Practitioners SIG
British Blood Transfusion Society

Spread across 5 Health and Social Care Trusts but functioning as one coordinated regional network, the Northern Ireland (NI) Haemovigilance Team has built a reputation for collaboration, consistency, and unwavering commitment to patient safety. Behind the scenes sits a team keeping watch over everything that's going on and connecting all the dots: the Haemovigilance Practitioners (HVPs).

Although spread across different sites, teams, and specialties, we work closely together every day. There's always someone on the end of the phone, someone sharing information or learning, or someone asking, "Has anyone else seen this?" It's that constant collaboration, that sense of being one team across five Trusts, that really makes Haemovigilance in NI a bit different. What follows is a look behind the scenes — who we are, how we work, and why our model may be of interest to others across the UK.

Who We Are: Five Trusts, One Network
NI's Haemovigilance work stretches right across our five Trusts, from busy acute hospitals to smaller community sites. Each Trust is different — different patient populations, different pressures, different ways of working — and each brings its own strengths to the regional picture.

Our Haemovigilance team includes a mix of backgrounds — biomedical science and nursing — a blend that brings clinical insight, laboratory knowledge, and different perspectives to the table.

Belfast Trust (BHSC): The largest Trust and employing approximately 20,000 staff and providing regional services including major trauma, regional Fertility Centre, Renal Medicine and Transplantation, and NI's only dedicated children's hospital.

South Eastern Trust (SEHSC): Employs approximately 16,000 staff across 3 hospital sites and multiple community practices. Regional specialist Plastic Surgery and Hand Therapy, major Neonatal Intensive Care, complex elective surgery, and integrated prison healthcare across the region.

Western Trust (WHSC): Employs approximately 12,000 staff across a wide network of facilities and provides healthcare services to approximately 300,000 residents. The Trust covers the largest geographical area in NI (approximately 4,842 square kilometres). The Trust operates a Specialist Palliative Care, advanced robotic surgery, Primary Percutaneous Coronary Intervention (PPCI) for cardiac emergencies, and complex neurology and rheumatology.

Northern Trust (NHSC): Employs approximately 12,000 staff and provides a range of health and social care services to a population of approximately 479,000 residents.

It covers a geographical area of 2,773 square kilometres. The Trust operates high-volume elective care, a designated Paediatric ADHD Assessment Service,

and specialised community outreach programs for elderly and disabled individuals across remote areas.

Southern Trust (SHSC): Employs approximately 13,000 staff and delivers services from several hospitals and community-based settings. The Trust operates a regional specialist Perinatal Mental Health Service, complex acute stroke services, a high-performing paediatric feeding service, and specialised eye (orthoptic) care.

In addition to our work within Health and Social Care Trusts, we also provide Haemovigilance support to the Independent sector across NI. This includes private hospitals, ensuring that consistent standards of transfusion safety, governance, and reporting are upheld across all providers.

What Brings Us Together: Regional Workstreams That Make a Difference
What makes this NI Haemovigilance Team unique is not just the number of HVPs — it's the regional mindset. Transfusion related incidents, trends, learning, and training are shared across NI, meaning improvements in one Trust quickly benefit all. Although each Trust maintains its own Haemovigilance responsibilities, the defining feature of the NI model is how often we operate regionally. Below are some of the key areas where our collaboration has the biggest impact.



1. Patient Safety First — Always

Patient safety is our starting point, midpoint and endpoint. It is at the heart of everything we do. Every incident, near miss, or exemplary piece of practice is openly shared across all Trusts. A recurring theme in our work is that learning should never sit in one place — If something goes wrong (or brilliantly right) in one hospital, the entire region benefits from that knowledge.

This means:

- Faster implementation of safe practice
- Early recognition of emerging patterns
- More consistent transfusion processes for patients across NI



2. Education: Supporting Everyone, from Students to Senior Clinicians

Education is one of our busiest — and most rewarding — workstreams. From delivering teaching sessions in universities for our student nurses, to providing Right Patient, Right Blood competency assessments for medical students and Trust staff, the NI Haemovigilance Team are focused on ensuring everyone involved in transfusion is fully informed and competent to practise safely.

We offer a bit of everything — Massive Blood Loss SIMs, ad hoc teaching, and loads of practical, real-world training for staff at all levels. And with the new digital systems coming in, digital focused training and troubleshooting has become a new skillset many of the HVPs have had

to add to their toolbox.

Because our training programmes are largely aligned across all five Trusts, staff who rotate or move between Trusts encounter the same principles, same expectations, and same high standards. It's one of the ways our small region achieves consistency.



3. Audit: A Regional Lens on Transfusion Practice

Audit is where the team's regional structure truly shines.

Through the NI Education and Quality Improvement Group, a subgroup of the Northern Ireland Transfusion Committee (NITC), all five Trusts review feedback together and jointly agree an annual audit workplan. As a region, we plan, design, and pilot the audit proformas collaboratively to make sure they're meaningful and workable in every setting — from major hospitals to smaller community sites.

All data collectors receive bespoke training, ensuring confidence, accuracy, and shared understanding. This regional approach gives us a clear, reliable picture of what transfusion practice actually looks like across NI.



4. Digital Transformation: HVPs at the Heart of Change

NI is currently undergoing one of the most ambitious digital transformations in UK healthcare — and the NI



For a small region, the impact is enormous

Haemovigilance team sits right at the centre of it.

Regional developments include:

- A single regional Laboratory Information Management System (LIMS)
- A single regional Electronic Patient Record (EPR)
- A new region wide Blood Production and Blood Tracking system, integrating everything from donation to bedside traceability

For a small region, the impact is enormous. Combined they bring greater



BLOOD USAGE IN NORTHERN IRELAND

19.45

units per 1,000 population

- ✓ Relatively lower utilisation
- ✓ Appropriate and efficient use
- ☐ Consistent regional approach

This reflects a collaborative approach to supporting the appropriate use of blood across Northern Ireland.

standardisation, cleaner more meaningful data, and a deeper ability to understand – and improve – transfusion practice across the region.

Digital transformation has naturally come with challenges, particularly for haemovigilance in ensuring patient safety doesn't get lost. Alongside their day-to-day work, HVPs are increasingly becoming IT trainers, workflow testers, and digital problem-solvers. As a team we have embraced these digital changes and all the positives they can offer us. However, our commitment and passion for patient safety means our role goes beyond adapting to the digital changes. It includes challenging and maximising the capabilities of our new digital systems to ensure they make transfusion practice safer, stronger and better for all our patients.



5. Leading the Way: Regional Strength, National Impact

Our work does not happen in isolation. We play an active role within the Northern Ireland Transfusion Committee, helping to shape regional strategy, policy, and audit priorities.

In parallel with the ongoing digital transformation, we are also progressing the standardisation of regional transfusion documentation, including a downtime transfusion administration record and a regional transfusion request form, supporting consistency and safety across all Trusts.

The NI Haemovigilance Team is closely connected to wider UK and Ireland networks, contributing to and learning from national forums and expert groups. Our involvement extends to a number of UK and Ireland groups, including the Patient Information Leaflet Working Group and the Transfusion eLearning Editorial Board. From June 2025, the Regional Haemovigilance co-ordinator will hold the role of Chair of the UK and Ireland Blood Transfusion Network. We have also represented NI and the UKI network on the recent update of the SaBTO consent and shared decision-making guidance, as well as leading the review of the UK-wide Out-of-Hospital Transfusion Framework.

Together, these connections help ensure that Northern Ireland remains aligned with best practice while also sharing learning and experience with the wider transfusion community.

Why This Matters

One of the benefits of being a small region is that we work really well together – and we make the most of it. NI's geography, size, and our very connected transfusion teams mean we are all aiming to standardise practice as much as possible. The NI Haemovigilance Teams do not really feel like five separate Trusts; it feels more like one big regional team, constantly swapping ideas, sharing learning, and backing each other up. This structure allows NI to:

- Implement change quickly
- Align policies and education
- Respond collectively to national guidance
- Present unified data and learning
- Support the aim of safe, appropriate, and reduced unnecessary transfusions as evidenced by our audit data.

Our model is increasingly recognised as an example of how a small region can achieve big change – and how working together amplifies impact. And we will continue to strengthen this further in the coming years.

Looking Ahead

The next two years are set to be demanding on the team. As LIMS and EPR programmes reach full integration, and as the new blood tracking system rolls out, there's plenty to keep us busy. The NI Haemovigilance Team is already right in the middle of this work, making sure transfusion safety doesn't get lost in the noise while everything around us modernises.

NI may be small, but we definitely punch above our weight. As we move forward, we are excited to keep that momentum going, staying connected with colleagues across the UK and Ireland, sharing what we learn, picking up new ideas, and keeping transfusion safety right where it belongs: at the frontline of patient care. And hopefully, at some point... getting back to our day jobs!