Transfusion Practitioners Group
British Blood Transfusion Society

Highlight Report – TP Special Interest Group (SIG): Dec 2025

- **BBTS Conference 2025**
  We sincerely hope those who attended the annual conference in October enjoyed themselves. For those who were unable to attend, please find attached presentation summaries prepared by some of the TPs who kindly contributed to the programme this year.

- **BBTS Conference 2026 – Glasgow > 15-17th September**
  We are delighted to offer all TPs and those working in equivalent roles, an opportunity to present in the TP session during BBTS conference 2026. Please complete a speaker nomination form to express your interest in presenting.

  We are also welcoming nominations for the 2026 TP SIG Award - to be presented at conference. This award will be given in recognition of the outstanding contribution made to the transfusion community by a TP or individual working in an equivalent role.

  Further information and both nomination forms are available on the TP SIG website - the closing date for both submissions is the **end of Feb 2026**.

- **Bloodlines** - The latest article submitted on behalf of the BBTS TP SIG is attached - written by Stuart Lord who describes a case of acute haemolysis in acute myeloid leukaemia.

- **BBTS TP forum**
  This forum is free to use (no need for BBTS membership) and has been designed to share ideas, pose questions and provide support to all TPs and those in equivalent roles from our four nations. We have over 100 members but if you are yet to join, please register via the link above. Your local TP SIG representative will then authorise your registration. Once a member, please click the button in red below to ensure you are notified of all new posts:

- **TP SIG Chair – message from Karen Mead**
  It has been an absolute pleasure to be Chair of this group over recent years, to have the opportunity to meet and work with you all on behalf of BBTS and to be an integral part of the exciting workstreams that are currently taking place within the TP and wider transfusion communities. However, it is now time for me to step down and pass on this wonderful opportunity to another TP. I look forward to continuing as a TP SIG member under the direction of our new Chair – to be announced in the New Year.

- **Contact details and further information** can be found on our dedicated webpage: BBTS | Transfusion Practitioners |

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BBTS Conference 2025 – TP Highlights

TP SIG Award Presentation

This award was presented to Wendy McSporran, Advanced Transfusion Practitioner from the Royal Marsden NHS Trust in recognition of the outstanding contribution made to the transfusion community.

Wendy is well known and loved within the Transfusion community and has sat on many local, regional, national and UK wide groups – including our very own TP SIG. She has written and co-authored numerous transfusion guidelines, policies, papers and National Comparative Audit reports, continually promoting and progressing the TP role.

As detailed in the nominations, Wendy is:

“recognised for having an unwavering passion for patient safety, dedication to support clinical colleagues, openness to change and a strong advocacy for research driven transformation”

“widely respected within the transfusion community and is frequently sought after by transfusion experts for her own expertise in developing transfusion strategies, professional development frameworks, audits and in response to the IBI”

“a tireless ambassador for all the TPs with a selfless dedication to the role, supporting and encouraging others – not for praise or recognition but simply because she believes in the importance of our work and its impact on patient safety”

Huge congratulations to Wendy!

TP SIG: Twenty Year as a Transfusion Practitioner – Triumphs, Trials and Transformation
Wendy McSporran, Advanced Transfusion Practitioner, Royal Marsden NHS Trust

The presentation reflected on two decades of being a Transfusion Practitioner, the role evolution over time, highlighting achievements, challenges and future directions.

Early challenges
In the early years TPs faced significant hurdles: lack of structured induction, lone working, and learning on the job due to the absence of formal training. Unfortunately, these issues persist today.

There was reflection on the communities and networks built by TP's and how crucial these connections had been to support in the role, provide shared learning and ultimately contribute to retention in the role.

Key Achievements through 20 years
There had been many personal & local team achievements such as the introduction of one-unit transfusions and nurse authorisation policies and a slow culture shift toward 'less is more' and subsequently improving patient outcomes. There was discussion of the importance of the research in guiding interventions to change practice, both in terms of transfusion medicine but also implementation science. There was an overview of the TP contribution at both transfusion 2024 & Transformation and the increased visibility of the workforce due to the symposiums.

Current Challenges
Despite lots of TP's success stories it was highlighted the role sometimes remains undervalued and often invisible. Digital transformation has introduced new opportunities for better data and patient safety, but also significant demands on TP time. Many practitioners now serve as subject matter experts when advising on system configuration and as clinical trainers for bedside technology.

Looking ahead
Lastly the future was considered. The introduction of the new TP framework aims to strengthen the role, provide clarity and support for ongoing professional development. The new award from BBTS for the TP SIG will contribute to improved recognition of the role and it was acknowledged that this years recipient would not have been able to achieve much without the support of fellow TP's and the wider transfusion community.

TP SIG: Exercise Euclid – Improving major incident response in the absence of a major incident
Sarah Beuschel and Lorraine Lewis-Prosser, Transfusion Practitioner Team, Wales

The Aneurin Bevan University Health Board (ABUHB) Emergency Planning Team along with faculty from key areas developed an enhanced tabletop exercise (named Exercise Euclid) over a 6-month period to test major incident procedures.

Key players from core departments were involved in a real-time exercise to test staff awareness of their roles and responsibilities and to test the efficacy of their Major Incident (MI) action cards. The

exercise was played out in the Education Centre by existing ABUHB staff with no effect on the day to day running of the hospital.

The Civil Contingencies Act 2004, states that every Health Board should complete a 3-yearly live exercise, and the objective was to test the ABUHB Major Incident Procedures (MIP) and Mass Casualty Plan (MCP).

The ABUHB MCP stated capacity to facilitate 8 x P1s (requires immediate life-saving interventions), 10 x P2s (requires urgent but not immediate care) and 20-30 x P3 (requires medical care but can wait). The Blood Sciences/Transfusion teams tested their specific responsibilities and procedures. The Transfusion Practitioner (TP) action card identified one TP to be based in the emergency department (ED) with 10 O RhD negative and 10 O RhD positive boxed red cell units to support the clinical teams.

Overall analysis concluded that ABUHB would be able to meet the MCP objectives. Feedback from key players and observers, identified necessary amendments to action cards. The TP action cards were amended quite significantly as a result of the exercise.

The ED team commented during the debrief on how beneficial it was to have transfusion support in the clinical area.

Whilst this was a 4-hour, real-time exercise, the stress and anxiety experienced by the key players was so realistic. The relief, at the point of standdown was tangible.

The exercise identified that secondary areas such as Critical Care and Theatres, had not received many patients at the 4 hour exercise end time, which gave teams confidence they had time to create room for incoming casualties but also identified a need to test the resilience of an MIP from 4 hours onwards.

TP SIG: A TP led collaborative project from the SW RTC

Karen Mead, Specialist Transfusion Practitioner, North Bristol NHS Trust

Incident investigation and reporting is a major part of the Transfusion Practitioner (TP) role, demanding a significant amount of time, effort and expertise. The process is further complicated by the differing requirements and expectations of various organisations that are part of the UK haemovigilance pathway.

Currently, there is no national or regional template available to capture all the key aspects necessary to meet these requirements. Therefore, an initial template was designed within North Bristol Trust, and the Southwest (SW) TP group subsequently set up a working group to develop and test this, ensuring it satisfies the main requirements of the participating individual Trusts, Serious Hazards of Transfusion (SHOT) haemovigilance scheme and the Medicines and Healthcare products Regulatory Agency (MHRA).

The template incorporates both the SHOT human factors (HF) investigation tool and the Patient Safety Incident Response Framework (PSIRF) from NHS England. PSIRF advocates the use of the System Engineering Initiative for Patient Safety (SEIPS) framework which is becoming increasingly

adopted within NHS Trusts. Therefore, the template includes a colour-coded key which allows easy conversion between the SHOT HF headings and the SEIPS framework.

In addition, the Haemovigilance Team Lead from MHRA kindly provided feedback regarding layout and suitability of the template for direct submission into the Serious Adverse Blood Reactions and Events (SABRE) portal. This led to a restructuring of the template, with subsequent agreement that the front page can be submitted as part of the SABRE confirmation process, satisfying the regulatory requirements without the need to input additional text into the portal.

The template is now available on the BBTS TP forum as a PowerPoint and a Word document to support individual preferences. Permission has been granted from the SW TP group to share these templates with any TP who may find it beneficial to lead and structure their incident investigation and subsequent reporting process.

Haemonetics Sponsored Lunch Symposium – BloodTrack TX solution: Supporting patient safety, streamlining efficiency and fostering innovation at the bedside

Anna M.Y. Li, Lead Transfusion Practitioner, Royal Free Hospital

My BloodTrack TX journey – An NHS England never event ABO incompatible transfusion on a day ward, where the patient recovered and survived, eventually led to the introduction of the BloodTrack TX system for bedside blood administration. It was a decade long journey that began with seeking to understand the 'why'. Distraction, persuasion, being pressurised were found to be core contributing factors. In contrast, an electronic barcode scanning system cannot be subjected to these human factors, and it never skips steps with its forcing functions. Assembling a business case became the priority. To be effective, it had to detail how the proposed solution would couple to our existing systems as well as the organisational strategy and values. Strategic fit was found in the shape of the HIMSS level 6 objective to go paperless. Transfusion was a paperweight where prescriptions to traceability tags created paper mountains. The business case was accepted but then new barriers formed: funding, planning, IT ecosystem, continuous monitoring. Barriers were overcome by gaining buy in from the digital lead for funding, having a digital representative as a core member, and utilising a pilot to navigate the linking of systems for human-sense checking. A key lesson in this journey, was that celebrating milestones was as essential as having for example a train-the-trainer framework, to maintain momentum to delivery.

SS7 Transfusion Transformation: How Transfusion Transformation is supporting the role of the Transfusion Practitioner

Stuart Lord, Lead Transfusion Practitioner, Gloucestershire Hospitals NHS Foundation Trust

Presentation on behalf of the TP Professional Framework working group as part of the Transfusion Transformation session at the BBTS 2025 symposium

The Transfusion 2024 strategy, launched in 2019 by NHS Blood and Transplant (NHSBT), the National Blood Transfusion Committee (NBTC), and NHS England, recognised the need for a sustainable transfusion workforce. Central to this vision was supporting and standardising the Transfusion Practitioner (TP) role, the vital link between clinical teams, laboratories, and governance structures.

Transfusion Transformation marks the next strategy. In 2024, TPs in England shared insights on the role's challenges, rewards, and future needs, shaping the TP Professional Development Framework, a key initiative to strengthen and future-proof the workforce. Due for publication in Spring 2026, the framework will formalise education, training, and career pathways, ensuring consistency across the NHS. Co-created with practising TPs, guided by a development lead and consultant, it is being shaped by those who know the role best.

The initiative highlights the expanding influence of TPs in policy, audit, incident management, and education, particularly in Patient Blood Management (PBM) and transfusion safety. Collaborating with laboratory managers, consultants, and healthcare leaders, TPs design training, drive compliance, and implement changes that improve patient care though the role often remains under-recognised. By standardising expectations, providing structured development, and fostering collaboration, Transfusion Transformation seeks to make the TP role more visible, valued, and equipped to meet modern transfusion demands, ultimately enhancing patient safety and outcomes.

SS9 SHOT: Improving Transfusion Information for Patients (written by the SHOT Team)
Speaker 1 – SHOT Transfusion Safety Standards and changes to the annual SHOT report
Dr Shruthi Narayan, SHOT Medical Director

Dr Narayan provided an overview of the SHOT Transfusion Safety Standards which are a formal set of standards designed to improve the safety and quality of blood transfusion practice across healthcare organisations in the UK. The standards were created in response to systemic gaps highlighted by consecutive SHOT reports, the Infected Blood Inquiry, and other independent safety investigations with the aim to provide a stable, structured framework so organisations can embed continuous improvement into daily operations.

SHOT Transfusion Safety Standards - Scope of the standards
SHOT Transfusion Safety Standards
SHOT Transfusion Safety Standards Toolkit

Speaker 2 – Transfusion laboratory errors: looking back to step forwards
Victoria Tuckley, SHOT Laboratory Incident Specialist

Victoria delivered an overview of transfusion laboratory events reported to SHOT in 2024. The presentation highlighted examples of good practice, an analysis of laboratory events by process step, near-miss data, and incidents where laboratory errors led to delays. Contributing factors to laboratory delays were explored, including clinical influences and the impact on patients.

Three key take-home messages for hospitals were identified

- Laboratory delays have more than doubled in 2024, with worsening patient impact including 3 deaths (1 probably related, 2 possibly related)
- Adopt a "back to basics" approach when reviewing training materials to ensure staff have the core knowledge and skills required for both routine and non-routine tasks.
- Regularly review, update, and adhere to business continuity plans (BCPs), ensuring they address a range of scenarios to support organisational resilience.
- Review and fully embed the SHOT Transfusion Safety Standards.

SHOT: Laboratory errors cumulative data page
Laboratory blood component telephone request forms - Serious Hazards of Transfusion
Laboratory communication toolkit - Serious Hazards of Transfusion
Tools supporting safe and effective communications - Serious Hazards of Transfusion
Transfusion delays investigation tool - Serious Hazards of Transfusion
Laboratory handover log - Serious Hazards of Transfusion

Speaker 3: Addressing transfusion delays
Dr Josephine McCullagh, Consultant Clinical Scientist – NHSBT and Barts Health and a member of the SHOT Working Expert Group

Dr Josephine McCullagh provided an overview of the transfusion delays reported to SHOT and trends. Transfusion delays are increasing year on year, with increasing serious adverse outcomes and delays in major haemorrhage cases. A significant increase in laboratory delays has been noted. Key gaps include communication failures, inadequate training, understaffing, and poor implementation of major haemorrhage protocols, leading to late escalation and delayed transfusion. She also shared some insights looking at impact of the CAS alert from 2022 that was released to address transfusion delays. The SHOT team with input from key stakeholders from around the UK are developing new resources to support hospital clinical and laboratory teams, including the concessionary release toolkit and major haemorrhage simulation toolkit, to improve safety and response times. Colleagues are encouraged to look at gaps in local practices and address them to ensure timely provision of transfusion support for patient.

Avoidable, Delay and Under or Overtransfusion Cumulative data - Serious Hazards of Transfusion

Speaker 4 – Clinical implementation of the validated intraoperative bleeding scale (VIBe scale)
Mr Steve Leung, Consultant Urological Surgeon, Edinburgh

Mr Leung provided an insight into the clinical implementation of the validated intraoperative bleeding scale (VIBe scale) and its impact on recognition of major bleeding, timeliness of intervention, and language and communication surrounding major haemorrhage protocol activation. This was a recorded session.

Speaker 5 – Improving transfusion information for patients
Denise McKeown, Regional Haemovigilance Co-ordinator/ Manager of BHSCT Haemovigilance Team, Belfast and Victoria Tuckley, SHOT Laboratory Incident Specialist

Denise and Victoria presented an overview of the update patient information resources and My Transfusion app, a digital resource designed to support adult patients who are receiving, or are likely to receive, blood transfusions. The app helps patients understand the transfusion process, prepare for appointments, and access clear, reliable information about their care.

Patient transfusion information leaflet

- The presentation highlighted the patient information leaflet provided to individuals receiving a blood transfusion.
- The leaflet has undergone a comprehensive review to ensure it reflects current requirements.
- It has been refreshed and updated to improve clarity, relevance, and usability.
- The updated version is due for imminent release and implementation.

My Transfusion app

- Designed for adult patients receiving transfusions, as well as their carers and relatives.
- Supports patients throughout the transfusion journey, including information on risks, benefits, and alternatives.
- Aligned with current national guidelines.
- Developed using insights from both patients and healthcare professionals.

A promotional pack for healthcare professionals has also been developed to support awareness and uptake of the app. This includes information about the My Transfusion app, email and newsletter templates, and details of additional supporting resources.

My Transfusion app - information for patients
My Transfusion app - information for healthcare professionals
My Transfusion app - information for healthcare professionals

Speaker 5 Summary from Denise McKeown, Regional Haemovigilance Co-ordinator/Manager of BHSCT Haemovigilance Team

I presented on the update to the Receiving a Blood Transfusion patient information leaflet, I joked that it sounded simple—just an update, right? Well, not quite. This has been a bit of a journey.

It all started with the review date coming and going, as well as the publication of the updated SaBTO guidelines on patient consent and shared decision making. Suddenly, our PIL was out of date and needed a refresh.

So, who took this on? The patient information leaflet (PIL) working group, which brings together representatives from all 4 UK nations. It's a collaborative effort, making sure the updated leaflet is consist, accurate and high quality.

The journey? Definitely not a straight road but here's where we've landed, an updated PIL with:

- Clearer language and better visuals
- Stronger focus on informed consent and shared decision-making
- Expanded sections on risks, alternatives, and post-transfusion advice
- More transparency—including real-world data (tried and tested on my mam!)

What's next: Content approval, final design and image inclusion followed by publication, translations and accessibility formats.

The takeaway? Blood transfusion is serious—but how we talk about it doesn't have to be scary. This isn't just about a leaflet; it's about culture change. We want this tool to empower patients, support safe transfusion practice, and keep improving how we communicate about blood components.

Last but not least, congratulations are extended to Rachel Moss, Advanced Transfusion Practitioner, Great Ormond Street Hospital for Children NHS Foundation Trust who was the BBTS Gold Award Winner 2025:

BEYOND COMPATIBILITY: A CASE OF ACUTE HAEMOLYSIS IN ACUTE MYELOID LEUKAEMIA (AML)

Stuart Lord
Lead Transfusion Practitioner
Gloucestershire Hospitals NHS Foundation Trust

Transfusion Practitioners Group
British Blood Transfusion Society

Case Study
Clostridium perfringens bacteraemia, a rare but severe infection known to cause intravascular haemolysis.

Overview
This case study examines a rapidly deteriorating clinical presentation involving a patient with Acute Myeloid Leukaemia (AML) who developed haemolysis within 24 hours of receiving a red blood cell transfusion. Initial clinical suspicion and investigation focused on transfusion-related complications, prompting an urgent multidisciplinary review led by the Transfusion Practitioners. The source of haemolysis was later identified as *Clostridium perfringens* bacteraemia.

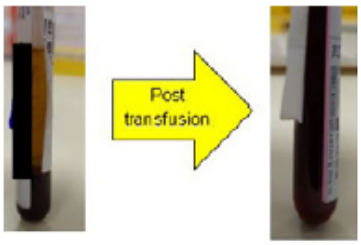
Background
Cancer treatment is inherently complex. Systemic Anti-Cancer Therapy (SACT) involves the use of cytotoxic drugs that target malignant cells but also carry the risk of damaging healthy tissue. All cytotoxic regimens come with side effects, and clinicians carefully balance therapeutic benefit against potential toxicity. One adverse effect is mucositis, concerning painful inflammation and ulceration of the mouth and gastrointestinal tract, which can compromise mucosal integrity and predispose patients to infection.

In this case, a patient presented with a two-month history of lethargy and general malaise, with symptoms initially attributed to COVID-19. Blood tests revealed severe neutropenia, and a bone marrow biopsy confirmed AML. Clinical Haematology, together with the patient, decided on and commenced a cytotoxic regime of Venetoclax and Cytarabine.
Transfusion Episode

Several weeks into the SACT, the patient was found to be anaemic with a haemoglobin of 75 g/L. A red blood cell transfusion was decided upon; the patient consented, and a Group and Screen was sent to the Blood Transfusion laboratory with a crossmatch request for one unit of packed red blood cells. Blood group serology testing was undertaken, with the patient grouping as A D positive.

Positive and a negative antibody screen. One unit of A D Positive packed red blood cells was issued via electronic issue in the Blood Transfusion laboratory, ready for the clinical team to collect. This was administered to the patient and was uneventful.

Adverse Reaction
Within 24 hours of transfusion, signs of haemolysis emerged, including haematuria, jaundice, abdominal pain, fever, shivering, and general malaise. Oxygen saturation levels declined, requiring oxygen support. Treatment for neutropenic sepsis with intravenous antibiotics was initiated as the most likely cause at this point. Urgent blood samples were sent, including a Group and Screen. Post-centrifugation of the sample(s), the plasma was grossly haemolysed. Repeat samples were requested, which showed worsening haemolysis in the centrifuged samples.



▲ **Figure 1:** The EDTA sample on the left, taken before the transfusion on the patient for a Group & Screen, shows normal plasma after centrifugation. In contrast, the post-transfusion sample on the right, also centrifuged, revealed clear haemolysis in the plasma.

Clinical Differential and Impression
An 'adverse reaction to a blood component' investigation was initiated in accordance with local policy and reported externally to SaBRE. ABO incompatibility was initially suspected but ruled out through verification of correct and compatible donor

Pre transfusion Hb	
Haemoglobin	75
Pre transfusion Bilirubin	
Bilirubin	21
Post transfusion Hb	
Haemoglobin	48
Post transfusion Bilirubin	
Bilirubin	225

and patient blood groups, patient

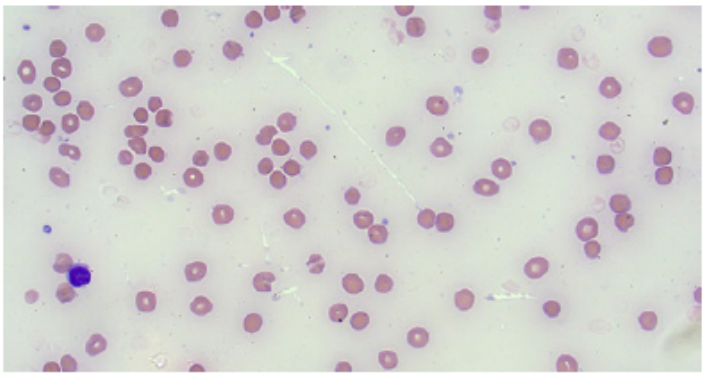


Figure 2: Image of the peripheral blood film post transfusion, demonstrating the presence of significant numbers of spherocytes together with thrombocytopenia and leucopenia

> Within 24 hours of transfusion, signs of haemolysis emerged, including haematuria, jaundice, abdominal pain, fever, shivering, and general malaise.

identification checks (and re-checks), and laboratory serological results. The pre and post transfusion samples evidenced serological compatibility with the implicated unit, with negative antibody screens demonstrated. This led to a broader investigation into other transfusion-related and clinical causes due to the demonstrated lack of serological evidence of a transfusion immunological reaction. NHS Blood and Transplant (NHSBT) was contacted for further advice, and both pre and post Group and Screen samples from the patient as well as the implicated donor unit were sent for testing and investigation.

Differential diagnosis included hyperhaemolysis and Tumour Lysis Syndrome at this point, both considered plausible given the underlying haematological malignancy and recent chemotherapy. However, patient blood cultures returned positive for *Clostridium perfringens*, a gram-positive anaerobic bacterium known to produce alpha toxin that disrupts cell membranes and causes intravascular haemolysis.

NHSBT confirmed that the implicated blood units did not grow *Clostridium perfringens*, ruling out transfusion-transmitted infection. The infection was attributed to translocation from the gastrointestinal tract, likely due to mucositis, a known complication of chemotherapy in immunocompromised patients.

Discussion

This case highlights the diagnostic complexity and urgency required when managing acute haemolytic episodes in patients. The rapid onset of symptoms following transfusion raised immediate concerns about transfusion reactions, necessitating a thorough and coordinated response across multiple disciplines, including Clinical Haematology, Microbiology, Transfusion Medicine, and NHSBT.

Identification of *Clostridium perfringens* as the causative agent was critical in understanding the pathophysiology of the haemolysis. This bacterium, commonly found in the gastrointestinal tract, soil, and decaying vegetation, produces alpha toxin that leads to destruction of red blood cells and septic shock. In this case, the infection likely originated from chemotherapy-induced mucosal damage, allowing bacterial translocation into the bloodstream.

Although the transfusion was not the source of infection, the haemovigilance investigation played a vital role in ruling out blood component-related causes. The process ensured compliance with regulatory standards and provided clarity for the clinical team and the patient's family.

Conclusion

The case of bacteraemia-induced haemolysis in a patient with AML receiving chemotherapy illustrates the challenges of diagnosing and managing complex clinical presentations. While the haemolytic episode was initially suspected to be transfusion-related, comprehensive investigation revealed an infectious cause unrelated to the blood component. The findings reinforce the importance of haemovigilance, multidisciplinary collaboration, and rapid diagnostic processes in improving patient safety and outcomes.

This case contributes to the broader understanding of *Clostridium perfringens* bacteraemia and its implications in haematology and transfusion practice. Vigilance in monitoring immunocompromised patients and coordinated care remain essential in navigating adverse clinical events. Given the timing of haemolysis relative to transfusion, the Blood Transfusion laboratory commenced urgent serological investigation into a possible transfusion reaction after liaising with the clinical team. The table below summarises the pre and post transfusion Haemoglobin and Bilirubin results.