

SHOT Newsletter November 2026

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Upcoming Events

- National Pathology Week
- Advances in Transfusion Medicine Symposium
- Patient involvement events
- Cell salvage educational event



Abstracts from Annual SHOT Symposia now published

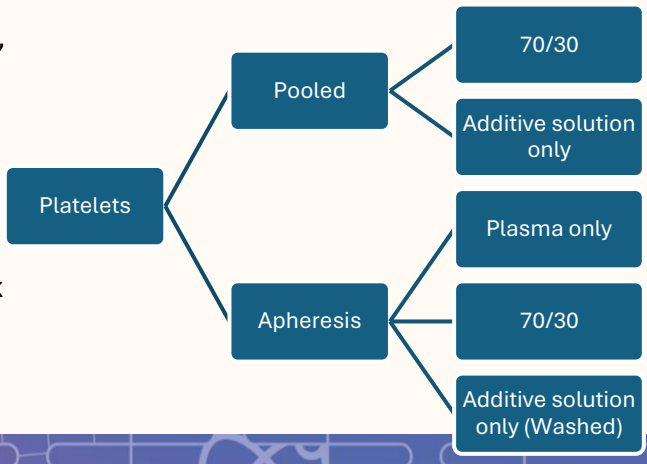
The abstracts from the SHOT symposia have now been published in Transfusion Medicine supplement Transfusion Medicine - Wiley Online Library

Discover the innovation, insights, and real-world impact shaping transfusion practice today. Explore the SHOT Symposium abstract submissions and broaden your knowledge through the experiences and research of colleagues across the field of transfusion.

Dendrite reporting – Apheresis platelets

If you are reporting an event to SHOT relating to platelets, please ensure you select the correct platelet component type/suspension medium in Dendrite. The recently available Apheresis (70% PAS/30% plasma) component is being overrepresented in our data, with this component type being selected in error.

SHOT routinely use the component type data, and the ask from the SHOT team is to please ensure you are selecting the correct component type when reporting to SHOT.



New SHOT participation and benchmarking data for 2025

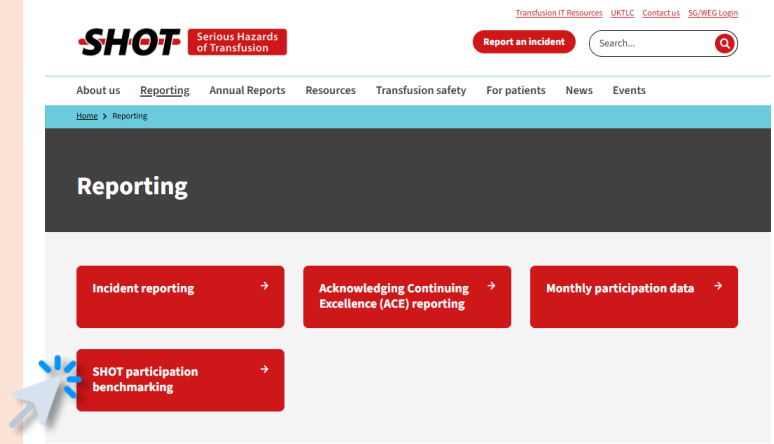
The SHOT participation benchmarking data has been published for 2025 calendar year. Teams can use the data to monitor organisation's level of participation in the SHOT scheme in comparison to organisations of similar blood usage.

To access this data:

- Select the SHOT participation benchmarking page
- Login via the 'here to view' link
- Accounts are password protected
- You will be able to view all reports, as well as your own organisation's reports
- If you don't have a login or have forgotten the password, please email shot@nhsbt.nhs.uk

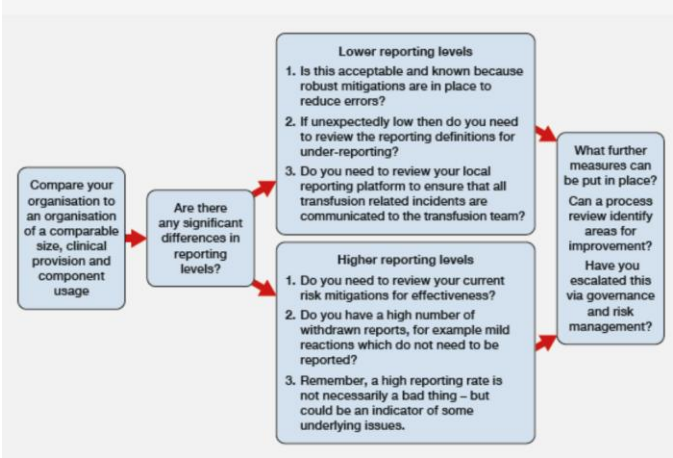
The data includes:

- Regional graphs
- Usage graphs
- Individual reports
- Historic participation data





Click here to access the participation benchmarking data page



How to use this benchmarked participation data

Please use the data to monitor your own organisations level of participation in the SHOT scheme in comparison to organisations of similar size.

UK Health Security Agency data for TTI surveillance

The UK Heath Security Agency (UKHSA) dashboard which covers investigations and outcomes of suspected transfusion transmitted infections (TTIs) in blood donors and recipients is now available as a link from the SHOT website via the 'Number of recipients with confirmed probable TTI' page, or directly via the UKHSA data dashboard page.

Gap Analysis Tool : Essential standards for transfusion IT systems

A new **Gap Analysis tool** is now available to for the '**Essential standards for safe transfusion in clinical IT systems.'**

This gap analysis tool can be used by organisations to evaluate whether their practice is in line with the standards.

These standards establish a baseline for safety-critical functionality, helping organisations reduce risk, improve traceability, and embed best practice across transfusion pathways.



Click here to access the Essential standards in clinical IT systems

Click here to access the Gap analysis tool for standards in clinical IT systems

Gap analysis tool for the 'Essential standards for safe transfusion in clinical IT systems'

Section	Criteria	System 1 compliance	System 2 compliance	Current activity / evidence	Action(s) needed to meet standard	Lead(s)
1	General Requirements					
1.1	System supports safe administration of all blood components and products in accordance with BSH guidelines, SHOT Transfusion Safety Standards and BSQR.					
1.2	System functionality operates on all available hardware (e.g., printers, scanners, workstations, handheld devices) used in clinical environments in the UK.					
1.3	System only allows users access privileges to perform parts of the transfusion workflow that are within their remit of job role and/or associated with the user's training and competencies performed.					
1.4a	Critical safety alerts cannot be overridden, (e.g., patient ID band mismatch with component label, component expired, ID band not scanned) and must provide a hard stop to the workflow with appropriate notice to the user.					
1.4b	Where safety non-critical alerts are able to be overridden, this must only be allowed by an individual with appropriate access level. The system must record justification and include the identification user and is auditable for monitoring.					

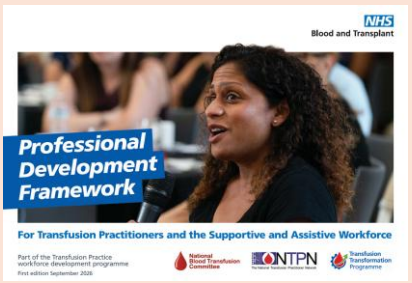
Transfusion Practitioner Professional Development Framework

The Professional Development Framework for Transfusion Practitioners and the Supportive and Assistive Workforce, developed through the Transfusion 2024 (T2024) strategy, provides a structured approach to support individuals, managers and organisations in identifying the knowledge, skills and professional development needs of the transfusion practice workforce across all career stages, roles and healthcare settings.

Click here to access the TP Professional Development Framework

National Transfusion Practitioners Network NBTC webpage

Developed with and for the transfusion practice workforce, the Framework was co-produced with transfusion practitioners, professional bodies and key stakeholders to ensure that it reflects the realities of practice and addresses the workforce's needs, challenges and aspirations. It supports professional development, workforce capability, career progression, succession planning, and the delivery of high-quality, safe transfusion patient care.



National Pathology Week 2026



National Pathology Week (NPW) 2-8 Nov 2026

NPW is the Royal College of Pathology's annual celebration of pathology, with this year's theme being '**Welcome to the lab**'.

The Pathology Alliance are delivering a series of 13 online events that extend through the whole of November. Undergraduates, foundation doctors and trainee scientists (and any non-specialists interested in finding out more about pathology) are encouraged to attend these informative 1-hour events. Click here to access.

Join SHOT in celebrating National Pathology Week

SHOT has created a National Pathology Week page on the SHOT website, featuring 7 different topics and highlighting resources relevant to the transfusion laboratory that SHOT hopes you will find useful and adaptable to fit your own local processes.

From resources to help optimise transfusion IT systems, to toolkits to improve laboratory communication and transfusion team's involvement in major haemorrhage simulations, SHOT will be sharing these with you throughout the week to help improve transfusion safety. There are also LinkedIn posts from SHOT celebrating these events.

Click **here** to access link to the SHOT National Pathology Week pages and resources

SHOT and RCPath webinar



SHOT are pleased to participate in the:
Advances in Transfusion Medicine Symposium 2026

- Wednesday 25th Nov 2026 09:30-13:00
- Thursday 26th Nov 2026 09:30-13:00

These webinars will run as two half-day virtual sessions via Zoom with interactive Q&A.

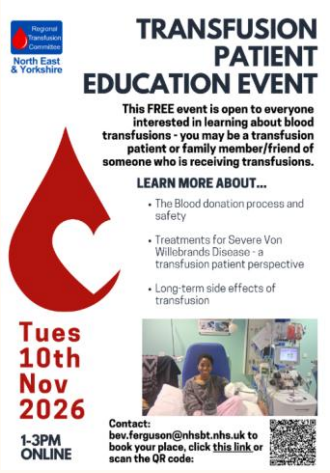
There will cover exciting developments in transfusion medicine and science with high-quality research supporting evidence-based practice. This symposium brings together experts from various clinical disciplines and also leaders in transfusion science to provide an update on key developments

The event is relevant to consultant haematologists, nursing and laboratory staff, transfusion practitioners, trainees and all other healthcare professionals working in the field of transfusion.

This event is being supported by the RCPath Oliver Memorial Fund and SHOT. There is no cost for participation, but pre-registration is essential and separate registration is required for each day.

Click here for more information including programme and registration links

PATIENT INVOLVEMENT EVENTS



The North East and Yorkshire RTC Transfusion patient event is free to anyone interested in learning about blood transfusion.

Click **here** to access link



NBTC are looking for patient representatives to collaborate with them by sharing experiences and guiding us on how we can improve transfusion services.

Click **here** to access link

CELL SALVAGE EVENT

The UK Cell Salvage Advisory Group is holding its annual education event on 12 Nov 2026 – **Advancing knowledge on Intraoperative Cell Salvage**

UK CELL SALVAGE ADVISORY GROUP

UKCSAG Annual Education Event 2026
Advancing Knowledge in Intraoperative Cell Salvage

12th November 2026
1:00pm - 4:15pm
Microsoft Teams
FREE Event
Open to all clinical and laboratory staff with an interest in Cell Salvage

Join International and UK experts for an afternoon of practical insights, updates, and discussion on current Cell Salvage practice.

To register, click here or

Topics include:
- ICS Filters: What You Need to Know
- Swab Washing: Top Tips for Success
- Reinfusion: Best Practice Essentials
- Hip Surgery & Metallosis
- ICS and Malignancy
- Drugs, Additives & Permissions for ICS Use
- Vaginal Cell Salvage
- ICS and Haemovigilance
- Cell Salvage in Sickle Cell Disease

Click **here** to access the UK Cell Salvage Advisory Group page on the JPAC website

Click **here** to access the UK Cell Salvage Advisory Group annual education event

Chapter spotlight: Laboratory errors

Key findings

- Laboratory errors contributed to 2 patient deaths, both due to delayed transfusions.
- There has been a large increase in major morbidity caused by laboratory errors, with cases more than doubling to 9 in 2025 from 4 in 2024.
- There were 3 cases of ABO-incompatible (ABOi) transfusion of plasma components.
- There was an increase of cases occurring during the component availability step, with the number of errors at other steps decreasing.

Gaps identified

- Delays in transfusion and lack of component availability with profound patient impact.
- Not meeting transfusion requirements for patients of childbearing potential.
- Inadequate capacity planning and staff support systems.
- Insufficient training support for newly qualified transfusion laboratory staff.
- Lack of actions and effectiveness review following investigation.

Good practice

- Duty of candour practice has been followed through relevant communication channels.
- Over 90% of laboratory reports have been reviewed through governance procedures.

Case 18.1: Death related to delay in transfusion due to incomplete handover and lack of recognition of clinical urgency (imputability 2 – probable)

A patient with a likely new diagnosis of acute myeloid leukaemia on background of myeloma was admitted to the emergency department (ED) with a haemoglobin (Hb) of 56g/L and platelet count of 8×10^9/L. They were stable and had been receiving regular top-up transfusions over the past 2 months. Red cells were requested and as the patient had atypical red cell antibodies the sample needed to be tested at the reference laboratory. Clinicians were informed the estimated time of red cell delivery would be on the following day, but the haematology consultant was not contacted for advice by laboratory staff as per policy.

Information about the impending delivery and urgent transfusion was not verbally handed over at laboratory shift change. The units were recorded as being expected on the laboratory handover sheet, but the urgency of the transfusion was not logged. The red cells arrived much quicker than expected, but the ED was not informed that they were available. The clinical team were hesitant to transfuse emergency group O red cells due to the presence of alloantibodies, despite the patient's Hb dropping further to 40g/L during this period. No further communication was made by the ED team to the laboratory to chase blood availability as they were expecting the delivery the next day. Fifteen hours after admission an emergency call was made as the patient had collapsed onto the floor with cardiac arrest an hour after they had last been reviewed. A unit of emergency O D-positive blood was administered but the patient did not survive.

There was no bed available on the haematology ward, so the patient remained in the ED for the whole 15 hours. The investigation noted the ED was extremely overcrowded with excessive corridor care. It also noted a hesitancy from the clinical teams to use emergency blood due to red cell antibodies being present. Advice was sought from haematologists upon admission, but they were not contacted after this for further guidance despite deterioration.

Next steps

- Evaluate capacity plans to ensure laboratories are staffed to meet service needs.
- Meaningful changes should be implemented after incident review to prevent reoccurrence.
- Implement and maintain SHOT Safety Standards in the laboratory.

Scan or click the QR code to read the laboratory chapter in full

Scan or click the QR code to access the Case studies from 2025 Annual SHOT Report