NHS
Blood and Transplant

The Update for July 2026

Audit series on anticoagulant reversal in trauma and anticoagulant-associated bleeding closes 5 August 2026

The NBTC Haematology and Trauma Working Group would like to remind colleagues that there is still time to participate in the 2026 re-audit on the reversal of anticoagulant-associated bleeding in trauma patients.

This national audit follows the initial 2022 audit and aims to:

- Identify whether hospitals have guidelines for the reversal of DOACs and vitamin K antagonists (VKAs)
- Assess, through individual case reviews, whether these guidelines are being followed

Hospitals can participate in one or more of the following:

- Organisational survey (one submission per hospital)
- Reversal of DOAC-associated bleeding in trauma patients audit
- Reversal of warfarin-associated bleeding in trauma patients audit

All hospitals are welcome to take part, including major trauma centres, trauma units and District General Hospitals. Data collection may be undertaken retrospectively or prospectively.

For further information, audit materials and sign-up details, please visit NBTC Audit Series on Anticoagulant Reversal in Trauma and Anticoagulant Associated Bleeding

To sign up or discuss participation, please contact:

Monday, Thursday or Friday - Grace Brennan grace.brennan@nhsbt.nhs.uk

Tuesday or Wednesday - Sue Katic sue.katic@nhsbt.nhs.uk

Thank you to all organisations already taking part.

If your hospital has not yet joined the audit, we encourage you to consider participating and contributing to this important national work.

Dr Fatts Chowdhury
Chair, NBTC Haematology & Trauma Working Group
Consultant Haematologist in Transfusion Medicine, NHSBT

How to make a complaint about our service or report a potential blood pack defect

We have recently updated both our process for managing complaints from hospitals, and the complaint form for hospitals to use. The document and complaint form are now available on our webpage. There is also a separate form for reporting potential pack defects.

You can raise your dissatisfaction either by email, verbally to your customer service manager or by using the form on the webpage. Whichever way you prefer, it is important you include the following:

- the name of your hospital
- the time and date of the incident
- relevant reference numbers (for order/delivery/sample)
- details of any patient impact

These details are critical: they give us all the information we need so we can fully investigate your complaint immediately after you have reported it.

Delia Smith - Projects and Customer Insights Manager, Hospital Customer Service

Referring samples to RCI for Fetal Maternal Haemorrhage (FMH) by Flow Cytometry (FC)

When sending samples to RCI for measurement of FMH volume, it is important to send a separate maternal EDTA sample that has not been used for other tests. Samples should not be centrifuged or tested on a blood group analyser.

The larger fetal cells separate from maternal cells during centrifugation. This can affect the accuracy of FMH testing if the same sample is used, as it is difficult to re-mix effectively. If the sample has already been used for blood grouping, the larger fetal red cells sitting closer to the plasma/red cell interface may have be sampled preferentially, reducing the volume remaining and leading to underestimation of the fetal bleed. See the recently updated British Society for Haematology guidance

If only one maternal sample is available and this has been centrifuged, please discuss the case with the RCI laboratory. If the sample is irreplaceable (e.g. anti-D immunoglobulin has already been given, or the woman has already been discharged) then testing under concession may be considered, but the results will be issued with a caution about their accuracy. Clinical advice can be sought from an NHSBT consultant (telephone numbers are listed in appendix 1 of the RCI user guide).

Wisdom Musabaike - Assistant Director of RCI

How to request blank antibody cards from RCI

We would like to remind you to contact your RCI lab to request blank antibody cards.

We are aware some hospitals are using the RCI report cessation email address to request the cards. Please note, we are no longer managing the inbox for this email address so your request will not be actioned.

Wisdom Musabaike - Assistant Director of RCI

The UK Cell Salvage Advisory Group (UKCSAG) has transitioned from an Action Group to an Advisory Group

The UKCSAG is pleased to announce its official transition to being the UK Cell Salvage Advisory Group. The change reflects the expertise, leadership, and advisory role its members provide supporting best practice across intraoperative cell salvage.

For more information about the work of the group and its resources, visit the UKCSAG webpage.

Tracy Johnston - Patient Blood Management Practitioner, PBM England

Launch of a new patient information leaflet for intraoperative cell salvage

The UKCSAG is pleased to launch a new patient information leaflet for intraoperative cell salvage, now available on the UKCSAG JPAC webpage. This valuable patient resource has been developed to support informed patient decision-making and enhance the consent process.

Download the ICS patient information leaflet

Download a poster about the ICS patient information leaflet (PDF 112KB)

Tracy Johnston - Patient Blood Management Practitioner, PBM England

Serious Hazards of Transfusion (SHOT) newsletter for July is now available

The highlights in this month's newsletter are:

- 2025 Annual SHOT Report is available
- New Essential Standards for Safe Transfusion in Clinical IT Systems to support safer digital transfusion practice
- New SHOT resources on learning from excellence and everyday events, and staff fatigue and transfusion safety
- Updated TACO Safety Alert and Transfusion Safety Standards FAQs, including changes following the decommissioning of the Red Cell Dosage Calculator (RCDC)
- Celebrating 20 years of the UK Transfusion Laboratory Collaborative (UKTLC)
- Launch of the UK Cell Salvage Advisory Group (UKCSAG) as a new advisory group

Read the newsletter

Sign up to receive the newsletter every month.

The SHOT team

Save the date: Patient Blood Management (PBM) England conference 4 November 2026

Our flagship conference returns on 4 November with an inspiring speaker panel to mark PBM Awareness Week (2 to 6 November). A poster competition will also launch, with judging during the week. Start planning and watch for more details coming soon!

Aimee Burtenshaw - Patient Blood Management Practitioner, Clinical Services

The Update is produced by Hospital Customer Service on behalf of NHS Blood and Transplant
NHSBT.customerservice@nhsbt.nhs.uk
0208 201 3107