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Cite this as: *BMJ* 2025;390:r1565

<http://doi.org/10.1136/bmj.r1565>

Published: 28 July 2025

# Transfusion safety continues to be compromised in the NHS

## Failures of process and oversight cannot be allowed to persist

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Just over a year after the Infected Blood Inquiry urged the NHS to improve the safety of blood transfusion, the UK has recorded its highest number of transfusion related deaths.<sup>1</sup> The 2024 report from the Serious Hazards of Transfusion (SHOT) scheme, the UK haemovigilance programme that started in 1996, shows 59 deaths, up from 38 in 2023.<sup>2</sup> This 55% jump in a year is not an anomaly: transfusion related deaths have been increasing every year since 2021 and have quadrupled over the past decade.<sup>2</sup>

The leading causes are transfusion associated circulatory overload (TACO), which accounted for 31 deaths in 2024 compared with 15 the year before, and transfusion delays, which caused 18 deaths (up from 13).<sup>2</sup> These deaths do not reflect complex clinical challenges, especially as TACO risk assessment has been in place since 2015,<sup>3</sup> but failures of process and oversight that have been allowed to persist. This systematic inertia has been seen in other NHS scandals.<sup>4,5</sup>

Parallels with the Ockenden review into maternity failures are impossible to ignore.<sup>4</sup> SHOT highlights that deaths from TACO were linked to inadequate monitoring and failure to act on early clinical deterioration, which echoes Ockenden's emphasis on missed "red flags" in maternal deterioration. SHOT documents that hierarchical barriers prevent junior staff from challenging unsafe senior decisions, mirroring Ockenden's findings. What emerges from both reports is systems that are functionally flawed, with overstretched staff working within structures that fail to support timely intervention. Both highlight ineffective governance mechanisms, with SHOT noting "safety recommendations filed, not actioned."

At the heart of the problem lies a disconnect between those who identify risks and those with the power to address them. Hospital transfusion committees report being downgraded to forums, with 75% lacking formal mechanisms to escalate risks to trust boards.<sup>6</sup> This is similar to Ockenden's findings of the trust board "not having a full understanding of issues and concerns, resulting in a lack of strategic direction." Both scenarios reveal organisations where safety is siloed rather than embedded at all levels. The Infected Blood Inquiry's recommendation for statutory duties of candour and board level oversight of transfusion safety was a step in the right direction.<sup>1</sup> But without enforcement, such measures risk becoming another box ticking exercise.

### Taking action

Tackling many of the risks highlighted in the SHOT report requires a reduction in unnecessary transfusions through robust patient blood management strategies. These include early treatment

of anaemia, restrictive transfusion thresholds, and blood conservation techniques such as pre-operative administration of tranexamic acid (reducing bleeding by 25%) and intra-operative cell salvage (cutting transfusion demands by 35%).<sup>7-9</sup> Well implemented blood management programmes in Western Australia and Ontario, Canada, have produced sustained reductions in unnecessary transfusions.<sup>10,11</sup> These approaches will also help improve blood stocks in the UK, which have been fragile in recent years.<sup>12</sup> They are also economically prudent because fewer transfusions mean lower costs, shorter hospital stays, and fewer complications.<sup>10</sup>

Beside barcode scanning, automated alerts, and digital audit tools have been shown to substantially reduce misidentification and delays. However, their adoption remains inconsistent across the NHS despite repeated recommendations by SHOT and guidance from the National Institute for Health and Care Excellence (NICE).<sup>13-15</sup> The NHS's push towards digital transformation must consider transfusion safety, with targeted funding to ensure universal rather than piecemeal implementation.<sup>16</sup> Such investment would pay for itself many times over by reducing errors, litigation, and resource wastage.

Leadership is the linchpin, especially as the transfusion pathway involves multiple staff in different patient care settings.<sup>17</sup> Without accountability, even the best strategies will falter.<sup>18</sup> NHS integrated care and trust boards must report on transfusion safety metrics and demonstrate to regulatory bodies, such as the Care Quality Commission, that there is good governance enabling hospital transfusion committees to act on SHOT recommendations.

The role of patients too cannot be overlooked. As the Infected Blood Inquiry made clear, ignoring patient voices carries devastating consequences. Empowering patients with information—for example, through SHOT's "My Transfusion" app—so that they can ask questions, ensure confirmation of identification, and report symptoms, creates a safety net. Patients are vital partners in prevention.

We do not need another inquiry. SHOT, Ockenden, and the Infected Blood Inquiry have already diagnosed the problem. Preventable deaths, repeated errors, and ignored warnings will continue unless the NHS breaks free from cycles of inertia and amnesia to embrace meaningful change.<sup>18</sup> The remedy is leaders that listen, act, and invest—in systems, in staff, in digital tools, and in patient engagement.<sup>19</sup> The NHS cannot afford to keep repeating the same mistakes. Patients deserve action now.

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Competing interests: We have read and understood BMJ policy on declaration of interests and declare that C-HT chairs the National Blood Transfusion Committee. EB is a parent of three sons infected through blood products as infants and has been an NHS chair for 20 years.

Provenance and peer review: Commissioned; not externally peer reviewed.

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