1 Foreword

I am writing this foreword on the day the final report of the Infected Blood Inquiry (IBI) has been released. I have listened to the live stream presentation, of around an hour, by the chair of the Inquiry, Sir Brian Langstaff. His presentation was both eloquent and concise. Every moment of it was compelling, yet it barely scratched the surface of the report the Inquiry produced, which runs to seven volumes. I have had the opportunity to read the summary pages, and skim through volume one. The report is comprehensive, but even so cannot hope to be exhaustive. It is wide ranging and detailed; acknowledging the depth of tragedy and human suffering which necessitated the Inquiry. For those of you who do not have time to read the report, I highly recommend Sir Brian's live stream, which is available through the IBI website.

Several important themes come through. There were major failings illustrated in the report around consent, around patient autonomy, and around medical paternalism. Medical record keeping and audit were likewise found to have been seriously inadequate. The IBI report describes in detail what happened, the nature of the response at the time, and what should happen going forward (IBI, 2024). In part, the report's recommendations address political remedies, and recommend how processes should be changed and improved. The future role of SHOT and haemovigilance processes more widely are outlined in volume one of the report (pages 261 through 267). These conclude with the recommendation:

'That all NHS organisations across the UK have a mechanism in place for implementing recommendations of SHOT reports, which should be professionally mandated, and for monitoring such implementation.'

The IBI report goes on to underline the desirability of establishing the outcomes of every transfusion of blood components. Had this been achieved at the time of the principal events described in the report, Sir Brian writes, it is likely that alarm bells would have rung sooner. The Scottish 'Account for blood' scheme is described, and most importantly, current major threats, including transfusion-associated circulatory overload (TACO) are cited. The desperate and urgent need for effective IT solutions is also mentioned. Sir Brian recommends:

Establishing the outcome of every transfusion

(i) That a framework be established for recording outcomes for recipients of blood components. That those records be used by NHS bodies to improve transfusion practice (including by providing such information to haemovigilance bodies)

> *Success in achieving this will be measured by the extent to which the SHOT reports for the previous three years show a progressive reduction in incidents of incorrect blood component transfusions measured as a proportion of the number of transfusions given.*

(ii) To the extent that the funding for digital transformation does not already cover the setting up and operation of this framework, bespoke funding should be provided

(iii) That funding for the provision of enhanced electronic clinical systems in relation to blood transfusion be regarded as a priority across the UK

These goals align closely with the current philosophy of SHOT, and the priorities we have identified over recent years. This year's Annual SHOT Report, including data until the end of December 2023, emphasises that errors continue to account for most reports. Near miss events make up a large proportion of the total incidents. As laid out in the report of the IBI, reporting of all new incidents is crucial. This year's Annual SHOT Report relates that transfusion delays and pulmonary complications

(both TACO and non-TACO) remain leading causes of transfusion-related deaths in the UK, accounting together for over 76% of the deaths reported.

Notwithstanding that, the absolute risk of death remains relatively low, at 1 in 58,000 components issued. Harms are at least five times more common. It is unlikely that this situation can be improved upon with current low levels of resourcing, with under-reporting, and while SHOT collates data and produces reports, but lacks an effector arm.

In conclusion, I would like to quote two sentences from Sir Brian's comments at the report launch which, for me, are the absolute essence of the culture we should nurture.

'Most, if not all, infections would have been prevented if patient safety had been paramount throughout'.

'The public should be trusted with the truth'.

It is timely for Trusts and Health Boards in the UK to take full account of Sir Brian's findings in the IBI, and ensure that SHOT recommendations are effectively implemented. I commend this year's Annual SHOT Report to you.

Professor Mark Bellamy, Past President, Intensive Care Society; Professor of Critical Care, The Leeds Teaching Hospitals NHS Trust, and Outgoing Chair of the SHOT Steering Group

Reference

Infected Blood Inquiry (IBI), 2024. *The Report HC 569-I,* London: Crown. Available at: https://www.infectedbloodinquiry.org.uk/reports/inquiry-report (Accessed 20 May 2024).