

# Foreword

# 1

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'May you live in interesting times' is often quoted as an ancient Chinese curse. In fact, the origins are probably British, and far later; there is no evidence for an ancient Chinese origin to this saying, nor, apparently, is there any equivalent expression in modern Chinese parlance. Nonetheless, the coronavirus era we have entered in the early part of 2020 is interesting, tragic and terrifying in equal measures. One of the upsides, however, of 'interesting times', is that they are indeed interesting, if not fascinating and full of challenge.

This year's Annual SHOT Report looks back at trends and data for the last calendar year, but also highlights several very important messages for us in the present extraordinary times. The data in the report come from across the United Kingdom (UK) and include material from all areas of healthcare where transfusion is practised. As in previous years, it is certain that under-reporting is significant. Reporting rates in some of the higher usage Trusts/Health Boards vary twentyfold. Given the cultural, resource and procedural similarities of these organisations, it is highly unlikely that the error and mishap rate varies by anything like this much, so reporting rates are likely to play a large part. One area where this is likely to have greatest impact is in the reporting of near misses, the most fertile learning area.

The leading causes of transfusion-related incidents are, again this year, 'human factors' related, with procedural failures and flawed decision-making contributing in large measure. While decision support tools and information technology have gained some traction, and continue to help us progress in these areas, their universal adoption remains some way off. Until these are more widespread, we continue to rely on education and peer pressure to encourage best practice.

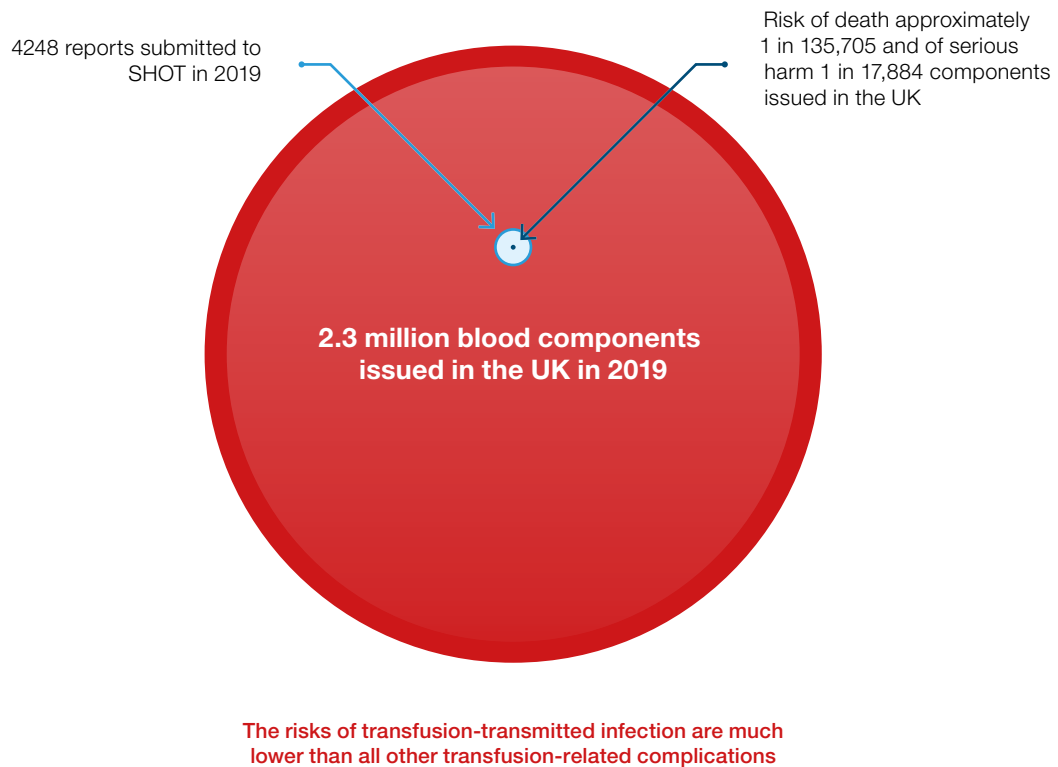
A 'human factors' approach is key to understanding why errors and accidents continue to occur, despite, in many cases, adequate training, knowledge, expertise and currency. Those areas of hospitals which are under greatest stress and pressure, for example, emergency departments, continue to report a year on year increase in errors. Despite this, transfusion remains very safe indeed, with the risk of serious harm being 1 in 17,884 and death 1 in 135,705 transfused components in the UK.

In the new era of the coronavirus pandemic there is economic and health-economic stress. Maintaining high rates of reporting, and a learning culture, is more important than ever. Actual harm remains rare; to learn effectively, and promote safety, we need to learn as much from the near misses as we do from the actual incidents. Learning from our mistakes is important; but so, too, is learning from what goes well. If we learn only from our mistakes, we assume that our underlying systems, procedures and culture are already robust, and the mistakes represent either glitches in the system, or deviations from it. But it is equally important for us to realise that this is seldom the case. Why do things go well? What is it about a system which prevents more frequent failures? Why are some systems better at this than others? For example, in a busy railway concourse, most people do not bump into one another. We take this for granted; and yet, it is quite extraordinary, something we should find surprising.

A 'Safety-II' approach should, and must, complement our traditional, error-focused 'Safety-I' culture. Safety-II must become embedded in our approach to improving and developing what we do. Why do things go well, how do systems and procedures adapt to promote and maintain safety, and what can we learn from that? The current extraordinary situation gives unprecedented opportunities to learn about resilience, to learn the lessons of what goes well, to understand how systems do not fail, and how this resilience can be generalised. We, at SHOT, are hugely thankful to all our reporters over the last year, for the quality and diligence of reporting. Although this may seem a subsidiary activity during the current

pandemic, it is not. The dark days of this pandemic, and its aftermath, offer us learning opportunities which are unique and unprecedented. It is crucial and more important than ever before to maintain and progress our reporting and learning culture.

**Figure 1.1:**  
**Risk of harm  
or death from  
blood transfusion  
in the UK**



*Note: This is a representative image and not accurate to scale*