1 Foreword

At the time of writing, we are emerging from another period of COVID-19 lockdown and stringent societal restrictions. The vaccination program is well advanced, and so there is a sense of hope that we may well now be passed the worst, and able to return to some form of 'normality'. Whether this will be the case, or whether we are simply in the precursor phase of further waves and surges of the pandemic, is not yet clear. Certainly, the spectres of waning immunity and new viral variants mean that while we can have hope, we cannot have confidence in the future.

The death toll from COVID-19 has been severe, but the NHS has survived. It has survived though at a great cost. Much work delivering 'routine' healthcare has been set aside. And for those patients, their needs were not 'routine'; many have conditions which have progressed, tragically, in some cases, beyond effective treatment. Healthcare workers are exhausted, and many plan to leave their profession. We now face years of backlog. The pressures on the NHS are different now to those at the height of the pandemic, but they are not less. In many ways, they are far greater.

However, we are in a very different position now should we have to face a further wave, another surge, of COVID-19 infection, compared with a year ago. We have learned a huge amount about COVID-19 as a disease, and even more about how to manage a pandemic, both in society and in the health services. Much of what we have learned will outlast the pandemic and has wider applicability. For example, new needs have accelerated the development of technologies and skills and catapulted us into better and more agile practices. This has been particularly true in haemovigilance. Several members of the SHOT Steering Group have shared their personal reflections with me; there are many similarities and common experiences.

The most obvious among these is that meetings, teaching and training, and debriefing after errors, incidents and near misses, can be done very effectively by electronic means. Small group videoconferences have proved extremely effective at disseminating learning points and promoting inclusivity and have meant that the 'reach' of these activities is much greater. They can be more targeted and structured in a more bespoke way. Delivered in small groups, their impact has likely also improved.

But unto each yin, its yang: beside these positives, there have been some recurring negatives. Among these is the observation that the incidents reported to SHOT through the pandemic have been remarkably similar to those reported in previous years. This calls into question the effectiveness with which learning is disseminated to, and retained by, the healthcare teams at the sharp end of transfusion. One lay commentator has suggested that every healthcare organisation should have a senior person to act as a transfusion champion. Observing that healthcare professionals have 'extremely hierarchical structures', the commentator suggested that to be effective, the champion would need to be at the apex of the pyramid. It has also been suggested that the thrust of safety efforts should target those which continue to cause greatest harm, in particular, transfusion-associated circulatory overload. There are golden opportunities here for the wider implementation of information technology in transfusion prescribing, and the use of decision aids.

It seems unlikely that society will ever be quite the same again; nor will healthcare. The opportunities for using change to advance transfusion safety are plain to see. Let us seize the moment.

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