Grŵp Goruchwylio Iechyd Gwaed Cenedlaethol
Blood Health National Oversight Group

To: Hospital Transfusion Committee Chairs

*Cc: Medical Directors, Quality and Safety Leads, Transfusion Lab Managers, Transfusion Practitioners, Consultant Haematologists, Blood Health Team (BHT)*

RE: Organisational response to 2021 SHOT recommendations

January 8th 2023

Dear Colleagues,

I am writing on behalf of the BHNOG Serious Hazards of Transfusion (SHOT) working group, which was established to review and support the implementation of SHOT recommendations on an All-Wales basis.

The purpose of the BHNOG SHOT working group is to:

1. Develop a national strategy to support implementation of SHOT guidance endorsed by the BHNOG
2. Work with health boards to Identify gaps in compliance with annual SHOT recommendations and
3. where necessary, develop resources to support implementation
4. Report quarterly to BHNOG on SHOT related activities, to include updates on progress with SHOT guideline implementation, and highlights from national SHOT meetings.
5. Escalate barriers to implementation of SHOT recommendations at both local and national level to BHNOG

Whilst for previous reports Hospital Transfusion Teams (HTT), could provide information for the gap analyses, the 2021 recommendations require a different type of data, outside the remit of those teams, thereby requiring a response from clinical / senior management. The recommendations are weighted heavily towards the overall organisational responsibility for patient safety and empowerment. The SHOT Recommendations report (2021) is available at

https://www.shotuk.org/shot-reports/report-summary-and-supplement-2021/
https://www.shotuk.org/wp-content/uploads/myimages/2021-SHOT-Gap-Analysis-Tool.xlsx.

You will be aware haemovigilance through SHOT is a requirement of the Medicines and Healthcare products Regulatory agency (MHRA)[1] which is monitored through the Blood Safety Quality Regulations (BSQR) (2005) Compliance Report for each Health Board. Improving patient safety through investigation and patient engagement aligns with the principles of Patient Blood Management (PBM), which is an integral part of the 2021 Blood Health Plan and the appropriate use of blood.

Representing your Health Boards, as HTC chairs, we understand you are best placed to ensure our request for data is channelled to the most appropriate people in your organisation and a gap analysis can be constructed as soon as possible, as part of a report for the BHNOG. A simplified version of the gap analysis is attached to this letter and needs to be returned to the BHT wbs.bloodhealthteam@wales.nhs.uk by 24/02/2023. If there are any concerns or issues with completion, please contact your local HTT for support.

This work and our success relies heavily on your support and that of your HTC. As BHNOG Chair I would like to thank you on behalf of the BHNOG SHOT Working Group for that continued support of haemovigilance, and trust you can further continue that support by assisting this data collection by the deadline

Yours sincerely,

Dr Brian Tehan, Chair of BHNOG

1. https://www.gov.uk/guidance/blood-authorisations-and-safety-reporting

SHOT Key Recommendations 2021

1. **Patient as safety partners** - Staff must ensure that they involve, engage and listen to patients as 'partners' in their own care, including transfusion support. Engaging patients, their families, and carers as 'safety partners' helps co-create safer systems, identify, and rectify preventable adverse events. The responsibility of delivering safe care remains in the hands of the healthcare professionals and patients should not feel that if they do not wish or are unable to contribute to their own safety they will, as a result, receive substandard care. Involvement should be encouraged, but patients should not feel pressured into being partners in their own safety if they are not comfortable or able to do so. It is important to note that patients taking ownership of their own care does not and should not diminish the responsibility of health professionals.

2. **Workforce planning, safe staffing and a well-resourced healthcare system -** Healthcare leaders must ensure that systems are designed to support safe transfusion practice and allocate adequate resources in clinical and laboratory areas to support the following:
   - Safe staffing levels
   - Staff training in technical and non-technical skills
   - Appropriate equipment, including IT systems

3. **A just, learning safety culture in all organisations** - All healthcare leaders must promote a just, learning safety culture with a collective, inclusive, and compassionate leadership. Effective leaders must ensure staff access to adequate training, mentorship, and support. All staff in clinical and laboratory areas have a responsibility to speak up in case of any concerns and help embed the safety culture in teams.

| Main recommendation | Action required | Compliant Y/N | If No actions to achieve compliance |
|---|---|---|---|
| Patient as safety partners | Ensure that organisational systems and processes are designed to be patient-centred | | |
| | Develop/implement policies and procedures for engaging patients, families and carers in their own care as well as in quality improvement patient safety initiatives and healthcare design | | |
| Workforce planning, safe staffing and a well-resourced healthcare system | Safe staffing levels in both clinical areas and transfusion laboratories. Minimum staffing levels should ideally be based on the overall workload, the acuity and complexity of work involved, considering the 3 previous years' data, for all absences including sickness, mandatory training, annual leave, and maternity leave. Senior leaders should ensure adequate staffing levels so that requisite time needed for staff training and competency-assessments is provided | | |
| | There is a clear escalation and mitigation policy where staffing levels fall below the minimum staffing levels for all health professionals. Staff must be able to escalate concerns if necessary | | |
| | A proportion of the budget is ring-fenced for training staff involved in transfusion. Staff must receive training in technical and non-technical skills including the NHS National Patient Safety Syllabus and those involved in incident investigation must receive appropriate training in relevant skill | | |
| | Adequate resources are available for staff to carry out transfusions safely. This includes implementation of effective and reliable transfusion IT systems to reduce the risk of errors at all steps in the transfusion pathway, provided they are configured and used correctly | | |
| | Policies, procedures, and resources including IT are set up based on user-centred design principles and are simple, easy to follow | | |

| Main recommendation | Action required | Compliant Y/N | If No actions to achieve compliance |
|---|---|---|---|
| A just, learning safety culture in all organisations - | Ensure staff feel able to talk about their concerns and report when things go wrong | | |
| | Ensure policies state what staff should do following an incident, how it should be investigated, and what support should be given to patients, families, and staff. They should promote a just and learning culture dealing with people in a just, compassionate way with an inclusive approach, acknowledging through learning to support the changes required when people make errors | | |
| | Ensure all staff have access to complete the NHS Patient Safety Syllabus training programme | | |
| | Ensure that staff involved in incident investigations receive adequate training in using human factors principles-based investigation frameworks and identifying effective corrective and preventative actions | | |
| | Ensure that staff have access to a good mentorship programme | | |
| | Regularly assess their organisation's safety culture using a safety assessment survey and take appropriate actions to address any concerns identified | | |