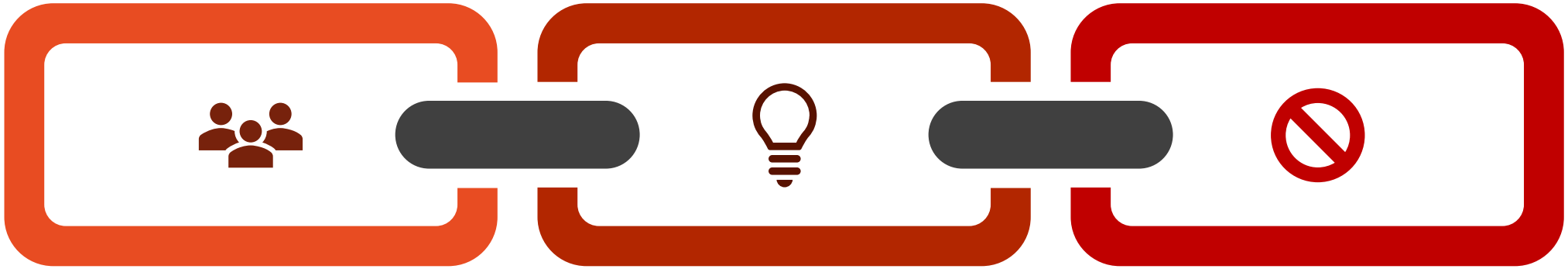
NMA course

The SHOT Team

Objectives

- Discuss the role of SHOT and the haemovigilance process in UK
- Understand the role of haemovigilance in improving transfusion safety and the role of the NMA within this process
- Apply knowledge to a SHOT reported incident

Haemovigilance



A set of surveillance procedures from the collection of blood and its components to the follow up of the recipients

To collect and assess information on unexpected and undesirable effects resulting from the therapeutic use of labile blood components

To prevent their occurrence or recurrence

Role of SHOT

Transfusion pathway is complex, involving a wide variety of teams both clinical and laboratory

Analysis

SHOT collects and analyses information on transfusion reactions and adverse events from all healthcare organisations in the UK

Experts

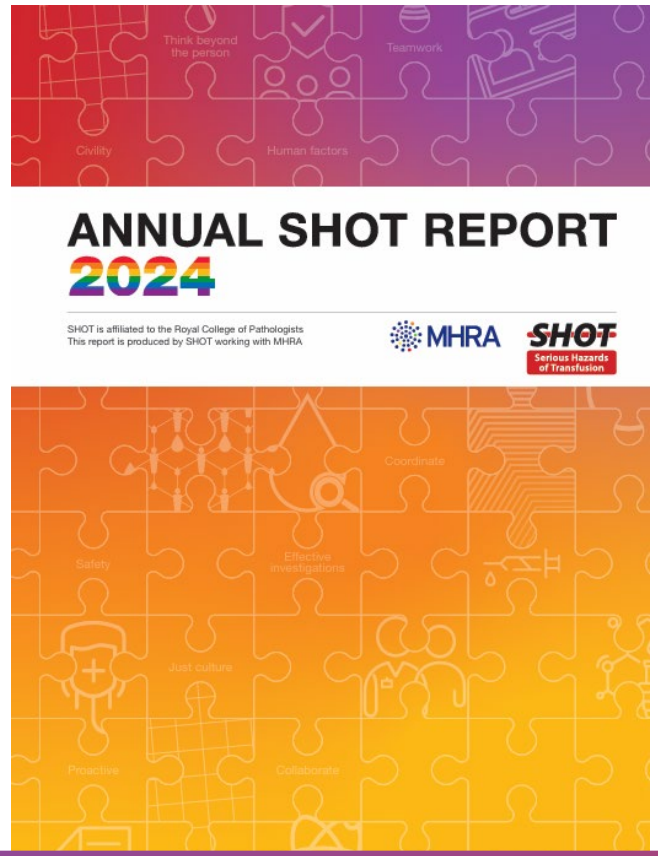
Input from working experts and steering group members

Components

Red cells, plasma, cryoprecipitate, platelets, anti-D Ig administration, immune anti-D cases and prothrombin complex concentrates

Aims

Where risks and problems are identified, SHOT produces recommendations to improve patient safety



2024 Annual SHOT Report now available via the SHOT website

SHOT Serious Hazards of Transfusion

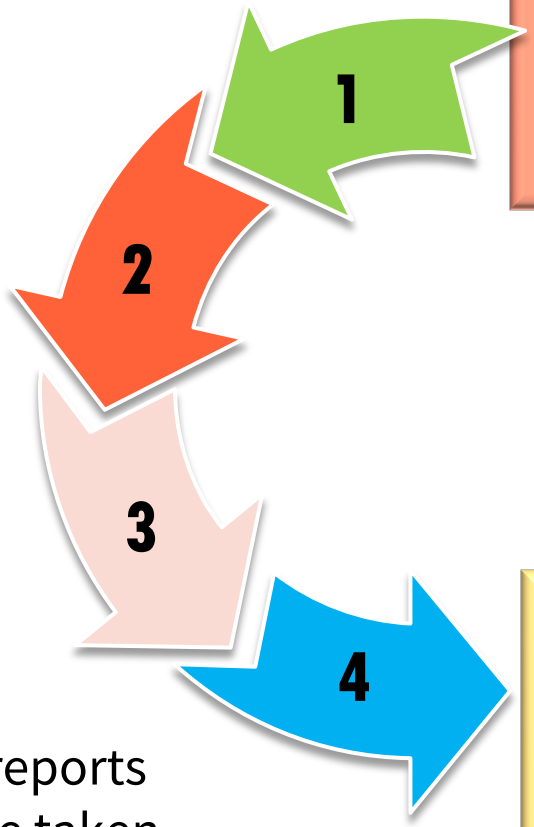
Flow of haemovigilance information in the UK

Nominated person submits reports via SABRE/SHOT portal

Monthly download of reports, collated, triaged, reviewed

Cases reviewed by SHOT Working Expert Group members

Trends, learning from analysed reports informing actions that need to be taken



Reportable incident
Error/Reaction/Near miss/ACE

SHOT Serious Hazards of Transfusion

Confirm all serious reactions to MHRA
Annual SHOT Report and related resources
Any urgent actions needed-Safety Alerts

Staffing issues, mismatch with workload, skill mix

Staff knowledge, training issues; HFE awareness and application

Complicated/complex processes resulting in workarounds; pandemic spillover of practices

Challenges with resources: IT, equipment

Recurrent themes in analysed incidents

IT issues: suboptimal implementation, poor training of staff

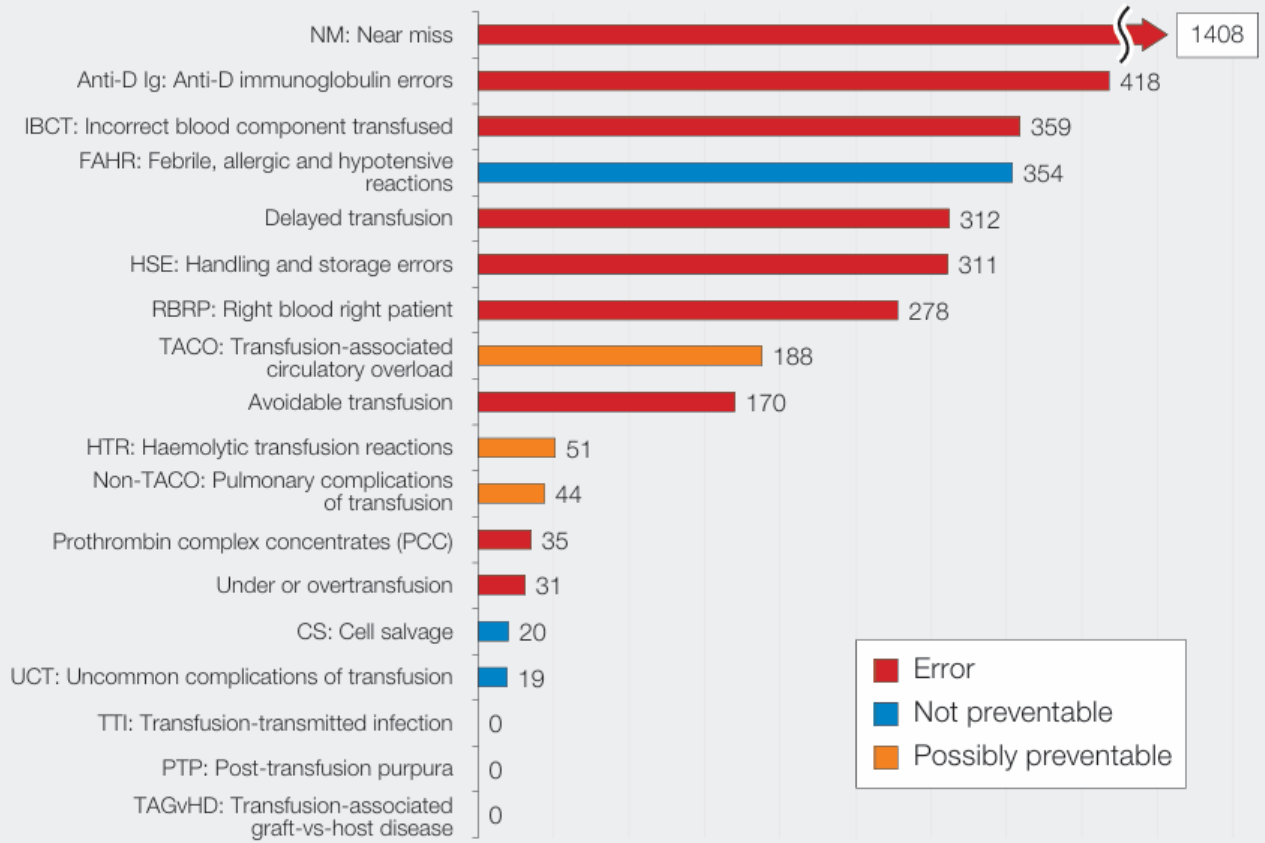
Overreliance on IT
Complacency, alert fatigue, warning flags not heeded

Communication issues including suboptimal handover

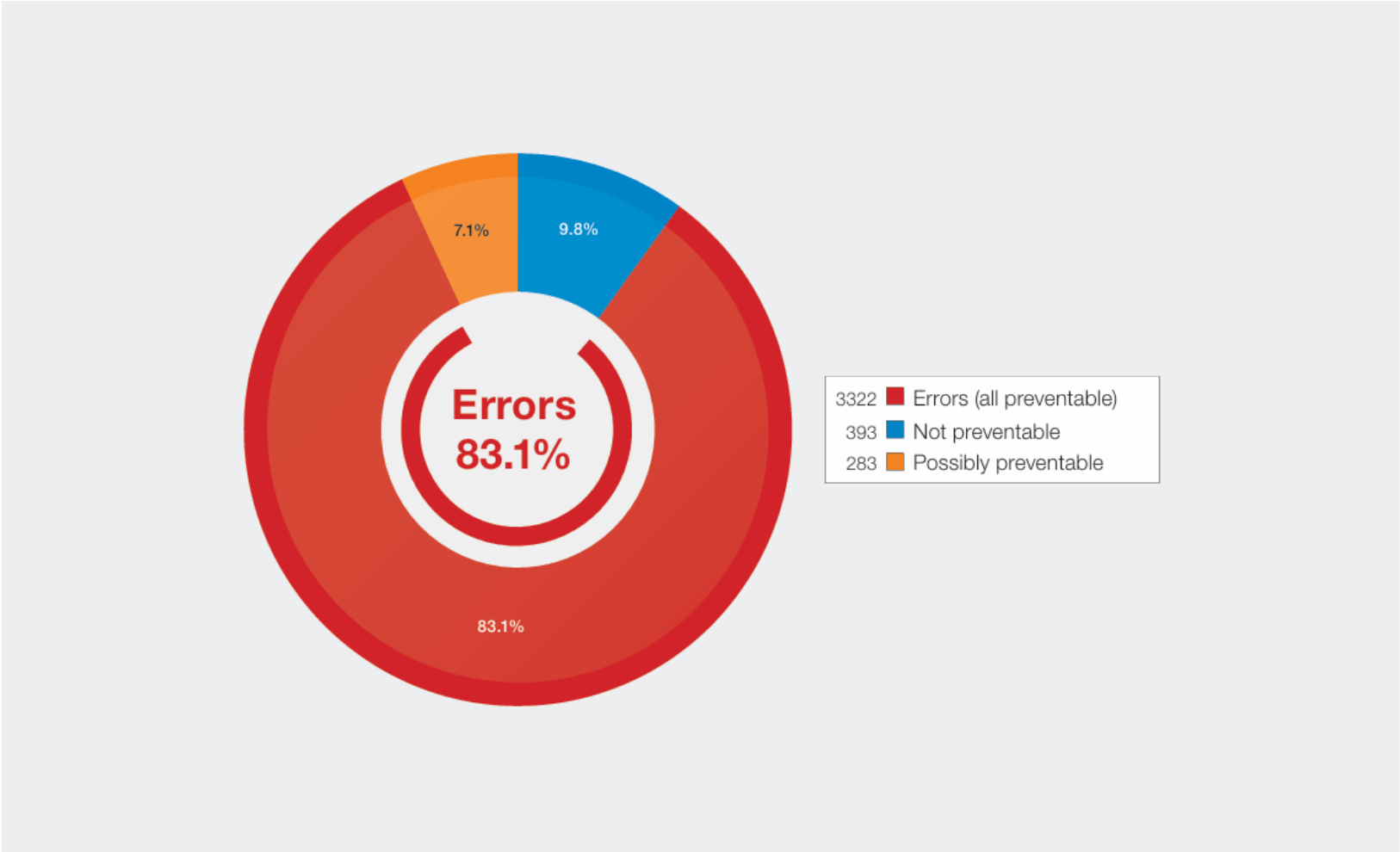
Safety culture, leadership


SHOT Serious Hazards of Transfusion
SHOT Transfusion Safety Standards
For a list of the organisations endorsing the SHOT Transfusion Safety Standards, please visit: Transfusion Safety Standards - Serious Hazards of Transfusion
1 Transfusion safety
2 Transfusion information technology (IT) and equipment
3 Supporting staff to work safely
4 Staff education and training
5 Safety culture
6 Patients as safety partners
7 Haemovigilance and risk management
8 Governance
1

Summary data for 2024

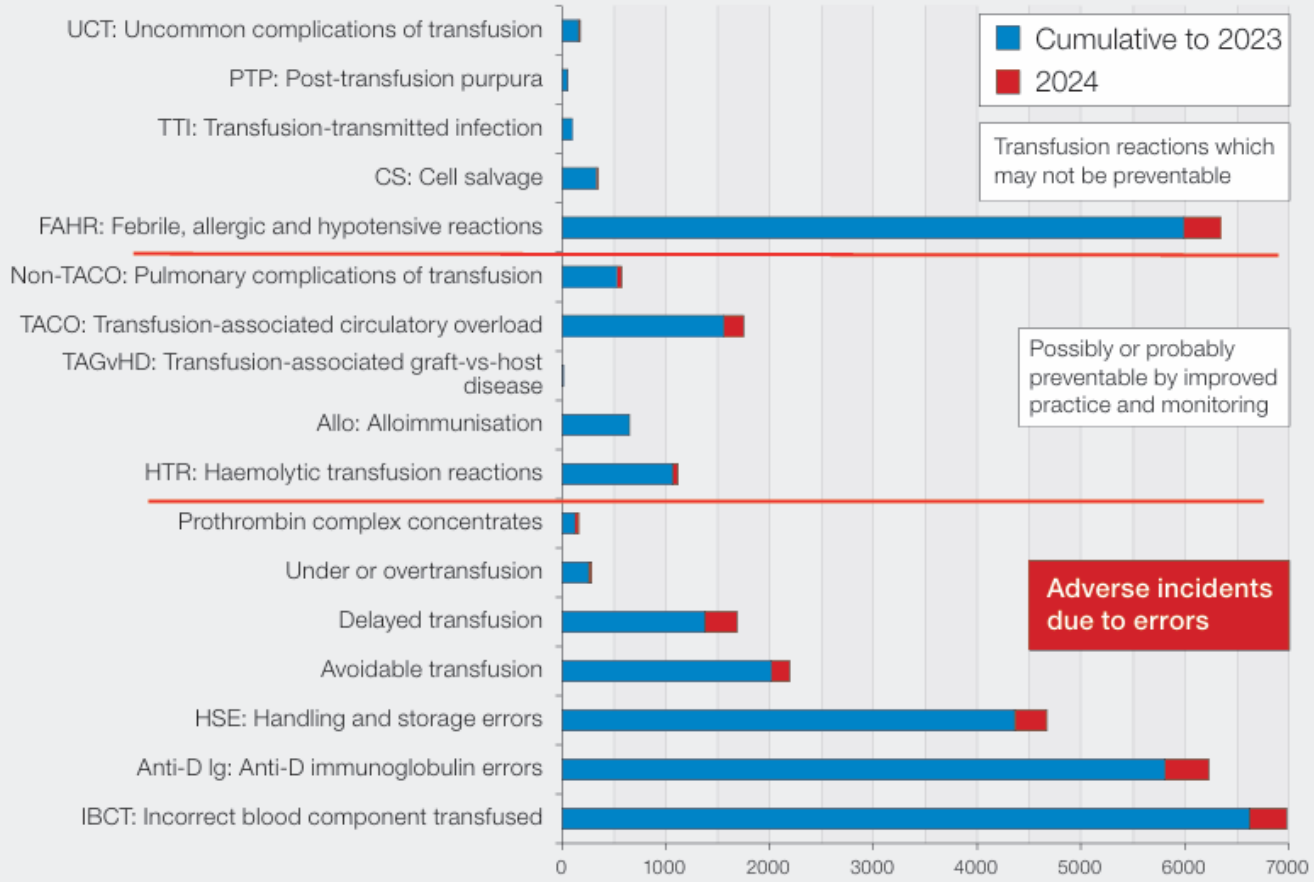


Errors account for most reports in 2024 (n=3322/3998)



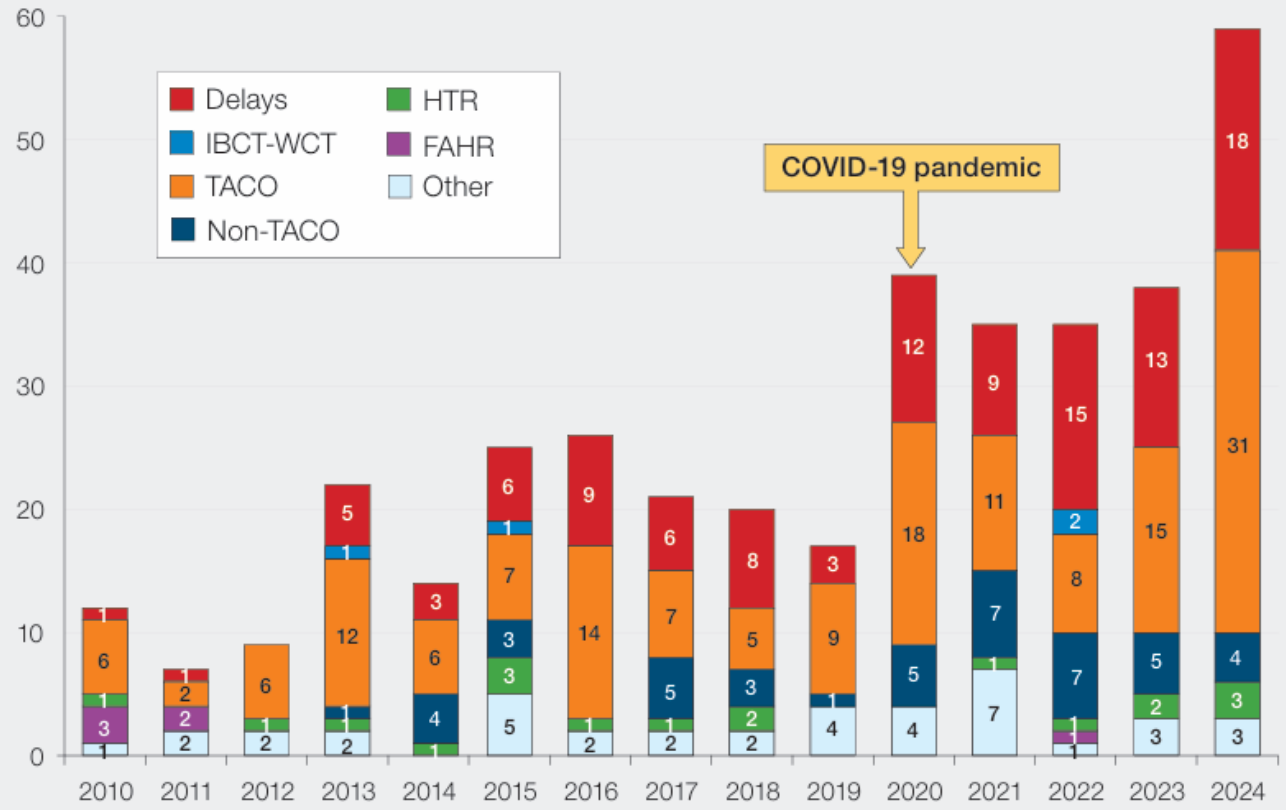
Cumulative data for SHOT categories 1996-2024

(n=33343)



Delayed transfusions

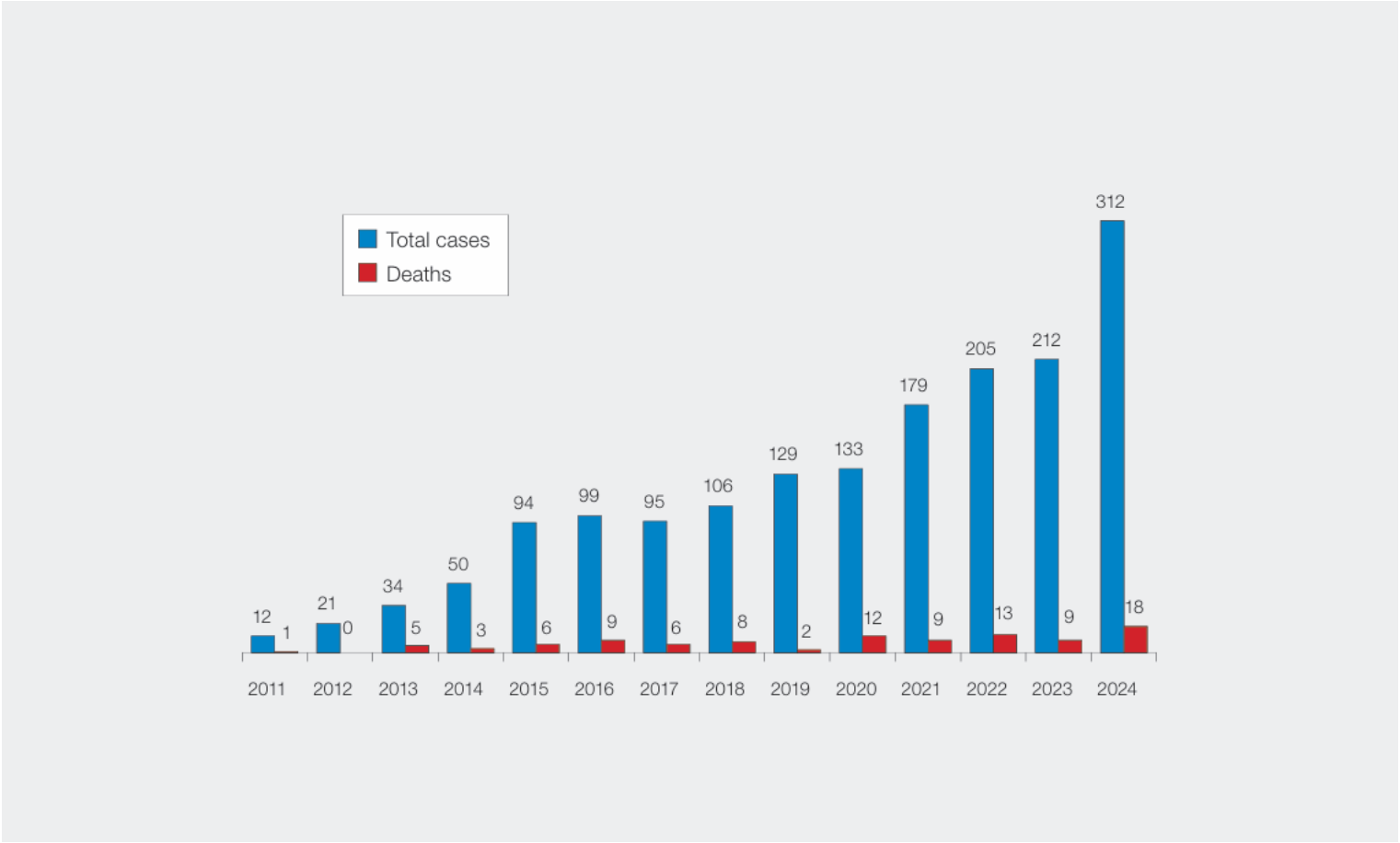
Transfusion-related deaths 2010 to 2024 (n=379)



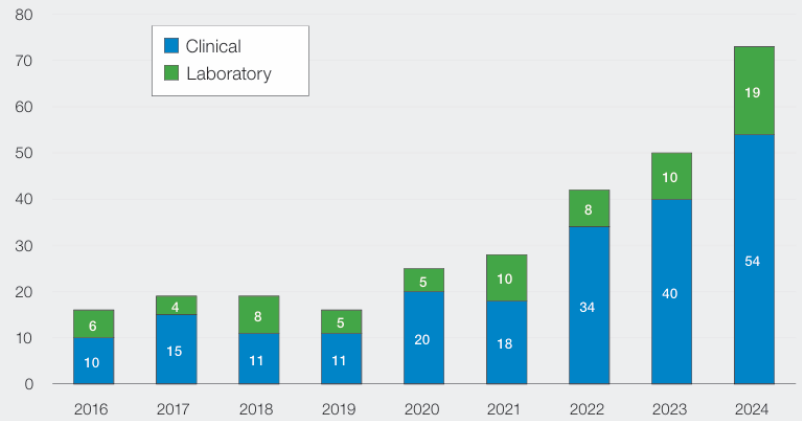
Delays

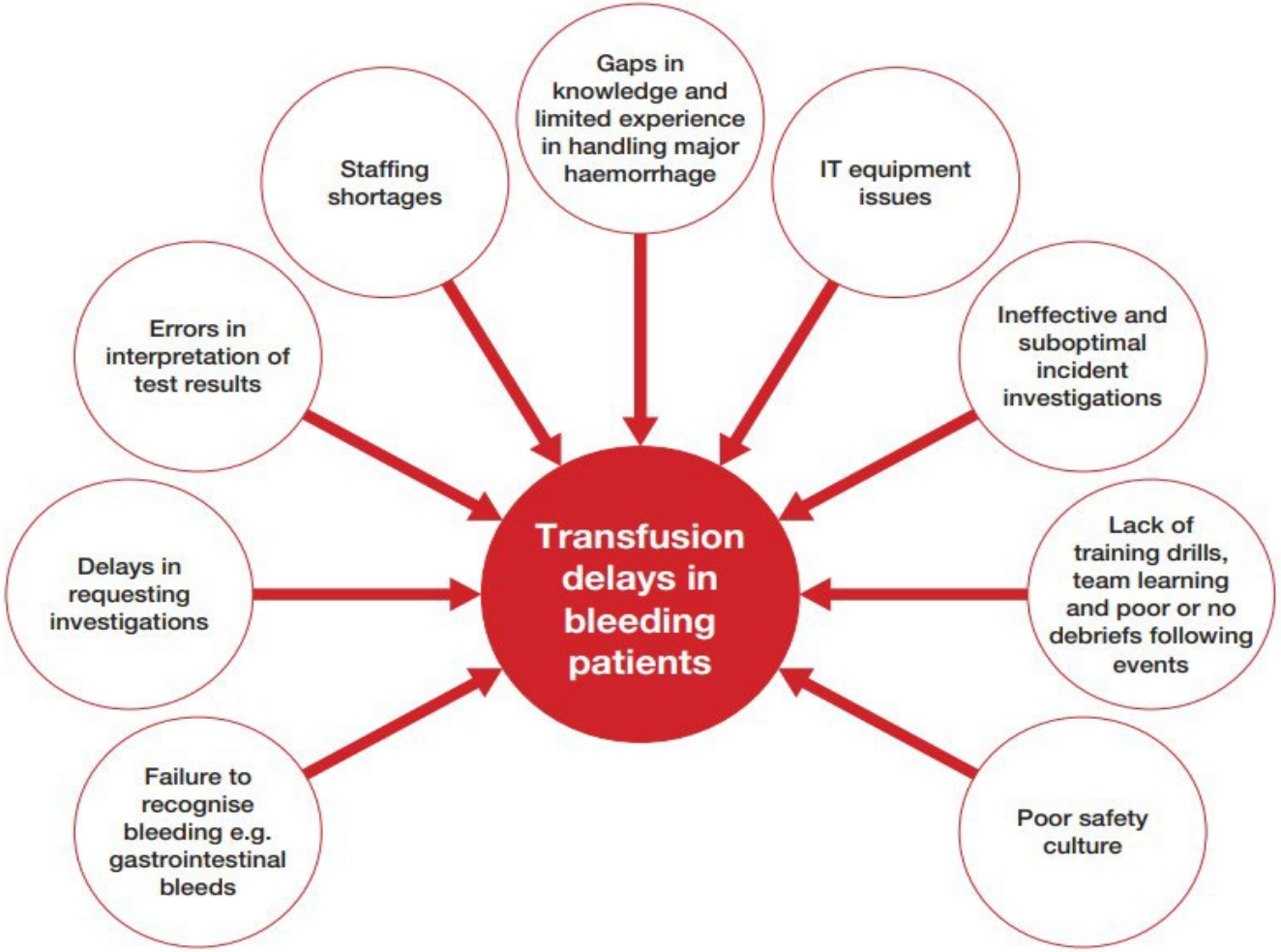
- Communication failure
- Logistical issues
- Technical issues
- Clinical decision making
- Sample error
- Recognition of bleed
- Insufficient trained staff
- Component not in stock

Delayed transfusions by year 2011-2024



Major Haemorrhage delays





A man in his 80s with myocardial ischaemia and anaemia, Hb 63g/L, received a first unit of red cells but the second was delayed for 12 hours contributing to his death

The request form had incorrect details so was rejected

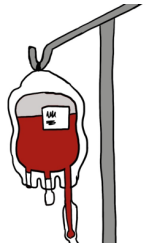
The revised request form could not be found when the porter came to collect the unit

The porter did not inform the clinical area of this

A further collection form had to be sent

It is important that transfusion requests are completed accurately to avoid delays –

Urgent need for blood during surgery - pager failure



Theatre staff needed blood during repair of an AAA for a man in his 80s but could not contact the BMS due to pager failure

The delay was 30 minutes and was thought to have contributed to the patient's death

Major haemorrhage drills should include testing of communication channels and equipment

Clinical staff must be able to reach transfusion laboratory staff in case of emergencies

MHRA

Central Alerting System

SHOT Serious Hazards of Transfusion

Preventing transfusion delays in bleeding and critically anaemic patients.

Date of Issue:	17-Jan-22	Reference No:	SHOT/2022/001
This alert is for action by: **NHS and independent (acute and specialist) sector where transfusions are carried out.**			
Access to blood components and products is a complex safety critical issue that is relevant across many departments and professions. Implementation of this alert should be coordinated by an executive leader (or equivalent role in organisations without executive boards) and supported by their designated senior leads for medical, nursing and pathology teams.			

Incorrect Blood Component Transfused

SHOT Serious Hazards of Transfusion

Safe Transfusion Practice: Transfusion Checklist

Transfusion Request Ensure that:	Signature to confirm
The reason for transfusion is documented in the patient record	
Details on the transfusion authorisation (prescription) sheet are completed and any specific requirements documented	
All fields on the transfusion request form are completed and the form is signed	
The identity details on the transfusion sample are completed correctly and samples labelled at the patient's bedside. These must be handwritten unless electronic systems are available that generate and print a label at the bedside from the patient ID band are available	
The patient has (and where appropriate family/carers have) received information, has agreed to the transfusion, and this is documented **Or** In cases where the patient is unconscious and/or unable to consent and the blood component is given in patient's best interest, ensure this is documented in the patient's notes, and information given retrospectively	
The laboratory is informed of the degree of urgency of the request	
Pre-Transfusion Checks	

Department of Health

CAS Alert

Safe Transfusion Practice: Use a bedside checklist

09 November 2017

Alert reference number: **CEM/CMO/2017/005**

Since the first report in 1997 the UK national haemovigilance surveillance programme, Serious Hazards of Transfusion (SHOT), has repeatedly identified that patients are harmed, and some die, as a result of being given the incorrect type of blood.

In 2014 a patient died as a result of an ABO-incompatible transfusion in a high profile case. The nurse collected, then administered a unit intended for another patient with a similar name. This would have been prevented if the final bedside check had been undertaken correctly.

There were seven ABO-incompatible transfusions reported to SHOT in 2015, and three in 2016. All of these were preventable. In addition to the risk of ABO-incompatible transfusion, patients may have other specific, and sometimes critical, transfusion requirements such as irradiated blood, CMV negative serology blood and extended phenotype blood.

Two critical points occur in preparation for transfusion; the first is to correctly identify the patient and label the sample when taking blood for a pre-transfusion blood sample, and the second is to check the details on the unit of blood and the patient's identity at the point of transfusion.

Evidence from SHOT shows that the bedside check performed at the point of transfusion is not always undertaken correctly and that this puts patients at risk of serious complications or death. SHOT therefore recommends a structured process with a **bedside checklist** which must confirm the following:

- Positive patient identification including first name, family name and date of birth; unless impossible, this should be done by asking the patient to state their names and date of birth
- Unique identification number (hospital number, NHS number or equivalent)
- Check that it is the correct and compatible component (against the prescription and label on the component) for this patient at this time
- Check that the component meets any specific requirements for that patient

Actions

Who: All organisations providing NHS funded care which involves the provision of blood transfusions.

When: Immediate

1. Organisations should assess their bedside systems (including electronic systems) to ensure a confirmatory step is in place where the individual performing the checks must sign to say all steps have been followed.

2. This alert (and supporting information) should be circulated to all relevant staff, including to community nursing staff and midwives who may be involved in the transfusion of blood products in the community.

Patient A (group O D-positive) with Pneumonia, respiratory failure and renal impairment was in HDU and required a red cell transfusion due to a **Hb of 69 g/L**

Nurse 1, who was caring for patient A, was going on their break and asked nurse 2 to arrange collection of a unit of red cells for patient A. It was thought a unit of red cells would still be available for patient A, without the need for a further request and sample (they had received a transfusion earlier in the week)

There was a unit available, so nurse 2 asked the Porters to collect it and gave them a handwritten transfusion slip, **but the details were for patient B** (group B D-negative), who nurse 2 was caring for. **A red cell unit intended for patient B was collected**

Nurse 1, returned from break and checked with nurse 2 that the details on the red cell unit and the compatibility label matched (they did). **This was done outside of patient A's room**

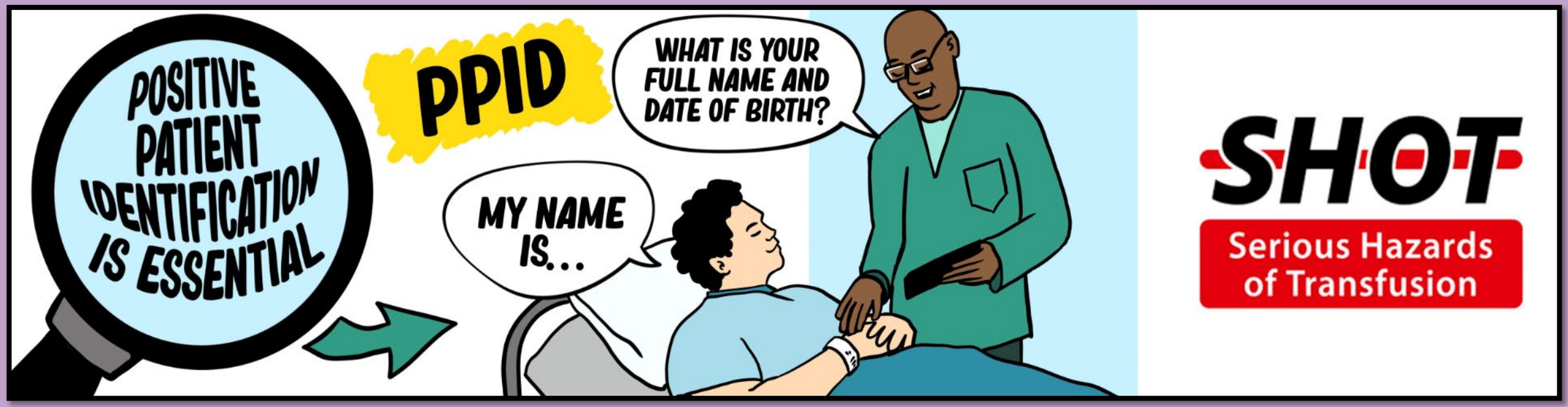
Nurse 1 began the transfusion. Observations were carried out correctly and no adverse reaction in the patient was identified during the transfusion

Two days later the laboratory received a further sample for patient A with a request for more red cells. **When tested, the patient's ABO blood group was 'different to what was previously recorded'**

When TP reviewed patient A's medical notes **there was a sticker attached for a unit of red cells issued for patient B**

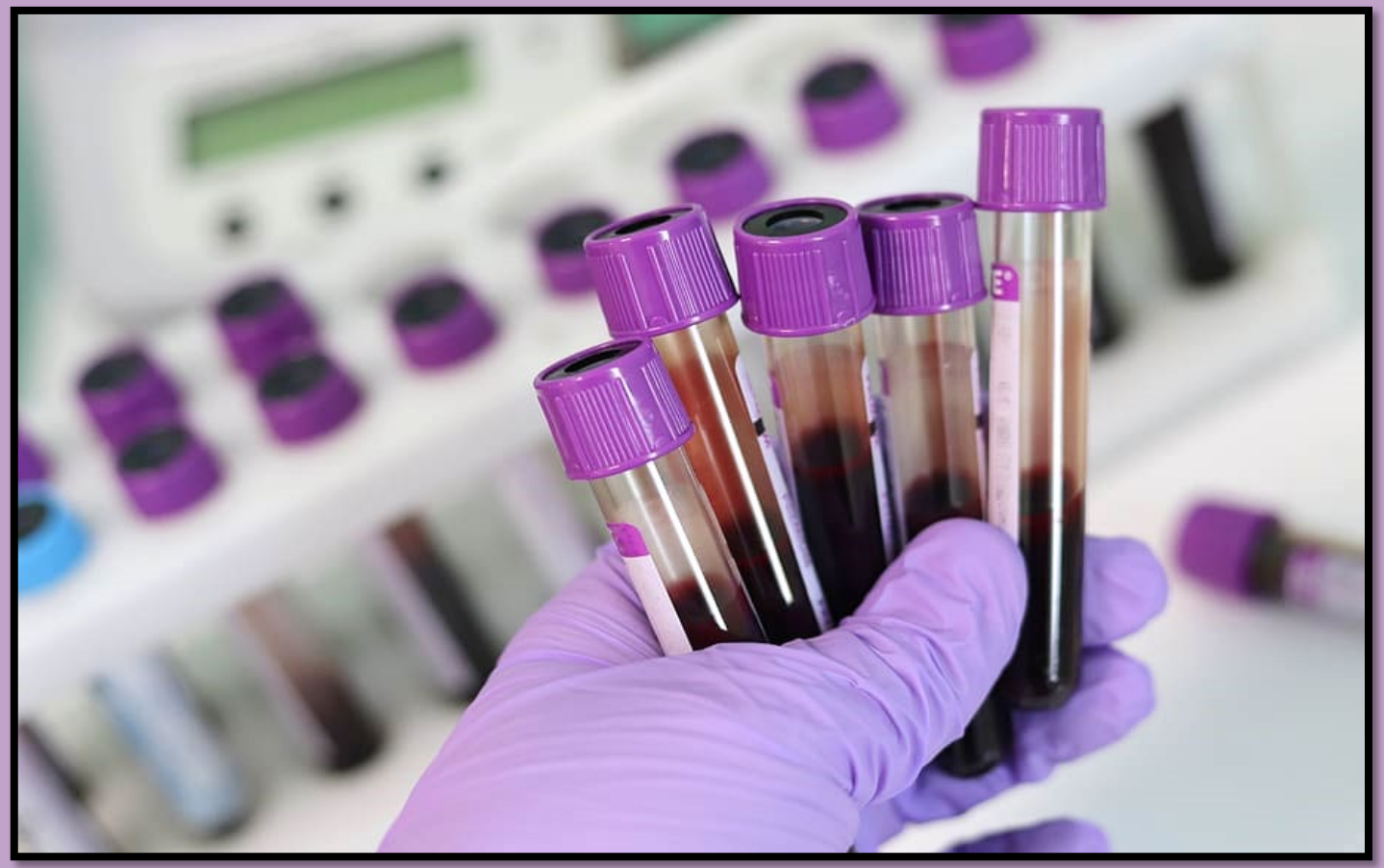
Nurse 1 had earlier removed one of patient A's arterial lines and had needed removed their ID/wristband whilst doing this

Patient Identification

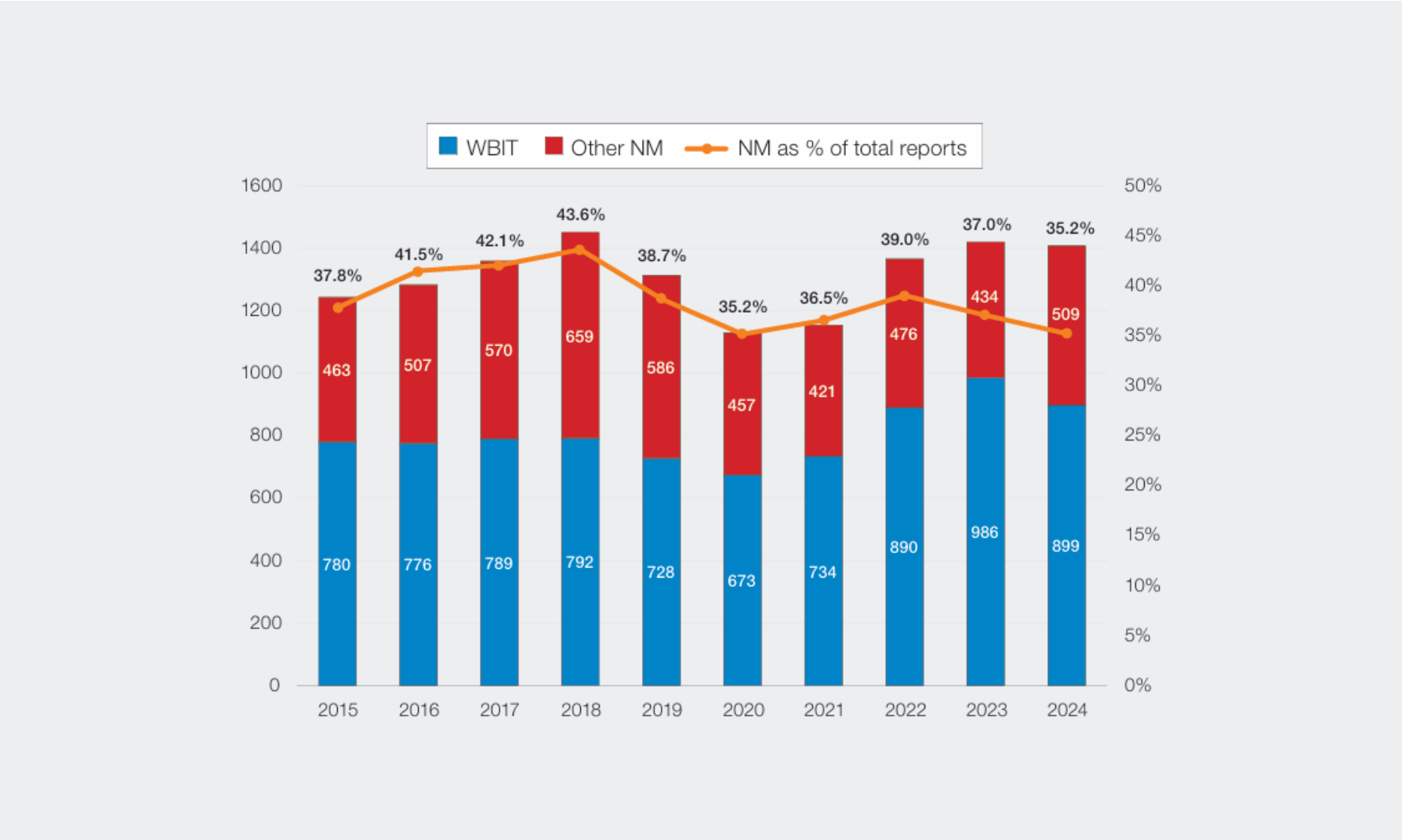


New from July 2025…My Transfusion app

Wrong Blood In Tube



A decade of NM (other) and WBIT reports (2015-2024)



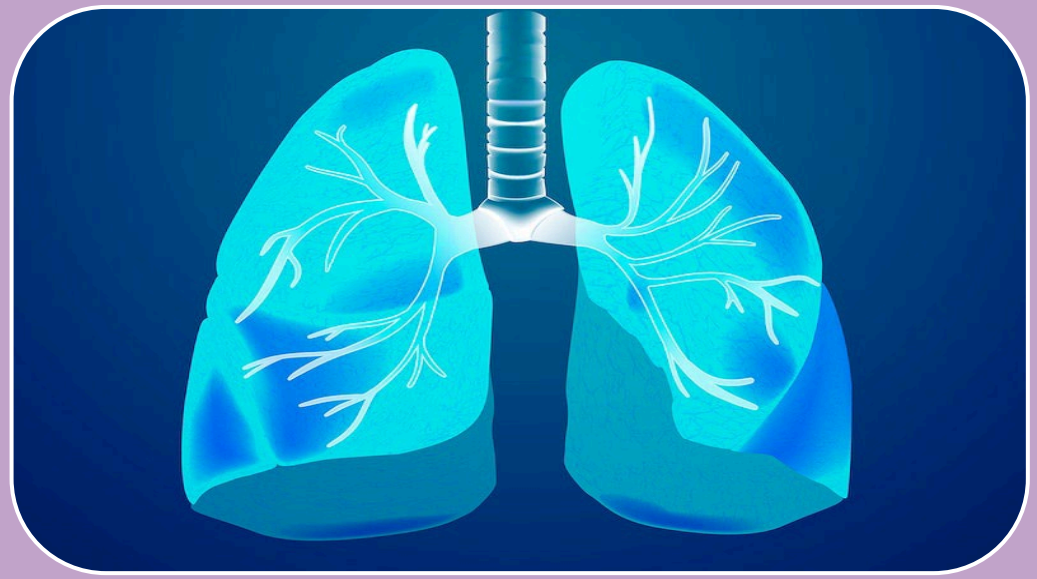
THE SAMPLE CIRCLE

All samples must be labelled at the patient side
using positive patient identification.

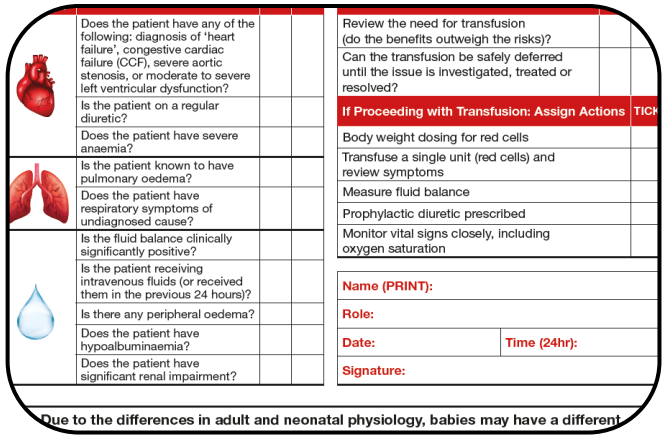
Unlabelled blood samples MUST NOT leave the SAMPLE CIRCLE.

Unlabelled blood samples outside the circle should be disposed of.

Pulmonary complications of transfusion



Pulmonary complications of transfusion remain a leading cause of transfusion-related mortality and morbidity, contributing to >50% of transfusion-related deaths reported to SHOT from 2013 to 2024

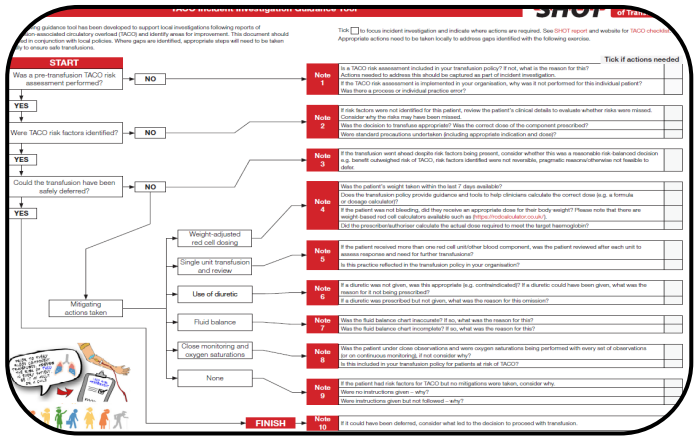


	Does the patient have any of the following: diagnosis of 'heart failure', congestive cardiac failure (CCF), severe aortic stenosis, or moderate to severe left ventricular dysfunction?			Review the need for transfusion (do the benefits outweigh the risks)?
	Is the patient on a regular diuretic?			Can the transfusion be safely deferred until the issue is investigated, treated or resolved?
	Does the patient have severe anaemia?			**If Proceeding with Transfusion: Assign Actions** TICK
	Is the patient known to have pulmonary oedema?			Body weight dosing for red cells
	Does the patient have respiratory symptoms of undiagnosed cause?			Transfuse a single unit (red cells) and review symptoms
	Is the fluid balance clinically significantly positive?			Measure fluid balance
	Is the patient receiving intravenous fluids (or received them in the previous 24 hours)?			Prophylactic diuretic prescribed
	Is there any peripheral oedema?			Monitor vital signs closely, including oxygen saturation
	Does the patient have hypoalbuminaemia?			**Name (PRINT):**
	Does the patient have significant renal impairment?			**Role:**
				Date: **Time (24hr):**
				Signature:

Due to the differences in adult and neonatal physiology, babies may have a different

The 2024 reporting year recorded **188** TACO cases which is the highest ever reported to SHOT.

A TACO pre-transfusion risk assessment should be utilised whenever possible prior to every transfusion, especially in vulnerable patients.



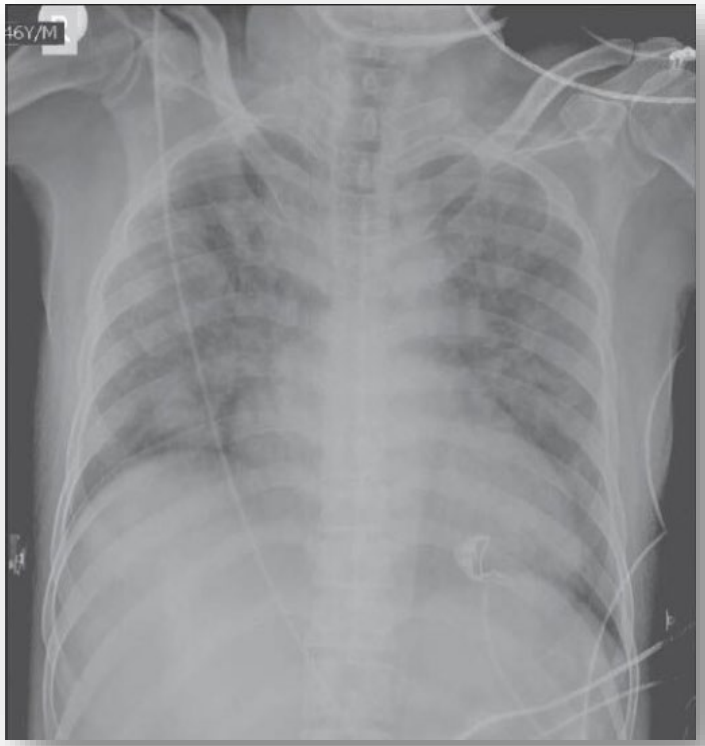
It is important that all TACO cases are used as a learning opportunity to prevent or mitigate TACO in other patients.

A TACO investigation guidance tool available from 'Current resources' on the SHOT website helps optimise learning from these events

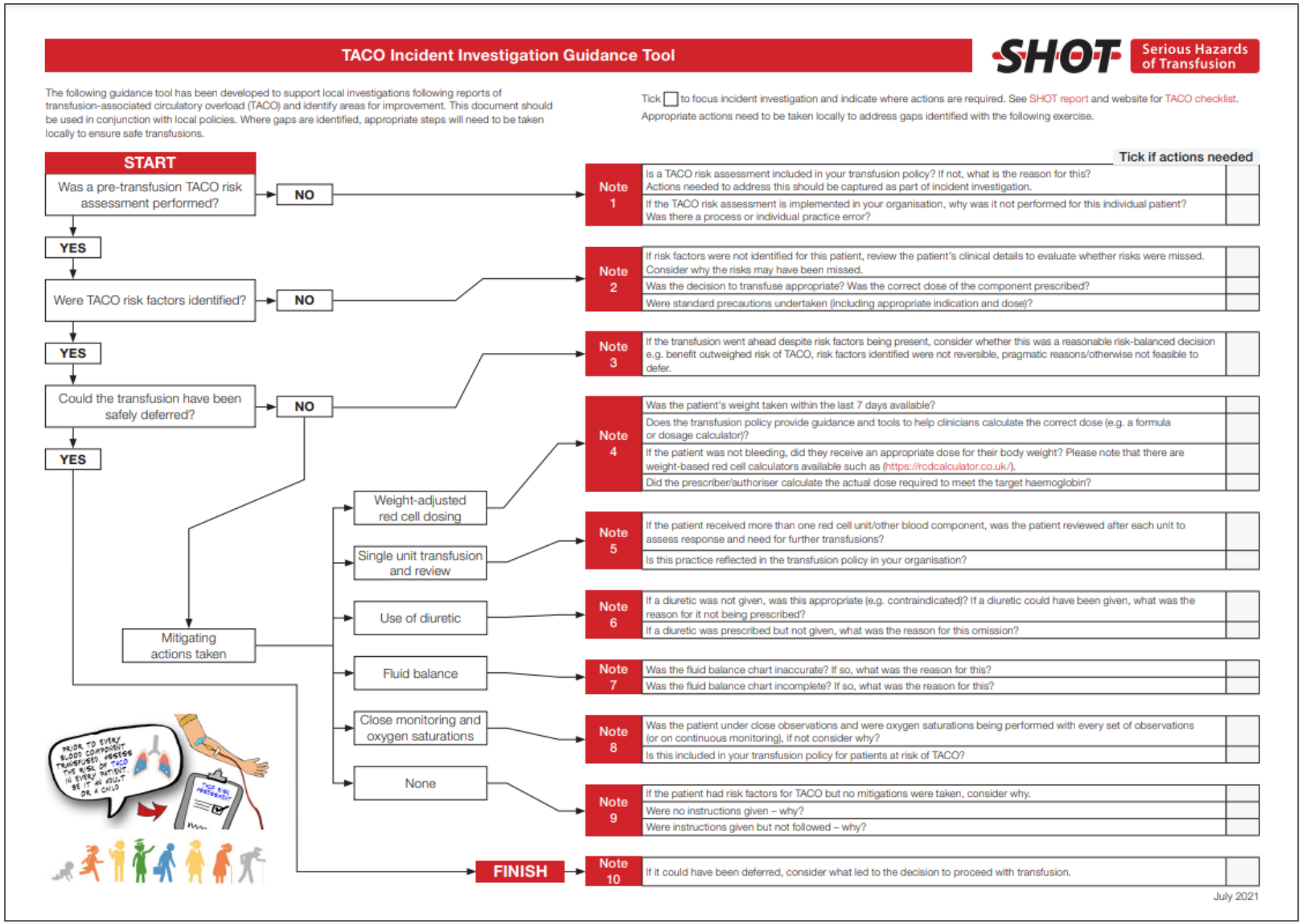
Patients with severe chronic anaemia should receive only minimal red cell transfusion with the aim of alleviating symptoms as opposed to aiming for a Hb correcting to meet a target Hb level

Case study

- Female patient in her 80s with iron deficiency anaemia, cardiac and renal impairment and pre-transfusion peripheral oedema
- Hb result was 48g/L
- Weight 50kg
- Received 2 units of red blood cells and during 2nd unit became breathless and O2 sat dropped to 91%
- Post-transfusion chest X-ray showed fluid overload
- Administered oxygen and IV diuretic with improvement
- Patient fully recovered



A **TACO investigation guidance tool** has been developed and can be accessed from ‘Current resources’ on the SHOT website



TACO Incident Investigation Guidance Tool

SHOT Serious Hazards of Transfusion

The following guidance tool has been developed to support local investigations following reports of transfusion-associated circulatory overload (TACO) and identify areas for improvement. This document should be used in conjunction with local policies. Where gaps are identified, appropriate steps will need to be taken locally to ensure safe transfusions.

Tick ☐ to focus incident investigation and indicate where actions are required. See SHOT report and website for TACO checklist. Appropriate actions need to be taken locally to address gaps identified with the following exercise.

START

Was a pre-transfusion TACO risk assessment performed?

NO → **Note 1**

- Is a TACO risk assessment included in your transfusion policy? If not, what is the reason for this? Actions needed to address this should be captured as part of incident investigation.
- If the TACO risk assessment is implemented in your organisation, why was it not performed for this individual patient? Was there a process or individual practice error?

YES

Were TACO risk factors identified?

NO → **Note 2**

- If risk factors were not identified for this patient, review the patient’s clinical details to evaluate whether risks were missed. Consider why the risks may have been missed.
- Was the decision to transfuse appropriate? Was the correct dose of the component prescribed?
- Were standard precautions undertaken (including appropriate indication and dose)?

YES

Could the transfusion have been safely deferred?

NO → **Note 3**

- If the transfusion went ahead despite risk factors being present, consider whether this was a reasonable risk-balanced decision e.g. benefit outweighed risk of TACO, risk factors identified were not reversible, pragmatic reasons/otherwise not feasible to defer.

YES

Mitigating actions taken

- Weight-adjusted red cell dosing → **Note 4**
  - Was the patient’s weight taken within the last 7 days available?
  - Does the transfusion policy provide guidance and tools to help clinicians calculate the correct dose (e.g. a formula or dosage calculator)?
  - If the patient was not bleeding, did they receive an appropriate dose for their body weight? Please note that there are weight-based red cell calculators available such as (https://rcdcalculator.co.uk/).
  - Did the prescriber/authoriser calculate the actual dose required to meet the target haemoglobin?
- Single unit transfusion and review → **Note 5**
  - If the patient received more than one red cell unit/other blood component, was the patient reviewed after each unit to assess response and need for further transfusions?
  - Is this practice reflected in the transfusion policy in your organisation?
- Use of diuretic → **Note 6**
  - If a diuretic was not given, was this appropriate (e.g. contraindicated)? If a diuretic could have been given, what was the reason for it not being prescribed?
  - If a diuretic was prescribed but not given, what was the reason for this omission?
- Fluid balance → **Note 7**
  - Was the fluid balance chart inaccurate? If so, what was the reason for this?
  - Was the fluid balance chart incomplete? If so, what was the reason for this?
- Close monitoring and oxygen saturations → **Note 8**
  - Was the patient under close observations and were oxygen saturations being performed with every set of observations (or on continuous monitoring), if not consider why?
  - Is this included in your transfusion policy for patients at risk of TACO?
- None → **Note 9**
  - If the patient had risk factors for TACO but no mitigations were taken, consider why.
  - Were no instructions given – why?
  - Were instructions given but not followed – why?

FINISH → **Note 10**

- If it could have been deferred, consider what led to the decision to proceed with transfusion.

July 2021

SHOT Serious Hazards of Transfusion

Preventing transfusion delays in bleeding and critically anaemic patients.

Date of Issue:	17-Jan-22	Reference No:	SHOT/2022/001

This alert is for action by: **NHS and independent (acute and specialist) sector where transfusions are carried out.**

Access to blood components and products is a complex safety critical issue that is relevant across many departments and professions. Implementation of this alert should be coordinated by an executive leader (or equivalent role in organisations without executive boards) and supported by their designated senior leads for medical, nursing and pathology teams.

Explanation of identified safety issue:

Transfusion delays are preventable. Patients should not die or suffer harm from avoidable delays in transfusion.

The urgent provision of blood components and/or blood products is vital for life threatening bleeding and severe anaemia as described in the three situations below. A rapid, focused approach is required as delays can result in preventable death or end-organ damage.

Delays in provision and transfusion of blood during major haemorrhage have been identified repeatedly in Annual SHOT Reports[1]. Delays are compounded by failure to recognise bleeding, communication failures and the presence of red cell antibodies in the patient blood sample[1].

Autoimmune haemolytic anaemia (AIHA) is a relatively uncommon disorder caused by autoantibodies directed against the patient's own red blood cells, with an estimated prevalence of 17:100,000 and a mortality rate of 11%[2,3]. Urgent provision of blood may be needed for patients with severe anaemia. Laboratory testing may be complicated by the presence of the autoantibodies.

Anticoagulation is associated with an increased risk of bleeding which can be life/limb or sight threatening. Rapid reversal of anticoagulation in these cases is mandatory and delays impact patient safety. Prothrombin Complex Concentrates (PCC) are human blood products recommended for use as first line treatment for warfarin reversal (and for some other oral anticoagulants) when patients present with severe, life threatening bleeding. PCC should ideally be given within an hour once the anticoagulant reversal decision is made, particularly in patients with intracranial haemorrhage (ICH)[4]. Delays or omissions in administration can result in serious morbidity (such as expansion of an ICH) or death[5,6]. Poor communication, patient transfer between departments, dosage calculation and perceived need for consultant approval contribute to PCC delays[1].

Actions required

Local organisations must have:

Actions to be completed as soon as possible and no later than 15 July 2022

1. Reviewed and updated policies and procedures to cover:
   a. Rapid release of blood components and products for major haemorrhage, AIHA and reversal of anticoagulants.
   b. Compliance with SHOT[1], NICE[4] and BSH[7] recommendations.
   c. Agreed criteria where rapid release of PCC is acceptable without the initial approval of a haematologist.
   d. Concessionary, rapid release of the best matched red blood cells for patients with red cell antibodies.
   e. Criteria and pathways for laboratory escalation to a haematologist where transfusion is urgent, and the presence of antibodies might delay release of red blood cells.
   f. Treatment of patients who refuse transfusion of blood components and/or products.

2. Reviewed, updated, and implemented training programmes to include:
   a. Recognition of bleeding, importance of communication, processes for activation of major haemorrhage protocols and rapid access to blood components and products in clinical staff training programmes.
   b. Major haemorrhage drills, simulations and debriefs into regular staff training activities, including clinical and laboratory teams.
   c. Concessionary, rapid release of the best matched red blood cells for patients with red cell antibodies.
   d. A process for recording participation and identifying dates for re-training.
   e. Treatment of patients who refuse transfusion of blood components and/or products.

3. Implemented processes to audit and investigate all transfusion delays, using appropriate investigation tools to identify system factors for improvement.

For further detail, resources and supporting materials see: www.shot.org

For any enquiries about this alert contact: SHOT@nhsbt.nhs.uk

National Patient Safety Alert

SHOT Serious Hazards of Transfusion

Medicines & Healthcare products Regulatory Agency

Reducing risks for transfusion-associated circulatory overload

Date of Issue:	4-Apr-24	Reference No:	NatPSA/2024/004/MHRA

This alert is for action by: **NHS and independent (acute and specialist) organisations where transfusions occur**

This is a safety critical and complex National Patient Safety Alert that is relevant across many departments and professions. Implementation should be coordinated by an executive leader (or equivalent role in organisations without executive boards) and supported by their designated senior leads for medical, nursing, midwifery, scientific and allied health professionals.

Explanation of identified safety issue:

Transfusion-associated circulatory overload (TACO) is defined as acute or worsening respiratory compromise and/or acute or worsening pulmonary oedema during or up to 12 hours after transfusion, with additional features including cardiovascular system changes not explained by the patient's underlying medical condition, evidence of fluid overload and a relevant biomarker. **TACO is one of the most common causes of transfusion-related deaths in the UK and cases have increased substantially in recent years. Identifying risk factors for TACO prior to transfusion allows initiation of appropriate mitigating measures.**[1]

TACO deaths are potentially preventable. TACO can occur in any individual of any age, including elderly people, children, and neonates. The risk is increased by the following factors:

- cardiac dysfunction
- renal dysfunction
- low body weight
- hypoalbuminaemia
- pre-existing fluid overload
- high volume in relation to body weight
- severe chronic anaemia
- women with severe pre-eclampsia

Non-bleeding adult patients with severe chronic anaemia are particularly vulnerable to risk of TACO. Errors in prescription for blood components have been reported in children and can contribute to TACO. Pulmonary complications of transfusion within this group can be difficult to identify, particularly in neonates. There should be awareness of TACO as a potential cause of respiratory deterioration following transfusion in this group.[2,3]

TACO risk reduction measures include:

- avoiding unnecessary transfusions
- single-unit transfusion or transfusing only the minimum number of units (or weight-adjusted red cell dose) needed to meet the haemoglobin (Hb) target (using red cell calculator[4]) and assessing response
- consideration of weight-adjusted red cell dosing for patients of low body weight (including children)
- avoiding transfusions in excess of recommended infusion rates
- administering a diuretic when appropriate
- monitor vital signs closely, including oxygen saturation

Further supporting information about TACO and this alert can be found in the supporting FAQ document.[5]

Actions required

Actions to be completed as soon as possible and no later than 4 October 2024:

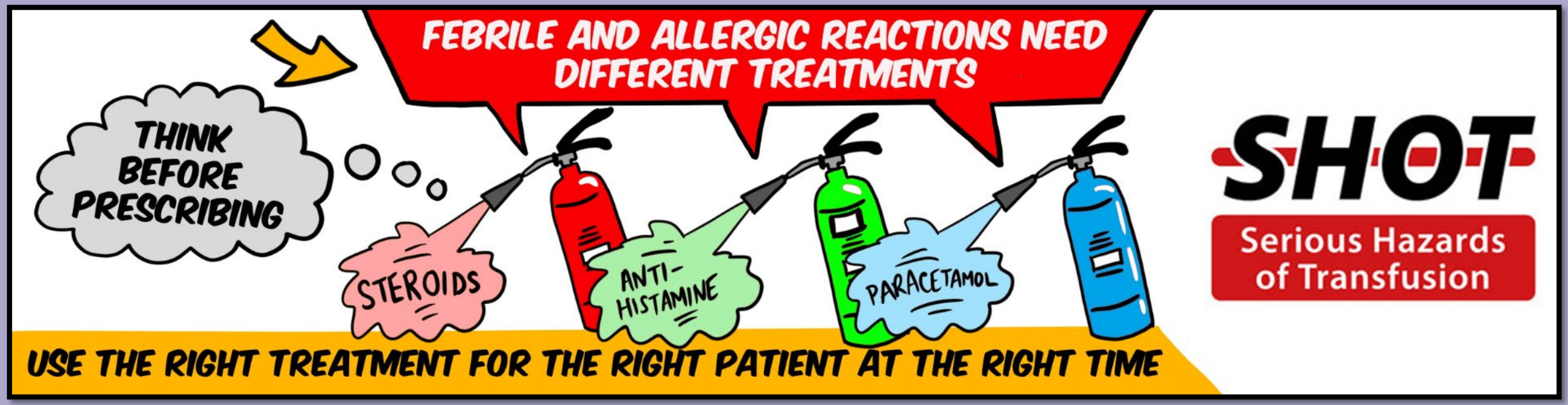
1. Review and update **policies, procedures and processes** to ensure:
   a. All transfusions are compliant with recommendations from British Society for Haematology (BSH),[6,7] SHOT,[8] and NICE[9]
   b. A TACO risk assessment is undertaken utilising the SHOT risk assessment tool[1] prior to transfusions*
   c. Appropriate mitigation measures are initiated for individuals at risk – see FAQ document[5]
   d. Patients and carers should be informed of TACO as a significant potential complication of transfusion and likely symptoms, as part of complying with Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO) consent for transfusion guidance[10]
   e. Inclusion of guidance on timely management of TACO, including the use of diuretics, oxygen, and other supportive measures
   f. Clear communications on discharge to patients and staff involved in the care of the patient about blood components and/or blood products administered and any complications such as TACO
   g. Use of the structured TACO incident investigation tool[11] from SHOT
2. Review, update, and **implement training programmes** to include:
   a. Use of TACO pre-transfusion risk assessment tool*
   b. Appropriate use of mitigation measures – FAQ document[5]
   c. Management of severe chronic anaemia in non-bleeding patients using minimal/single-unit transfusion support, and anaemia management with iron therapy where appropriate
   d. Recognition and prompt management of TACO, importance of timely interventions and escalation of care as appropriate
   e. Empowerment of clinical staff and biomedical scientists to question practices of prescribing/requesting blood components
   f. A process for recording participation and identifying dates for re-training
   g. Knowledge and awareness to report TACO cases locally, as well as to MHRA and SHOT by hospital transfusion teams
3. **Undertake regular audit** on the use of the TACO risk assessment tool for adult patients*, consent practices, management of chronic severe anaemia, avoidable transfusions, volume of red cell transfusion and communication of information at discharge to relevant teams involved in the care pathway including patients

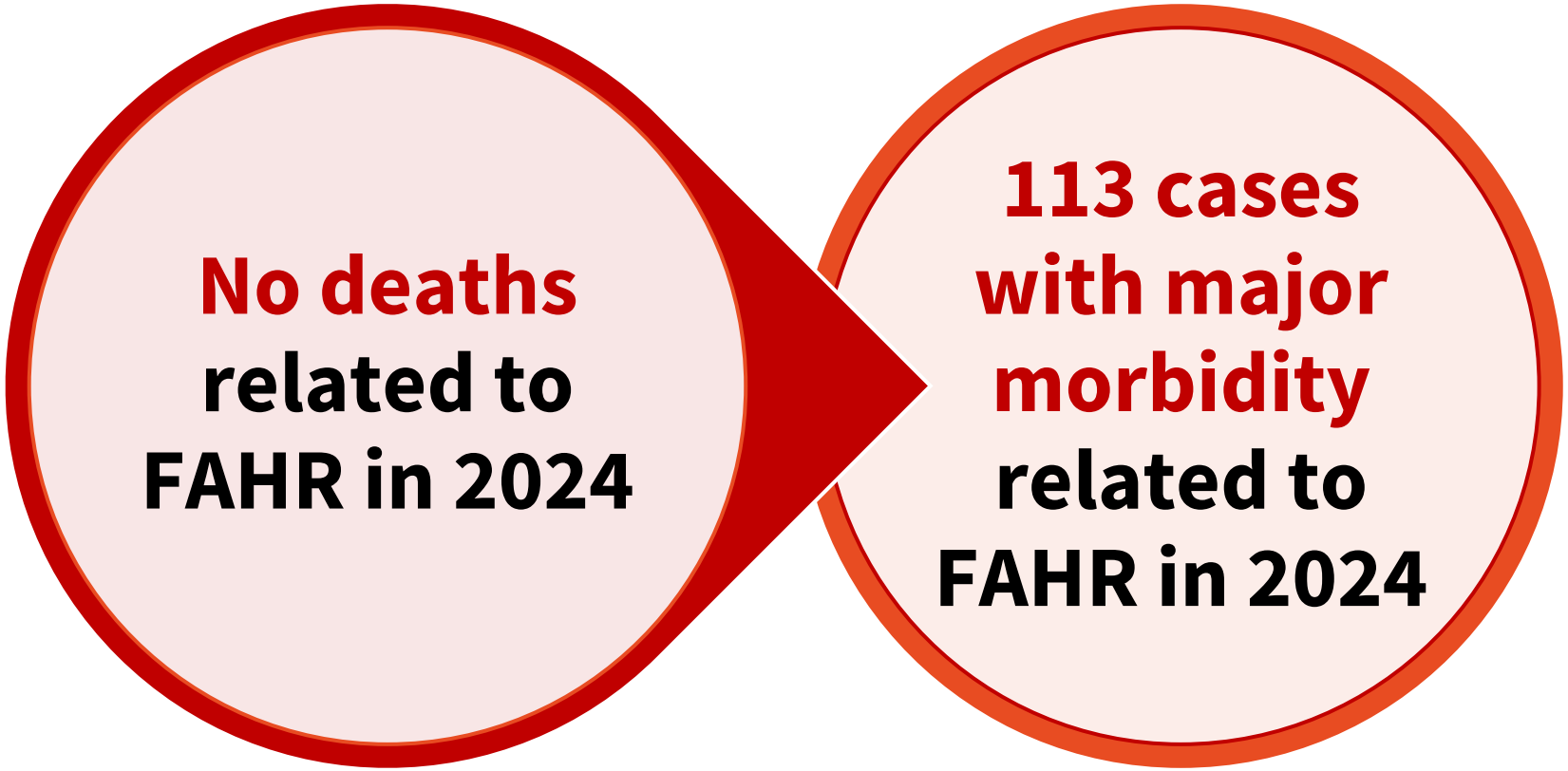
It is important to note that the TACO risk assessment tool has not been formally validated for paediatric age groups, but the risk factors are similar. Careful attention to appropriate volume and rate of transfusion is vital.

For further detail, resources and supporting materials see: https://www.gov.uk/drug-device-alerts and https://www.shotuk.org/

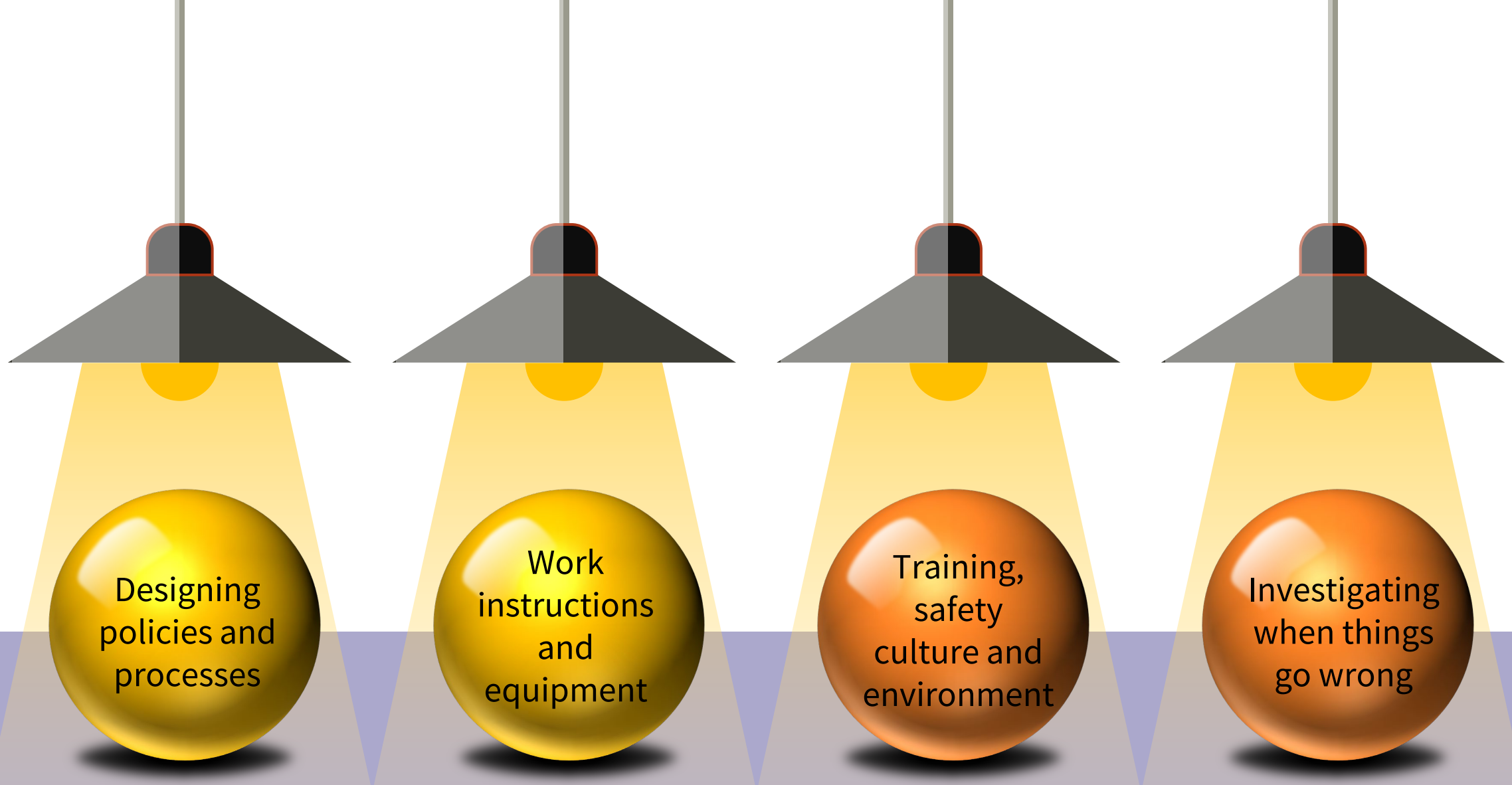
For any enquiries about this alert contact: info@mhra.gov.uk or SHOT@nhsbt.nhs.uk

Febrile, Allergic and Hypotensive Reactions



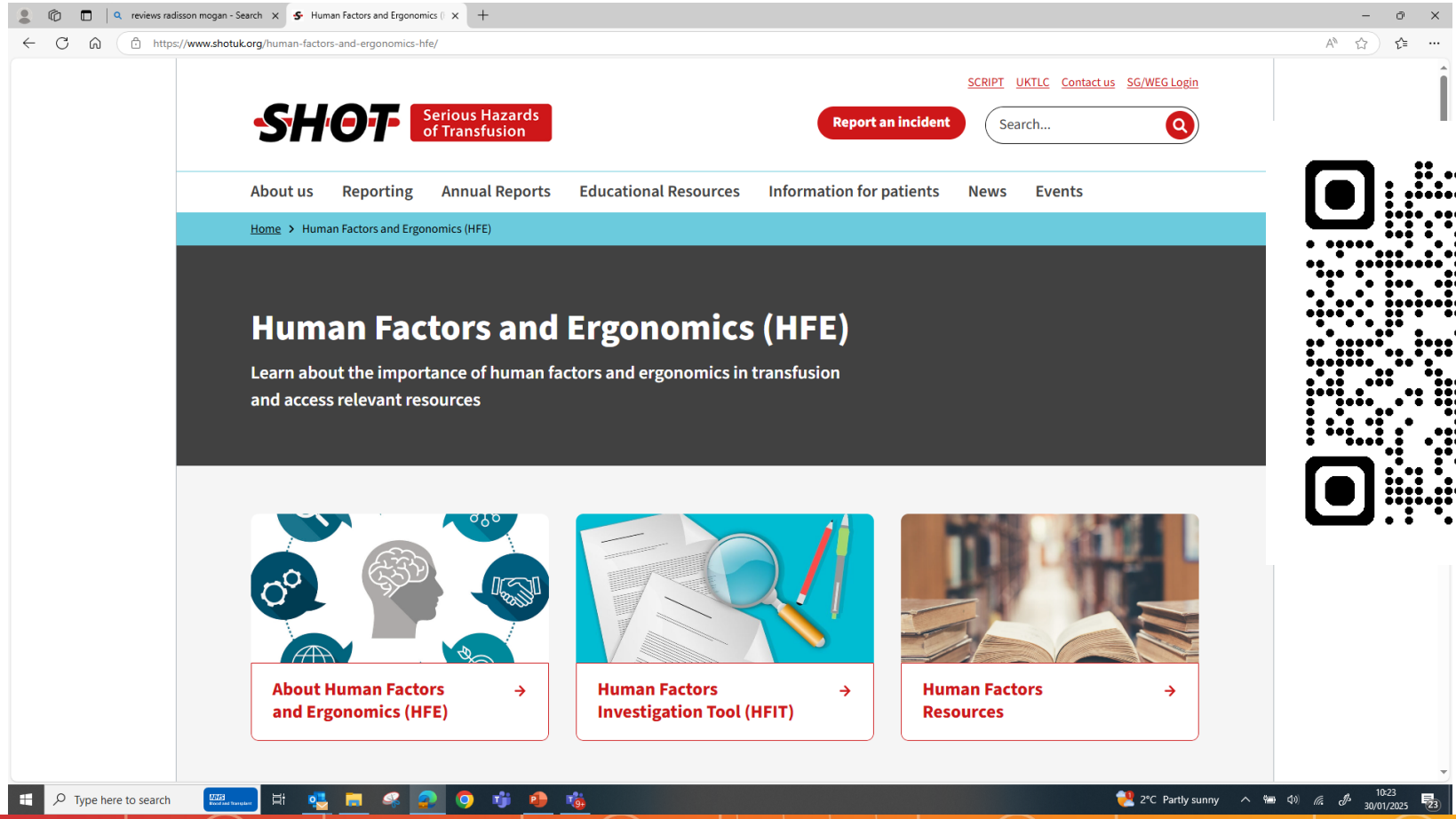

No deaths related to FAHR in 2024
113 cases with major morbidity related to FAHR in 2024

345 Febrile and allergic reactions in 2024	**33** severe allergic reactions in 2024	Difficulties in accurately categorising events continue
Red cells usually associated with febrile reactions	Plasma and platelets more commonly cause allergic reactions	Inappropriate use of antihistamines with or without steroids seen



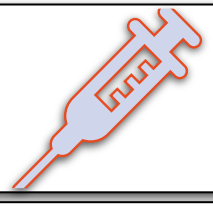
Human Factors principles are important in all these aspects of transfusion safety

Human Factors resources developed by SHOT



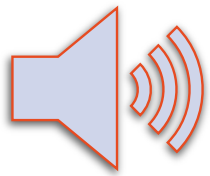
SHOT **A**cknowledging **C**ontinuing **E**xcellence in Transfusion

- Learning from all events and experiences including excellence
- Appreciative enquiry
- Making visible the hidden work people do to successfully navigate problems
- Build resilient teams and systems



A health care assistant (HCA) spotted a registered agency **nurse taking two samples for group and save at the same time**

The HCA **reiterated safe practice** and local policy (that samples must be taken at different times by different people)



They **disposed of duplicate sample**, and **raised a near miss incident** on the local reporting system

A repeat sample was taken and sent to the laboratory. The patient in question had been admitted with a fractured neck of femur, and there was no previous blood group on the system

A wrong blood in tube incident was potentially avoided

The transfusion practitioner **provided positive feedback to the HCA** and **escalated the incident to the Central Safety team**. They have also incorporated this scenario in **mandatory transfusion training**

What can you do?

Report any errors or concerns to Transfusion Practitioner

Ensure a safe environment for transfusions

Be a champion for transfusion safety

Suggested activities

Spend some time with a haemovigilance reporter when they are completing a SHOT report

Attend a hospital transfusion committee meeting

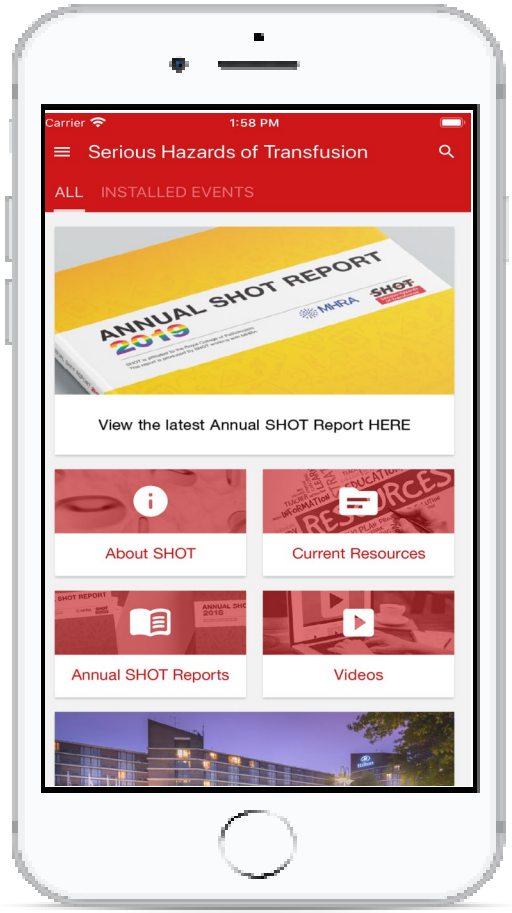
Attend an investigation meeting

Review your hospital transfusion policies

Carry out a consent review and use of checklist / SRNM

Carry out a review of your Trust's SHOT reports

SHOT App



Download on the App Store

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Acknowledgements

- **The reporters and hospital staff who share their incidents**
- The SHOT Steering Group and Working Expert Group members
- MHRA haemovigilance team
- The UK Forum for funding

For further information visit: www.shotuk.org

https://stock.adobe.com/uk/