2023 Annual SHOT Report – Supplementary information

Chapter 2: Participation in UK Haemovigilance

Additional data tables and analysis not included in the main 2023 Annual SHOT Report.

Number of SHOT reports by UK country

Table 2.2: Total number of reports to SHOT by UK country 2020-2023

	2020		2021		2022		2023	
	Number	%	Number	%	Number	%	Number	%
England	3370	82.94	3366	82.34	3668	83.92	4173	83.93
Northern Ireland	110	2.71	131	3.20	117	2.68	116	2.33
Scotland	403	9.92	401	9.81	380	8.69	465	9.35
Wales	180	4.43	190	4.65	206	4.71	218	4.38
United Kingdom	**4063**	**100**	**4088**	**100**	**4371**	**100**	**4972**	**100**

Table 2.3: Total number of reports per 10,000 components by UK Blood Service 2020-2023

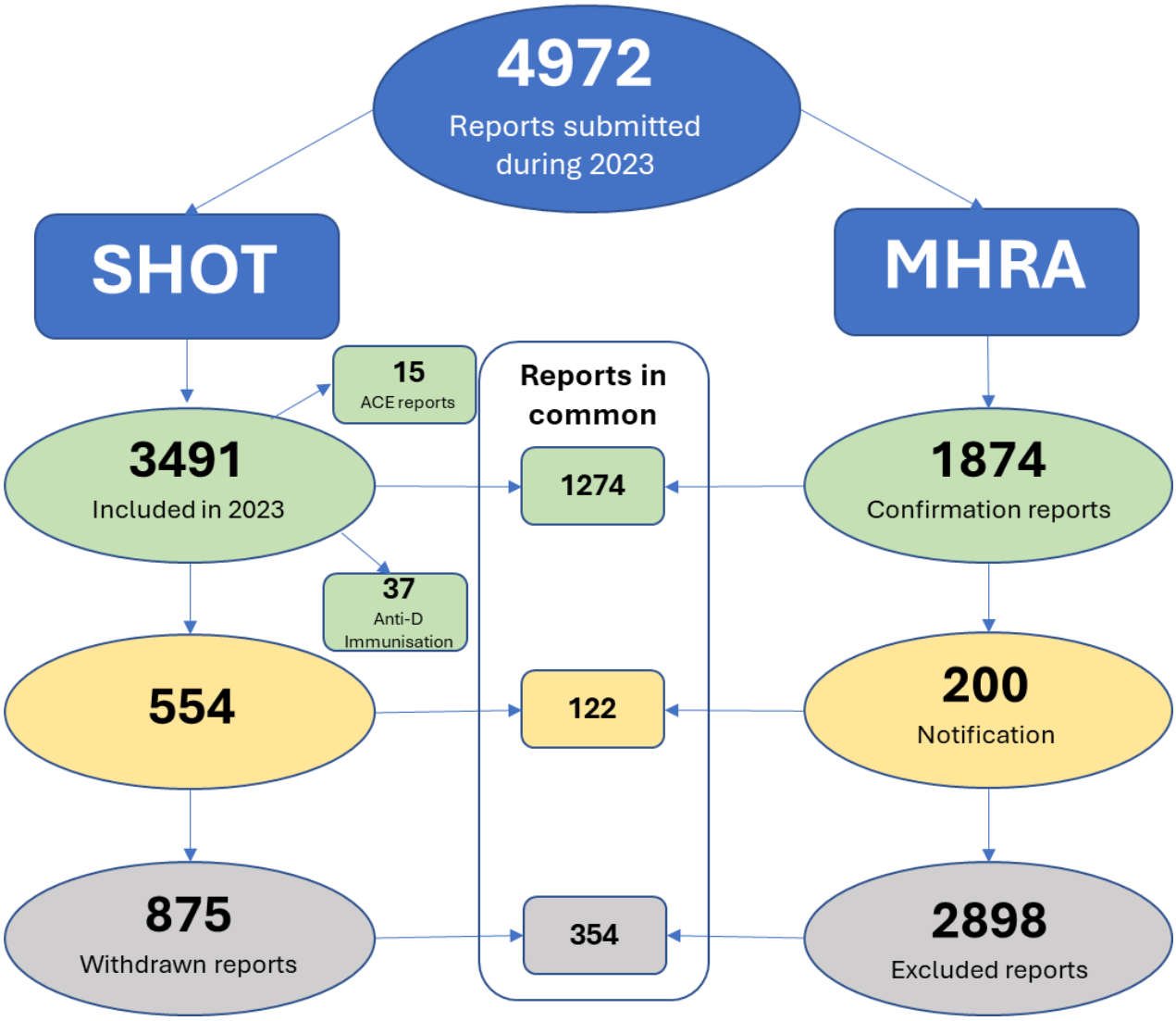
	2020	2021	2022	2023
NHS Blood and Transplant	19.1	18.0	19.4	22.4
Northern Ireland Blood Transfusion Service	22.6	23.4	20.2	20.2
Scottish National Blood Transfusion Service	24.1	22.5	20.9	25.3
Welsh Blood Service	19.3	20.0	21.8	24.1
Total (rate for all services combined)	**19.6**	**18.6**	**19.6**	**22.6**

Reporting to SHOT and the MHRA

Figure 2.7 below details how the 4972 reports were included by each organisation. Only 1274/4972 (25.6%) of reports were accepted for inclusion in the 2023 analysis by both SHOT and the MHRA, and this demonstrates the differences in reporting criteria between the two organisations.

There were 554 reports to SHOT that were submitted during 2023, but still incomplete at the end of December 2023. This equates to 11.1% of all submitted cases, which is similar to 2021 where there were 465/4088 (11.4%) cases that were still incomplete at the end of the calendar year. There had been a slight reduction in 2022 at 9.4%. Once completed, these reports will be included in subsequent Annual SHOT Reports.

Figure 2.7: Reports submitted to SHOT and the MHRA in the calendar year 2023 (n=4972)



Analysis of transfused errors by location

The number of incidents reported from the ED has increased substantially in recent years, but has levelled out in 2023, with a very similar number reported to 2022. The numbers of reports from other areas have also remained consistent, with no glaring fluctuations.

Unfortunately, there are no denominator data available regarding the number of transfusions undertaken in each of these areas, so it is difficult to draw meaningful conclusions from this data.

Figure 2.8: Five-year trend of error reports from different departments

Figure 2.8a: Emergency departments

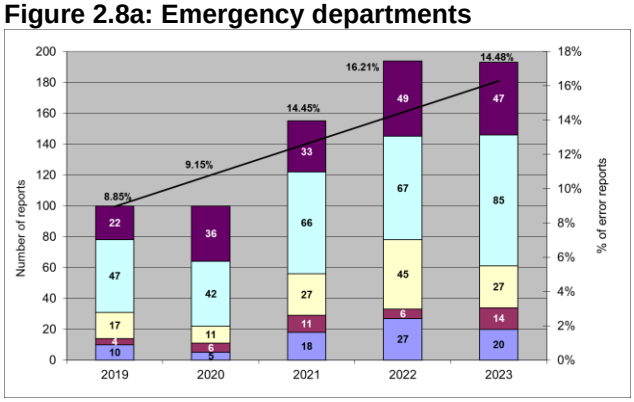


Figure 2.8b: Theatres

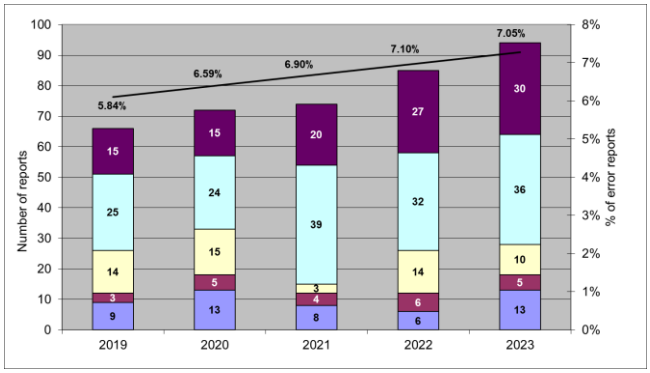


Figure 2.8c: General wards

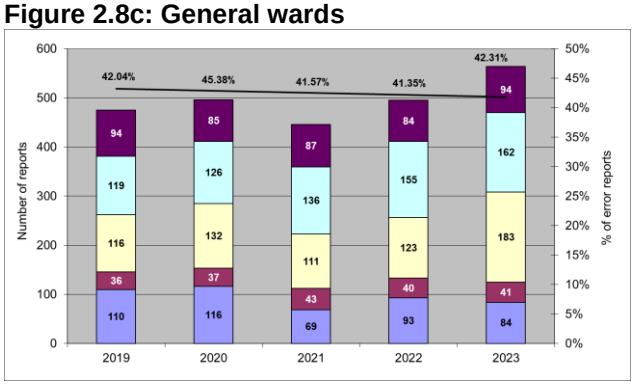
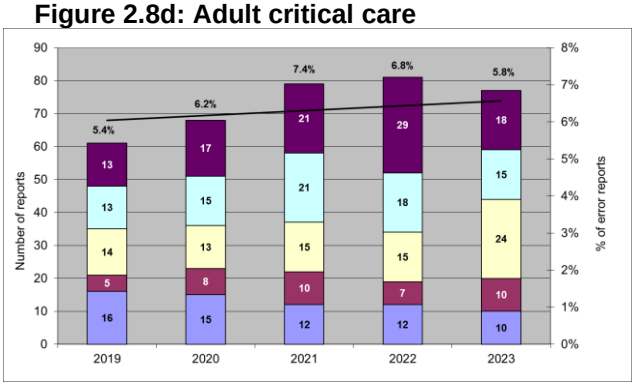


Figure 2.8d: Adult critical care



Incorrect blood component transfused - specific requirements not met

Incorrect blood component transfused - wrong component transfused

Handling and storage errors

Avoidable, delayed and under or overtransfusion, and incidents related to prothrombin complex concentrates

Right blood right patient