# Participation Benchmarking FAQs

**Questions/Answers**
Below are some questions that have been asked about the participation benchmarking reports. Answers are provided to help in understanding the data provided and the process taken to finalise the reports.

1. **Why isn't the data anonymised?**
Most data were anonymised for the reporting years of 2010 to 2012 as an initial trial, but even during that period Scottish and Welsh organisations already requested de-anonymised data. The NHS is encouraging a culture of openness, so after consultation, SHOT now publishes de-anonymised data.

2. **Will other organisations be able to see our data?**
Yes and comparative charts have been produced for each Regional Transfusion Committee (RTC) or devolved country, and for organisations of similar size based on number of components issued.

3. **How can the data be compared when Trusts/Health Boards are of different sizes?**
The data are presented as number of SHOT reports per 1,000 blood components (per 100 for anti-D immunoglobulin (Ig)) so different sized organisations won't be apparent within the comparative charts.

4. **Was there any approval sought for this presentation of benchmarked participation data?**
Initial approval was obtained from SHOT's Steering Group, which is comprised of representatives from all relevant professional bodies.
Approval was also obtained from the UK Forum, National Blood Transfusion Committee (NBTC) and individually from the four UK Blood Services.

5. **Has SHOT informed Trusts/Health Boards about benchmarking participation?**
Trusts/Health Boards were not individually informed, but benchmarked participation reports using have been distributed since June 2012 covering reports made from calendar year 2010 onwards. The initial plans were described in the 2010 Annual SHOT Report (published 2011), a poster was presented at the BBTS Annual Scientific Meeting in September 2011 (available on the SHOT website www.shotuk.org) and further information has been given in subsequent Annual SHOT Reports.

6. **Why were Octapharma asked to supply issue data about their FFP, but not the anti-D Ig companies?**
Octaplas (solvent-detergent treated FFP) data were needed from all reporting organisations to include in the overall denominator, for plasma usage. In some UK countries it is supplied by the Blood Service, so they provided the totals within their plasma issue figures, but for those supplied directly by Octapharma, it was simpler to work with the company, so they could liaise with their customers, rather than try to ask all organisations in the UK.
It would have been more difficult to work with anti-D Ig suppliers, because there are several companies supplying different Trusts/Health Boards. Anti-D Ig data were only needed from organisations that had reported incidents, which is a much lower number than those reporting all other incidents, hence it was easier to ask for data relating to anti-D Ig usage to be provided directly by the reporting organisations.

**7. Can other organisations or commercial companies tell how much Octaplas our Trust/Health Board use?**

No, because the data are presented only as per 1,000 units of components issued, so it isn't even split by plasma components and certainly there is no indication of which organisations use Octaplas.

**8. Within our Trust/Health Board we report for several hospitals, so how will you know our issue data for components?**

The benchmarked participation data are only being provided by Trust/Health Board, not by individual reporting hospital or laboratory. SHOT's online reporting database links all individual organisations to their Trust/Health Board and individual component issue data have been totalled for the whole Trust/Health Board.

**9. What do the categories 'Serious Adverse Reactions' and 'Serious Adverse Events' mean?**

It would have been too complex to try and benchmark participation according to each category listed in the SHOT definitions. 'Serious Adverse Reactions' and 'Serious Adverse Events' are the overarching categories into which reporters categorise their incidents in the online SHOT database, so most SHOT reporters are already familiar with these terms and the types of incidents in each. They broadly equate to 'clinical reactions' and 'avoidable errors' and any disparity between the types of incidents reported might indicate the reporting organisation is not detecting incidents in both categories equally.

**10. Why have you included 'withdrawn' reports?**

The benchmarking project is designed to reflect how well an organisation participates in SHOT reporting, but knowing what to report can sometimes be complicated and occasionally incidents are withdrawn if they are decided on reflection not to be SHOT reportable. Therefore, withdrawn reports are valid, because they show an intention to participate fully. For the 2012 data, there were more withdrawn reports than in previous years which relate to mild acute transfusion reactions (ATR), because the definition of ATR had been revised. It is expected that erroneous reporting of mild ATR will reduce as reporters get used to the revised definitions.

**11. Won't organisations be less likely to report incidents if they think other people are judging them?**

The feedback from previous exercises is reassuring and does not suggest any problems. These benchmarked reports are designed to show the level of participation in SHOT, so it would be counter-intuitive for participants to conclude that reduced reporting would reflect well on their organisation. In some instances, the comparative data might indicate that an organisation is over-reporting or under-reporting in relation to other similar organisations, so participation might be affected, but only positively by reporters being alerted to situations when they are either reporting or not reporting inappropriately.

**12. Wouldn't it have been simpler to categorise organisations into the same low to high categories that the Blood Stocks Management Scheme (BSMS) use?**

There will be a similarity between the usage bands but SHOT needed to produce bands with a broadly equal number of organisations, so that the comparative graphs would be readable. In some cases the BSMS bands would have produced comparative graphs that were too cluttered and were therefore unclear. Also, the BSMS usage clusters are based on red cell usage alone, but SHOT data are being compared per 1,000 total components used.