Foreword and SHOT Update

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Welcome to the Annual SHOT Report for events reported from across the United Kingdom (UK) in 2015. It is encouraging that the level of participation remains high. We are pleased to note that serious adverse reactions, (SARs) i.e. those reactions resulting in serious harm or death, are rare. We continue working towards a closer alignment with the Medicines and Healthcare Products Regulatory Agency (MHRA) and reporting to the European Union (EU). From October 2015 the SHOT Working Expert Group (WEG) took over assessment of adverse reactions, forwarding to the MHRA those that required inclusion in the returns to the EU. The MHRA serious adverse events have been integrated together with the SHOT data into a single chapter and the full MHRA report can be found in the 2015 Annual SHOT Report: Web Edition.

Some topics and additional material will be found in the SHOT Web Edition. Subjects include those where reports are few and there are no new observations, and include post-transfusion purpura (PTP), transfusion-related acute lung injury (TRALI), complications related to cell salvage (CS), handling and storage errors (HSE), errors associated with the right blood nevertheless being transfused to the right patient (RBRP), the full report on incidents related to anti-D immunoglobulin administration (anti-D) and anti-D immunisation in pregnancy study, alloimmunisation data and an update of events in patients with haemoglobin disorders.

Medical practice is under pressure. More than a third of NHS staff reported work-related stress in the 2015 staff survey. Emergency departments are struggling, 2 in 5 new consultant physician posts were not filled in 2015, a third of general practitioner training places remain vacant, and overall funding is tight. Once again, the majority of SHOT reports follow mistakes (often multiple) in the transfusion process (77.7%) related to human factors. We have observed a worrying number of adverse reactions and events related to poor communication and poor clinical decisions. Laboratory errors have increased and there are concerns that local investigations and root cause analyses are not being fully completed. The UK Transfusion Laboratory Collaborative survey completed in March 2015 confirmed that many laboratories are under pressure with vacancies (some very longstanding) and increased workloads. Clinical reports also note similar issues. Information technology when properly set up can be a significant safety improvement but some of our incidents demonstrate inadequate validation resulting in dangerous errors.

We are extremely grateful to our working expert group who complete the analysis and writing around their already busy jobs. Tony Davies, who has been an excellent ambassador for SHOT, retired in December 2015 and has been succeeded by Jayne Addison.

This year for the first time we include a chapter with data on donor vigilance provided by the four UK Blood Services. This was compiled by a new working group and demonstrates the full reach of haemovigilance, from donor to recipient.

We hope you find this report useful and are always very pleased to receive comments and feedback.

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