

This 2025 Annual SHOT Report represents the 30th year of haemovigilance in the UK and I have taken the opportunity to look back over the history of SHOT and some of the early Annual SHOT Reports. It has been both nostalgic and inspiring to see how much has been achieved in transfusion safety by healthcare professionals across the UK, and internationally.

SHOT was launched in November 1996 and the first Annual SHOT Report, published in December 1997, covered the 12 months from October 1996-September 1997. There were seven reporting categories and 141 completed questionnaires of which incorrect blood component transfused comprised 47% of cases and transfusion-transmitted infection 5% of cases. In contrast, this year, a total of 4046 reports were received with the largest category being near miss at 33.9%. There were no confirmed transfusion-transmitted infections.

The vision of the founding members of the SHOT, its Steering Group and Standing Working Group (now the Working Expert Group) was to 'collect data on serious sequelae of transfusion of blood components'. The aim was to use that information to contribute to 'improving the safety of the transfusion process, informing policy within transfusion services, improving standards of hospital transfusion practice and aiding production of clinical guidelines for the use of blood components' (Williamson, et al., 1996). These principles remain the core values of the current SHOT organisation.

The remit of SHOT, the Steering Group and the Working Expert Group have expanded considerably over the intervening years. New reporting categories were introduced to cover all aspects of transfusion safety from vein-to-vein. The addition of near miss reporting categories has greatly enhanced our learning from errors that are detected before transfusion takes place. We also learn from the analysis of human factors and ergonomics questions which give a different and more insightful view of why errors occur, and continue to occur, and a better understanding of the effectiveness of corrective and preventive actions following investigation of adverse events.

This year we introduce the first Blood Services chapter. This, together with the chapters on blood donation and acknowledging continuing excellence in transfusion (ACE), provide a more complete overview of transfusion safety when analysed alongside the longstanding and familiar reporting categories that have been with us since the early years of SHOT. These new categories will continue to develop as engagement with reporters improves and will help increase our understanding of the challenges as well as the improvements in patient safety across the whole vein-to-vein transfusion pathway.

In this year's Annual SHOT Report you will find that participation remains high, and we thank reporters for their time, commitment and diligence. The data profile remains similar to recent years with preventable errors comprising the majority of reports, demonstrating persistent weaknesses in the systems in place to deliver safe transfusions. The publication of the SHOT Transfusion Safety Standards in July 2025, in response to the Infected Blood Inquiry recommendation, aims to identify and address gaps in practice that could further improve patient safety. In this Annual SHOT Report, the one and only recommendation for UK hospitals is to use these standards to benchmark their practice and identify targeted improvements. Where relevant, the Annual SHOT Report highlights specific standards applicable to particular areas of practice or adverse events, while broader principles are reflected throughout the report. You will also find a preliminary report of the progress made by the four UK nations in implementing and monitoring these standards (see Chapter 4, Key Messages and Progress Update).

Finally, I would like to congratulate the SHOT team for all their hard work and dedication to haemovigilance practice as well as research and education. In the 30th year of SHOT this has been recognised by the International Haemovigilance Network (IHN) who awarded them the IHN Award in March this year at the IHN symposium in Rome. Well-deserved international recognition, well done!

Dr Megan Rowley

SHOT Steering Group Chair