Annual SHOT Report 2012 – Supplementary Information

Chapter 2: Participation in the SHOT Haemovigilance Reporting Scheme

Additional Tables – not included in the main 2012 report

Participation breakdown for NHS Trusts/Health Boards for 2012

	Number of NHS organisations	Organisations registered on the SHOT Database	Registered Organisations with no reports made in 2012
England	158	157	1
Wales	5	5	0
Scotland	15*	15	2
Northern Ireland	5	5	0
TOTAL	**183**	**182**	**3**

** This figure includes 1 Special Health Board that has also made reports to the SHOT Database.*

Participation in the SHOT Haemovigilance Reporting Scheme - Previous Recommendations

Year first made	Action	Recommendation
2011	**Trust/Hospital/Health Board chief executive officers (CEOs), hospital transfusion teams (HTT)**	All hospitals/Trusts and Health Boards where transfusion activity takes place should be vigilant for errors in the transfusion process and also report unexpected pathological reactions to SHOT and the Medicines and Healthcare products Regulatory Agency (MHRA) in accordance with European Union (EU) directives transposed into UK law and recommendations from professional bodies
2011	**Hospital Transfusion Team (HTT)**	Reporters should gather as much information as possible about the events they report, and complete the relevant questionnaires on the SHOT database fully. This enables the SHOT incident specialists to evaluate the event and ensure it is in the appropriate category
2008 & 2009	**Action: CEOs of Trusts and hospitals in England, Northern Ireland and Wales, and of Health Boards in Scotland, HTTs**	In the 2008 report SHOT highlighted an NPSA/NHS Confederation briefing document, 'Act on Reporting: Five actions to improve patient safety reporting'.[8] All reporters should undertake the following action plan to improve their reporting both locally and to SHOT. **Establish current level of reporting** What is your rate of reporting – how does it compare with that of similar organisations? How has it changed over time? **Give feedback to staff** Does your organisation provide feedback to individual reporters and staff? How can this be improved? Have you combined incident data with other sources such as investigations, litigation and complaints to 'tell the story' of key risks and challenges? **Focus on learning** What changes in patient care have been made as a result of reporting? Could your staff give examples of changes following reporting, such as new equipment or practice?

		Engage frontline staff What formal training do you provide on incident reporting for new and existing staff? Do you have safety champions at directorate or ward level? **Make it easy to report** How easy is it for staff to report incidents? Do all clinical specialties and staff groups report? **Make reporting matter** Do staff believe that your reporting systems are focused on improving safety rather than blaming individuals? What do recent staff survey results tell you? How are you assured that incident reporting is being used to 'close the loop' and act on the risks identified?