Independent report

Guidelines from the expert advisory committee on the Safety of Blood, Tissues and Organs (SaBTO) on patient consent for blood transfusion

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Background information

It is an accepted principle that a patient should give valid consent before receiving medical treatment, and this includes when they receive a transfusion of blood and blood components (such as fresh frozen plasma and platelets).

In October 2011, SaBTO published its guidelines on Patient Consent for Blood Transfusion. Since then there have been landmark judgments concerning consent, and changes in advice on consent from professional and other bodies. Audits show there is still wide variation in consent practice around the country, and in light of these events and the ongoing Infected Blood Inquiry, SaBTO agreed that these guidelines should be reviewed.

This report is a complete revision of the 2011 report. While the principles underlying consent remain much the same, the latest recommendations provide additional guidance specific to consent for blood transfusion, including identification of which patients should be consented (for example, where transfusion might occur during a procedure where the patient is incapacitated) and duration of consent. The work was undertaken by SaBTO and the final report amended after professional and lay consultation.

It should be noted that SaBTO is an independent advisory body. DHSC has not mandated the recommendations, and it is for the NHS and other UK healthcare bodies locally to decide on their implementation.

Summary of recommendations

We recommend that:

- Informed and valid consent for transfusion is completed for all patients who will likely, or definitely, receive a transfusion. These recommendations apply to transfusion of whole blood, red blood cells, platelets, fresh-frozen plasma (FFP), cryoprecipitate and granulocytes, as well as those who are exposed to blood or blood components. These recommendations also apply to where transfusion might occur during a procedure where the patient is incapacitated, for example, where blood is routinely requested prior to surgery or where a 'group and save' or 'cross-match' sample is taken pre-procedure. Such shared decision-making discussions should be documented in the patient's clinical record.
- Patients who have a been given a blood transfusion and were not able to give informed and valid consent prior to the transfusion are informed of the transfusion prior to discharge and provided with relevant paper or electronic information.
- All patients who have received a transfusion have details of the transfusion (type[s] of component), together with any adverse events associated with the transfusion, included in their hospital discharge summary to ensure both the patient and their family doctor are aware. The patient should also be informed that they are no longer eligible to donate blood (with the exception of individuals who have received Convalescent Plasma from donating Convalescent Plasma to treat individuals with SARS-CoV-2).
- The UK Blood Services provide a standardised source of information for patients who may receive a blood transfusion in the UK.

- Training in consent for transfusion is included in all relevant undergraduate healthcare practitioners training, followed by continuous, regular knowledge updates (minimum 3-yearly) for all healthcare practitioners involved in the consent for transfusion process.
- There is a centralised UK-wide information resource for healthcare practitioners to facilitate consent for transfusion discussions, indicating the key issues to be discussed when obtaining informed and valid consent for a blood transfusion, and providing up-to-date information on the risks of transfusion. This resource should be provided by the UK Blood Services. The feasibility of developing and maintaining this resource should be completed by the UK Blood Services within 6 months of the publication of these recommendations.
- All UK healthcare organisations who provide blood transfusions employ mechanisms (such as audit) to monitor the implementation and compliance with these SaBTO recommendations, with subsequent improvement plans developed and implemented if indicated.

Introduction and background

The need to review the 2011 Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO) report titled 'Patient Consent for Blood Transfusion' [footnote 1] was identified by the Chair of SaBTO. It was considered timely to do this as the report had been published more than 8 years previously. Furthermore, since the initial report, the United Kingdom (UK) Supreme Court Montgomery v Lanarkshire ruling in 2015[footnote 2] provided additional guidance on consent and the ongoing Infected Blood Inquiry[footnote 3] identified concerns about whether and to what extent people were treated without knowledge or consent.

In November 2019, a SaBTO Consent for Blood Transfusion Working Group was established. The membership is shown in Appendix 1. The remit and scope of this group, approved by SaBTO, included the following:

Review relevant updates relating to blood transfusion consent including:

- the 2015 Montgomery v Lanarkshire ruling [footnote 2]
- General Medical Council (GMC) Guidance for Consent: Patients and Doctors Making Decisions Together (2008) [footnote 4]
- updated UK variant Creutzfeldt-Jakob (vCJD) precautionary measures [footnote 5]
- National Institute for Care and Health Excellence (NICE) Blood Transfusion guideline 2015 [footnote 6]
- NICE Blood Transfusion Quality Standards 2016 [footnote 7]
- Choosing Wisely recommendations for blood transfusion 2015 [footnote 8].

'Blood transfusion' for the purposes of this working group refers to the transfusion of blood components, as defined by the Blood Safety and Quality Regulations (BSQR SI 2005 No.50 as amended) [footnote 9] which define blood components as a therapeutic constituent of blood [red blood cells, platelets, fresh-frozen plasma (FFP), cryoprecipitate and granulocytes].

Blood products (such as albumin or intravenous immunoglobulin) are out of scope as these are classified as medicinal products and subject to different regulations.

Although technically a blood product, for the purpose of consent for transfusion, Solvent Detergent Fresh Frozen Plasma (SD FFP) should be subject to the same consent processes and recommendations.

The recommendations are pertinent to all patients who may be exposed to blood components (therefore including, for example, patients undergoing extracorporeal membrane oxygenation (ECMO), pump priming or organ perfusion), and to both autologous (obtained from the same individual) and allogeneic (donated) transfusions as many of the most frequent serious risks of transfusion are similar (for example, transfusion associated circulatory overload (TACO) and wrong blood component transfused).

The recommendations are about ensuring patients are informed about transfusion and have an opportunity to discuss their treatment options. These recommendations are a set of principles which should be incorporated into local practices for all patients, taking into account specific issues related to paediatric patients and those with deemed mental incapacity. It is not the remit of these recommendations to provide detailed guidance related to paediatrics, reduced mental capacity, refusal of blood components (including Advanced Directives), or to advise on legalities related to consent, which should be covered by standard hospital practices. However, the recommendations must be in line with current legislation on consent and relevant regulations.

The recommendations must consider any operational impacts, and any impacts on all stakeholders, including but not exclusively donors, patients and patient groups, the UK blood, tissues, cells and organ establishments, health care practitioners involved in transfusion, the wider National Health Service (NHS), and the public.

The group met on 4 occasions and corresponded by telephone and email. Legal advice was sought from the legal representatives of all 4 UK nations. Before approval by SaBTO (13 October 2020), there were widespread consultations with interested parties and stakeholders.

Seventy-four consultation responses were received (see Appendix 2 for list of organisations where responses were received). All responses were scrutinised by the Chair of the SaBTO Consent for Blood Transfusion Working Group, and the Chair of SaBTO, with oversight from other working group members. Subsequent changes to the recommendations included:

- clarification of the scope and remit of the recommendations; that they are a set of principles for patients who may need a transfusion and not detailed guidance related to paediatrics, mental capacity, refusal of blood components or specific consent legalities
- removal of a section related to the provision of information to patients unlikely to receive a transfusion; this section was deemed unnecessary and with the potential to result in some confusion and unneeded information overload
- for long-term multi-transfused patients where transfusion is needed to manage a specific condition, treatment plans should incorporate the management of any complications of transfusion, which incorporate patient consent as appropriate, or as requested by the patient, rather than at a pre-set (annual) date
- a shift of emphasis on healthcare organisations employing mechanisms to self-monitor compliance with these recommendations, with subsequent improvement plans, rather than specifically recommending external monitoring and regulation (such as Care Quality Commission)

Since 2011, improvements in obtaining consent for transfusion has been made, but further progress is needed. In 2014, the National Comparative Audit of Consent for Blood Transfusion [footnote 10] found that the implementation of informed consent for transfusion was sporadic and compliance with the 2011 SaBTO recommendations was generally low. Results included:

- 81% had documentation of the clinical indication for transfusion in the notes
- 85% of staff stated that they had explained the reason for transfusion to the patient, but only 65% stated that they had documented this
- documentation of consent was only evident in 43% of notes reviewed, and patient recall was variable

Anecdotal evidence and the experiences of the SaBTO consent working group members suggest that current practice remains similar to that in 2014.

The purpose of these new updated recommendations is to clarify existing practice and enhance standards for the provision of information about blood transfusion and obtaining patient consent.

The working group has taken into account the 2015 decision of the UK Supreme Court in Montgomery v Lanarkshire (UKSC 2013/0136) [footnote 2]. This was a landmark legal decision for informed consent and the shared decision-making model practiced in the UK. The court's decision redefined the standard for informed consent and disclosure.

The Supreme Court held that a patient should be told whatever they want to know, not what the doctor thinks they should be told, and establishing a duty of care to warn of material risks. The test of materiality defined in the Montgomery ruling was whether "a reasonable person in the patient's circumstances would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it". The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments.

This clarifies that when seeking consent to treatment, the question of whether the information given to the patient is adequate is judged from the perspective of a reasonable person in the patient's position. For the purposes of consent, the ruling from Montgomery replaces the application of previous tests founded in Bolam and refined in Sidaway [footnote 11] [footnote 12] to consent establishing a duty of care to warn of material risks and the patient's right to make informed treatment decisions takes precedence above the healthcare practitioners professional judgment/discretion in disclosing information.

Although Montgomery changed the legal position, the principle of involving patients in their treatment and sharing information with them about risks and benefits has been in place for some time. The Montgomery decision therefore clarifies the law of informed consent and aligns it with GMC guidance. It represents a shift towards a more collaborative approach to consent between patients and medical practitioners.This means finding the time to explain the risks and benefits of a recommended course of action and the other options.

The ruling makes it clear that any intervention must be based on a shared decision-making process, to help patients make an informed choice.

The working group has also considered the NICE (2015) Blood Transfusion guideline (NG24) [footnote 6] and the NICE (2016) Blood Transfusion Quality Standards [footnote 7], which both include the provision of verbal and written information about blood transfusion.

The working group also considered the GMC (2008) guidance Consent: Patients and Doctors Making Decisions Together [footnote 4] which should be referred to for all aspects of consent including capacity to consent, patients who refuse treatment and consent in children. This GMC consent guidance has undergone review, with new guidance available November 2020 [footnote 13].

Informed and valid consent

Historically, it was the remit of a doctor to undertake the consent process. As non-medical roles have developed and advanced, a wider range of health care practitioners are now involved in consent.

These healthcare practitioners should be trained and deemed competent (as per local hospital policy) to undertake consent, be familiar with the key principles of good practice in obtaining consent and have sufficient knowledge and experience of transfusion to be able to provide the information needed for the patient to make a decision, answer any questions that may be raised, and be aware of the range of ethical issues that commonly arise in transfusion practice.

As a guiding principle, the provision of information and the informed consent discussion should be undertaken by the healthcare practitioner who has made the decision to transfuse (or who has authorised the transfusion). Where necessary, this may be delegated to another appropriately trained and deemed competent healthcare practitioner.

For the purpose of this paper, informed and valid consent is the process by which a patient learns about and understands the purpose, benefits, and potential risks of the transfusion. For consent to be valid, it must be voluntary, informed and given by a competent patient with capacity [footnote 4] [footnote 13] [footnote 14] [footnote 15]. Consent should be considered informed decision-making that assists the patient to decide whether to consent to a particular intervention and respecting their right to autonomously decide how they wish to proceed.

Consideration should be given whether the transfusion is the only available treatment, whether any alternative treatments are available and suitable, and the risks and benefits of those alternatives as opposed to the transfusion. In addition to the provision of information about the nature and purpose of the proposed treatment, an active discussion should result in shared decision-making, allowing the patient to ask their own questions, and to raise any concerns they wish addressed, before they make a decision to receive, or refuse, the transfusion.

The dialogue needs to be focused on the individual to ascertain what risks are or are not acceptable to that individual's circumstances. Non-medical considerations may influence a patient's choice. What is not a material risk for one patient may be a material risk to another. The healthcare practitioner must provide information in a comprehensible way and ensure it is understood. The detail desired varies from patient to patient. The healthcare practitioner's duty is not discharged by deluging a patient with technical information or by simply obtaining a signature on a consent form.

The amount of information required to make consent informed may vary depending on complexity and risks of treatment as well as the patient's wishes.

It is recommended that the following framework (adapted from the NICE Blood Transfusion Guideline 2015 NG24) [footnote 6] is used when providing verbal and written information to patients, and their family members or carers (as appropriate):

- the reason for the transfusion
- the benefits of the transfusion
- the risks of transfusion – both short- and long-term risks (and including any additional risks pertinent to long term multi-transfused patients)
- any transfusion needs specific to them
- any alternatives that are available, and how they might reduce their need for a transfusion
- the possible consequences of refusing a blood transfusion
- the transfusion process
- that they are no longer eligible to donate blood (with the exception of individuals who have received Convalescent Plasma from donating Convalescent Plasma to treat individuals with SARS-CoV-2 [footnote 16])
- that they are encouraged to ask questions

If the patient changes their mind at any point before the transfusion, they are entitled to withdraw their consent and this should be documented and managed appropriately.

Consent of children and young people should comply with GMC guidance [footnote 4] [footnote 13].

It is recognised that for some patients, especially those in the pre-operative setting, it may be difficult to determine whether a transfusion will be required during the procedure (that is, from the time the procedure starts and the patient loses capacity to give consent until the time the patient recovers capacity, and so may include the post-operative period where the patient may remain under sedation). It would not only be impractical but also inappropriate to consent all pre-operative patients to transfusion.

Patients often have to assimilate large volumes of information relevant to their condition and treatment options, and so providing additional information on the indications, benefits, risks and alternatives to an unlikely transfusion could be deemed not only unnecessary but may also be detrimental to the patient, resulting in information overload and the possibility that important information and understanding related to other more relevant risks may be missed.

Recommendation: informed and valid consent for transfusion is completed for all patients who will likely, or definitely, receive a transfusion. These recommendations apply to transfusion of whole blood, red blood cells, platelets, fresh-frozen plasma (FFP), cryoprecipitate and granulocytes as well as those who are exposed to blood or blood components.

These recommendations also apply to where transfusion might occur during a procedure where the patient is incapacitated, for example, where blood is routinely requested prior to surgery or where a 'group and save' or 'cross-match' sample is taken pre-procedure.

Such shared decision-making discussions should be documented in the patient's clinical record.

There are a few exceptions when treatment may be able to go ahead without the person's consent, even if they are capable of giving their permission. NHS Guidance [footnote 17] states that "it may not be necessary to obtain consent if a person:

- needs emergency treatment to save their life, but they're incapacitated (for example, they're unconscious). The reasons why treatment was necessary should be fully explained once they have recovered.
- immediately needs an additional emergency procedure during an operation. There has to be a clear medical reason why it would be unsafe to wait to obtain consent".

Where patients are deemed to lack capacity, or should a patient need to receive a transfusion in an emergency and is unable to provide consent, this must be documented in the patient's clinical record. Local procedures must be followed, including the appropriate management of patients where there is evidence that they would refuse a transfusion. The patient will need to be informed post-emergency (when the patient is deemed to have capacity) and retrospective patient information related to transfusion provided.

Duration of consent

For all patients, healthcare practitioners should consider how long the consent for transfusion remains valid. We will consider this under 2 patient groups:

- Short-term consent. For example, where consent is obtained at the start of a patient's admission, as part of a procedure-specific consent, or pre-operatively, where transfusions may be required at various points during that admission
- Long-term consent. For example, long-term multi-transfused patients with a haemoglobinopathy or other haematological conditions, where transfusions are administered over successive admissions or out-patient treatments

It should therefore be recognised that there is a difference between a patient with, for example, a haemoglobinopathy condition, who receives regular transfusions every few weeks for that condition, and a patient with an oncology condition who has surgery, and then a course of chemotherapy, and then further surgery, with each treatment stage potentially requiring transfusion.

There are too many variables and individual patient scenarios for SaBTO to provide definitive guidance. We suggest that the duration of consent needs to be discussed and agreed with the patient as part of the shared decision-making process, and in line with local policies. If it is deemed appropriate that consent may span more than one transfusion episode, or across the duration of a patient admission period, this should be documented in the patient's clinical notes.

Where patients are alert and orientated, verbal agreement to the transfusion should be obtained from the patient by the healthcare practitioner administering the transfusion at the time of each transfusion episode prior to administration. Healthcare practitioners should be

mindful that patients can change their mind at any point, and patients are entitled to withdraw their previous consent.

Where long-term transfusions are required to manage a specific condition, full and informed consent, which includes long-term effects of transfusion, should be obtained at the start of their treatment plan. It is not necessary, or practical, to continue to obtain full and informed consent prior to each and every transfusion episode, but it is important that patients receive ongoing information regarding the risks, benefits and any potential alternatives to transfusion.

Consent should be formally renewed if the patient raises any concerns or expresses a wish to review consent, or if new information has become available, for example about the risks of transfusion or any other treatment options. Long-term patient treatment plans should include the management of any complications of transfusion, and these management plans should incorporate patient consent as appropriate.

Documentation of consent

It is important to recognise that seeking and obtaining of consent is more than a signature on a form. It is the process of providing the information that enables the patient to understand (and in some cases accept) risk and make a decision to undergo a transfusion. This was found in the recent case of Thefaut v Johnston [2017] EWHC 497 [footnote 18] where Green J observed that:

> It is accepted that the simple fact that Mrs Thefaut signed the hospital consent form is not to be taken as an indication of acceptance of risk. In my view the document is of no real significance on the present facts. (It would have greater significance in emergency cases involving no prior contact between patient and the clinician).

The 2011 SaBTO Consent for Transfusion recommendations [footnote 1] did not require signed consent by the patient. Instead it was recommended that the verbal consent provided by the patient should be recorded in the patient's records by the healthcare practitioner. The emphasis should be on the shared evidence-based dialogue and decision-making element of the consent process, rather than on obtaining the patient's signature. This recommendation has not been changed, although it should be recognised that this is the minimum requirement, and individual organisations may choose to implement consent signed by the patient. Where consent forms include a 'tick box', these should be formatted in a way which supports valid and informed consent.

Information after transfusion (retrospective information)

The provision of retrospective information falls into 2 main categories:

- patients who lacked capacity to receive information and to provide informed and valid consent pre-transfusion but regain capacity post-transfusion (for example, emergency transfusions)
- patients who were told pre-procedure (for example, pre-operatively) that they might require a transfusion as part of that procedure. These patients must be informed whether they received a transfusion

The provision of retrospective information is important to ensure not only that patients are informed of any associated potential risks relating to transfusion, but also to ensure that they are aware that because they have received a blood transfusion, they are no longer eligible to donate blood (with the exception of individuals who have received Convalescent Plasma from donating Convalescent Plasma to treat individuals with SARS-CoV-2 [footnote 16]).

Recommendation: patients who have a been given a blood transfusion and were not able to give informed and valid consent prior to the transfusion are informed of the transfusion prior to discharge and provided with relevant paper or electronic information.

This retrospective information should be provided to the patient when they are deemed to have capacity and are therefore able to understand the implications of having received a blood transfusion.

Recommendation: all patients who have received a transfusion have details of the transfusion (type[s] of component), together with any adverse events associated with the transfusion, included in their hospital discharge summary to ensure both the patient and their family doctor are aware. The patient should also be informed that they are no longer eligible to donate blood (with the exception of individuals who have received Convalescent Plasma from donating Convalescent Plasma to treat individuals with SARS-CoV-2).

Information resources for patients and public

The provision of written information to patients can help assist the consent process by facilitating the opportunity for the patient to digest, recapitulate and reaffirm their decision. Patient information leaflets which summarise the main risks and benefits of the transfusion can be useful to help patients understanding and recall of this information. Such information leaflets can only provide generic information and do not take into account individual patient circumstances, conditions, values or priorities. The leaflets are intended only to support and reinforce verbal information and discussion.

Patient information leaflets are freely available from each of the UK Blood Services. The UK Blood Services are currently considering the development of a standardised patient information leaflet across the whole of the UK, plus an additional on-line information resource for patients and the wider public.

Recommendation: the UK Blood Services provide a standardised source of information for patients who may receive a blood transfusion in the UK.

Where other organisations provide information related to transfusion (for example NHS Choices, or patient support organisations such as Sickle Cell, Thalassaemia or other haematology support groups), these organisations should work cooperatively with the UK Blood Services to ensure relevant up-to-date information is included.

Training and information resources for healthcare practitioners

In order to provide informed and valid consent for transfusion, it is vital that all healthcare practitioners involved in the transfusion process are supported to maintain their knowledge of consent and its relevance and importance in blood transfusion.

There have been considerable advances since the 2011 SaBTO Patient Consent for Blood Transfusion recommendations [footnote 1]. The GMC (2013) Good Medical Practice [footnote 19] is the core guidance for all registered doctors and all other GMC guidance builds on these core principles. The GMC (2015) Promoting Excellence [footnote 20] sets out standards which are key requirements for the management and delivery of undergraduate and postgraduate medical education and training in the UK with the focus on patient safety.

The Code [footnote 21] from the Nursing and Midwifery Council (2015) provides professional standards of practice and behaviour for nurses, midwives and nursing associates in the UK, and the NMC (2018) Realising Professionalism: Standards for Education and Training provide a framework for nursing and midwifery students [footnote 22]. Patient safety is central to these standards.

The British Society for Haematology (2017) [footnote 23] recommends that all staff should receive regular (minimum 3 yearly) knowledge and skills training in blood transfusion for all of the processes they are involved in. The Learn Blood Transfusion (http://www.learnbloodtransfusion.org.uk/) e-learning package now has a module specific to consent and blood transfusion.

> Recommendation: training in consent for transfusion is included in all relevant undergraduate healthcare practitioners training, followed by continuous, regular knowledge updates (minimum 3-yearly) for all healthcare practitioners involved in the consent for transfusion process.

It is recognised that there is a continued need to support healthcare practitioners maintain their knowledge and the SaBTO Consent Working Group has considered that a centralised UK-wide (online) information resource would be beneficial to help support consent for transfusion discussions.

> Recommendation: we recommend a centralised UK-wide information resource for healthcare practitioners to facilitate consent for transfusion discussions, indicating the key issues to be discussed when obtaining informed and valid consent for a blood transfusion, and providing up-to-date information on the risks of transfusion.

This resource should be provided by the UK Blood Services. The feasibility of developing and maintaining this resource should be completed by the UK Blood Services within 6 months of the publication of these recommendations.

Monitoring compliance and improvement plans

The National Comparative Audit (NCA) of Patient Information and Consent (2014) [footnote 10] indicates that the implementation of consent for transfusion was sporadic and compliance was generally low. Future NCA's should include consent for transfusion (where appropriate) to continue to provide compliance data and identify areas for improvement.

Recommendation: all UK healthcare organisations who provide blood transfusions employ mechanisms (such as audit) to monitor the implementation and compliance with these SaBTO recommendations, with subsequent improvement plans developed and implemented if indicated.

Appendix 1: SaBTO consent for transfusion working group members

Name	Professional role or affiliation	Membership role
Andrea Harris	Clinical Services Professional Nursing Lead, NHSBT	Working Group Chair
James Neuberger	Liver Transplant Physician	SaBTO Chair
Charles Baker	Clinical Director Anaesthesia, Intensive Care & Theatre Specialist, University Hospitals of North Midlands NHS Trust	National Blood Transfusion Committee: Patient Involvement Working Group Chair
Ann Benton	Consultant Haematologist, Welsh Blood Service	Welsh Blood Service
Damien Carson	Consultant Anaesthetist, South Eastern Health and Social Care Trust	Northern Ireland Transfusion Committee
Anne Davidson	Patient Blood Management Practitioner Team, NHS Blood and Transplant	NHS Blood and Transplant – Patient Blood Management
Roger Graham	SaBTO Lay Organ Representative	Lay Representative

Name	Professional role or affiliation	Membership role
Mike Murphy	Professor of Transfusion Medicine, University of Oxford and Consultant Haematologist, NHSBT and Oxford University Hospitals NHS Foundation Trust	Transfusion Medicine Specialist
Shruthi Narayan	Consultant Donor Medicine, NHSBT and SHOT Medical Director	Serious Hazards of Transfusion (SHOT)
Megan Rowley	Consultant in Transfusion Medicine Scottish National Blood Transfusion Service	Scottish National Blood Transfusion Service
Rhonda Skeete	National Blood Transfusion Committee (NBTC) Patient Involvement Working Group	Lay Representative

Appendix 2: list of stakeholders who provided feedback in the stakeholder consultation

Name of organisation	Responder's role(s)
Buckingham Healthcare Trust	Transfusion Practitioner
Liverpool foundation Trust (Aintree)	Transfusion Practitioner
Blackpool Teaching Hospital/Lancashire Teaching Hospital	Consultant Clinical Scientist/Transfusion Practitioner
University Hospitals of Morecambe Bay NHS Foundation Trust	Medicine Document Group
Warrington Teaching Hospital	Collective response forwarded by Transfusion Practitioner
Wirral NHS Trust	Transfusion Practitioner/Consultant Anaesthetist/Consultant Haematologist
Stockport NHS Foundation Trust	Transfusion Practitioner
Pennine Acute Hospital Trust	Consultant Haematologist/Transfusion Lead
Southport & Ormskirk Trust/St Helens & Knowsley Teaching Hospital	Transfusion Practitioner
North Middlesex University Hospital	Deputy Clinical Lead Transfusion

Name of organisation	Responder's role(s)
North Bristol Trust	Consultant Haematologist/Transfusion Practitioner
Scottish National Blood Transfusion Service (SNBTS) & British Society for Haematology	Consultant Transfusion Medicine/ Transfusion Task Force Member
West Suffolk Trust	Transfusion Nurse Specialist
Torbay & South Devon Trust	Senior Specialist Practitioner
Wrexham Maelor Hospital	Consultant Haematologist
Newcastle upon Tyne Hospital Trust	Advanced Transfusion Practitioner
Western Health and Social Care Trust	Co-ordinator
North Lincolnshire & Goole Hospital Trust	Transfusion Manager
Ashford & St Peters' Hospital Trust	Consultant Anaesthetist/ Patient Blood Management Committee Chair
Medway Foundation Trust	Chair Transfusion & Thrombosis Group
Nottingham University Hospitals NHS Trust	Consultant Haematologist
Barts Health Trust	Senior BMS Training Officer Haematology & Transfusion
Milton Keynes University Hospital	Transfusion Practitioners
Betsi Cadwaladr University Health Board	Transfusion Nurse Practitioner
SNBTS Transfusion Team	Transfusion Practitioner
Haem-oncology unit SJH	Speciality Doctor
On behalf of Royal College of Physicians & Surgeons of Glasgow	Honorary Secretary
University Hospitals Trust Birmingham & NHS Blood and Transplant	Consultant Haematologist
York Teaching Hospital	Transfusion Practitioner
Sherwood Forest Hospital	Consultant Haematologist

Name of organisation	Responder's role(s)
University Hospital Southampton	Transfusion Practitioner
Royal College of Surgeons of Edinburgh	Head Birmingham Centre
NHS Dumfries & Galloway	Transfusion Practitioner
Doncaster & Bassetlaw Teaching Hospital	Consultant Haematology & Transfusion Lead
Blood Health National Oversight Group for Wales	Blood Health Lead
Bradford Teaching Hospitals Foundation Trust	Lead Nurse - Transfusion
University Hospital Coventry & Warwickshire	Consultant Haematologist
Barnsley Hospital Foundation Trust	Transfusion Practitioner
Rotherham Hospital	Consultant Haematologist/Transfusion Lead
The Christie Foundation Trust	Transfusion Practitioner
Manchester University Foundation Trust	Consultant Haematologist/Clinical Lead for Transfusion
Scottish Clinical Transfusion Advisory Committee	Consultant Anaesthetist/ Chair of SCTAC
The Royal College of Pathologists	Chair, Transfusion Medicine Speciality Advisory Committee
Royal College of Physicians of Edinburgh	Acting President
Great Western Hospitals Foundation Trust	Transfusion Practitioner
British Orthopaedic Association	Consultant Trauma & Orthopaedic Surgeon/Member of Medico-legal Committee
Harrogate & District Foundation Trust	Transfusion Practitioner
Royal College of Anaesthetists (RCoA)	RCoA Lay Committee
Royal College of Nursing	Professional Lead Learning & Development Nursing Department

Name of organisation	Responder's role(s)
NHS Shetland	Biomedical Scientist
Royal Cornwall Hospitals	Lead Transfusion Practitioner
Royal Papworth Hospital	Consultant Haematologist
Aneurin Bevan University Health Board	Chair HTC
Yeovil District Hospital	Transfusion & Anaemia CNS, Patient Blood Management Lead
NHS Lothian	Consultant Haematologist
SNBTS	Associate Director of Patient services
University Hospitals Southampton Foundation Trust	Lead Blood Transfusion Nurse Practitioner
Salford Royal Foundation Trust	RTC Chair/NW Honorary Treasurer Neuroanaesthesia and Critical Care Society
NHS Grampian	Consultant Anaesthetists
SNBTS	Transfusion Practitioner
Royal Surrey NHS Foundation Trust	Transfusion Practitioner
Royal Surrey County Hospital NHS Foundation Trust	Senior Sister ICU & Practice Development
NHSBT/ University Hospitals Bristol and Weston Area NHS Trust	Consultant Haematologist
Leeds Teaching Hospitals	Transfusion Practitioner
Serious Hazards of Transfusion (SHOT)	Retired Medical Director
University Hospital Southampton NHS Foundation Trust	Transfusion Practitioner
Glasgow Royal Infirmary	Consultant Haematologist
Dudley Group NHS Foundation Trust	Lead Transfusion Practitioner

Name of organisation	Responder's role(s)
St Peters and Ashford Hospitals	Consultants, Haematology CNSs and Haematology Day unit team
Great Ormond Street Hospital	Transfusion Practitioner
Scottish National Blood Transfusion Service	Consultant in Transfusion Medicine/ Admin Assistant
Royal College of Obstetricians and Gynaecologists	Senior Director, Clinical Quality
British Medical Association	Acting Director of Policy

1. SaBTO (2011) Patient Consent for Blood Transfusion (https://www.gov.uk/government/publications/patient-consent-for-blood-transfusion)
2. Montgomery v Lanarkshire Health Board [2015] (https://www.supremecourt.uk/cases/uksc-2013-0136.html)
3. Infected Blood Inquiry (https://www.infectedbloodinquiry.org.uk/)
4. General Medical Council (2008) Consent: Patients and Doctors Making Decisions Together (https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice)
5. Advisory Committee on Dangerous Pathogens. Prevention of CJD and vCJD by the Advisory Committee on Dangerous Pathogens' Transmissible Spongiform Encephalopathy (ACDP TSE) subgroup (https://www.gov.uk/government/publications/guidance-from-the-acdp-tse-risk-management-subgroup-formerly-tse-working-group)
6. National Institute for Care and Health Excellence (2015) Blood Transfusion Guideline [NG24] (https://www.nice.org.uk/guidance/ng24)
7. National Institute for Health and Clinical Excellence (2016) Blood Transfusion Quality Standard [QS138] (https://www.nice.org.uk/guidance/qs138)
8. Choosing Wisely UK (https://www.choosingwisely.co.uk/)
9. Blood and Safety Quality Regulations (2005) (https://www.legislation.gov.uk/uksi/2005/50/contents/made)
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