Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 10 July 2024

TB2024.53

Title:	**Infected Blood Inquiry Report**

Status:	**For Discussion**
History:	**This is the first report in this subject**

Board Lead:	**Chief Medical Officer**
Author:	**Clare Winch, Director of Regulatory Compliance and Assurance**
Confidential:	**No**
Key Purpose:	**Assurance**

Executive Summary

1. The purpose of this paper is to provide the Board with a summary of the report findings from the Infected Blood Inquiry, along with the full recommendations. In addition it provides an overview of the initial trust response and next steps.
2. The Infected Blood Inquiry was established in 2017 to examine why men, women and children in the UK were given infected blood and infected blood products during the 1970s and 1980s, which sadly exposed them to Hepatitis C and HIV.
3. As one of the UK's leading haemophilia centres, Oxford Haemophilia Centre has fully supported the Infected Blood Inquiry since it was established, providing extensive evidence as well as witness statements when necessary.

Recommendations

4. The Trust Board is asked to:
    - Review and note the report.

Infected Blood Inquiry Report

1. Purpose

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2. Background

2.1. The Infected Blood Inquiry was established in 2017 to examine why men, women and children in the UK were given infected blood and infected blood products during the 1970s and 1980s, which sadly exposed them to Hepatitis C and HIV.

2.2. As one of the UK's leading haemophilia centres, Oxford Haemophilia Centre has fully supported the Infected Blood Inquiry since it was established, providing extensive evidence as well as witness statements when necessary.

2.3. The Chair of the Inquiry, Sir Brian Langstaff, published the Inquiry's Report on 20th May 2024. You can read the Report here.

2.4. You can also read his accompanying letter to the Cabinet Office Minister here. Finally, you can watch Sir Brian's remarks and Reflections here.

3. Infected Blood Inquiry Report

3.1. The report presents findings from the Infected Blood Inquiry, focusing on the transmission of infections through NHS-supplied blood and blood products between 1970 and 1998.

3.2. It details systemic, collective, and individual failures in handling the risk of infections, leading to thousands of patients suffering from diseases like HIV and Hepatitis C. in addition, it estimates that over 3,000 deaths can be attributable to infected blood, highlighting the extensive impact on patients and their families.

3.3. Finally it makes a range of recommendations for addressing the consequences of these failures and preventing future incidents.

3.4. The key failures identified in the Infected Blood Inquiry Report are:

- *Safety Neglected:* The paramount consideration of patient safety was not upheld, leading to catastrophic consequences.
- *Systemic Failures*: There were collective and individual failures to deal ethically and appropriately with the risk of infections from blood products.

- *Delayed Response*: There was a slow response to the risks of AIDS and Hepatitis, and inadequate adjustments to treatment regimes to make them safer.
- *Lack of Transparency*: There was a lack of openness, transparency, and candour, resulting in the truth being hidden for decades.

3.5. The report spans seven separate volumes as set out below:

Volume	Title
1	Overview and Recommendations (including lessons to be learned)
2	People's Experiences (including Treloar's specifically)
3	What happened and why? (covering basic concepts, knowledge, blood services, blood products and addressing risk)
4	What happened and why? (covering the role of government, haemophilia centres, pharmaceutical companies, haemophilia society)
5	What happened and why? (covering blood transfusion: clinical practice, screening and lookbacks)
6	Response of Government and Public Bodies (covering initial response 1985-1988, various other agencies / bodies)
7	Response to Government (covering document destruction, self-sufficiency report, lines to take, delay in holding an inquiry, devolved nations, calls for compensation, commentary on the response)

3.6. A total of twelve key recommendations were made in the report these are summarised as follows:

No.	Recommendation
1	**Compensation Scheme**: Establish a compensation scheme for those affected by the infected blood tragedy.
2	**Public Recognition**: Formal public recognition and apology, along with a tangible reminder such as a memorial. a) A permanent memorial be established in the UK and consideration be given to memorials in each of Northern Ireland, Wales and Scotland. It should be funded by the UK government. b) A memorial be established at public expense, dedicated specifically to the children infected at Treloar's school. c) There should be at least three events, approximately six months apart, drawing together those infected and affected, the nature and timing of which should be determined by a working party as described above, facilitated by some central funding.
3	**Learning from the Inquiry** a) The General Medical Council, and NHS Education for Scotland, Health Education and Improvement Wales, Northern Ireland Medical and Dental Training Agency

No.	Recommendation
	and NHS England, should take steps to ensure that those "lessons to be learned" which relate to clinical practice should be incorporated in every doctor's training. b) They should look favourably upon putting together a package of training materials, with excerpts from oral and written testimony, to underpin what can happen in healthcare, and must be avoided in future. c) The Inquiry website is maintained online.
4	**Preventing future harm to patients**: achieving a safety culture a) Duty of candour (i) A statutory duty of candour in healthcare should be introduced in Northern Ireland. (ii) The operation of the duties of candour in healthcare in Scotland and in Wales should be reviewed, as it is being in England, to assess how effective its operation has been in practice. (iii) The review of the duty of candour currently under way in England should be completed as soon as practicable. (iv) The statutory duties of candour in England, Scotland, Wales (and Northern Ireland, when introduced) should be extended to cover those individuals in leadership positions in the National Health Service, in particular in executive positions and board members. (v) Individuals in leadership positions should be required by the terms of their appointment and by secondary legislation to record, consider and respond to any concern about the healthcare being provided, or the way it is being provided, where there reasonably appears to be a risk that a patient might suffer harm, or has done so. Any person in authority to whom such a report is made should be personally accountable for a failure to consider it adequately. b) Cultural change. (i) That a culture of defensiveness, lack of openness, failure to be forthcoming, and being dismissive of concerns about patient safety be addressed both by taking the steps set out in (a) above, and by making leaders accountable for how the culture operates in their part of the system, and for the way in which it involves patients. c) Regulation. (i) That external regulation of safety in healthcare be simplified. As a first step towards this, there should be a UK wide review by the four health departments of the systems of external regulation. (ii) That the national healthcare administrations in England, Northern Ireland, Scotland and Wales explore, and if appropriate, support the development and implementation of safety management systems ("SMS"s) through SMS coordination and do so as a matter of priority. d) Patient records. (i) Before the end of 2027 there should be a formal audit, publicly reported, of the extent of success of digitisation of patient records in each of the four health jurisdictions of the UK, measuring at least the levels of patient access to their personal records, their ability to identify and correct apparent errors in them, their interoperability, and the confidence of health professionals in the detail, accuracy and timeliness of any record they enter, and that little material which should be recorded has been omitted. Next steps should be identified. e) Consideration should be given by the national healthcare administrations in England, Scotland, Wales and Northern Ireland, to further coordination of their approaches particularly to ensure that patterns of harm, or trends, are identified

No.	Recommendation
	and any response which for the sake of patient safety would be better coordinated than left to each individual administration can collaboratively be agreed and implemented.
5	**Ending the defensive culture in the Civil Service and Government:** The Government should reconsider whether, in the light of the facts revealed by this Inquiry, it is sufficient to continue to rely on the current non-statutory duties in the Civil Service and Ministerial Codes, coupled with those legal duties which occur on the occasions when civil servants and ministers interact with courts, inquests and inquiries, as securing candour.
6	**Monitoring liver damage for people who were infected with Hepatitis C:**. All patients who have contracted hepatitis via a blood transfusion or blood products should receive the following care: (i) those who have been diagnosed with cirrhosis at any point should receive lifetime monitoring by way of six-monthly fibroscans and annual clinical review, either nurse-led, consultant-led or, where appropriate, by a GP with a specialist interest in hepatitis (ii) those who have fibrosis should receive the same care (iii) where there is any uncertainty about whether a patient has fibrosis they should receive the same care (iv) fibroscan technology should be used for liver imaging, rather than alternatives (v) those who have had Hepatitis C which is attributable to infected blood or blood products should be seen by a consultant hepatologist, rather than a more junior member of staff, wherever practicable (vi) those bodies responsible for commissioning hepatology services in each of the home nations should publish the steps they have taken to satisfy themselves that the services they are commissioning meet the particular needs of the group of people harmed by NHS treatment
7	**Patient Safety: Blood transfusions** a) Tranexamic acid (i) In England Hospital Transfusion Committees and transfusion practitioners take steps to ensure that consideration of tranexamic acid be on every hospital surgical checklist; that hospital medical directors be required to report to their boards and the chief executive of their Trust as to the extent of its use; and that the board report annually to NHS England as to the percentage of eligible operations which have involved its use. If the percentage is below 80% or has dropped since the previous year, this report should be accompanied with an explanation for the failure to use more tranexamic acid and thereby reduce the risk to patient safety that comes with using a transfusion of blood or red blood cells. (ii) In Scotland, Wales and Northern Ireland offering the use of tranexamic acid should be considered a treatment of preference in respect of all eligible surgery. (iii) Consideration be given to standardising and benchmarking transfusion performance between hospitals in order to deliver better patient blood management. b) Progress in implementation of the Transfusion 2024 recommendations be reviewed, and next steps be determined and promulgated; and that in Scotland the 5 year plan is reviewed in or before 2027 with a view to determining next steps. The responsibility for this in England is that of NHS England, shared with the National Blood Transfusion Committee, the Royal Colleges (as appropriate), and NHSBT.

No.	Recommendation
	c) Transfusion laboratories should be staffed (and resourced) adequately to meet the requirements of their functions. d) That those bodies concerned with undergraduate and postgraduate training across the UK of those people who are, or intend to be, working in the NHS ensure that they are adequately trained in transfusion, that the standards by which sufficiency of training is measured are defined, and accountability for training in transfusion be defined. e) That all NHS organisations across the UK have a mechanism in place for implementing recommendations of SHOT reports, which should be professionally mandated, and for monitoring such implementation. f) Establishing the outcome of every transfusion. (i) That a framework be established for recording outcomes for recipients of blood components. That those records be used by NHS bodies to improve transfusion practice (including by providing such information to haemovigilance bodies). (ii) To the extent that the funding for digital transformation does not already cover the setting up and operation of this framework, bespoke funding should be provided. (iii) That funding for the provision of enhanced electronic clinical systems in relation to blood transfusion be regarded as a priority across the UK.
8	**Finding the undiagnosed.** (a) When doctors become aware that a patient has had a blood transfusion prior to 1996, that patient should be offered a blood test for Hepatitis C. (b) As a matter of routine, new patients registering at a practice should be asked if they have had such a transfusion.
9	**Protecting the safety of haemophilia care.** a) That peer review of haemophilia care should continue to occur as presently practised, with any necessary support being provided by NHS Trusts and Health Boards; and b) That NHS Trusts and Health Boards should be required to deliberate on peer review findings and give favourable consideration to implementing the changes identified with a view to ensuring comprehensive, safe, care. c) A peer review of each centre should take place not less than once every five years. d) The necessary administrative and clinical resources should be provided by hospital trusts and boards, integrated care boards, and service commissioners to facilitate multi-disciplinary regional networks to discuss policy and practice in haemophilia and other inherited bleeding disorders care, provided they involve patients in their discussions. e) recombinant coagulation factor products should be offered in place of plasma-derived ones where clinically appropriate. Service commissioners should ensure that such treatment decisions are funded accordingly. f) that the National Haemophilia Database, run by the UKHCDO, merits the support of additional central funding.
10	**Giving patients a voice** a) That the patient voice be enabled and empowered by the following measures: (i) clinical audit should as a matter of routine include measures of patient satisfaction or concern, and these should be reported to the board of the body concerned. *Success in this will be measured by comparing the measure of satisfaction from one year to the next, such that the reports to the board concerned demonstrate a trend of*

No.	Recommendation
	improvement by comparing this year's outcomes with the similar outcomes from at least the two previous years. (ii) that the following charities receive funding specifically for patient advocacy: the UK Haemophilia Society; the Hepatitis C Trust; Haemophilia Scotland; the Scottish Infected Blood Forum; Haemophilia Wales; Haemophilia Northern Ireland; and the UK Thalassaemia Society. (iii) that favourable consideration be given to other charities and organisations supporting people infected and affected that were granted core participant status (as listed on the Inquiry website) to continue to provide support for at least the next 18 months. Further support should be reviewed at that stage with a view to it continuing as appropriate. (iv) particular consideration be given, together with the UK Thalassaemia Society and the Sickle Cell Society, to how the needs of patients with thalassaemia or sickle cell disease can best holistically be addressed. V steps be taken to give greater prominence to the online Yellow Card system to those receiving drugs or biological products, or who are being transfused with blood components.
11	**Responding to a call for a public inquiry**: recommendation for government to address timeliness and responsibility for this area.
12	**Giving effect to recommendations of this inquiry**: recommendation in relation to the tracking of completion of actions

3.7. These recommendations aim to address the consequences of the infected blood disaster and prevent similar events in the future. The recommendations are not all directed to NHS Trusts some are for the government and other bodies to specifically respond to. They have been included in this report for completeness and to add context.

4. The Trust's role and response so far / next steps

4.1. As stated earlier in the report we have been involved, where necessary in supporting the evidence gathering of the inquiry and providing statements when asked.

4.2. In addition we have been supporting patients and staff in relation to the role of the Oxford Haemophilia Centre. We have ensured these groups were made aware of the changes already put in place both nationally and within the Trust, and that policies and procedures are updated and delivered in line with national guidance and best practice.

4.3. We were proactive in acknowledging the receipt of the report and offering our apologies to all those impacted by the failings included in the report.

4.4. We have reviewed the report and await the formal response and further guidance from the other bodies highlighted in the report. These responses will help frame local actions that will then need to be taken going forward.

4.5. Meanwhile we have already started reviewing our own practice in relation to some of the specific recommendations of relevance to OUH so that we can develop our own action plan. This includes:

- Recommendation 6: The hepatology team are conducting look back and gap analysis in relation to the specific recommendations about the care of patients that contracted hepatitis as a result of blood transfusion or blood products.
- Recommendation 7: Consideration of tranexamic acid was included in the pre-operative WHO checklist in 2023 and OUH participates in a national annual audit of adherence to guidance on use of tranexamic acid. Compliance was 80% in Q4 of 2023/24. Several other initiatives are also already underway to ensure appropriate blood transfusion practice includes strengthening consent documentation; auditing practice against NICE guidance and feeding back areas for improvement; and identification and treatment of pre-operative iron deficiency to reduce the need for transfusion.
- Recommendation 9: The OUH Haemophilia continues to participate in a process of regular peer review. The most recent peer review visit took place on 8 May 2024 with excellent initial verbal feedback including from patients. A formal report is expected in the next few months. The formal report from the centre's previous peer review visit in 2019 was also very positive. The following is an extract from the high level summary of the 2019 visit:

  "*This well-established and high-functioning team was offering an excellent service. Staff were highly committed professionals, working very well together and taking personal responsibility for the care they provided… Patient feedback was very positive... Families and carers, as well as patients, felt involved and supported*."

5. Recommendations

5.1. The Trust Board is asked to:

- Review and note the report.