Joined Up Care Derbyshire

INTEGRATED CARE PARTNERSHIP

19 June 2024

ITEM 07

Report sponsor: Robyn Dewis, Director of Public Health

Report author: Robyn Dewis, Director of Public Health

Infected Blood Inquiry Report - Statement of the Integrated Care Partnership

Purpose

1.1 The purpose of this report is to highlight to the Integrated Care Partnership (ICP) the publication of the Infected Blood Inquiry Report, to acknowledge and consider it and to make an initial response to its findings and recommendations.

Recommendations

2.1 To recognise the infected blood scandal as “the worst treatment disaster in the history of the NHS”.

2.2 To commit to considering the implications of the recommendations within our Partnership, specifically those that relate to local services.

2.3 To commit to reviewing actions in relation to these recommendations within 12 months.

Reasons

3.1 To ensure that the ICP is fully cognisant of the Inquiry Report and its implications for our local population and provision of health and care in Derby and Derbyshire.

Supporting information

4.1 The report - published over seven volumes - of the Infected Blood Inquiry was published on the 20th May 2024. The report is the conclusion of the public inquiry after more than 30,000 people in the UK during the 1970s and 1980s were infected with HIV, hepatitis B, hepatitis C Creutzfeldt-Jakob disease ("vCJD") infections after being given contaminated blood products.

4.2 The scope of the inquiry was broad but focused particularly on:

1. the scale of the harm: the number of those infected amounts to tens of thousands, many of whom have died (and continue to die);
2. the geographical scope, encompassing as it does all four nations within the United Kingdom;
3. the timeframe: since the NHS began, exploring over five decades of decision-making, action and inaction;
4. the remit, which has been to examine not only the events which caused or contributed to the infection of so many people ("what happened and why"?) but also the response of government, the NHS and others in the decades following the transmission of infection, and how that response has compounded the harms already inflicted.

4.3 The report summarises the scale of the scandal,

"As to scale, more than 3,000 deaths are attributable to infected blood and blood products. Around 380 children with bleeding disorders were infected with HIV, a third of the 1,250 people with bleeding disorders infected with HIV, with the majority also being coinfected with Hepatitis C and some with Hepatitis B and other infections as well. Three quarters of those with bleeding disorders who were infected with HIV have died. Between 80 and possibly up to about 100 people were infected with HIV through transfusions. About 85% of those have died.

Around 26,800 people were infected with Hepatitis C through blood transfusions between 1970 and 1991, of whom about 22,000 were chronically infected beyond the initial six months, with 2,700 surviving to the end of 2019. Between 2,400 and 5,000 people with bleeding disorders were infected with Hepatitis C without being infected with HIV, but sometimes with Hepatitis B and other infections as well. There is insufficient evidence to estimate the numbers of people infected with Hepatitis B through blood and blood products. There were five recorded cases of confirmed or probable blood-borne variant Creutzfeldt-Jakob disease ("vCJD") infections. Three were symptomatic and all have died"[1].

4.4 The Inquiry Report finds that, "that most infections could and should have been avoided"[2] and that this was caused by a catalogue of failures.

[1] The Infected Blood Inquiry - The Report, Overview and Recommendations. p11. Link: https://www.infectedbloodinquiry.org.uk/sites/default/files/Volume_1.pdf

[2] The Infected Blood Inquiry - The Report, Overview and Recommendations. p28. Link: https://www.infectedbloodinquiry.org.uk/sites/default/files/Volume_1.pdf

4.5 The Inquiry Report sets out lessons learnt and twelve recommendations, in summary:

1. Compensation
2. Recognising and remembering what happened to people
3. Learning from the Inquiry
4. Preventing future harm to patients: achieving a safety culture
5. Ending a defensive culture in the Civil Service and government
6. Monitoring liver damage for people who were infected with Hepatitis C
7. Patient Safety: Blood transfusions
8. Finding the undiagnosed
9. Protecting the safety of haemophilia care
10. Giving patients a voice
11. Responding to calls for a public inquiry
12. Giving effect to Recommendations of this Inquiry.

4.6 Derby and Derbyshire Integrated Care Partnership would like to acknowledge the publication of the Infected Blood Inquiry - The Report, and to make an initial response to the findings and recommendations.

Firstly, we would like to formally recognise this as, in the words of the report, “the worst treatment disaster in the history of the NHS”.

Secondly, we commit to considering the implications of the recommendations within our partnership, specifically those that relate to local services including:

1. Learning from the Inquiry- including considering how lessons learnt are incorporated into clinical practice
2. Preventing future harm to patients: achieving a safety culture- including those relating to duty of candour and culture
3. Monitoring liver damage for people who were infected with Hepatitis C- including ensuring the appropriate follow up is conducted and fibroscan technology utilised
4. Patient Safety: Blood transfusions- including the use of tranexamic acid and recording the outcomes of transfusion
5. Finding the undiagnosed- including asking about transfusion history
6. Protecting the safety of haemophilia care- including peer review
7. Giving patients a voice- including engagement with patient advocacy organisations

Finally, we commit to reviewing actions in relation to these recommendations within 12 months.

Public/stakeholder engagement

5.1 Volume 3 of the Inquiry Report considers people’s experiences and on what happened to infect almost 90 children at Treloar’s College. This can be accessed: https://www.infectedbloodinquiry.org.uk/sites/default/files/Volume_2.pdf

Other options

6.1 None considered.

Financial and value for money issues

7.1 None directly arising from this report.

Legal implications

8.1 None directly arising from this report.

Climate implications

9.1 None directly arising from this report.

Socio-Economic implications

10.1 None directly arising from this report.

Other significant implications

11.1 This report proposes consideration of the implications of the recommendations within our partnership of the Infected Blood Inquiry - The Report as set out in 4.6.

This report has been approved by the following people:

Role	Name	Date of sign-off
Legal		
Finance		
Service Director(s)		
Report sponsor	Robyn Dewis, Director of Public Health	11/06/2024
Other(s)		

Background papers:	Infected Blood Inquiry - The Report (accessible via: https://www.infectedbloodinquiry.org.uk/reports/inquiry-report)
List of appendices:	None.