MINISTERIAL ENGAGEMENT BRIEFING:
JENNI MINTO MSP, MINISTER FOR PUBLIC HEALTH AND WOMEN'S HEALTH

The Infected Blood Inquiry – Publication of the Final Report
Date: Monday, 20 May 2024

What	Publication of The Infected Blood Inquiry's Final Report
Where	Central Hall, Westminster, Storey's Gate, London, SW1H 9NH
When	20 May 2024, 13:00-15:30
Who	The Infected Blood Inquiry chair and team, along with infected and affected victims. A number of other Ministers plan to attend: • John Glen, the Minister for the Cabinet Office, • Maria Caulfield, DHSC Health Minister, and • Robin Swann, Northern Ireland Health Minister. The Welsh will not be sending a Minister, although former Minister Julie Morgan will be attending to support Haemophilia Wales.
Why	Following the publication of its final report at 12.30pm, the chair of the Infected Blood Inquiry, Sir Brian Langstaff, will speak about his findings. This will be followed by reflections from the Inquiry participants about their experiences. Representatives from prominent charities, organisations, and support groups within the infected blood community across the United Kingdom will be in attendance. <u>Agenda</u> 13:00 – 13:30 (approx.) lunch 14:00 – Sir Brian Langstaff will speak about the report 14:40 – Reflections – Experiences of the Inquiry participants 15:40 – Event ends, but there will be tea and coffee and a chance to speak to some of those involved plus potential slot for media interviews if requested.
Speech details	N/A – you are not expected to deliver a speech at this event
Supporting officials	**<Redacted>**

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TOP LINES

- I welcome publication of the Infected Blood Inquiry's report and thank the Inquiry Chair and staff for their work in producing such a comprehensive final document.

- I would also like to pay tribute to those who have been infected, their families and support organisations. This was a terrible tragedy and many victims have experienced unimaginable suffering.

- On behalf of the Scottish Government, I want to reiterate our sincere apology to those who have been infected or affected by NHS blood or blood products.

On compensation

- **<Text redacted>**

Next steps

- We will consider this very detailed report fully and the Scottish Government has set up an Oversight Group to help consider the Inquiry's recommendations for Scotland.

- The Scottish National Blood Transfusion Service now has extremely high standards of blood safety and I would continue to encourage anyone who can do so to give blood - this remains essential for thousands of patients across Scotland who need blood transfusions.

- We are determined, however, to use the Inquiry's report to ensure lessons have been learned so a tragedy like this can never happen again.

ANNEX B

Background to the UK Infected Blood Inquiry (IBI)

1. The IBI is a UK-wide inquiry established in 2018 by the UK Government (UKG) to investigate how thousands of people were infected with HIV and/or Hepatitis from both infected blood transfusions and infected blood products (plasma-derived medicines, which at the time were primarily given to haemophiliacs). It is also considering the support those infected and affected by this tragedy received over the years from the NHS and governments and what further actions are needed both to support those individuals and to minimise risks of similar tragedies in future.

2. The SG had already set up a public inquiry on infected blood. The Penrose Inquiry considered what happened in Scotland and Lord Penrose published his Inquiry report in 2015. Many stakeholders were unhappy with the Inquiry's findings and the Penrose Inquiry was branded a whitewash by campaigners because Lord Penrose largely concluded that the NHS and government could not have done much to avoid the infections given the limited knowledge and testing available at the time in relation to both HCV and HIV.

3. Following sustained pressure on the UK Government, the then Prime Minister announced in 2017 that there would be a UK-wide statutory inquiry on infected blood. The IBI has much broader terms of reference and is expected to be far more critical of the NHS and governments (both UK and Scottish) than Lord Penrose was.

4. The SG has supported the work of the IBI, providing many thousands of documents from hundreds of files (both historic and some more recent). **<Redacted>**

5. Up to April 2023, the IBI had cost over £130 million - this does not include the costs to SG and other public sector bodies of legal support and staff time (although it does include funding for the legal costs of the infected and affected). The Penrose Inquiry cost £12 million in total. Thompsons solicitors represent many (around approximately 300) of the infected and affected in Scotland.

The infected blood tragedy and its victims

6. The Penrose Inquiry Final Report (25 March 2015) estimated that in Scotland
   - Approximately **3,000 NHS patients were infected with HCV** from infected blood – 2,500 infected via transfusions and 478 patients with bleeding disorders such as haemophilia.
   - Approximately **78 patients were infected with HIV** – 60 patients with bleeding disorders and 18 patients infected via blood transfusion.

7. Infections also occurred on a large scale around the world. Note though that many transfusion recipients would have died without knowing they were infected so not all of those infected will seek compensation (probably around 50% of the 2,500 infected via transfusion will have died without ever knowing they were infected with HCV). Also, a minority of those infected will have cleared their HCV infection naturally after an acute illness – so they were never chronically infected.

8. There are currently **590** full members of the Scottish Infected Blood Support Scheme - SIBSS (465 infected people and 125 widows or partners). Also many infected people died before SIBSS was established – over 200 payments had been made in relation to people known to have died by 2015, but in fact the number of deaths was probably higher. Although some of those people will have widows, widowers or partners who are SIBSS members, others will not and so any bereaved relatives of those infected will probably have received little financial support so far.

Key dates

9. Hepatitis C

- SNBTS introduced HCV screening of blood donations so that all SNBTS and hospital blood bank stock for transfusion had been tested negative **by 1 September 1991**.
- Factor VIII (for haemophilia A patients) was virus inactivated for HCV from April 1987.
- Factor IX (for haemophilia B patients) was virus inactivated for both HIV and HCV by October 1985.

10. HIV

- Factor VIII was virus inactivated for HIV by December 1984.
- Blood for transfusion was all tested for HIV **by mid-October 1985**.

11. Factor concentrate, used to treat people with bleeding disorders such as haemophilia, was produced by pooling human blood plasma from donors and concentrating it to extract the required clotting factor (normally Factor VIII or Factor IX). In the 1970s and particularly early 1980s many of these products became contaminated with HIV, Hepatitis B (HBV) and especially Hepatitis C (HCV). Some of those unintentionally infected their partners, often because they were unaware of their own infection. Many others who did not have a bleeding disorder were infected with HCV – and in a few cases HIV or HBV - as a result of contaminated blood transfusions up until September 1991. A large number were unaware of their infection for many years before diagnosis.

12. The ability to heat treat plasma products, like Factor VIII and Factor IX, to destroy Hepatitis C wasn't developed until 1985 so most haemophiliacs alive at the time had received products before then. Although cryoprecipitate (frozen blood product prepared from blood plasma) was a lower risk, it wasn't risk free.

13. Donated blood is now subject to careful checks to exclude higher risk donors and rigorous screening for blood borne viruses to minimise the risk of transmission of an infection to transfusion recipients.

Scottish Government Position

14. In the SG's closing submission to the IBI of December 2022, the SG reiterated the First Minister's apology of 2015 for what had happened and paid tribute to the courage of the infected and affected who have given evidence to the IBI. The submissions set out SG's position in a number of areas in which the IBI may make recommendations.

15. On **compensation**, the SG supports the payment of compensation and the setting up of an appropriate scheme to deliver it –the SG agrees there is a moral obligation to do so. The SG also said we remain supportive of the Scottish Infected Blood Support Scheme (SIBSS) continuing **<Redacted>**

16. The submission stated that in Scotland, the Duty of Candour Procedure Scotland Regulations of 2018 came into force on 1 April 2018 and those regulations apply where an unintended or unxpected incident has occurred during the provision of healthcare and it has resulted in death or harm. However, the SG said it will consider any recommendations for further improvement which the IBI wishes to make.

17. The SG also confirmed it remains committed to **providing psychological support services** to the infected blood community as long as there is a demand for it and that SG is committed to ensuring the delivery of palliative care services for all patients, including those with advanced liver failure, according to what they need and wherever they may be.

ANNEX C

Compensation for victims of infected blood

1. In 2022, Sir Robert Francis KC produced a report for the Cabinet Office setting out proposals for a compensation framework for infected blood victims. The Inquiry has largely followed Sir Robert's proposals. Both SG and the UK Government have accepted that there is a moral case for compensation for this group given they have suffered for so long.

2. The IBI published two interim reports on compensation. The first interim report, which was published on 29 July 2022, focussed on making interim compensation payments of £100,000 to all those infected and all bereaved partners currently registered on UK infected blood support schemes. These payments were made in October 2022. In Scotland, they were made by National Services Scotland, NSS (who manage SIBSS) and funded by UK Government. The second interim report was published on 4 April 2023. The report made 17 recommendations in relation to a compensation scheme, including that there should be a UK-wide compensation scheme delivered by a new arms-length body.

3. On 17 April 2024, UK Government tabled amendments to the UK Victims and Prisoners Bill to establish a UK-wide infected blood compensation scheme and to make further interim compensation payments to the relatives of those who have sadly died, via their estates. The UK Government amendments provide for the following:

- establish a new arms-length body called the Infected Blood Compensation Authority ("IBCA") to deliver the infected blood compensation scheme, to be funded by the UK Government;
- require the Secretary of State or the Minister for the Cabinet Office to lay regulations to establish the infected blood compensation scheme and set out details of who will be eligible for that scheme. Those eligible can include people infected via blood transfusions, via blood products (medicines made from human plasma) or via tissue transplants, along with people who were subsequently infected by those infected people (known as secondary infectees) and people who have been affected by those people being infected (such as their relatives);
- require the Secretary of State or the Minister for the Cabinet Office to set out in the scheme regulations how payment amounts are to be determined, including allowing for compensation payment levels to be set or to be capped at a specified amount;
- enable the Secretary of State or the Minister for the Cabinet Office to set out in the scheme regulations the procedure for making and deciding applications for payments;
- enable the Secretary of State or the Minister for the Cabinet Office to make provision for a review of decisions by the IBCA, but requires the Secretary of State to provide for appeals to the First Tier Tribunal;
- enable data sharing with the IBCA, for example by NHS National Services Scotland ("NSS") as managers of SIBSS;
- place a 'duty to cooperate' with the IBCA on certain organisations, including the Scottish Ministers (Scottish Government) and NSS, as well as any other

persons set out in Regulations made by the Secretary of State or the Minister for the Cabinet Office;
- enable the Secretary of State or the Minister for the Cabinet Office to make arrangements for the provision of support and assistance to applicants;
- require the Secretary of State or the Minister for the Cabinet Office to make arrangements for the payment of £100,000 to personal representatives of qualifying infected persons, the latter defined as a deceased person who was registered under an infected blood support scheme or with a relevant organisation. Payments are only to be made to representatives of deceased infected persons to or in respect of whom no interim compensation payments have already been made;
- require the Secretary of State to make arrangements for the procedure for making payments to personal representatives. Arrangements may include arrangements for one or more persons (which could include the Scottish Ministers) to administer the payments on behalf of the Secretary of State or the Minister for the Cabinet Office;
- make provision for information sharing for the purpose of any matter connected with the making of payments to personal representatives;
- set out details of the membership of the IBCA and how the Chair and other members will be appointed by the Secretary of State, as well as staffing arrangements. In addition, this requires the UK Government to provide funding to the IBCA both for the costs of the compensation scheme and for its running costs. It also requires the IBCA to provide annual reports;
- allow the Secretary of State or the Minister for the Cabinet Office to make 'transfer schemes', which could enable the IBCA to take on some of the Scottish Government's or NSS' functions in relation to work of the existing infected blood support schemes, as well as their liabilities;
- enable the Treasury to make regulations about taxes affected by a transfer scheme;
- make consequential amendments to reflect the fact that the IBCA will take on the obligations of a public body under existing legislation;
- enable the Scottish Ministers to lay affirmative regulations in the Scottish Parliament to make consequential amendments as a result of the IBCA being a new public authority; and
- amend the extent clause of the Bill to extend these compensation provisions to the whole of the UK.

4. These amendments represent UK Government's response to the second interim report. The detail of the wider compensation scheme is still to be laid out in regulations. However, an announcement is expected from UK Government shortly after the publication of the IBI's report, which **could also include details of further interim compensation payments of £210,000 each to infected people**. We expect UK Government to fund both the further interim payments and the wider compensation scheme.

5. Paying money to estates (rather than paying specific relatives directly) is not the route recommended by the IBI. But given the operational challenges of delivering interim payments to relatives, UK Government has concluded that payments to estates provides a practical and pragmatic solution. We are currently working with the Cabinet Office and DHSC to agree the processes and timetable for NSS to make these additional interim payments on behalf of the UK Government. A new gov.uk

website will be available soon (likely from next week), which should provide guidance on the process and the probate or confirmation steps estates will need to follow.

<Redacted>

6. **<Redacted>**In addition, it is expected that any SIBSS payments from April 2025 will be taken into account in calculating people's compensation awards (although previous SIBSS payments won't be). **<Redacted>** (although people may also have the option of taking a large lump sum instead of future regular payments to cover their award for future loss of income).

<Redacted>

ANNEX E

Responding to the Inquiry's final report
Establishing an Oversight group to deliver the recommendations

<Text redacted – out of scope>

ANNEX F

Q&A

<Text redacted>

ISSUE 20 May: The Infected Blood Inquiry's (IBI's) final report is published. The report heavily criticises governments and the NHS across the UK for failings over the past five decades that led to people being infected with Hepatitis and HIV from infected blood products and transfusions and for failures in how governments responded to the tragedy.

- Around 3,000 people were infected with Hepatitis C and approx. 78 with HIV as a result in Scotland (Penrose Inquiry estimates).
- UK Gov has confirmed on 21 May its compensation scheme will largely follow Inquiry recommendations and that further interim compensation payments of £210k each to infected victims – to be made by the Scottish Infected Blood Support Scheme (SIBSS) and the other three UK support schemes (as quickly as possible (timing of payments tbc).
- SG will carefully consider the Inquiry recommendations and is establishing a senior level Oversight Group to consider the recommendations for Scotland.

TOP LINES

I welcome the Inquiry's Final Report and I sincerely apologise to everyone who has been impacted by infected blood

- I welcome publication of the Infected Blood Inquiry's report.
- The former First Minister previously made a sincere and heartfelt apology in March 2015 to everyone who has been infected or affected as a result of infected NHS blood or blood products – and I reiterated her apology in my statement on Tuesday.
- I want to pay tribute again to the infected and affected victims. Some 3,000 families in Scotland have faced decades of unnecessary heartbreak and pain due to hepatitis and HIV infections.
- And I thank all those campaigners who worked so hard to make this report happen, and to seek justice for those impacted by this tragedy. They have shown amazing tenacity in getting to this point.

We will carefully consider the Inquiry's report and the recommendations for Scotland

- The Scottish Government has set up a Group to look at how best to take forward the Inquiry's recommendations for Scotland. That group with involve stakeholders representing Haemophilia Scotland and the Scottish Infected Blood Forum.
- The Inquiry's damning findings make difficult reading for us all. As I said in my statement on Tuesday, I am determined to use the Inquiry's report to ensure lessons have been learned and to make

sure we have a culture of openness and transparency in our public services.

- We introduced the organisational Duty of Candour in 2018, which now places a legal duty on all health and social care organisations to be open and honest when something goes wrong.
- The Scottish Government has already been undertaking a review of the Duty of Candour guidance, but I know the Inquiry has asked us to review the operation of that duty so we are looking carefully at that recommendation.

I recognise that the Inquiry has criticised a number of individuals and organisations in Scotland. Clearly, responsibility for the failures that the Inquiry report sets out sits across a number of public bodies and we all must take our share of that responsibility

- **<Text redacted>**It will be important for the four devolved UK administrations to work together to respond to the Inquiry recommendations, and I would urge open communication to facilitate this.

I want to ensure victims get compensation as soon as possible

- This Government has been clear for several years that there is a moral case for a compensation scheme.
- We do already offer support with many victims' current living costs via the Scottish Infected Blood Support Scheme – the Scottish Government pays some £11 million per year for SIBSS - and I know that SIBSS members value that. But SIBSS is not a compensation scheme.
- So compensation for victims of infected blood is long overdue and the amendments to the UK Victims and Prisoners Bill will ensure those in Scotland have access to the scheme on the same basis as those elsewhere in the UK.
- The UK Government's announcement on 21 May on details of the compensation scheme is another step towards ensuring those infected and their bereaved relatives in Scotland receive compensation as soon as possible.
- I also welcome the announcement of further interim payments to both infected people and to estates of victims who have sadly died. We will work with the UK Government and the Scottish Infected Blood Support Scheme to ensure these payments can be made as soon as possible.

I can reassure everyone that Scotland now has extremely high standards of blood safety

- All donated blood in Scotland is now tested for a range of viruses, including hepatitis and HIV, before it is distributed to hospitals.

- Therefore I would continue to encourage anyone who can do so to give blood – blood transfusions remain essential for thousands of patients across Scotland.
- Patients who have received or are receiving transfusions should not be worried. Even before September 1991 the risk of an individual transfusion being infected were very low.
- However any patients who think they had a transfusion before September 1991 should speak to their GP practice about being tested for Hepatitis C if they have not had a test already.

The Scottish Government has already taken steps in 2015 to raise awareness and offer Hepatitis C testing to anyone who had a transfusion before September 1991

- A short-life working group considered the recommendation from Lord Penrose on how best to offer testing and the Scottish Government took forward those recommendations.
- In 2016, the Scottish Government issued public information notices to thousands of premises across Scotland, such as pharmacies, dentists and GPs, inviting people to seek a Hepatitis C test if they previously had a transfusion.
- And the former Chief Medical Officer wrote to Health Boards and GP practices in 2015 asking them to offer Hepatitis C testing to anyone who came forward who previously had – or was likely to have had – a transfusion before September 1991.
- However it is not too late for patients to seek a test from their GP practice.

Our 2023 Sexual Health and Blood Borne Virus Action Plan recommitted us to the elimination of Hepatitis C as a public health concern in Scotland by March 2025

- This builds on the significant progress which has already been made since the publication of the first Hepatitis C Action plans in 2006 and 2008.
- Whilst the impact of the COVID-19 pandemic slowed progress towards this ambitious target, the Scottish Government is still working with NHS Boards and other key stakeholders to outline creative approaches towards identifying and treating people with Hepatitis C.

<Text redacted>

Infected Blood Inquiry

Background

- UK-wide inquiry established 2018. Chaired by former judge Sir Brian Langstaff
- Remit to examine:
  - the circumstances in which men, women and children treated by national Health Services in the UK were given infected blood and infected blood products, in particular since 1970
  - the response of government, the NHS and others in the decades following the transmission of infection
- In the UK, around 30,000 NHS patients estimated to have been infected with HCV and up to 1350 with HIV from infected blood or blood products.
- In Scotland, approx. 3000 patients were infected with HCV and 78 with HIV
- Final report published 20 May 2024 (Homepage | Infected Blood Inquiry)

Findings and recommendations

- “I have to report a catalogue of failures … Each on its own is serious. Taken together they are a calamity … I have to report that it could largely, though not entirely, have been avoided. And I have to report that it should have been.”
- “I have also to report systemic, collective, and individual failures to deal ethically, appropriately, and quickly with the infections when the risk materialised, and with the consequences for thousands of families.”

The Inquiry Report | Infected Blood Inquiry

Findings and Recommendations

- Report runs to 2500 pages, organised into seven volumes
- Criticisms of Governments, NHS, and clinicians are extensive, and include:
  - Failures in the licensing regime by allowing the importation and distribution of blood products which carried a higher risk of infection
  - Failure to ensure sufficient supply of blood products from UK donors and to ensure risks from that supply minimised as far as possible
  - Failures in donor selection and screening
  - Complacency about risks of HCV and being slow to respond to risks of HIV
  - Failures to adopt alternative treatment regimes and safer transfusion practices that could have reduced infections
  - Failings in relation to consent, openness, transparency, candour and accountability
  - Repeated failures to offer meaningful apology or redress to those harmed

Findings and Recommendations

- Report contains multiple recommendations, set out under 12 themes, and covering:
- Compensation schemes and establishment of memorials in the 4 nations
- External regulation of healthcare; safety management systems; digitisation of patient records
- Clinical monitoring of people infected with hepatitis C; HCV testing of those who received blood or blood products prior to 1996; provision of haemophilia care
- Staffing and resourcing of transfusion laboratories;
- Use of tranexamic acid for all eligible surgery
- Clinical training in safe transfusion practice, implementation and monitoring of recommendations of SHOT reports; recording outcomes for recipients of blood transfusions
- Duty of candour in NHS and ending defensive culture in the Civil Service and Government
- Giving patients a voice, e.g. through clinical audit and funding for patient advocacy charities.
- The Government should consider and commit to implementing the recommendations in the report (or give sufficient reason why not), and report back to parliament on progress by the end of this year.

Next Steps

- Compensation – working at 4 nations level to make further interim compensation payments in coming weeks and months and with the UK Government, **<Redacted>**, with first final payments possible before end of the year.
- Working with UKG and governments of devolved nations to consider and implement recommendations on 4 Nations basis where appropriate
- Scottish Infected Blood Inquiry Oversight and Assurance Group
  - To consider and oversee recommendations to be taken forward at Scotland level
  - Chaired by Christine McLaughlin, Director of Population Health, SG
  - Membership includes DCMO, DsPH, SNBTS, SAMD, HIS, representatives of Haemophilia Scotland and the Scottish Infected Blood Forum
  - First meeting June 26th

Minister for the Cabinet Office (MCO) and HM Paymaster General meeting with Infected Blood Campaigners and Stakeholders, 10 May 2024, Edinburgh - Note

1. You attended a meeting on 10 May 2024 with John Glen MP, MCO, and Scottish infected blood stakeholders, including Haemophilia Scotland (HS) and the Scottish Infected Blood Forum (SIBF), as well as affected campaigner **<Redacted>**. You were invited to attend the meeting in support of the Scottish stakeholders. The purpose was to set out the way forward on responding to the final report of the Infected Blood Inquiry (IBI) and on compensation, and to listen to the views of stakeholders. MCO had already conducted similar outreach meetings in Wales and Northern Ireland.

2. MCO gave an update on progress. He said this was the seventeenth of eighteen outreach meetings he has had. He very much welcomed the presence of the Scottish Minister today and committed to respecting the confidentiality of the meeting. He apologised to all the victims in the room for the failures of successive Governments, but knew that was not enough.

3. MCO said the UK Government (UKG) has now agreed to pay compensation to infected and affected victims. The new compensation body would be set up on Royal Assent of the Victims and Prisoners Bill, expected in June or July. In the meantime a shadow entity would be set up, headed by experienced civil servant David Foley, who would be working to recruit staff as soon as possible. UKG would be clear very soon after 20 May about how those who are not registered with current infected blood support schemes would be registered for compensation; those already registered would be ported over to the new body. The aim would be to avoid duplicative re-registration. MCO said victims needed to be involved in appointments to the new body and its various committees. Victims would also be involved in the drawing up of the Regulations to set up the scheme. Interim payments of £100k have already been announced for estates of victims.

4. MCO provided an outline of the work that had needed to be done to set up the compensation scheme, partly in explanation of why things had taken so long. He said that when he came into the job in November he had set up an expert group to provide advice on the compensation scheme. Sir Jonathan Montgomery had been chosen to head up the group based on his extensive experience. Perhaps this could have been done with more consultation, but the priority had been to move at pace. The expert group has been looking at how to turn the IBI's recommendations into a workable scheme with clear heads of loss. MCO said he recognised that that bands would not work for everyone so there would need to be an appeal process. This work has not been completed, so he cautioned that everything he said today would be provisional.

<Redacted>

5. You (Jenni Minto) said that it was crucial to put the needs of victims at the heart of all our processes going forward. It was hugely appreciated that MCO had come to Scotland to engage with stakeholders in this way. **<Redacted>** You also noted that you were pleased that officials from across the UK were working together closely on the details of the scheme and hoped that would continue. Finally, you acknowledged the change of tone that MCO had brought to this work since he took over.

<Redacted>

INFECTED BLOOD COMPENSATION SCHEME – SUMMARY OF KEY ELEMENTS

Overview

The UK Government published details of its proposals for its compensation scheme on Tuesday 21 May following the statement to the UK Parliament by Minister for the Cabinet Office (MCO), John Glen MP. This is set out on the new webpages for the shadow Infected Blood Compensation Authority (IBCA) at:
Infected Blood Compensation Scheme Summary - GOV.UK (www.gov.uk)

MCO confirmed that Sir Robert Francis KC has been appointed as interim chair of the IBCA, which has been welcomed by campaigners. He also confirmed the shadow body is expected to have around 20 staff by the end of May so that it can prepare quickly to deliver compensation once the Victims and Prisoners Bill receives Royal Assent and regulations on the scheme have been progressed.

The UK Government has confirmed the following key details:

- The Scheme will be open to both infected and affected people.
- The Scheme will be UK-wide.
- For the majority of applicants, **tariffs** will be used to calculate compensation. In defined circumstances, a bespoke assessment of individual needs by the IBCA will help to ensure the appropriate compensation is awarded.
- Compensation tariffs for the Scheme will be informed, but not limited, by current practice in UK courts and tribunals.
- Support scheme payments will continue to be paid on an ex-gratia basis until 31 March 2025. This means that any payments received before and up to 31 March 2025 will not be deducted from compensation awarded through the new Scheme. From 1 April, SIBSS payments would be counted towards compensation awards.
- Any past or future interim compensation payments will be automatically deducted from the compensation awards made through the Scheme.
- For people diagnosed with an eligible infection before 1 April 2025, the Scheme will remain open to applications for 6 years, **until 31 March 2031**. For people diagnosed after 1 April 2025, the Scheme will remain open to applications for 6 years from the person's date of diagnosis.
- Accepting compensation through the Scheme will not remove any right a person has to pursue a claim in court (note – some people do have claims that are sisted (i.e. on hold) in the Scottish courts – we hope people would be content with the compensation awards from the IBCA, but if not we would expect the Scottish courts to consider any government compensation received in calculating people's awards).
- Compensation payments through the Scheme will not impact people's eligibility for means tested benefits and will be exempt from tax.

Eligibility and Applications

Those who are members of SIBSS or whose relative was a member of a former Alliance House scheme will automatically be eligible for the scheme. It is expected their details will be provided to the IBCA so they should not have to apply to join (although they may need to provide extra details if they want an individualised assessment or a particular award, such as the Carers' award).

The following infected people will be eligible for compensation - note those in bold are not eligible for SIBSS and will need to apply directly to the IBCA as SIBSS will not be able to accept applications from these groups (SIBSS eligibility will **not** change).

Any person **infected** by NHS blood, blood products or a tissue transplant or a **secondary infectee** who was infected by an infected person:

- with HIV;
- with an **acute** or chronic case of Hepatitis C (not specified, but it is understood this includes all those whose HCV has been treated and cleared);
- with **chronic** (more than 6 months) **Hepatitis B** (HBV);
- with **acute (less than 6 months) Hepatitis B where the person died as a result of the Hepatitis B infection during the acute period**.

The following **affected** people will also be eligible:

- spouses, civil partners, cohabiting partners (living with the person for at least a year)
- parents, adoptive parents and others acting in the capacity of a parent
- children, including adopted or step children
- siblings, including adoptive or step siblings
- carers, who were friends or family and who provided unpaid care for at least 16.5 hours per week to an infected person for at least six months

In addition, **estates of infected people** can also apply for compensation where the infected person has died, but the estates of affected relatives who have died will not be eligible.

Tariffs for compensation

To try to promote simplicity for applicants and speed of making awards, the scheme proposes that 'core' awards for most will be based on set tariffs. However, in 'exceptional' circumstances, people will be able to seek an individualised assessment (a 'supplemental' route).

Illustrative rates given by the UK Gov are set out below, although care awards and financial loss awards will be calculated using a formula based on individual circumstances – however the figures below give the likely range of award for most people.

Compensation will be made up of five separate awards:

- an injury award (for physical and mental impacts of infection)
- a social impact award (reflects the stigma suffered)
- autonomy award (for impacts on family and private life)
- care award (for past and future care needs)
- financial loss award (for past and future financial losses)

Illustrative awards for a living infected person

	Total award across all Categories of award+
Hepatitis C (Acute)	£35,500
Hepatitis C or Hepatitis B (Chronic)	£665,000 - £810,000
Hepatitis C or Hepatitis B (Cirrhosis)	£985,000 - £1,130,000
Hepatitis C or Hepatitis B (Decompensated cirrhosis, and/or liver cancer and/or liver transplantation)	£1,412,000 - £1,557,000
HIV	£2,225,000 - £2,615,000
HIV and Hepatitis C/Hepatitis B (Chronic)	£2,270,000 - £2,660,000
HIV and Hepatitis C/Hepatitis B (Cirrhosis)	£2,315,000 - £2,705,000
HIV and Hepatitis C/Hepatitis B (Decompensated cirrhosis and/or liver cancer and/or liver transplant)	£2,345,000 - £2,735,000

Note – awards for the affected are more complex as they will depend more on individual circumstances, but further information can be shared if helpful.

Payments and the future of SIBSS

Infected and affected people will have a choice of receiving their compensation as a lump sum or as periodic payments – however it says the periodic payments will be for ‘a fixed number of years’ (rather than for life) so this is causing some concerns for beneficiaries. Estates will receive their final award as a one-off lump sum.

In the event that someone’s compensation award is less than they would have got through continued support scheme payments (which is likely for some widows/ers/ partners), an additional top-up payment will be provided to bring the compensation they receive up to the level of the support payments. This will ensure that no one will receive less than they do now.

Conclusions

<Redacted>.

We understand that Sir Robert Francis will be engaging with the infected and affected so hopefully some of these points can be addressed.

MINISTERIAL ENGAGEMENT BRIEFING:
JENNI MINTO, MINISTER FOR PUBLIC HEALTH AND WOMEN'S HEALTH

Minister for the Cabinet Office (MCO) and HM Paymaster General meeting with Campaigners and Stakeholders

Date: Friday, 10 May 2024

What	MCO and HM Paymaster General meeting with Campaigners and Stakeholders
Where	UK Government Hub, 1 Sibbald Walk, Edinburgh, EH8 8FT
When	10 May 2024, 11:00-12:00
Who	• Rt Hon John Glen MP, MCO and HM Paymaster General; • Stakeholders including Haemophilia Scotland and the Scottish Infected Blood Forum (SIBF), as well as affected campaigner ,<**Text redacted**>
Why	MCO is meeting representatives from prominent charities, organisations, and support groups within the infected blood community across the UK. Through these meetings he wants to share the progress being made in establishing a compensation scheme for those infected and affected, reassure the community that their concerns are being heard, and seek input on specific issues. This will be an opportunity for stakeholders to share views directly with MCO. You have been invited to attend to support Scottish stakeholders. <u>Agenda</u> 1. Welcome 2. Minister's update on legislative and delivery progress 3. Attendees' views and priorities for: a. Government Response to Inquiry Report a. Ongoing communication and engagement 4. AoB
Speech details	N/A
Supporting officials	**<Redacted>**

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ANNEX A

Biographies

Minister for the Cabinet Office, the Rt Hon John Glen MP

John Glen MP was appointed Paymaster General and MCO on 13 November 2023.

He was previously Chief Secretary to the Treasury between 25 October 2022 and 13 November 2023.

Representatives of Haemophilia Scotland

<Redacted>

ANNEX B

Background

1. MCO and HM Paymaster General, the Rt Hon John Glen, is holding a number of meetings with stakeholders and campaign groups across the UK to discuss the progress he is making in establishing a scheme of compensation for those infected and affected, reassure the community that their concerns are being heard, and seek input on specific issues.
2. This follows amendments tabled by UK Government (UKG) to the Victims and Prisoners Bill on 17th April, and their acceptance in the Lords at the Bill's report stage on 30 April.
3. The Government amendments are summarised in **Annex D.**
4. Stakeholders provided comments on the amendments to the Health, Social Care and Sport Committee, and it is likely the same themes will come up in the meeting with MCO.
5. Overall, stakeholders support the progress made in establishing a compensation scheme, although remain concerned about the role of the UKG's expert group in drafting regulations which will govern the details of the scheme, such as eligibility, payments rates, how appeals will function, and how the new scheme will interact with the four existing support schemes.
6. Stakeholders are also seeking further reassurance about how the infected blood community will be involved in appointments to the Infected Blood Compensation Authority (IBCA) and about how they will be involved in the IBCA's various committees. They have also pressed that the IBCA should be chaired by a (current or former) judge.
7. You wrote to MCO to raise these points on 7 May.
8. Mainly, questions from stakeholders will be for MCO to answer. However, some top lines and Q+A have been provided in **Annex C** for reference

ANNEX C

Top Lines

Stakeholder Concerns

- I have written to MCO to raise a number of your concerns so I hope he able to give us some reassurance today on these points.

Establishing a Compensation Framework

- I am pleased the amendments tabled at the Report stage of the UK Victims and Prisoners Bill make progress in establishing an arms-length body to administer compensation payments, and require that regulations are made to establish an Infected Blood Compensation Scheme.

- I look forward to working with MCO on the details of the regulations which will govern the details of the scheme.

Further Interim Payments to Estates

- I have been pressing UKG to make payments to the families of the deceased since the Second Interim Report was published, so I am pleased a provision to make these payments was included in the amendments.

- Although the payments as outlined in the amendment would not necessarily go to all of the groups the Inquiry recommended, I am pleased that payments would deliver compensation to some of those who have gone without support for too long.

- [*If asked about further interim payments to infected people*] Of course if the UK Government is able to provide funding, we will ensure SIBSS is able to make the further interim compensation payments in the same way as was done in October 2022.

- We have particularly been focused on seeking payments for bereaved relatives who have had no or only relatively small amounts of compensation or financial support – that is still a priority given these are families who are not getting any regular payments from SIBSS.

<Text redacted>

ANNEX D

SUMMARY OF UK GOVERNMENT AMENDMENTS TO THE UK VICTIMS AND PRISONERS BILL

1. The UK Government amendments provide for the following:

- establish a new arms-length body called the Infected Blood Compensation Authority ("IBCA") to deliver the infected blood compensation scheme, to be funded by the UK Government;
- require the Secretary of State or the Minister for the Cabinet Office to lay regulations to establish the infected blood compensation scheme and set out details of who will be eligible for that scheme. Those eligible can include people infected via blood transfusions, via blood products (medicines made from human plasma) or via tissue transplants, along with people who were subsequently infected by those infected people (known as secondary infectees) and people who have been affected by those people being infected (such as their relatives);
- require the Secretary of State or the Minister for the Cabinet Office to set out in the scheme regulations how payment amounts are to be determined, including allowing for compensation payment levels to be set or to be capped at a specified amount;
- enable the Secretary of State or the Minister for the Cabinet Office to set out in the scheme regulations the procedure for making and deciding applications for payments;
- enable the Secretary of State or the Minister for the Cabinet Office to make provision for a review of decisions by the IBCA, but requires the Secretary of State to provide for appeals to the First Tier Tribunal;
- enable data sharing with the IBCA, for example by NHS National Services Scotland ("NSS") as managers of SIBSS;
- place a 'duty to cooperate' with the IBCA on certain organisations, including the Scottish Ministers (Scottish Government) and NSS, as well as any other persons set out in Regulations made by the Secretary of State or the Minister for the Cabinet Office;
- enable the Secretary of State or the Minister for the Cabinet Office to make arrangements for the provision of support and assistance to applicants;
- require the Secretary of State or the Minister for the Cabinet Office to make arrangements for the payment of £100,000 to personal representatives of qualifying infected persons, the latter defined as a deceased person who was registered under an infected blood support scheme or with a relevant organisation. Payments are only to be made to representatives of deceased infected persons to or in respect of whom no interim compensation payments have already been made;
- require the Secretary of State to make arrangements for the procedure for making payments to personal representatives. Arrangements may include arrangements for one or more persons (which could include the Scottish Ministers) to administer the payments on behalf of the Secretary of State or the Minister for the Cabinet Office;
- make provision for information sharing for the purpose of any matter connected with the making of payments to personal representatives;
- set out details of the membership of the IBCA and how the Chair and other members will be appointed by the Secretary of State, as well as staffing arrangements. In addition, this requires the UK Government to provide funding to the IBCA both for the costs of the compensation scheme and for its running costs. It also requires the IBCA to provide annual reports;
- allow the Secretary of State or the Minister for the Cabinet Office to make 'transfer schemes', which could enable the IBCA to take on some of the Scottish Government's or

NSS' functions in relation to work of the existing infected blood support schemes, as well as their liabilities;

- enable the Treasury to make regulations about taxes affected by a transfer scheme;
- make consequential amendments to reflect the fact that the IBCA will take on the obligations of a public body under existing legislation;
- enable the Scottish Ministers to lay affirmative regulations in the Scottish Parliament to make consequential amendments as a result of the IBCA being a new public authority; and
- amend the extent clause of the Bill to extend these compensation provisions to the whole of the UK.

Minister for Public Health and Women's Health

PUBLICATION OF THE INFECTED BLOOD INQUIRY'S (IBI's) FINAL REPORT – INITIAL SUMMARY OF KEY FINDINGS AND RECOMMENDATIONS

Priority and Purpose

1. **Immediate**. To provide an initial summary of the key findings and recommendations contained in the IBI's final report, which was released under embargo at 8am this morning. The report was made publicly available from 12.30.

Recommendation

2. That you note this summary and that we will provide more detailed advice on the implications for Scotland of the report in due course, including advice on whether or not the Scottish Government (SG) should accept relevant recommendations.

Context and Issues

3. The IBI is a UK-wide inquiry established in 2018 by the UK Government (UKG) and chaired by former judge, Sir Brian Langstaff, to investigate how thousands of people were infected during the 1970s and 1980s with HIV and/or Hepatitis from both infected blood transfusions and infected blood products. As set out in previous advice, in Scotland approximately 3000 NHS patients were infected with Hepatitis C Virus (HCV) from infected blood and 78 with HIV. Infections also occurred on a large scale around the world.

4. Sir Brian's final report makes clear that the situation across the UK came about as a result of "a catalogue of failures … Each on its own is serious. Taken together they are a calamity … I have to report that it could largely, though not entirely, have been avoided. And I have to report that it should have been." Sir Brian concludes that this was the result of "systemic, collective, and individual failures to deal ethically, appropriately, and quickly with the infections when the risk materialised, and with the consequences for thousands of families."

5. The report runs to 2500 pages and is organised into seven volumes. A short summary of what is contained in each of the seven volumes is included at **annex A**. As expected, the report makes a number of damning criticisms of NHS, Government and blood service practice particularly in the 1980s. The report also makes twelve key and overarching recommendations, several of which will need go be taken forward at UK level. An initial summary of these criticisms and recommendations, with a focus on those most relevant to Scotland, is set out below. The full set of recommendations is included at **annex B**.

6. Sir Brian set out in the final report the numerous failures across the UK over the decades as follows:

- **Deaths illness and suffering were caused to people with bleeding disorders**, including as a result of failures in the licensing regime by allowing the importation and distribution of blood products which carried a higher risk of causing hepatitis, and though failure to ensure sufficient supplies of blood products;

- **Infections, leading to deaths, illness, and suffering, were caused to people who received blood transfusions**, including by failing to ensure sufficiently careful and rigorous donor selection and screening and allowing continued collection of blood from prisons, and missing out on the opportunity to screen out some high risk donors by surrogate testing as a response to the risk of HIV transmission;

- **Clinicians and the health service in particular failed those with bleeding disorders and those who were transfused**, including by being complacent about the risks of non-A no-B Hepatitis (Hepatitis C) and being slow to respond to the risks of AIDS.

- **The harms done to those infected and affected were compounded** by repeated and ongoing failures to acknowledge that they should not have been infected and to offer any meaningful apology and redress.

7. The IBI published its final report alongside a publication event in London, which you attended. **<Text redacted>**. The Prime Minister has also now made a statement on behalf of the UK Government (UKG) focussing on an apology to the victims and committing to taking forward compensation and considering the recommendations in the IBI's report. **<Text redacted>** and understand that the FM will make a statement to MSPs at 14:15 tomorrow.

8. We have highlighted in the media statement and GIQ that SG is setting up a senior level Oversight Group to consider those aspects of the report that might need to be taken forward at Scottish level. The first meeting of this group, which will be chaired by Christine McLaughlin, has now been confirmed for 26 June. By this point, we will have considered the report more fully and will be able to begin substantive discussions with stakeholders on the way forward. **<Text redacted>**.

Infected Blood Compensation

9. Although today's report does not focus on issues related to compensation – because these issues have already been covered in the two interim reports published by the IBI in 2022 and 2023 – much of the focus this week will be on compensating the victims of the infected blood tragedy. For that reason recommendation one in the final report is that compensation – as set out in the two interim reports – should be paid quickly.

10. UKG tabled amendments to the Victims and Prisoners Bill in April to establish a UK-wide infected blood compensation scheme and to make interim compensation payments of £100k to the estates of those who have sadly died, meaning that compensation will reach relatives. This follows the £100k interim payments already

made across the UK to infected people and their bereaved partners in October 2022.

11. A further announcement on compensation is likely to be made by the Minister for the Cabinet Office (MCO), John Glen, tomorrow. **<Text redacted>**, this is expected to include plans to make an additional interim compensation payment to infected people of £210,000 each. This would make a total of £310,000 interim compensation paid so far to every infected person currently registered with the all the UK support schemes, including the Scottish Infected Blood Support Scheme (SIBSS), which amounts to the minimum final compensation to which infected persons are likely to be eligible under the final scheme. We are working with colleagues to ensure that these further interim payments can be delivered in Scotland by SIBSS (likely by early September). We expect all compensation payments to be funded by UKG.

Key Criticisms of SG and its predecessors in the IBI's Final Report

12. The criticisms made in today's report of SG and its predecessors, along with NHS Scotland and the Scottish National Blood Transfusion Service (SNBTS), are as was set out in the briefing pack for your attendance at the event in London today sent by **<Redacted>** on 15 May (Annex D in that briefing). The report criticises a number of former staff and Ministers, **<Text redacted>**.

13. As expected, the IBI's report also criticises the Scottish Office for:

- Delays in implementing HCV testing of donated and failure to implement alternative 'surrogate' tests before tests for HCV and HIV became available;

- Delays in ensuring safe Factor VIII was available in Scotland to prevent haemophiliacs being infected with HCV;

- Failure among officials, clinical advisers and NHS clinicians to take patient safety seriously enough and act quickly when evidence of the risks of HIV and HCV being transmitted via blood started to emerge, along with an over-reliance on following the lead of the Department of Health in England and waiting until action could be taken on a four nations basis;

- Failure to take decisive action to stop higher risk donors, such as prisoners, from donating blood earlier;

- Not starting a comprehensive lookback more quickly after HCV testing was introduced to identify past recipients of donations from HCV positive donors.

14. In addition, there are also criticisms of the Scottish Office, Scottish Executive and SG for:

- Not doing enough to address the concerns of infected and affected people – in particular seeking to delay or avoid paying compensation and ex gratia payments to those infected with HIV and HCV respectively;

- Not investigating their concerns fully or taking the impact of HCV infection seriously enough – in particular argue that the NHS and government did what they could based on the knowledge and testing available at the time - and failure to hold a public inquiry until the SG announced the Penrose Inquiry in 2008;

- Not providing recombinant products (products without human plasma that could transmit infections) for all haemophiliacs as soon as they became available in the 1990s;

- Not ensuring parity of financial support across the UK once SIBSS was established in 2017 – with both the SG and UKG allowing disparities to develop;

- Not taking action more quickly to ensure NHS Boards only provided blood transfusions where patients really needed them and not ensuring Health Boards used alternatives to transfusion whenever they were appropriate, such as tranexamic acid and red cell salvage (where someone provides blood in advance of an operation so if they need a transfusion their own blood can then be given back to them).

Key Recommendations in the IBI's Final Report

15. In addition to criticism, the IBI's final report also includes a comprehensive set of twelve recommendations, including some which will need to be considered at four nations and UK level. These recommendations include that compensation should be paid as soon as possible and that what happened to people should be recognised and remembered, including with memorials to be set up in each of the four UK nations. The key recommendations which will need to be considered by the new Scottish senior Oversight Group are:

    - That NHS Education for Scotland should ensure that lessons learned by the IBI about clinical practice should be incorporated in every doctor's training.

    - That the operation of the duty of candour in healthcare in Scotland should be reviewed and extended.

    - That the external regulation of healthcare in across the UK and in Scotland should be reviewed and simplified and implementation of a safety management system should be considered.

    - That there should be an audit of the extent of the success of the digitisation of patient records in Scotland by the end of 2027.

    - That those who contracted Hepatitis via NHS blood should receive particular care going forward, with regular monitoring for liver damage via fibroscans every 6 months (this should already happen for those with cirrhosis, but the Inquiry recommends others should have the scans as well).

    - That the use of tranexamic acid should be offered as a treatment to minimise the likelihood of needing blood transfusions for all patients having eligible forms of surgery.

- That further improvements should be made to transfusion practices and staffing levels in hospital transfusion laboratories and ongoing improvements to haemophilia care should continue.

- That patients who underwent a transfusion before 1996 should be offered a test for HCV and GPs should ask patients when they register with a practice if they have had a transfusion before.

- That the patient voice be enabled and empowered, with clinical audits routinely seeking patients' views.

- Haemophilia Scotland and the Scottish Infected Blood Forum should continue to receive government funding to advocate for their members.

- Finally, the Inquiry also recommends UK wide that there should be a review of the Civil Service Code and the Ministerial Code to improve candour in government and consider whether the Codes should be put on a statutory basis (although clearly it would be for the SG and Scottish Ministers to consider any changes for Scotland).

Conclusion and Next Steps

16. That you note this initial summary of the IBI's final report as published at 12.30 today and that we will provide further advice following a more detailed examination of this extensive report and of the expected announcement tomorrow by MCO on compensation.

<Redacted>
Public Health Capabilities
<Redacted>

Cabinet Secretaries and Ministers Copy List	**For Action**	**For Information Portfolio interest**	**For Information Constituency interest**	**For Information General awareness**
Cabinet Secretary for Health and Social Care		X		
First Minister			X	
Lord Advocate				X
Solicitor General				X

Officials Copy List
Permanent Secretary
DG Health and Social Care
Director for Population Health
Chief Medical Officer
Deputy Chief Medical Officers
Gill Hawkins

Officials Copy List
Alison Strath John Burns Simon Cuthbert-Kerr Daniel Kleinberg DG Corporate Communications NHS Recovery, Health and Social Care **<Text redacted>**SGLD Heads of Public Health Branch John Paterson **<Redacted>** **<Redacted>** **<Redacted>** SPADs Admin Ross Ingebrigtsen David Hutchison Craig White **<Redacted>** **<Redacted>** **<Redacted>** **<Redacted>** Lynne Nicol **<Redacted>** **<Redacted>** **<Redacted>** **<Redacted>** **<Redacted>** **<Redacted>** **<Redacted>** **<Redacted>** Legal Secretariat to the Lord Advocate Solicitor to the Scottish Government

Annex A

Summary of the contents of the seven volumes in the IBI's final report

Volume 1 - Overview and Recommendations

This volume provides an executive summary of the final report, a list of lessons learned, and a complete list of recommendations.

Volume 2 - People's Experiences

This volume addresses the impact of infected blood and blood products on people who have been infected and affected, with a special focus on the haemophiliac pupils at Treloar's School in England. The Inquiry received over four thousand statements from people infected and affected and concludes that there were numerous failures in relation to consent and communication.

Volume 3 – What Happened and Why

This volume sets out basic concepts such as risk and consent and the knowledge of Hepatitis and HIV in the 1970s and 1980s. The volume also considers the organisation of the blood services and the treatment of blood products.

Voilume 4 – What Happened and Why

This volume focusses on the role of Government in responding to risk and on the roles of pharmaceutical companies, Haemophilia Centres and the Haemophilia Society.

Volume 5 – What Happened and Why

This volume focusses on clinical practice in blood transfusion, HCV and HIV screening and surrogate screening, and lookbacks.

Volume 6 – Response of Government and Government Bodies

This volume focusses on the initial Government response and that of bodies such as the Eileen Trust, the Macfarlane Trust, and the Skipton Fund. The volume also covers the work of the various UK support schemes, including SIBSS.

Volume 7 – Response of Government

This volume covers document destruction, self-sufficiency, the use of Government lines to take, delays in holding a public inquiry, accountability in the absence of a public inquiry, and the Government's response to calls for compensation. A section on Scotland criticises former staff for their approach to the Scottish Executive investigation of infected blood, arguing the scope was too narrow and advice was taken at face value rather than interrogated, noting that a fairer and more comprehensive investigation and acceptance of the Health Committee's recommendations could have alleviated the harm done to people.

Annex B

The Infected Blood Inquiry's Recommendations – [note key elements for Scotland/Scottish bodies are highlighted in bold]

1. Compensation

My principal recommendation remains that a compensation scheme should be set up now.

2. Recognising and remembering what happened to people

(a) A permanent memorial be established in the UK and consideration be given to memorials in each of Northern Ireland, Wales and **Scotland**. The nature of the memorial(s), their design and location should be determined by a memorial committee consisting of people infected and affected and representatives of the governments. 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. The memorial should be such as is agreed with those who were pupils at Treloar's.

(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 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. Since the duty was introduced in 2023 in

Wales, the review there need not be immediate, but should be no later than the end of 2026.

(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.

Success in implementation will be measured by the extent to which there is an increase in the number of reports made of near miss incidents to the designated data collector; and a decline in the number of widespread or significant healthcare failures.

(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 also 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, with the aim of addressing all the points made earlier in this Report and in other reports since 2000.

(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 groups (as recommended by the HSSIB), and do so as a matter of priority.

Success in implementation will be measured by the percentage of patients who know to whom they can express any concerns they may have about safety, who will take up their cause, and what they can expect from them. At the same time, it will be measured by the extent to which those who are busy working within the system, especially those in leadership roles, have clarity as to what, precisely, is expected of them, from whom. It should also be measured by a reduction in avoidable harm

from both errors and systemic issues.

(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 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 a defensive culture in the Civil Service and government

(a) 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.

(b) If, on review, the Government considers that it is sufficient to rely on the current non-statutory duties in the Civil Service Code, it should nonetheless introduce a **statutory duty of accountability on senior civil servants** for the candour and completeness of advice given to Permanent Secretaries and Ministers, and the candour and completeness of their response to concerns raised by members of the public and staff.

(c) The Government should consider the extent to which Ministers should be subject to a duty beyond their current duty to Parliament under the Ministerial Code.

6. Monitoring liver damage for people who were infected with Hepatitis C.

(a) 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 the NHS, shared with NBTC, the Royal Colleges (as appropriate), and NHSBT.

(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).

Success in achieving this will be measured by the extent to which the SHOT reports for the previous three years show a progressive reduction in incidents of incorrect blood component transfusions measured as a proportion of the number of transfusions given.

(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 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 calls for a public inquiry

(a) that a minister should retain the power to call an inquiry as the minister sees fit, in accordance with the Inquiries Act 2005 – but where a minister does not choose to do so, then:

(b) if there is sufficient support from within Parliament for there to be an inquiry, the question whether there should be one should be referred to PACAC for it to consider the question.

(c) If it appears to PACAC that there is sufficient concern to justify a public inquiry, either because what happened and why has caused concern (as the committee sees it) or there are likely to be lessons learned which may prevent similar concerns arising in future, the committee may recommend to an appropriate minister that there be an inquiry.

(d) If the minister disagrees with the recommendation, they must set out in detail and publish reasons for this disagreement which are sufficient to satisfy PACAC that the matter has been carefully and properly considered.

12. Giving effect to Recommendations of this Inquiry

(a) Within the next 12 months, the Government should consider and either commit to implementing the recommendations which I make, or give sufficient reason, in sufficient detail for others to understand, why it is not considered appropriate to implement any one or more of them.

(b) During that period, and *before* the end of this year – the Government should report back to Parliament as to the progress made on considering and implementing the recommendations.

(c) This timetable should not interfere with earlier consideration and response to the Recommendations of the Second Interim Report of the Inquiry

(d) The Public Administration and Constitutional Affairs Committee ("PACAC") should review both the progress towards responding to the Inquiry's recommendations and, to the extent that they are accepted, implementing those recommendations

(e) PACAC should accept the role in respect of any future statutory inquiry of reviewing government's timetable for consideration of recommendations, and of its progress towards implementation of that inquiry's recommendations.

Public Health Capabilities Division
22 May 2024

Minister for Public Health and Women's Health

FOUR NATIONS MEETING WITH THE MINISTER FOR THE CABINET OFFICE (MCO): FURTHER INTERIM COMPENSATION AND CONSIDERATION OF THE FUTURE OF THE SCOTTISH INFECTED BLOOD SUPPORT SCHEME (SIBSS)

Priority and Purpose

1. **Immediate.** To seek your response to questions raised in the letter you received yesterday from MCO, John Glen, and to provide you with speaking points (Annex A) for your four nations ministerial meeting at 08.30 tomorrow.

Recommendation

2. That you confirm you agree in principle to make further interim compensation payments of £210,000 to all living infected beneficiaries currently registered with SIBSS, and also to those accepted onto SIBSS at a future date. Also that you agree to consider further the proposals made by MCO about the future of SIBSS.

Context and Issues

3. Following the publication of the Infected Blood Inquiry's (IBI's) final report on Monday, MCO announced yesterday in the House of Commons that additional interim compensation payments of £210,000 would be made to all living infected beneficiaries of the UK Infected Blood Support Schemes within 90 days. This follows on from the £100,000 payments made to infected persons and their bereaved partners in October 2022, as recommended by IBI chair Sir Brian Langstaff in his first interim report in July 2022. This would mean that all infected persons would have received £310,000 total, which is the minimum they can expect to receive under the various heads of loss as final compensation. The rationale for focussing further interim payments on living infected people, some of who are in life-threatening conditions, is that they are the ones in most immediate need. Payments to living infected people currently registered on the UK schemes can also be made in principle at speed.

4. Following his statement, MCO wrote to you and arranged a four nations ministerial meeting for tomorrow. The letter notes that details of a new infected blood compensation scheme have now been published, which will be set out in Regulations following the passage of the Victims and Prisoners Bill. MCO also notes that he gave an update in the Commons on the setting up of the new independent arms-length body, the Infected Blood Compensation Authority (IBCA), which will administer the scheme. We will provide separate advice on these developments.

5. More immediately, MCO makes two requests in his letter. First, he asks for your support in ensuring that the further interim payments are made as soon as possible and confirms that the money that will be required will be supplied by the UK Government. Second, MCO asks for an initial discussion with you and the other UK Ministers tomorrow on the future of the current support schemes (including SIBSS). MCO says he noted the very clear views expressed at his outreach meetings across the UK, including at the Edinburgh

meeting you attended, about security of payments. In response, he says he has now made clear that there will be no immediate changes to the current schemes, that any transition to the new IBCA will be managed sensitively, and that no one should be worse off as a result of the new compensation arrangements.

Options Considered and Advice

6. In terms of the first request, we recommend that you agree that further interim compensation payments to infected persons should be made as soon as possible. The First Minister effectively made this commitment in the Scottish Parliament yesterday. **There are 464 living infected persons currently registered with SIBSS, meaning a total of £97.44m payments to be made in Scotland.** **<Redacted>**

7. Making the payments should be quite straightforward as we have already made such payments in October 2022. In Scotland, such payments would be made by SIBSS staff at NHS National Services Scotland, following a legal direction to do so from the Scottish Government. We are currently in discussions with SIBSS to make sure they are ready to make the payments. We understand MCO wants to make the payments in late June. This should be do-able in Scotland, so long as we receive quick formal assurance from the Department for Health and Social Care (DHSC) that we will receive the funding. The UKG has already conferred the function of administering the payments in Scotland on Scottish Ministers via an updated scheme document published on 21 May on gov.uk.

8. In terms of the second request, we can welcome the various assurances given by MCO in his letter. We can also agree to continue discussions on the future of the schemes. **<Redacted>** You can make these points to MCO tomorrow without giving any commitments.

Sensitivities

9. Although the payments to infected persons will be welcome, there will be concerns particularly from both affected persons and those infected with Hepatitis B about when they will receive compensation. We are working at pace on making further £100,000 payments to estates, as provided for in the amendments tabled to the Victims and Prisoners Bill. However, making payments to estates is more complicated and will require regulatory changes at UK level to ensure the payments are not liable to inheritance tax and that they do not affect people's benefits. **<Redacted>**

10. **<Redacted>**. However, it is now clear that those with Hepatitis B will be eligible for compensation from the IBCA. **<Redacted>**. We also suggest that you should raise the issue of the IBCA prioritising applications from those infected with Hepatitis B at the four nations meeting tomorrow, as these people have received no compensation or support payments so far.

Financial Considerations

11. The net impact of the additional payments on the Scottish Government budget is nil given these payments are being funded by DHSC. We intend to make a budget allocation to National Services Scotland, to ensure SIBSS can make the payments to infected persons in June, so long as we receive the required formal financial assurances from DHSC in advance. **<Text redacted>**

<Redacted>

12. <Redacted>

Quality Assurance

13. This Submission has been approved by **<Redacted>**, Head of Unit, Public Health Capabilities.

Conclusion and next Steps

14. That you agree to use the lines in Annex A to respond at the four nations meeting to the questions raised by MCO in his letter of yesterday, confirming that you agree we should pay interim compensation of £210,000 to infected persons as soon as possible and that you agree to continue discussions about the future of SIBSS. If so, we will draft a letter for you to respond to MCO following the meeting tomorrow.

<Redacted>
Public Health Capabilities Division
07305 210643

Cabinet Secretaries and Ministers Copy List	For Action	For Information Portfolio interest	For Information Constituency interest	For Information General awareness
Cabinet Secretary for Health and Social Care		X		

Officials Copy List
Permanent Secretary DG Health and Social Care Director of Population Health Richard McCallum **<Redacted>** **<Redacted>** Simon Cuthbert-Kerr Daniel Kleinberg **<Redacted>** SGLD Heads of Public Health Branch **<Redacted>** **<Redacted>** **<Redacted>** **<Redacted>** **<Redacted>**

Officials Copy List
<Redacted> Communications NHS Recovery, Health and Social Care **<Redacted>** Jenni Gollan

<Text redacted>

ISSUE: The Infected Blood Inquiry's (IBI's) final report was published on **20 May 2024**. The report heavily criticises governments and the NHS across the UK for failings over the past five decades that led to people being infected with Hepatitis and HIV from infected blood products and transfusions.

Around 3,000 people were infected with Hepatitis C and approx. 78 with HIV as a result in Scotland (Penrose Inquiry estimates).

UK Gov expected to confirm today (at 12.30) its compensation scheme will largely follow Inquiry recommendations and that further interim compensation payments of £210k each to infected victims – to be made by the Scottish Infected Blood Support Scheme (SIBSS) and the other three UK support schemes.

SG will carefully consider the Inquiry recommendations and is establishing a senior level Oversight Group to consider the recommendations for Scotland.

<Text redacted>

ANNEX A

Background to the UK Infected Blood Inquiry (IBI)

1. The IBI is a UK-wide inquiry established in 2018 by the UK Government (UKG), and chaired by former judge Sir Brian Langstaff, to investigate how thousands of people were infected with HIV and/or Hepatitis from both infected blood transfusions and infected blood products (plasma-derived medicines, which at the time were primarily given to haemophiliacs). It also considered the support those infected and affected by this tragedy received over the years from the NHS and governments and what further actions were needed both to support those individuals and to minimise risks of similar tragedies in future.

2. The Scottish Government (SG) had already set up a public inquiry on infected blood. The Penrose Inquiry considered what happened in Scotland and Lord Penrose published his Inquiry report in 2015. Many stakeholders were unhappy with the Inquiry's findings and the Penrose Inquiry was branded a whitewash by campaigners because Lord Penrose largely concluded that the NHS and government could not have done much to avoid the infections given the limited knowledge and testing available at the time in relation to both Hepatitis C Virus (HCV) and HIV.

3. Following sustained pressure on UKG, the then Prime Minister announced in 2017 that there would be a UK-wide statutory inquiry on infected blood. The IBI had much broader terms of reference and has been far more critical of governments and the NHS than Lord Penrose was.

4. The SG has supported the work of the IBI, providing many thousands of documents from hundreds of files (both historic and some more recent). **<Redacted>**

The infected blood tragedy and its victims

5. The Penrose Inquiry Final Report (25 March 2015) estimated that in Scotland

- Approximately **3,000 NHS patients were infected with HCV** from infected blood – 2,500 infected via transfusions and 478 patients with bleeding disorders such as haemophilia.
- Approximately **78 patients were infected with HIV** – 60 patients with bleeding disorders and 18 patients infected via blood transfusion.

The Infected Blood Inquiry generally agrees on the approximate numbers infected here.

6. Infections also occurred on a large scale around the world. Note though that many transfusion recipients would have died without knowing they were infected so not all of those infected will seek compensation (probably some 50% of the 2,500 infected via transfusion will have died without ever knowing they were infected with HCV). Also, a minority of those infected will have cleared their HCV infection naturally after an acute illness – so they were never chronically infected.

7. There are currently **590** full members of the Scottish Infected Blood Support Scheme – SIBSS , managed by NHS National Services Scotland (465 infected people and 125 widows or partners). Also many infected people died before SIBSS was established – over 200 payments had been made in relation to people known to have died by 2015, but in fact the number of deaths was probably higher. Although some of those people will have widows, widowers or partners who are SIBSS members, others will not and so any bereaved relatives of those infected people will probably have received little financial support so far.

Key dates

8. Hepatitis C
   - SNBTS introduced HCV screening of blood donations so that all SNBTS and hospital blood bank stock for transfusion had been tested negative **by 1 September 1991** (although note the Infected Blood Inquiry notes it is still possible a few people might have been infected later so it recommends anyone transfused before 1996 should be tested for HCV).
   - Factor VIII (for haemophilia A patients) was virus inactivated for HCV from April 1987.
   - Factor IX (for haemophilia B patients) was virus inactivated for both HIV and HCV by October 1985.

9. HIV
   - Factor VIII was virus inactivated for HIV by December 1984.
   - Blood for transfusion was all tested for HIV **by mid-October 1985**.

10. Factor concentrate, used to treat people with bleeding disorders such as haemophilia, was produced by pooling human blood plasma from thousands of donors and to extracting the required clotting factor (normally Factor VIII or Factor IX). In the 1970s and particularly early 1980s many of these products became contaminated with HIV, Hepatitis B (HBV) and especially Hepatitis C (HCV). Some of those unintentionally infected their partners, often because they were unaware of their own infection. Many others who did not have a bleeding disorder were infected with HCV – and in a few cases HIV or HBV - as a result of contaminated blood transfusions up until September 1991. A large number were unaware of their HCV infection for many years before diagnosis.

11. The ability to heat treat plasma products, like Factor VIII and Factor IX, sufficiently to destroy Hepatitis C wasn't developed until 1985 so most haemophiliacs alive at the time had received products before then. Although cryoprecipitate (frozen blood product prepared from blood plasma) was a lower risk as it wasn't pooled (one unit of cryoprecipitate came from one donor), it wasn't risk free.

12. Donated blood is now subject to careful checks to exclude higher risk donors and rigorous screening for blood borne viruses to minimise the risk of transmission of an infection to transfusion recipients.

The IBI's final report

13. Sir Brian's final report makes clear that the situation across the UK came about as a result of "a catalogue of failures … Each on its own is serious. Taken together they are a calamity … I have to report that it could largely, though not entirely, have been avoided. And I have to report that it should have been". Sir Brian concludes that this was the result of "systemic, collective, and individual failures to deal ethically, appropriately, and quickly with the infections when the risk materialised, and with the consequences for thousands of families".

14. The report runs to 2500 pages and is organised into seven volumes. As expected, the report makes a number of damning criticisms of NHS, Government and blood service practice particularly in the 1980s. The report also makes twelve key and overarching recommendations, several of which will need be taken forward at UK level. An initial summary of these criticisms and recommendations, with a focus on those most relevant to Scotland, is set out below. The full set of recommendations is included at **Annex D**.

15. Sir Brian set out in the final report the numerous failures across the UK over the decades as follows:

- **Deaths, illness and suffering were caused to people with bleeding disorders**, including as a result of failures in the UK licensing regime by allowing the importation and distribution of blood products which carried a higher risk of causing hepatitis, and through failure to ensure sufficient supplies of blood products (this was less a factor in Scotland);

- **Infections, leading to deaths, illness, and suffering, were caused to people who received blood transfusions**, including by failing to ensure sufficiently careful and rigorous donor selection and screening and allowing continued collection of blood from prisons, and missing out on the opportunity to screen out some high risk donors by 'surrogate' testing (i.e. testing for other markers, such as past Hepatitis B infection) as a response to the risk of HIV transmission;

- **Clinicians and the health service in particular failed those with bleeding disorders and those who were transfused**, including by being complacent about the risks of non-A no-B Hepatitis (Hepatitis C) and being slow to respond to the risks of AIDS;

- **The harms done to those infected and affected were compounded** by repeated and ongoing failures to acknowledge that they should not have been infected and to offer any meaningful apology and redress.

Key Recommendations in the IBI's Final Report

16. The IBI's final report includes a comprehensive set of twelve recommendations, including some which will need to be considered at four nations or UK level. These recommendations include that compensation should be paid as soon as possible and that what happened to people should be recognised and remembered, including with memorials to be set up in each of the four UK nations. The key recommendations which will need to be considered by the new Scottish senior Oversight Group are:

    - That NHS Education for Scotland should ensure that lessons learned by the IBI about clinical practice should be incorporated in every doctor's training.

    - That the operation of the duty of candour in healthcare in Scotland should be reviewed and extended.

    - That the external regulation of healthcare in across the UK and in Scotland should be reviewed and simplified and implementation of a safety management system should be considered.

    - That there should be an audit of the extent of the success of the digitisation of patient records in Scotland by the end of 2027.

- That those who contracted Hepatitis via NHS blood should receive particular care going forward, with regular monitoring for liver damage via fibroscans every 6 months (this should already happen for those with cirrhosis, but the Inquiry recommends others should have the scans as well).

- That the use of tranexamic acid should be offered as a treatment to minimise the likelihood of needing blood transfusions for all patients having eligible forms of surgery.

- That further improvements should be made to transfusion practices and staffing levels in hospital transfusion laboratories and ongoing improvements to haemophilia care should continue.

- That patients who underwent a transfusion before 1996 should be offered a test for HCV and GPs should ask patients when they register with a practice if they have had a transfusion before.

- That the patient voice be enabled and empowered, with clinical audits routinely seeking patients' views.

- Haemophilia Scotland and the Scottish Infected Blood Forum should continue to receive government funding to advocate for their members.

- Finally, the Inquiry also recommends UK wide that there should be a review of the Civil Service Code and the Ministerial Code to improve candour in government and consider whether the Codes should be put on a statutory basis (although clearly it would be for the SG and Scottish Ministers to consider any changes for Scotland).

Annex B

Compensation for victims of infected blood

1. In 2022, Sir Robert Francis KC produced a report for the Cabinet Office setting out proposals for a compensation framework for infected blood victims. The Inquiry has largely followed Sir Robert's proposals. Both SG and the UK Government have accepted that there is a moral case for compensation for this group given they have suffered for so long.

2. The IBI published two interim reports on compensation. The first interim report, which was published on 29 July 2022, focussed on making interim compensation payments of £100,000 to all those infected and all bereaved partners currently registered on UK infected blood support schemes. These payments were made in October 2022. In Scotland, they were made by National Services Scotland, NSS (who manage SIBSS) and funded by UK Government. The second interim report was published on 4 April 2023. The report made 17 recommendations in relation to a compensation scheme, including that there should be a UK-wide compensation scheme delivered by a new arms-length body.

3. The UK Government wanted to wait for the Inquiry's final report before confirming its plans for compensation. However, following an amendment from Dame Diana Johnson MP to the UK Victims and Prisoners Bill it was forced to bring forward a statutory framework for compensation earlier. On 17 April 2024, UK Government tabled amendments to the Victims and Prisoners Bill to establish a UK-wide infected blood compensation scheme and to make further interim compensation payments to the relatives of those who have sadly died, via their estates. These amendments represent UK Government's response to the second interim report. The detail of the wider compensation scheme is still to be laid out in regulations. However, an announcement is expected from UK Government (Minister for the Cabinet Office, John Glen MP) on **21 May**, which **could also include details of further interim compensation payments of £210,000 each to infected people**. We expect UK Government to fund both the further interim payments and the wider compensation scheme.

4. Paying money to estates (rather than paying specific relatives directly) is not the route recommended by the IBI. But given the operational challenges of delivering interim payments to relatives, UK Government has concluded that payments to estates provides a practical and pragmatic solution. We are currently working with the Cabinet Office and DHSC to agree the processes and timetable for NSS to make these additional interim payments on behalf of the UK Government. A new gov.uk website will be available soon (likely from next week), which should provide guidance on the process and the probate or confirmation steps estates will need to follow.

5. **<Redacted>**

6. **<Redacted>**. However, it will be confirmed that any SIBSS payments from April 2025 will be taken into account in calculating people's compensation awards (although previous SIBSS payments won't be).
<Redacted>

7. **<Redacted>** (although people will also have the option of taking a large lump sum instead of future regular payments to cover their award for future loss of income).

<Redacted>

ANNEX D

The Infected Blood Inquiry's Recommendations – [note key elements for Scotland/Scottish bodies are highlighted in bold]

1. Compensation

My principal recommendation remains that a compensation scheme should be set up now.

2. Recognising and remembering what happened to people

(a) A permanent memorial be established in the UK and consideration be given to memorials in each of Northern Ireland, Wales and **Scotland**. The nature of the memorial(s), their design and location should be determined by a memorial committee consisting of people infected and affected and representatives of the governments. 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. The memorial should be such as is agreed with those who were pupils at Treloar's.

(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 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. Since the duty was introduced in 2023 in Wales, the review there need not be immediate, but should be no later than

the end of 2026.

(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.

Success in implementation will be measured by the extent to which there is an increase in the number of reports made of near miss incidents to the designated data collector; and a decline in the number of widespread or significant healthcare failures.

(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 also 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, with the aim of addressing all the points made earlier in this Report and in other reports since 2000.

(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 groups (as recommended by the HSSIB), and do so as a matter of priority.

Success in implementation will be measured by the percentage of patients who know to whom they can express any concerns they may have about safety, who will take up their cause, and what they can expect from them. At the same time, it will be measured by the extent to which those who are busy working within the system, especially those in leadership roles, have clarity as to what, precisely, is expected of them, from whom. It should also be measured by a reduction in avoidable harm from both errors and systemic issues.

(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 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 a defensive culture in the Civil Service and government

(a) 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.

(b) If, on review, the Government considers that it is sufficient to rely on the current non-statutory duties in the Civil Service Code, it should nonetheless introduce a **statutory duty of accountability on senior civil servants** for the candour and completeness of advice given to Permanent Secretaries and Ministers, and the candour and completeness of their response to concerns raised by members of the public and staff.

(c) The Government should consider the extent to which Ministers should be subject to a duty beyond their current duty to Parliament under the Ministerial Code.

6. Monitoring liver damage for people who were infected with Hepatitis C.

(a) 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 the NHS, shared with NBTC, the Royal Colleges (as appropriate), and NHSBT.

(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).

Success in achieving this will be measured by the extent to which the SHOT reports for the previous three years show a progressive reduction in incidents of incorrect blood component transfusions measured as a proportion of the number of transfusions given.

(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 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 calls for a public inquiry

(a) that a minister should retain the power to call an inquiry as the minister sees fit, in accordance with the Inquiries Act 2005 – but where a minister does not choose to do so, then:

(b) if there is sufficient support from within Parliament for there to be an inquiry, the question whether there should be one should be referred to PACAC for it to consider the question.

(c) If it appears to PACAC that there is sufficient concern to justify a public inquiry, either because what happened and why has caused concern (as the committee sees it) or there are likely to be lessons learned which may prevent similar concerns arising in future, the committee may recommend to an appropriate minister that there be an inquiry.

(d) If the minister disagrees with the recommendation, they must set out in detail and publish reasons for this disagreement which are sufficient to satisfy PACAC that the matter has been carefully and properly considered.

12. Giving effect to Recommendations of this Inquiry

(a) Within the next 12 months, the Government should consider and either commit to implementing the recommendations which I make, or give sufficient reason, in sufficient detail for others to understand, why it is not considered appropriate to implement any one or more of them.

(b) During that period, and *before* the end of this year – the Government should report back to Parliament as to the progress made on considering and implementing the recommendations.

(c) This timetable should not interfere with earlier consideration and response to the Recommendations of the Second Interim Report of the Inquiry

(d) The Public Administration and Constitutional Affairs Committee ("PACAC") should review both the progress towards responding to the Inquiry's recommendations and, to the extent that they are accepted, implementing those recommendations

(e) PACAC should accept the role in respect of any future statutory inquiry of reviewing government's timetable for consideration of recommendations, and of its progress towards implementation of that inquiry's recommendations.

ANNEX E

Responding to the Inquiry's final report

<Text redacted – out of scope>

Infected Blood Inquiry Final Report

Volume 7 – Response of Government
This volume covers: document destruction, self sufficiency report, lines to take, delays in holding a public inquiry, accountability in the absence of a public inquiry, **Scotland**, Northern Ireland and Wales, The Government's response to calls for compensation 202-2024, commentary on the Government's response.

<Text redacted – out of scope>

Chapter 7.8 - Governments response to calls for compensation (p264)
This chapter outlines the chronology of what happened and states that those infected have felt a lack of transparency and openness of what they have had to face. What happened was a terrible injustice and people deserve re-dress. There have been ample opportunities for the Government to explain what it is doing and the lack of transparency compounds harm.

The report makes the recommendation that a mechanism is needed to hold the executive to account before Parliament which ensures that the recommendations are fully and properly considered and involves a body which is open, independent, cross-party and respected for its objectivity.
Chapter 7.9 – The Government's Response (p289)
This chapter discusses a cover-up or hiding the truth and not telling people what they needed to know about the risks of treatment or alternatives being less informative and using inaccurate lines to take. **The truth has been hidden and there was a lack of candour.**
The seriousness of what was happening to patients was underplayed and people were given no information about the risks of viral transmission. Apologies have never been accompanied by any admission of wrongdoing. There has not been a proper acceptance of responsibility, ,there has not been openness and transparency and there has not been recognition and understanding of the harm done and its profound and devastating impact.

Minister for Public Health and Women's Health
Minister for Parliamentary Business

PUBLICATION OF THE INFECTED BLOOD INQUIRY'S (IBI's) FINAL REPORT – GOVERNMENT INITIATED QUESTION

Priority and Purpose

1. **Urgent**. To propose a method of acknowledging the publication of the UK-wide IBI's final report on 20 May and to set out next steps in the Scottish Government's consideration of the IBI's recommendations.

Recommendation

2. That you agree that a government initiated question should be lodged on 20 May and answered on 21 May in order to acknowledge the IBI's final report.

Context and Issues

3. The IBI is a UK-wide inquiry established in 2018 by the UK Government (UKG) to investigate how thousands of people were infected during the 1970s and 1980s with HIV and/or Hepatitis from both infected blood transfusions and infected blood products (plasma-derived medicines, which at the time were primarily given to haemophiliacs).

4. The previous Scottish infected blood Penrose Inquiry Final Report (25 March 2015) estimated that in Scotland approximately 3000 NHS patients were infected with Hepatitis C virus from infected blood – 2500 infected via transfusions and 478 patients with bleeding disorders such as haemophilia. Approximately 78 patients were infected with HIV – 60 patients with bleeding disorders and 18 patients infected via blood transfusion. Infections also occurred on a large scale around the world.

5. The Scottish Government (SG) has supported the work of the IBI, providing many thousands of documents from hundreds of files (both historic and some more recent). We have also supported many Ministerial and official witnesses with their written statements and in some cases oral evidence.

6. The IBI will publish its final report on 20 May 2024, alongside a publication event in London, which the Minister for Public Health and Women's Health will attend. The IBI is likely to make recommendations covering a wide range of healthcare-related topics. Many of these will need to be taken forward at UK level. But there are also likely to be recommendations that will be directed at SG, at the Scottish Health Boards, and potentially also at the Scottish National Blood Transfusion Service (SNBTS). SG is setting up a senior level Oversight Group to consider the recommendations that might need to be taken forward at Scottish level.

7. A great deal of attention next week, following publication of the report, will be on compensating the victims of the infected blood tragedy. Accordingly, on 17 April 2024, UKG tabled amendments to the Victims and Prisoners Bill to establish a UK-wide infected blood compensation scheme and to make further interim compensation payments (following the £100k interim payments already made across the UK to infected persons and their bereaved partners in October 2022) to the relatives of those who have sadly died, via their estates. This was done in response to an interim report on compensation produced by the IBI in April 2023. A further announcement on compensation is likely to be made early next week and we are working at speed at four nations level to ensure full compensation (to be funded by UKG) is paid to all those infected or affected as soon as possible.

Options Considered and Advice

8. **<Text redacted>**, the Government Initiated Question (GIQ) below should be lodged on 20 May and answered on 21 May. Whilst we are not making an announcement as such there is likely to be a lot of interest from MSPs next week so this may help respond to their queries.

<Text redacted>

***QUESTION**:*

To ask the Scottish Government whether it will provide an update on its plans to respond to the final report of the UK-wide Infected Blood Inquiry, which was published on 20 May 2024.

ANSWER:

The Scottish Government welcomes publication of the Infected Blood Inquiry's final report and thanks the Chair for his work in producing such a comprehensive document. The Scottish Government pays tribute to all those who have been infected, their families and support organisations and reiterates our sincere apology to those who have been infected or affected by NHS blood or blood products. A copy of the Inquiry's final report is available online at xxx.

The Scottish Government will consider this report fully and is setting up an Oversight Group to help consider the Inquiry's recommendations for Scotland. That group will involve senior staff from NHS Boards and the Scottish Government, along with charities representing the infected and affected.

Quality Assurance

9. This submission has been agreed by **<Redacted>**, Head of Unit, Public Health Capabilities Division.

Conclusion and Next Steps

10. That you agree that the GIQ above should be lodged on 20 May and answered on 21 May as part of the communications plan at annex A.

11. If you are content, in the absence of a specific Health Spad, could you indicate which MSP you would like to lodge the GIQ.

<Redacted>
Public Health Capabilities
<Redacted>

Cabinet Secretaries and Ministers Copy List	**For Action**	**For Information Portfolio interest**	**For Information Constituency interest**	**For Information General awareness**
Minister for Public Health and Women's Health	X			
Minister for Parliamentary Business	X			
Cabinet Secretary for Health and Social Care		X		
First Minister				X

Officials Copy List
Permanent Secretary DG Health and Social Care Director for Population Health Simon Cuthbert-Kerr Parliamentary Clerk Communications NHS Recovery, Health and Social Care **<Redacted>** **<Redacted>** **<Redacted>** **<Redacted>**SGLD Heads of Public Health Branch **<Redacted>** SPADs Admin Ross Ingebrigtsen David Hutchison

<Text redacted>

ENGAGEMENT TITLE: Meeting with Marie McNair MSP and her Constituent, <Redacted>

Date and time of engagement	Wednesday, 29 May 2024 at 11:00am
Where	Room TG 20-21, Scottish Parliament
Who	Marie McNair, MSP for Clydebank and Milngavie (Constituency) **<Redacted>**, Scottish Infected Blood Forum
Key purpose or message	In response to Ms McNair's supplementary question in PQs on 29 November 2023, you offered to meet with her, and her constituent, to discuss support for those infected with Hepatitis B from blood or blood products.
Top facts or figures	The UK Government has now published a summary of the Infected Blood Compensation Scheme, which makes clear those infected with Hepatitis B from blood or blood products will be eligible for compensation from the Infected Blood Compensation Authority.
Sensitivities	Although there is now more certainty around those who are infected with Hepatitis B receiving compensation**<Redacted>** has so far received no financial support in relation to **<Redacted>**infection and **<Redacted>**health is in decline. People with Hepatitis B will not be eligible for interim compensation from SIBSS as that is only for those already eligible under the current SIBSS scheme. However, the UK Government have said they intend compensation payments to begin to be made in this calendar year.
Official support	**<Redacted>**
Attached documents	Annex A: Summary – Key Issues and Lines to take Annex B: Background Annex C: Summary of Compensation Scheme Annex D: Copy of PQ S60-02813 and Supplementary Q+A

Annex A

Summary of Key Points

Key message: The UK Government has been clear those infected with chronic Hepatitis B from blood or blood products will be eligible for compensation from the Infected Blood Compensation Authority, and it is intended payments will begin to be made in this calendar year.

You can now register your interest for updates on the compensation scheme on the gov.uk webpage.

Ms McNair's constituent, **<Redacted>** at the Scottish Infected Blood Forum has campaigned for compensation on behalf of **<Redacted>** and others infected and affected.

Lines to Take

- I am sorry to hear about your health conditions, and I understand how difficult the long wait for news on compensation will have been for you.

- I am pleased the UK Government has confirmed those infected with Hepatitis B through blood or blood products will be eligible to receive compensation from the Infected Blood Compensation Authority, and that these payments will begin to be made from this calendar year.

- I will continue to represent your interests in my meetings with UK Government, as I am acutely aware that up until now you have had no financial support.

- I met with the Minister of the Cabinet Office last week and asked that applications for compensation from those in your position should be considered as a priority when the Infected Blood Compensation Authority is established.

- I acknowledge the promise of future compensation does not help you at this current time, but unfortunately our hands are tied on paying any interim payments before the IBCA is set up as we have to follow what the UK Government has set out in its scheme on interim compensation payments.

  <Redacted>

- If you have any specific questions about compensation, there is a website on gov.uk and also a telephone number if you would like to speak to someone directly. If you don't already have the details I can ensure these are sent to you.

- I'm sure **<Redacted>**will have made you aware that the Scottish Infected Blood Psychology Service will now accept referrals from anyone with a Hepatitis B infection from infected blood or their close relatives. If this would be helpful, I can ensure their contact details are sent on to you.

Annex B

Background

1. The UK Infected Blood Inquiry, chaired by Sir Brian Langstaff, made recommendations in its second interim report in April 2023 for an extensive UK-wide compensation scheme for those infected by infected NHS blood or blood products and their family members. The UK Government has now published a summary of the compensation scheme, which includes compensation payments to those infected with Hepatitis B through blood or blood products. A summary of the compensation scheme is provided at **Annex C**.

2. The summary scheme document indicates those with Hepatitis B, with liver cirrhosis, would be entitled to claim the following amounts under the tariff-based arrangements:

Hepatitis C or Hepatitis B (Cirrhosis)	£985,000 - £1,130,000
Hepatitis C or Hepatitis B (Decompensated cirrhosis, and/or liver cancer and/or liver transplantation)	£1,412,000 - £1,557,000

   UK Government has noted in our meetings that these sums are indicative and the IBCA will be engaging with the infected and affected community before recommending the final compensation package. Also some people will be able to seek individualised assessment (the supplemental process) if they feel the tariff does not reflect e.g. their care needs or their loss of income.

3. Up to now, those with chronic Hepatitis B infections, unlike those with Hepatitis C or HIV, have received no compensation or support payments. Those people with Hepatitis C and/or HIV on the current support schemes, or their bereaved partners, also received interim compensation of £100,000 in October 2022 following the publication of the Inquiry's first interim report in July 2022. The Inquiry was clear in its second interim report that those with Hepatitis B should get ongoing support scheme payments in addition to compensation, if they are chronically infected. The support schemes have never accepted people with Hepatitis B in the past because the blood services were testing donors for Hepatitis B from the early 1970s. **<Redacted>**

4. At your previous meetings with the Scottish Infected Blood Forum (SIBF), **<Redacted>**pressed strongly that those with Hepatitis B should receive some form of Scottish Infected Blood Support Scheme (SIBSS) payment now.

5. However, the Infected Blood Inquiry has consistently recommended a UK-wide approach both to compensation and in terms of ensuring general parity between the four support schemes, and there would be a risk in departing from seeking a UK-wide approach. **<Redacted>**

6. Now that the Compensation Scheme has been published, there is more certainty around when those infected with Hepatitis B will receive compensation for the losses and hardships they have suffered.

Annex C

INFECTED BLOOD COMPENSATION SCHEME – SUMMARY OF KEY ELEMENTS

Overview

The UK Government published details of its proposals for its compensation scheme on Tuesday 21 May following the statement to the UK Parliament by Minister for the Cabinet Office (MCO), John Glen MP. This is set out on the new webpages for the shadow Infected Blood Compensation Authority (IBCA) at:
Infected Blood Compensation Scheme Summary - GOV.UK (www.gov.uk)

MCO confirmed that Sir Robert Francis KC has been appointed as interim chair of the IBCA, which has been welcomed by campaigners. He also confirmed the shadow body is expected to have around 20 staff by the end of May so that it can prepare quickly to deliver compensation once the Victims and Prisoners Bill receives Royal Assent and regulations on the scheme have been progressed.

The UK Government has confirmed the following key details:

- The Scheme will be open to both infected and affected people.
- The Scheme will be UK-wide.
- For the majority of applicants, **tariffs** will be used to calculate compensation. In defined circumstances, a bespoke assessment of individual needs by the IBCA will help to ensure the appropriate compensation is awarded.
- Compensation tariffs for the Scheme will be informed, but not limited, by current practice in UK courts and tribunals.
- Support scheme payments will continue to be paid on an ex-gratia basis until 31 March 2025. This means that any payments received before and up to 31 March 2025 will not be deducted from compensation awarded through the new Scheme. From 1 April, SIBSS payments would be counted towards compensation awards.
- Any past or future interim compensation payments will be automatically deducted from the compensation awards made through the Scheme.
- For people diagnosed with an eligible infection before 1 April 2025, the Scheme will remain open to applications for 6 years, **until 31 March 2031**. For people diagnosed after 1 April 2025, the Scheme will remain open to applications for 6 years from the person's date of diagnosis.
- Accepting compensation through the Scheme will not remove any right a person has to pursue a claim in court (note – some people do have claims that are sisted (i.e. on hold) in the Scottish courts – we hope people would be content with the compensation awards from the IBCA, but if not we would expect the Scottish courts to consider any government compensation received in calculating people's awards).
- Compensation payments through the Scheme will not impact people's eligibility for means tested benefits and will be exempt from tax.

Eligibility and Applications

Those who are members of SIBSS or whose relative was a member of a former Alliance House scheme will automatically be eligible for the scheme. It is expected their details will be provided to the IBCA so they should not have to apply to join (although they may need to provide extra details if they want an individualised assessment or a particular award, such as the Carers' award).

The following infected people will be eligible for compensation - note those in bold are not eligible for SIBSS and will need to apply directly to the IBCA as SIBSS will not be able to accept applications from these groups (SIBSS eligibility will **not** change).

Any person **infected** by NHS blood, blood products or a tissue transplant or a **secondary infectee** who was infected by an infected person:

- with HIV;
- with an acute or chronic case of Hepatitis C (not specified, but it is understood this includes all those whose HCV has been treated and cleared);
- with **chronic** (more than 6 months) **Hepatitis B** (HBV);
- with acute (less than 6 months) Hepatitis B where the person died as a result of the Hepatitis B infection during the acute period.

The following **affected** people will also be eligible:

- spouses, civil partners, cohabiting partners (living with the person for at least a year)
- parents, adoptive parents and others acting in the capacity of a parent
- children, including adopted or step children
- siblings, including adoptive or step siblings
- carers, who were friends or family and who provided unpaid care for at least 16.5 hours per week to an infected person for at least six months

In addition, estates of infected people can also apply for compensation where the infected person has died, but the estates of affected relatives who have died will not be eligible.

Tariffs for compensation

To try to promote simplicity for applicants and speed of making awards, the scheme proposes that 'core' awards for most will be based on set tariffs. However, in 'exceptional' circumstances, people will be able to seek an individualised assessment (a 'supplemental' route).

Illustrative rates given by the UK Gov are set out below, although care awards and financial loss awards will be calculated using a formula based on individual circumstances – however the figures below give the likely range of award for most people.

Compensation will be made up of five separate awards:

- an injury award (for physical and mental impacts of infection)
- a social impact award (reflects the stigma suffered)
- autonomy award (for impacts on family and private life)
- care award (for past and future care needs)
- financial loss award (for past and future financial losses)

Illustrative awards for a living infected person

	Total award across all Categories of award+
Hepatitis C (Acute)	£35,500
Hepatitis C or Hepatitis B (Chronic)	£665,000 - £810,000
Hepatitis C or Hepatitis B (Cirrhosis)	£985,000 - £1,130,000
Hepatitis C or Hepatitis B (Decompensated cirrhosis, and/or liver cancer and/or liver transplantation)	£1,412,000 - £1,557,000
HIV	£2,225,000 - £2,615,000
HIV and Hepatitis C/Hepatitis B (Chronic)	£2,270,000 - £2,660,000
HIV and Hepatitis C/Hepatitis B (Cirrhosis)	£2,315,000 - £2,705,000
HIV and Hepatitis C/Hepatitis B (Decompensated cirrhosis and/or liver cancer and/or liver transplant)	£2,345,000 - £2,735,000

Note – awards for the affected are more complex as they will depend more on individual circumstances, but further information can be shared if helpful.

Payments and the future of SIBSS

Infected and affected people will have a choice of receiving their compensation as a lump sum or as periodic payments – however it says the periodic payments will be for 'a fixed number of years' (rather than for life) so this is causing some concerns for beneficiaries. Estates will receive their final award as a one-off lump sum.

<Redacted>

Annex D

<Text redacted – s25(1)>

	Recommendation	Lead	Policy area	SG Policy Lead
1.	1. Compensation	UKG		**<Redacted>**
2.	**2.** Recognising and remembering what happened to people			
	(a) A permanent memorial be established in the UK and consideration be given to memorials in each of Northern Ireland, Wales and Scotland. The nature of the memorial(s), their design and location should be determined by a memorial committee consisting of people infected and affected and representatives of the governments. It should be funded by the UK government.	UKG/SG/HS		**<Redacted>**
	(b) A memorial be established at public expense, dedicated specifically to the children infected at Treloar's school. The memorial should be such as is agreed with those who were pupils at Treloar's.	UKG		
	(c) There should be at least three events, approximately six months apart, drawing together those infected and affected, the nature	UKG		

	and timing of which should be determined by a working party as described above, facilitated by some central funding.			
3	**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 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.	SG/NES		**<Redacted>**
	(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.	SG/NES		**<Redacted>**
	(c) The Inquiry website is maintained online.	UKG		

4	**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.	UKG		
	(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. Since the duty was introduced in 2023 in Wales, the review there need not be immediate, but should be no later than the end of 2026.	SG	Patient safety	**<Redacted>**
	(iii) The review of the duty of candour currently under way in England should be completed as soon as practicable.			
	(d) The statutory duties of candour in England, Scotland, Wales (and Northern Ireland, when introduced) should be extended to cover those individuals in	SG	Patient safety	**<Redacted>**

	leadership positions in the National Health Service, in particular in executive positions and board members.			
	(e) 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	SG	Patient safety	**<Redacted>**
	Success in implementation will be measured by the extent to which there is an increase in the number of reports made of near miss incidents to the designated data collector; and a decline in the number of widespread or significant healthcare failures.			
	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	SG	Patient safety	**<Redacted>**

	steps set out in (a) above, and also 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, with the aim of addressing all the points made earlier in this Report and in other reports since 2000.	UK/SG	Patient Safety Commissioner/Public Services Ombudsman/HIS	**<Redacted>**
	(ii) 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, with the aim of addressing all the points made earlier in this Report and in other reports since 2000.		Patient safety	**<Redacted>**

	Success in implementation will be measured by the percentage of patients who know to whom they can express any concerns they may have about safety, who will take up their cause, and what they can expect from them. At the same time, it will be measured by the extent to which those who are busy working within the system, especially those in leadership roles, have clarity as to what, precisely, is expected of them, from whom. It should also be measured by a reduction in avoidable harm from both errors and systemic issues.			
	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	SG	Information Governance	**<Redacted>**

	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 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.	UKG/SG	Patient safety/ commissioner/HIS	**<Redacted>**
5	**5.** Ending a defensive culture in the Civil Service and government			
	a) 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.	UKG/SG		**<Redacted>**

	b) If, on review, the Government considers that it is sufficient to rely on the current non-statutory duties in the Civil Service Code, it should nonetheless introduce a statutory duty of accountability on senior civil servants for the candour and completeness of advice given to Permanent Secretaries and Ministers, and the candour and completeness of their response to concerns raised by members ofthe public and staff.			**<Redacted>**
	c) The Government should consider the extent to which Ministers should be subject to a duty beyond their current duty to Parliament under the Ministerial Code			**<Redacted>**
6	**Monitoring liver damage for people who were infected with Hepatitis C**			
	a) All patients who have contracted hepatitis via a blood transfusion or blood products should receive the following care:	SG	Hep C clinical leads	**<Redacted>**
	(i) those who have been diagnosed with cirrhosis at any point should receive lifetime monitoring by way of six-	SG		**<Redacted>**)

	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	SG		**<Redacted>**
	(iii) where there is any uncertainty about whether a patient has fibrosis they should receive the same care	SG		**<Redacted>**
	(iv) fibroscan technology should be used for liver imaging, rather than alternatives	SG		**<Redacted>**
	(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	SG		**<Redacted>**
	(f) 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	SG		**<Redacted>**

	they are commissioning meet the particular needs of the group of people harmed by NHS treatment			
7	**6.** Patient Safety: Blood transfusions			
	a) Tranexamic acid 7.			
	(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	SG		**<Redacted>**
	(iii) Consideration be given to standardising and benchmarking transfusion performance between hospitals in order to deliver better patient blood management.	SG	SNBTC	**<Redacted>**
	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 the NHS, shared with NBTC, the Royal Colleges (as appropriate), and NHSBT.*	SG		**<Redacted>**
	c) Transfusion laboratories should be staffed (and resourced) adequately to meet the requirements of their functions.	SG/Territorial Boards		**<Redacted>**
	d) That those bodies concerned with	SG/Universities		**<Redacted>**

	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	SG/Health Boards		**<Redacted>**
	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). *Success in achieving this will be measured by the extent to which the SHOT reports for the previous three years show a progressive reduction in incidents of incorrect blood*			

	component transfusions measured as a proportion of the number of transfusions given			
	(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.	SG/SNBTS/Health Boards	Clinical practices – ask **<Redacted>** etc	**<Redacted>**
	(iii) That funding for the provision of enhanced electronic clinical systems in relation to blood transfusion be regarded as a priority across the UK.	Gg/SNBTS/Health Boards	Clinical practices	**<Redacted>**
8	**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. 9.	SG		**<Redacted>**
	b) As a matter of routine, new patients registering at a practice should be asked if they have had such a transfusion	NHS Board leads	Ask **<Redacted>**	**<Redacted>**
9	**10.** 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	NHS Board leads		**<Redacted>**
	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	NHS Board leads		**<Redacted>**
	c) A peer review of each centre should take place not less than once every five years.	NHS Board leads		**<Redacted>**
	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.	NHS Board leads/NSD with SIBDN		
	e) recombinant coagulation factor products should be offered in place of plasma- derived ones where clinically appropriate. Service	NHS Board/NSD risk share		**<Redacted>**

	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	UKG		
10	**11.** Giving patients a voice			
	a) That the patient voice be enabled and empowered by the following measures: 12.			
	(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 improvement by comparing this year's outcomes with the similar outcomes from at least the two previous years*	SG/NHS	HIS and Health Boards	**<Redacted>**
	(ii) that the following charities receive funding specifically for patient advocacy: the UK Haemophilia Society; the Hepatitis C Trust; Haemophilia Scotland; the Scottish	SG		**<Redacted>**

	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.	UKG		
	(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.	UKG/SG	Primarily UKG lead but SG may need to work with charities - Clinical priorities	**<Redacted>**
	(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.	UKG		**<Redacted>**

11	**13.** Responding to calls for a public inquiry			
11a	a) that a minister should retain the power to call an inquiry as the minister sees fit, in accordance with the Inquiries Act 2005 – but where a minister does not choose to do so, then:	UKG	UKG lead potentially stakeholders may argue same for SG ministers	**<Redacted>**
	b) if there is sufficient support from within Parliament for there to be an inquiry, the question whether there should be one should be referred to PACAC for it to consider the question.	UKG		
	c) If it appears to PACAC that there is sufficient concern to justify a public inquiry, either because what happened and why has caused concern (as the committee sees it) or there are likely to be lessons learned which may prevent similar concerns arising in future, the committee may recommend to an appropriate minister that there be an inquiry.	UKG		
	d) If the minister disagrees with the recommendation, they must set out in detail	UKG		

	and publish reasons for this disagreement which are sufficient to satisfy PACAC that the matter has been carefully and properly considered.			
12	**14.** Giving effect to Recommendations of this Inquiry			
	a) Within the next 12 months, the Government should consider and either commit to implementing the recommendations which I make, or give sufficient reason, in sufficient detail for others to understand, why it is not considered appropriate to implement any one or more of them.	UKG	Clearly directed at UKG but SG will need to update Scottish Parliament in due course	**<Redacted>**
	b) During that period, and *before* the end of this year – the Government should report back to Parliament as to the progress made on considering and implementing the recommendations.	UKG		
	c) This timetable should not interfere with earlier consideration and response to the Recommendations of the Second Interim	UKG		

	Report of the Inquiry			
	d) The Public Administration and Constitutional Affairs Committee ("PACAC") should review both the progress towards responding to the Inquiry's recommendations and, to the extent that they are accepted, implementing those recommendations	UKG		
	e) PACAC should accept the role in respect of any future statutory inquiry of reviewing government's timetable for consideration of recommendations, and of its progress towards implementation of that inquiry's recommendations.	UKG		

ENGAGEMENT TITLE: Minister for Public Health and Women's Health visit to Scottish National Blood Transfusion Service (SNBTS)
(note on release - this engagement did not take place due to other Ministerial duties)

Date and time of engagement	Date - Wednesday 8 May 2024 Time - 09:45 – 11:15
Where	The Jack Copland Centre (JCC) 52 Research Avenue North Heriot-Watt Research Park Edinburgh, EH14 4BE.
Who	Professor Marc Turner, SNBTS Director **<Redacted>**, Head of SNBTS Communications
Key purpose or message	Professor Turner invited Ms Minto to visit the JCC to see first-hand the work that SNBTS does and to discuss the Infected Blood Inquiry's (IBI's) final report (20 May).
Agenda	**09:45 - 10:00:** Arrival at JCC main entrance. Greeted by Marc Turner who will give the Minister a short overview tour. **10:00 - 11:00:** Meeting Room and refreshments. Marc will give an introduction to the work of SNBTS and lead a discussion with the Minister on future issues, focusing on the publication of the IBI's final report on 20 May. **11:00 – 11:10:** Social media opportunity and departure. Photos, short piece to camera if time permits
Media handling	No official media planned. However, SNBTS may wish to conduct a short photo opportunity for social media.
Official support	**<Redacted>**– Senior Policy Officer, Blood Policy
Specific entrance car/parking arrangements	Car parking is available at the main entrance.
Briefing Contents	**Annex A – Key Messages for Social Media** **Annex B – SNBTS overview and background** **Annex C – Roundtable Discussion with Marc Turner on the Infected Blood Inquiry's Final Report**

Annex A

KEY MESSAGES FOR SOCIAL MEDIA

<Redacted – out of scope>

Annex B

<Redacted – out of scope>

Annex C

Roundtable Discussion with Marc Turner on the Infected Blood Inquiry (IBI)'s Final Report

The main rationale for this visit will be the opportunity for a roundtable discussion with Marc Turner. Marc will brief you on his perspective on what happened to infected blood victims and what has been done since.

The IBI is a UK-wide inquiry established in 2017 by the UK Government to investigate how thousands of people were infected with HIV and/or Hepatitis from both infected blood transfusions and infected blood products. The Inquiry will publish its final report on 20 May. It is estimated approximately 3,000 people in Scotland were infected with hepatitis C through NHS blood or blood products in the 1970s and 80s. Some were also infected with HIV. Infections also occurred on a large scale in the rest of the UK and around the world.

Factor concentrate, used to treat people with bleeding disorders such as haemophilia, was produced by pooling human blood plasma from donors and concentrating it to extract the required clotting factor (normally Factor VIII or Factor IX). In the 1970s and particularly early 1980s many of these products became contaminated with HIV, hepatitis B (HBV) and especially hepatitis C (HCV). Some of those unintentionally infected their partners, often because they were unaware of their own infection. Many others who did not have a bleeding disorder were infected with HCV – and in a few cases HIV or HBV - as a result of contaminated blood transfusions up until September 1991. A large number were unaware of their infection for many years before diagnosis.

Responding to the IBI's final report

It is likely that most of the recommendations in the final report will focus on current practice, which will mean practical implementations, potentially around future blood safety and transfusion practice for SNBTS and will need to involve others including CMO/DCMO/CNO with the territorial Health Boards around ensuring good practice is always followed on informed consent processes for transfusions and ensuring appropriate steps are taken to ensure transfusions are only given when needed.

Establishing an oversight/steering group to deliver the recommendations

The Scottish Government's Health and Social Care Management Board agreed that a group or taskforce should be established to bring together NHS and infected blood stakeholders in order to oversee or ensure the effective delivery of the Infected Blood Inquiry's recommendations, where those recommendations are to be implemented by the Scottish Government or NHS Scotland.

The group would not be expected to deliver the recommendations itself and, in most cases, should not need to consider in detail how recommendations ought to be delivered, but given there could be significant numbers of recommendations covering a wide range of healthcare-related topics, the group will act as a forum to agree prioritisation of recommendations, taking account of their feasibility and potential impacts on other Health Board work, and assign responsibility for taking forward individual recommendations to organisations, existing groups (where a relevant group exists) or teams.

It is expected that SNBTS will nominate a representative to be part of this group (assuming there will be recommendations for them which they would be involved in). The group will be chaired by the Director of Population Health and representatives from the Scottish Association of Medical Directors (SAMD), Directors of Public Health, Healthcare Improvement Scotland, Haemophilia Scotland and Scottish Infected Blood Forum will be invited to join the group, together with CMO/DCMO.

<Text redacted>

Topics for discussion with Marc Turner/questions to ask

- The history of the scandal in Scotland and what went wrong.
- Who was infected and why it happened.
- What could have been done better in Scotland.
- What changes have already been made since the 1990s to ensure such a scandal could not happen again and whether there is further work still to be done.
- What has already been done to make blood safe.
- **<Redacted>**
- What Marc has done to prepare SNBTS for the IBI's report and what he will say on the day.