



Llywodraeth Cynulliad Cymru
Welsh Assembly Government

WRITTEN STATEMENT BY THE WELSH ASSEMBLY GOVERNMENT

Title: Response to the Independent Inquiry into Contaminated
Blood and Blood Products

Date: 20 May 2009

By: Edwina Hart, Minister for Health and Social Services

An independent public inquiry was set up in March 2007, chaired by Rt Hon Lord Peter Archer of Sandwell QC, looking into the events in the 1970s and early 1980s relating to *'the supply to patients of contaminated NHS blood and blood products, its consequences for the haemophilia community and others affected: and further steps to address both their problems and needs and those of bereaved families'*.

The Inquiry's report was published on 23 February and concluded that:

- A full Public Inquiry into this issue should have been held much earlier to address the concerns of the haemophilia community.
- The procrastination in achieving national self-sufficiency to avoid the use of high-risk blood products from overseas had disastrous consequences. Had self-sufficiency been achieved earlier the scale of the catastrophe would have been significantly reduced. If in the future concern arises about the safety of blood products this lesson must be remembered.
- The doctor-patient relationship during the evolution of this tragedy sometimes had unfortunate consequences. The medical profession appears to have made good progress in this area. The importance of patient involvement when making difficult clinical decisions is now appreciated and should not be forgotten.
- Commercial priorities should never again override the interests of public health.

I welcome the report, Lord Archer and his fellow inquiry members have undertaken a comprehensive and detailed review bearing in mind the difficulty of examining events which took place over 20 years ago.

I have considered the Report's recommendations and have set out my response to each recommendation below. There are, however, a couple of recommendations which still require more detailed consideration.

The Report considered the supply of virus-contaminated blood and blood products, and the devastating effect of this on the haemophilia community in particular, from the early 1970s onwards, until tests became available for hepatitis C and HIV.

Recommendation 1 - A statutory committee to advise on the management of haemophilia

I agree entirely with the argument in Lord Archer's report that it is vital for patients to be represented where decisions about good practice in healthcare provision are being made. That is the key principle of the reform of healthcare provision in Wales currently underway.

Whilst I acknowledge that patient involvement is vital, I, together with the other UK health administrations, am not convinced that a new statutory committee, with powers over the supply of blood and blood products, as well as access to treatments for haemophilia, is the best means to involve haemophilia patients in such decisions.

We still think it vital to have strong mechanisms in place to provide independent expert advice on blood safety, and to recommend improvements. We have an established mechanism to do this through the expert scientific advisory committee on the Safety of Blood, Tissues and Organs (SaBTO), which advises the UK administrations. SaBTO has patient representation and is developing effective means of communicating its advice for stakeholders and the public.

Our collective view is that it is better to build on existing arrangements and existing expertise. We have, therefore, decided to build upon the existing UK-wide partnership, known as the Haemophilia Alliance, between patients, haemophilia doctors and others involved in their care. The Alliance will be asked to provide advice on matters relating specifically to the care of haemophilia patients and will also be invited to sit on relevant Welsh Assembly Government advisory groups. We will also ensure that strong links are made between the Alliance and SaBTO.

Recommendation 2 - Haemophilia patients and their partners to receive any tests recommended by the statutory committee

Any new relevant tests for transfusion transmitted infections recommended by the Haemophilia Alliance will be considered.

Recommendation 3 - All blood donors to receive the same tests (recommended by the statutory committee)

SaBTO already advises on tests for blood donors and will continue to do so.

Recommendation 4 - Free prescriptions and free access to other services “not freely available under the NHS including GP visits, counselling, physiotherapy, home nursing and support services” for those infected

Within Wales this recommendation is already being met as free prescriptions were introduced in April 2007. I am committed to ensuring that people with haemophilia and others who have been infected with hepatitis C and/or HIV from blood and blood products are well cared for, supported in their communities and fully informed about how best to look after their health. Any recommendations from the Haemophilia Alliance to improve the care of this patient group will be considered.

Recommendation 5 - Secure future of Haemophilia Society by adequate funding

The Department of Health in responding to the Lord Archer Report, is proposing to provide funding to the Haemophilia Society. The Welsh Assembly operates a number of grant schemes to support charitable and voluntary organisations which provide services for the people of Wales, which such organisations could consider applying to.

Recommendation 6 - Financial assistance should be increased and take the form of prescribed periodic payments

There are currently three payment schemes in operation in the UK.

The Macfarlane and Eileen Trusts were set up for patients inadvertently infected through blood and blood products with HIV. These Trusts have paid out over £45m to date. The Department of Health oversee the running, on behalf of the UK, of both the Macfarlane Trust and the Eileen Trust and in its response to the Lord Archer Report; it has committed to increase the funding available.

The Skipton Fund is a UK-wide ex gratia payment scheme to make payments to people who were infected with hepatitis C through treatment with NHS blood or blood products prior to September 1991. The Skipton Fund was established jointly by the four UK health administrations to administer the scheme and make payments to relevant claimants. The Scheme has paid out over £97m including over £5.3m to Welsh recipients. We will not be changing the way the Skipton Fund is currently operated but I, together with the other Health Ministers in the UK, am making a commitment to review the scheme in 2014, when the Trust has been in existence for 10 years.

Recommendation 7 - Access to insurance by providing premiums or setting up separate scheme

The Association of British Insurers (ABI) has assured the Department of Health that insurers do not treat haemophiliacs or those infected only with HIV or hepatitis C differently to people with other pre-existing conditions. In all

cases, a person's insurability and level of premiums are determined through assessment of their individual risk.

The increased payments made available by the Macfarlane and Eileen Trusts will help people infected with HIV to meet higher insurance premiums they may face.

Recommendation 8 - A look back exercise to identify any others who may be infected

A further look-back exercise to identify any other individuals not already identified by previous exercises will be undertaken and the UK Haemophilia Centre Doctors Organisation (UKHCDO) has been asked to undertake this.

In conclusion, the Welsh Assembly Government recognises and regrets the tragic outcome for many patients and their families, who have suffered as a result of the very treatments which should have transformed their lives for the better.

I have a responsibility; however, to consider the Report within the context of the needs of the wider NHS in Wales. I recognise that my response to the Report's recommendations is unlikely to satisfy fully the concerns and wishes of those individuals that have been so terribly affected.
