The Recommendations

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 plasmaderived 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.

Source: https://www.infectedbloodinquiry.org.uk/sites/default/files/Volume-1.pdf