NHS
Blood and Transplant

UK Infected Blood Inquiry: learning outcomes

IPFA 15th May 2025

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Outline

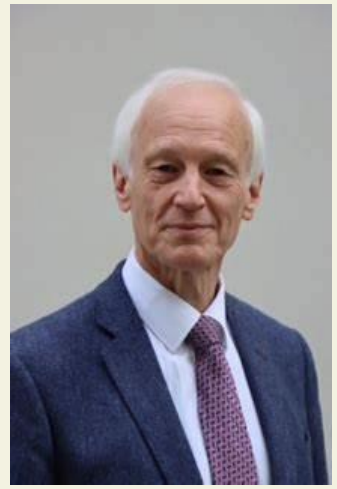
- Background
- General considerations
- Recommendations
- Transfusion microbiology

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Inquiries

- Previous inquiries
  - Archer inquiry- England
  - Penrose inquiry

- Government announcement July 2017 Infected Blood Inquiry (IBI)
- Independent statutory inquiry: Sir Brian Langstaff
- Commenced September 2018



‘The worst treatment disaster in the history of the NHS’ Lord Winston

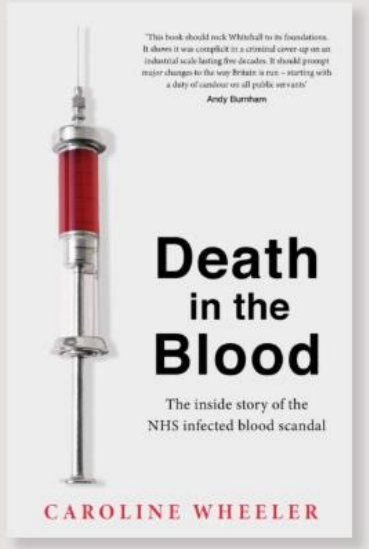
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Numbers harmed

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Plasma

- 1250 people with bleeding disorders infected with HIV
- Between 2400 and 5000 with hepatitis C



Blood transfusion

- 100 recipients infected with HIV
- Approximately 27,000 recipients infected with HCV, 22,000 chronic

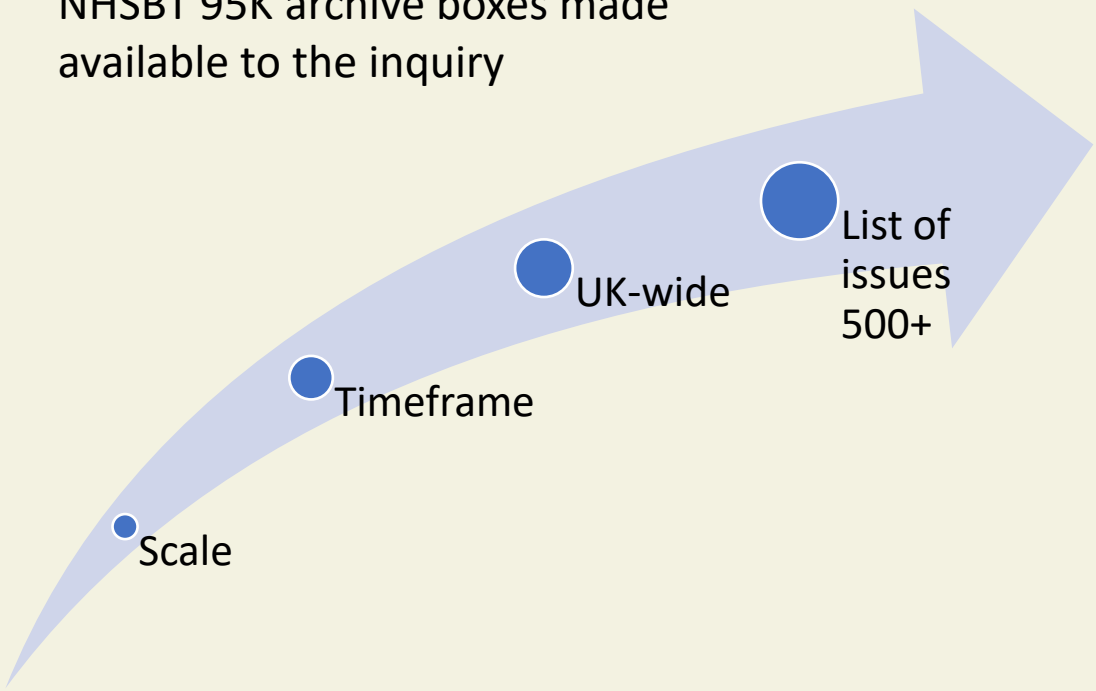
- More than 3000 deaths attributed to blood and blood products



Principles and scale of the inquiry

- People focussed
- Thoroughness
- Respect
- Openness and Transparency
- Independence
- Listening

NHSBT 95K archive boxes made available to the inquiry



September 2018 – May 2024…….May 2025 additional hearings

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The Inquiry Report

Published 20 May 2024 (7 Volumes)

Final report.
https://www.infectedbloodinquiry.org.uk/reports/inquiry-report

Chair of the Inquiry's final oral statement and reflection ceremony.
Infected Blood Inquiry Live Stream (youtube.com)




Infected Blood Inquiry
Remarks from
Sir Brian Langstaff
& Reflections
Central Hall Westminster
Monday 20 May 2024

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I have to report a catalogue of failures which caused this to happen. Each on its own is serious. Taken together they are a calamity. Lord Winston famously called these events ‘the worst treatment disaster in the history of the NHS’

Sir Brian Langstaff

Infected blood inquiry report, volume 1 page 2.

The Inquiry Report | Infected Blood Inquiry

General comments

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- Unethical lack of respective for patient autonomy
- Dangers of clinical freedom
- Institutional defensiveness
- ‘Group think’ lack of transparency and candour’
- Refusal to accept responsibility

Plasma

- Licensing
- Regional approach to blood collection
- National plasma targets not met
  - self sufficiency
- Viral inactivation
- Increased pool sizes

Recommendations

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

Infected Blood Inquiry

Recommendation 3: Learning from the inquiry- education

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Medical regulators and NHS England should ensure ‘lessons to be learned’ for clinical practice should be incorporated in doctor’s training



Use the inquiry and testimonials to do this



Inquiry remains online



Recognising and remembering what happened and incorporating into medical training

Recommendation 4: Preventing future harm to patients-achieving a safety culture

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- Duty of candour wider impact
- More rational approach to regulation and safety management
- Patient records-digitisation, access to records
- Coherent approach to data
- Recommendations of previous inquiries

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Recommendation 7: Patient Safety Blood Transfusion

- Tranexamic acid: surgical checklists, treatment of preference, standardisation and benchmarking of Tx performance
- Staffing with focus on laboratories
- Training in transfusion
- Implementing and monitoring SHOT recommendations
- Outcome of transfusion: framework for outcomes of recipients- use to improve practice, need for digitisation

SHOT: https://www.shotuk.org

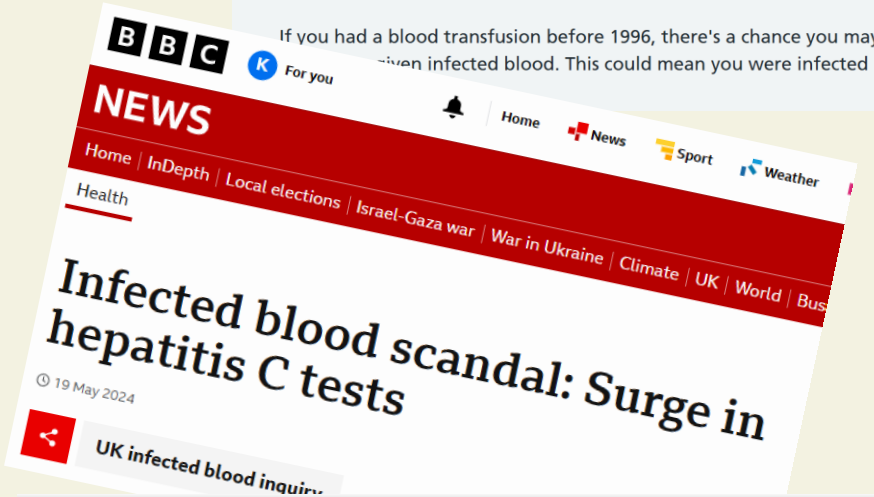
Recommendation 8: Finding the undiagnosed

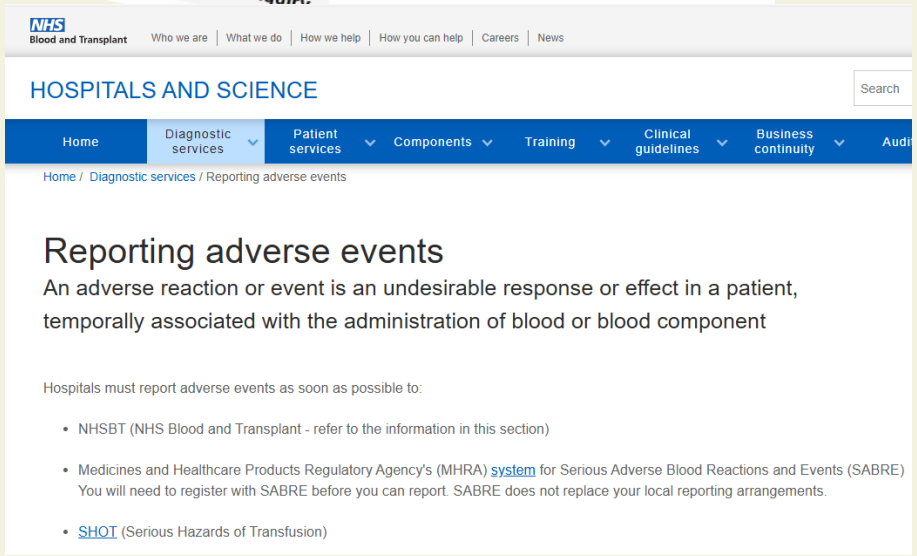
Advice regarding testing of those concerned and new patients registering with a GP

UKHSA and NHSE - online HCV testing

But….lookback and post transfusion infection investigations play a small part in finding undiagnosed







Recommendation 10: Giving patients a voice

- Consideration of holistic needs of those with Thalassaemia and Sickle Cell Disease
- Money made available for charities supporting infected and affected post IBI report
- Specific charities receive money for patient advocacy
- Giving patient a voice- yellow card scheme for Transfusions
- Clinical audit: include measures of patient satisfaction



Issues related to infection

- Slow and protracted nature of decision making
- Delays in introducing HCV testing-’best became the enemy of the good’
- ‘perfect outcomes rather than good outcomes that could meet Public Health need’
- Preoccupation with adverse publicity –AIDs leaflet
- Surrogate testing-desire to look for more knowledge

Recognising risk



Risks to patient not addressed quickly enough, clear structure for decision making required



Better understanding of risk- requires right expertise and need to be listened to



Horizon scanning-investment in wider PH



Coherent approach to data- trending

Impact on patients



Information and consent people not warned of risks misleading assurance



Importance of shared decision making



Lack of information took away ability to make an informed decision and *give* informed consent

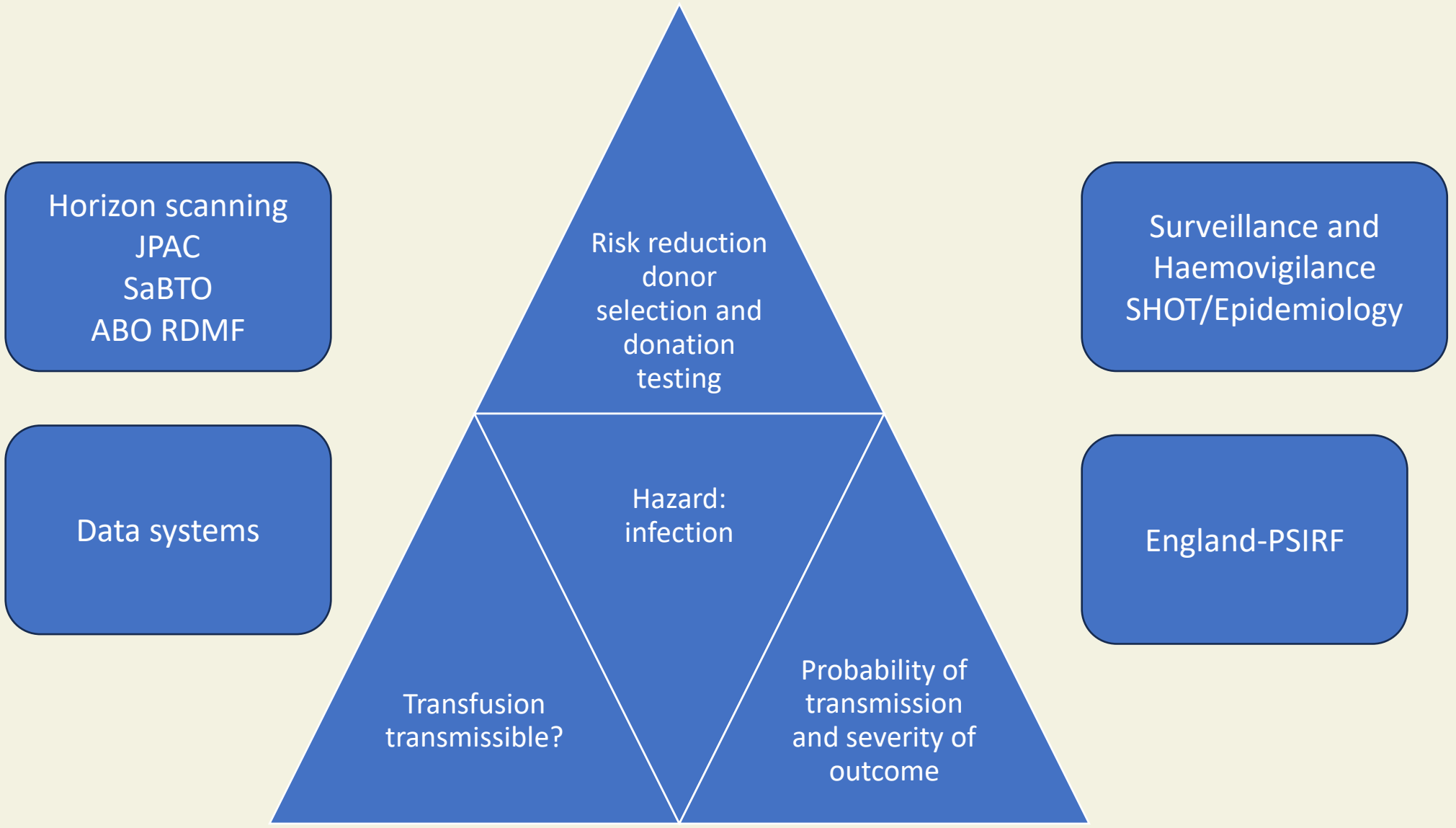


Understanding of risk: risk to patient and potentially family members



Importance of involvement of donors, patients and public in research and policy changes

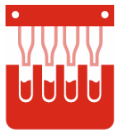
Are transfusion transmitted infections still of concern?



Collect and analyse the right data and share widely: are systems fit for purpose?

Safe Supplies 2023: Close monitoring of blood donations

Then and now

									
	UK-wide surveillance schemes to monitor safety and inform policy	HIV in the general population	Donor deferral for GBMSM	Donation screening	HIV, HCV or HBV positive donations removed from blood supply	Recent infections in repeat donors (seroconverted within 1 year)	Infectious window periods (days)	Estimated risk of missing an infectious HIV, HBV or HCV in the window period	TTIs reported in SHOT by year of transfusion
1996	Just set up	A third of cases undiagnosed HAART introduced	Permanent since 1983	Serology HIV, HCV, HBV, syphilis	445 donations 15.7 per 100,000	3 HIV 2 HCV 4 HBV (England)	HIV 15 HCV 59 HBV 80.5	HIV 0.13 in 1 million HCV 0.37 in 1 million HBV 1.43 in 1 million	6 1 HIV (3 recipients), 1 HCV 1 HBV 1 HAV 1 variant CJD 1 bacteria
2023	Nearly 30 years of data 4 donor selection policy reviews Horizon scanning	94% of cases diagnosed Treatment as prevention	GBMSM deferral removed, individualised since 2021	Serology HIV, HCV, HBV, HTLV, syphilis. NAT HIV, HCV, HBV, HEV. Bacteria	118 donations 6.6 per 100,000	2 HIV 0 HCV 3 HBV (UK)	HIV 9 HCV 4 HBV 30	HIV 0.05 in 1 million HCV 0 in 1 million HBV 0.7 in 1 million	2 1 malaria 1 HAV

https://hospital.blood.co.uk/diagnostic-services/microbiology-services/epidemiology/

Notes on data: HIV general population data from AIDSMAP & UKHSA; Risks estimated using 1996 to 1997 and 2021 to 2023 surveillance data, 1996 window periods and risks taken from Soldan et al 2005 Eurosurveillance; TTI taken from SHOT annual report TTI chapter. Risks and TTI data based on surveillance data supplied to NHSBT/UKHSA Epidemiology Unit by NHSBT, NIBTS, SNBTS and WBS.

‘To ensure the greatest possible safety, we need to avoid complacency. There is no basis for assuming that threats are all in the past: but watchfulness and learning the lessons of what happened in the infected blood disaster are critical to this’

Infected Blood Inquiry report volume 1, page 200

Summary

- General comments affecting everyone in healthcare: safety, training and staffing
- Management of data and use of digitisation in healthcare
- Issues specific to transfusion
- The need to act even when data is limited, honest and informed consent
- Cultural change and duty of candour

NHSBT implementation group [Infected Blood Inquiry - NHS Blood and Transplant (nhsbt.nhs.uk)]

Acknowledgments

Those infected and affected including those who gave evidence to the inquiry

Internal and external legal colleagues

Current and former NHSBT staff witnesses

NHSBT/UKHSA Epidemiology Unit



Picture: Reuters