Infected Blood Inquiry

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25:3:21

"Leaks"

Still no comment from the Cabinet Office about the leaked story that they were commissioning an independent review of the alternative means of compensating patients harmed by contaminated blood.

This is not the first leak in this subject area.

Patient campaigning groups recently got hold of briefing papers for ministerial meetings in January which according to them were full of inaccuracies.

The explanation may lie in the recent Inquiry decision to create a new expert group to assess the economic impact of illness caused by contaminated blood.

Perhaps the Cabinet office wanted their own expert opinion available when the DHSC are called to give evidence.

There are potentially billions of pounds at stake. If the NHS has to pay more it will blow a big hole in development plans or alternatively decimate the DHSC headquarters budget [which covers existing compensation costs in England]. Ministries in Scotland, Wales and Northern Ireland would be equally hit as they coughed-up their share.

Meanwhile the Inquiry continues taking evidence from the various bodies set up to handle financial support to victims and their families. We hear more evidence of rows about funding and threats to resign.

It will be interesting to see whether the DHSC evidence is defensive or thoughtful …

We hear allegations of bullying from hard pressed staff and one who was sacked and required to sign a non-disclosure order.

We hear from financial advisors who spent a lot of time with patients talking about debt management, insurance cover and mortgage difficulties.

Sadly we also learn of a manager who defrauded his Trust.

One disaster after another.

A long chain of evidence is about a Minister [Caroline Flint] claiming publicly to have given an 11% increased with one hand and withdrawing a separate grant on the other with a net result of an increase of less than 2%.

Questions are raised about the transfer of reserves to the Terrence Higgins Trust [£1.1m] when the charities were wound up rather than distributing the money to patients and their dependents.

We then have a witness some readers will remember Ann Lloyd former Chief Executive of NHS Wales.

For two years she had chaired the Caxton Trust

which at its peak had over 1000 beneficiaries.

She is questioned about the independence of her Trust.

Was she responsible to the DHSC for the disbursement of Government funds or to the charity.? Both seemed to be the answer.

She draws a neat distinction between campaigning [which her Trust did not do, although the Trust deed did not prohibit it] and acting as an advocate for patients.

Why was it, counsel asked, that the Caxton Trust underspent its allocation [they were not allowed to keep reserves] and still had registrants living in poverty?

Were they just being careful with the government's money or were claimants difficult to find? An interesting exchange about the definition of poverty and avoiding a dependency culture. [A later witness is questioned about concerns that if the compensation levels are too high some patients may not continue with treatment in order to avoid losing their benefits].

Ann Lloyd is a straightforward witness who the judge complimented for her crisp yes.. no… don't know, answers.

Two tentative conclusions on the basis of all this evidence.

First setting up multiple charities to channel support to patients and their families was not a good idea. None of them emerge with much credit, despite the best intentions of many of those involved.

Providing lifelong support for injured patients and their families is a complex and expensive business.

Instead of a constant battle about funding it would have been better if the DHSC had reached an agreement with the Treasury to offer a guaranteed life-long support system [an index linked pension of sorts] or a large enough capital sum to secure lifelong support. It was always going to be an expensive business.

It will be interesting to see whether the DHSC evidence is defensive or thoughtful about what they have learned from the mistakes that were made and what plans they have for the long-term care of patients the NHS damaged.

Substantially increased one off payments looks to be the best result for the DHSC particularly if they can persuade the cabinet office to pay.

Amongst the next set of witnesses is the man in charge of blood policy at the DHSC between 1998 and 2003 who will I suspect be called to give evidence more than once. His first visit is about his role as a Trustee of the Caxton Trust. The Trusts and the DHSC were clearly closely intertwined.

Should the Charity Commission have intervened?