NHS Blood and Transplant

Board Meeting in Public

Tuesday, 20 May 2025

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Presented for	☐ Approval ☐ Assurance	☒ Information ☒ Update	

Executive Summary (max 300 word count)

This paper provides the Board of NHS Blood and Transplant (NHSBT) an annual update on NHSBT's engagement with the Infected Blood Inquiry (IBI) as well as developments in the wider programme of work. It outlines:

a) initial findings from the Inquiry's final report,
b) progress of working groups,
c) our openness and stakeholder engagement approach,
d) key national strategic constraints (including funding and governance changes)
e) the impact of the spending review and governmental changes to the delivery of the recommendations
f) positive collaborative work with the four nations
g) the recent inquiry hearings
h) an update on recommendation 7
i) initial insight into the ongoing IBI Memorial Art Project Plan.

NHSBT continues to play a collaborative and supportive role in delivering the Inquiry's recommendations, offering expert advice and leadership where appropriate. We remain fully engaged with national partners through Department of Health and Social Care (DHSC) and NHS England (NHSE) coordination boards, while driving internal implementation with active oversight.

NHSBT's response is underpinned by a commitment to openness, transparency and compassion, exemplified by early apologies and voluntary sharing of information, and a duty of care to those affected/infected.

Previously Considered by

Summary of content shared at CGC

Recommendation	This paper is presented for information, to update the board on the IBI and the recommendations from NHSBT. On May 20, 2025, the UK will mark the first anniversary of the publication of the final report from the Infected Blood Inquiry, a significant milestone in addressing one of the National Health Service's (NHS) most devastating scandals. Through the last year NHSBT has engaged with NHSE, DHSE, affected and infected persons and other ALBs, and updates of those engagements have been shared internally and externally for work delivered to date.

	In addition to this paper the Board will see a reflective board story shared by a colleague whose relative was affected (infected) by the infected blood tragedy and has, sadly, passed away. Regular engagements with affected staff members.
Risk(s) identified (Link to Board Assurance Framework Risks)	
This links to Risk 01 – Harm to a donor or patient	
Strategic Objective(s) this paper relates to: [Click on all that apply]	
☒ Collaborate with partners ☐ Invest in people and culture ☒ Drive innovation ☒ Modernise our operations ☐ Grow and diversify our donor base	
Appendices:	

1. Introduction

1.1. Sir Brian Langstaff's Infected Blood Inquiry published its final report on 20 May 2024, detailing the tragic failings in the 1970s–80s contaminated blood scandal and the decades-long inadequate response.

1.2. The report spans seven volumes and delivered 12 primary recommendations (with 57 sub-recommendations) aimed at securing justice and preventing future harm. These recommendations cover a formal compensation scheme, a government apology, enhanced healthcare and support services for those infected and affected, improved transparency in public health communications, and long-term monitoring of victims' health.

1.3. Collectively, the Inquiry's findings are sobering, they stress broad lessons for the NHS and government, including the critical importance of honesty and Duty of Candour at all levels.

1.4. Seven of the twelve primary recommendations are health-related, allocated to DHSC, NHSE or relevant health bodies for action. Notably, Recommendation 7 focuses on Patient Safety in Blood Transfusion, which is directly pertinent to NHSBT's services.

1.5. Other health system recommendations address issues such as record-keeping and patient notification (e.g. Recommendation 4 on auditing digitised patient records), giving patients a voice (Recommendation 10) and training/education (Recommendation 3), areas where NHSBT has contributory responsibilities.

1.6. The remaining recommendations (including those on compensation and apology, e.g. Recommendations 1–3, 5, 11 and 12) are led by the Cabinet Office, but even in these domains NHSBT has offered support (for example, providing data or expert input.

1.7. It is noteworthy that NHSBT engaged proactively with the Inquiry from the outset led by our Chief Medical Officer (CMO). The organisation was the first to waive legal privilege on relevant documents and issued public apologies early in the Inquiry process.

1.8. This stance has been recognised as helping set a tone of openness. The Initial Findings of the Inquiry reaffirm NHSBT's resolve to not only acknowledge historic failures but also to apply the lessons learned going forward, particularly around transparency, accountability, and patient safety culture.

1.9. All Executive and Board members are mindful of the Inquiry's conclusions and the personal impact on those infected and affected, this continues to inform our strategy and actions.

2. IBI NHSBT Implementation Group

2.1. Following the final report, NHSBT swiftly established an IBI Implementation Group (May 2024) to drive and coordinate our response. This internal working group, led by the Chief Nursing Officer, brings together senior clinical, scientific and operational leaders and

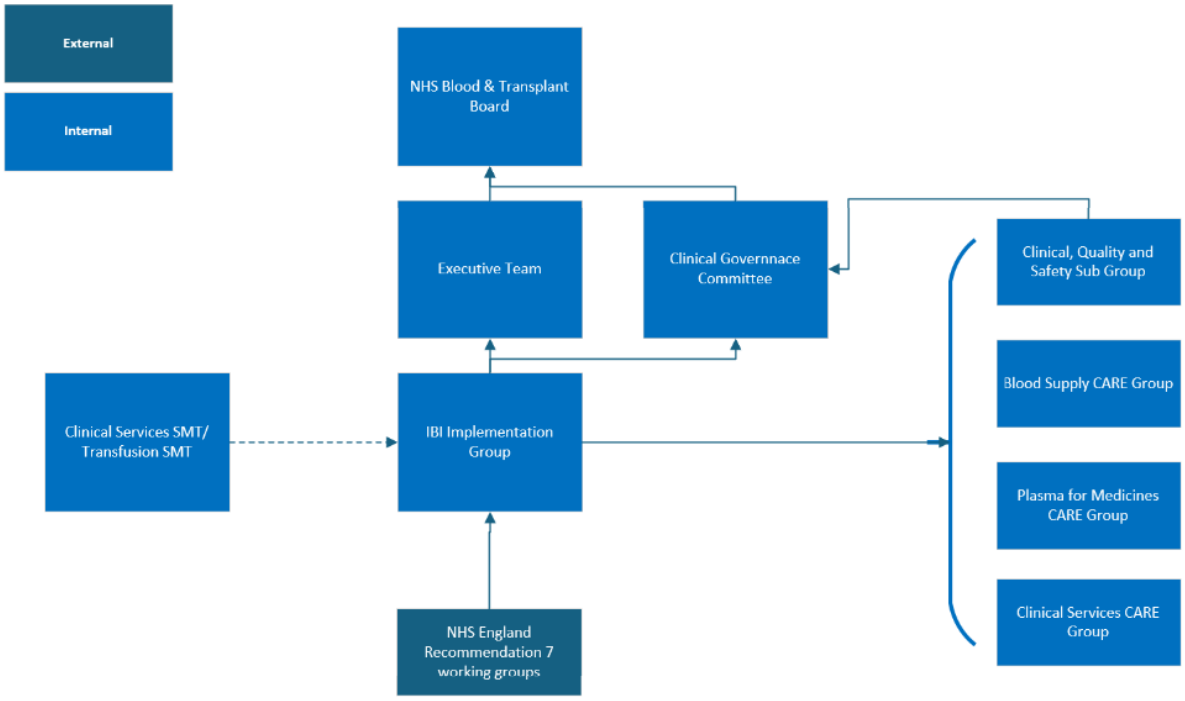
includes representatives from key stakeholder groups (including affected employees and donor representatives).

2.2. The group's Terms of Reference were agreed in mid-2024 (and are currently under review), and an initial gap analysis was completed to compare the Inquiry's recommendations against NHSBT's current practices. This gap analysis identified areas requiring action or improvement, particularly in relation to Recommendation 7's sub-elements on transfusion safety. The Implementation Group has met regularly (quarterly through 2024/25) to oversee progress on these action plans.

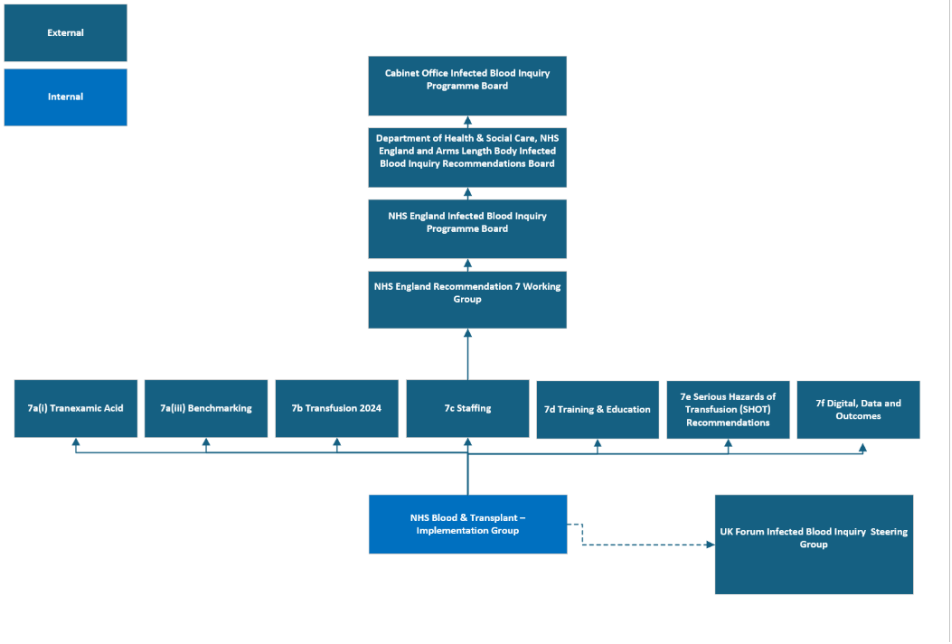
2.3. Outputs and updates from each meeting are shared robust governance processes that ensure transparency and staff awareness. The internal and external governance and subsequent reporting dissemination can be seen in the diagrams below.

3.

Internal Governance:



External Governance:



4. IBI National level

4.1. At the national level, NHSBT is an active participant in the DHSC-led IBI Recommendations Programme Board (established June 2024) which coordinates health system responses.

4.2. We also contribute to the NHSE IBI Delivery Board, ensuring that NHSBT's responsibilities (e.g. in transfusion practice, look-back exercises, data provision) are integrated with the wider NHS response. NHSBT subject matter experts chair or sit on various multi-agency working groups aligned to specific recommendations.

4.3. For example, for Recommendation 7 (Patient Safety: Blood Transfusion), NHSBT co-chairs the working stream alongside NHSE leads, and is a principal member of sub-groups on areas such as appropriate use of tranexamic acid, transfusion laboratory staffing, and haemovigilance reporting. A combined working group for Recommendation 3 and 7(d) (education and learning) has been formed with representation from all four UK nations, professional bodies, and NHSBT. This ensures a coordinated approach to transfusion education improvements across the UK.

4.4. Progress to date overseen by these groups includes development of a national action plan for safer transfusion practice, alignment of NHSBT's ongoing projects with Inquiry objectives, and collaboration on public communications. The working groups also serve as an early warning system for risks or delays, feeding into NHSBT's risk management (with escalation to the Executive as needed). The IBI Implementation Group will continue to provide oversight and assurance that NHSBT is meeting its commitments, reporting into our Clinical Governance Committee and up to the Board. Overall, this collaborative infrastructure, internal and external, gives confidence that NHSBT is fully engaged and contributing effectively to the multi-agency Inquiry response.

5. Openness approach and duty of candour

5.1. NHSBT has adopted an Openness Approach grounded in candour, transparency and compassion. We recognise that public trust is paramount, given the historic loss of confidence caused by the contaminated blood tragedy. In line with the Inquiry's emphasis on frankness, NHSBT's leadership has prioritised clear and honest communication.

5.2. The Board and Executive are also reinforcing a culture of Duty of Candour within NHSBT. This includes extending the duty to organisational contexts, being honest about mistakes and learning from them – not only in clinical settings but also in corporate governance. We note the Inquiry's recommendation to strengthen candour obligations for leaders, and we have included this in our internal policy reviews. Board members and senior managers have reflected on the Inquiry's lessons and committed to model candour and accountability in their roles.

5.3. Crucially, compassion underpins our openness. We acknowledge the hurt and trauma experienced by those infected and affected. All communications, whether a public update, staff briefing, or correspondence with victims' families, are framed with empathy and respect. We have encouraged managers to allow staff directly impacted to speak openly about their experiences and to ensure they feel heard and supported. This compassionate, transparent ethos not only meets our moral obligations but also mitigates reputational risk by showing that NHSBT is confronting the past honestly. The Board can take assurance that openness remains a guiding principle as we implement the Inquiry's recommendations.

6. Engaging with stakeholders and employees

6.1. Stakeholder engagement remains a vital component of NHSBT's response. This includes our active participation in the IBI Recommendation Working Groups, ensuring that the voices of those affected are represented and reflected in our actions. We are also engaging widely across the transfusion community, including healthcare professionals, system partners, and patients, to collaborate and ensure we are driving change in transfusion care transparency, inclusivity, and shared learning as we implement improvements across the organisation.

6.2. Our Communications team works closely with the Cabinet Office and DHSC to coordinate public communications so that affected communities receive timely and accurate information (for instance, aligning announcements on compensation progress to avoid confusion). This collaborative approach to stakeholder engagement helps maintain trust in NHSBT and the broader response effort.

6.3. Employee engagement and support is equally prioritised. NHSBT recognises that some of our own staff and donors have been personally impacted by the infected blood scandal. We have taken steps to engage employees through open forums and internal communications.

6.4. The Chief Nursing Officer has led targeted outreach to staff known to be affected, offering one-to-one meetings, counselling referrals, and encouraging use of our Employee Assistance Programme. There is a sustained emphasis on psychological safety and compassionate leadership for these colleagues. Managers have been briefed to allow time

off for anyone who wishes to attend Inquiry-related events or needs space on difficult anniversaries.

6.5. To foster broader staff engagement, we held several internal webinars sessions over the past year where employees could ask questions about the Inquiry and NHSBT's plans. These sessions were well attended and helped surface ideas (for example, staff suggested ways to improve how we archive historical records, which has been fed into our action plan).

6.6. We have made it clear that speaking up channels remain open for any staff who might have relevant information or concerns from past practices, reinforcing that there will be no recrimination for speaking up about safety issues. By actively engaging both external stakeholders and our employees, NHSBT demonstrates openness and accountability. This engagement mitigates the risk C&E-04 (Infected Blood Inquiry) on our BAF by building understanding and support, and it aligns with our strategic objective to invest in people and culture (through caring for our staff and valuing their input).

7. Spending Review (SR) impact assessment

7.1. The Inquiry's recommendations carry significant resource implications. NHSBT is mindful of the broader government spending review process which will determine funding for many of the health-related recommendations. There is ongoing dialogue with our DHSC sponsor team to ensure that the costs of implementing required changes are understood and factored into future budgets.

7.2. The Comprehensive Spending Review expected later this year is a key milestone, it will likely set out the government's financial commitment to addressing the Inquiry's findings, including funding for service enhancements, technology investments, and the new Infected Blood Compensation Scheme. NHSBT has prepared outline business cases for areas where investment may be needed (for example, modernising transfusion laboratory IT systems to capture transfusion outcomes, and expanding our capacity for look-back investigations). These have been shared with DHSC and HM Treasury via the IBI Programme Board, to inform spending review decisions.

7.3. Early indications are that the government is supportive in principle, the DHSC acknowledges that significant funding will be required over multiple years to fully implement the health system recommendations. However, until the spending review is concluded, and funds are formally allocated, NHSBT and partner organisations must plan prudently within a constraint current financial envelope.

7.4. We are prioritising actions that can be delivered within existing budgets or through reprioritisation.

7.5. The Board should note that any delay or shortfall in funding following the spending review could impact our timelines and scope of delivery. In particular, capital-intensive projects (like new IT systems or a major patient record audit) and workforce expansions depend on fresh funding. If funding is less than expected, we will need to adjust plans and possibly flag new

risks (e.g. risk of not meeting Inquiry expectations on schedule). Conversely, if full funding is provided, we will rapidly mobilise to utilise it effectively, ensuring value for money and clear benefit realisation. The spending review context is therefore a critical strategic factor, and we will keep the Board updated as the situation develops.

8. New Government

8.1. The political context for the Inquiry's implementation is evolving. One significant structural change already underway is the merger of NHS England into the DHSC, as part of broader health system reforms. This dissolution of NHSE as an arm's-length body means that responsibility for certain programs may shift within government. We have sought and received assurance that the established IBI workstreams will continue uninterrupted through this transition. NHSE (in its current form) has confirmed that the IBI Programme Board and related projects will proceed as planned and that any changes in oversight will be communicated formally. Nonetheless, NHSBT remains vigilant: we will maintain our collaborative efforts and be ready to adapt to new governance structures or reporting lines under a new government.

8.2. NHSBT is a trusted advisor on matters of blood safety and transfusion policy, ready to brief incoming officials on the complexities and to champion the needs of patients and donors

9. Positive joint working and four nations approach

9.1. NHSBT's engagement with the Inquiry has exemplified positive joint working across organisational and national boundaries. Given that blood safety is a UK-wide concern, we have prioritised a Four Nations approach in implementing relevant recommendations. NHSBT is actively collaborating with the devolved administrations and their blood services (Welsh Blood Service, Scottish National Blood Transfusion Service, and the Northern Ireland Blood Transfusion Service) to ensure consistent standards and shared learning. For instance, through the UK Blood Forum, NHSBT and the other national blood services exchange progress updates and coordinate actions so that improvements inspired by the Inquiry (such as updated donor deferral policies or look-back procedures) are aligned across the UK. This prevents duplication and inconsistency, offering a unified response to what was a UK-wide recommendation.

9.2. A concrete example of four-nation collaboration is in the education and training domain (Inquiry Recommendation 3 and 7d). The combined working group on transfusion education includes representation from all four health services. This group is designing standardized transfusion safety training curricula and e-learning modules that can be adopted across England, Scotland, Wales, and Northern Ireland. By defining common competencies and sharing materials, we ensure that a nurse or doctor in any UK country receives equivalent training about contaminated blood lessons and patient blood management best practices.

9.3. Similarly, for haemovigilance (Recommendation 7e), NHSBT is working with the devolved health authorities to reinforce that Serious Hazards of Transfusion (SHOT) recommendations are implemented nationwide. The IBI report highlighted that every NHS organization in the UK should have a mechanism to adopt SHOT's safety recommendations; in response, NHSBT and the National Blood Transfusion Committee (NBTC) are advocating for a UK-wide "zero tolerance" approach to ignoring haemovigilance findings. We are sharing tools and guidance to help hospital transfusion teams in each country track and report their compliance.

9.4. The Board can be reassured that NHSBT is not operating in isolation but as part of a cohesive four-nation effort, which strengthens the overall response to the Inquiry. This aligns with our strategic objective to collaborate with partners and has been positively noted by stakeholders as a model of how to handle nationwide health issues.

10. Infected Blood Inquiry further two days of hearings

10.1. On May 7 and 8, 2025, the Infected Blood Inquiry held two days of hearings to examine the timeliness and adequacy of the UK Government's response to compensation for victims of the contaminated blood scandal. These hearings were convened in response to widespread concerns from victims, campaigners, and legal representatives about delays and shortcomings in the compensation process.

10.2. Key Issues Addressed

- Delays in Compensation: Despite the establishment of the Infected Blood Compensation Authority (IBCA) in October 2024, only a limited number of individuals had received compensation by May 2025. As of early May, only 106 people had received payments, with a further 54 having received offers.
- Complex Application Process: Victims reported that the claims process was overly complex and lacked transparency, leading to further distress among those affected.
- Narrow Eligibility Criteria: Concerns were raised that the eligibility criteria for compensation were too restrictive, excluding many individuals who had suffered due to the scandal.

10.3. Witnesses and Testimonies: The hearings, that were attended by NHSBT representatives, featured testimonies from various stakeholders, including:

- Victims and Campaigners: Individuals such as Alan Burgess (The Birchgrove Group), Carolyn Challis (campaigner), and representatives from organizations like the Haemophilia Society and The Hepatitis C Trust shared their experiences and frustrations with the compensation process.
- Government Officials: Nick Thomas-Symonds, the Paymaster General, provided evidence on the government's handling of the compensation scheme
- IBCA Leadership: Sir Robert Francis KC, Interim Chair of the IBCA, and David Foley, Interim Chief Executive, addressed concerns about the authority's operations and responsiveness.

10.4. Outcomes and Next Steps: Following the hearings, the Inquiry invited core participants to submit written statements by May 23, 2025. These submissions will inform

an additional report by Inquiry Chair Sir Brian Langstaff, focusing on the government's response to compensation.

10.5. The hearings stressed the urgent need for the government to expedite the compensation process and address the systemic issues that have prolonged justice for the victims of the contaminated blood scandal.

11. Recommendation 7 updates

11.1. Follows a brief overview of the key workstreams developed in response to Recommendation 7 of the Infected Blood Inquiry (IBI). Aligned with the broader aims of the NHS and DHSC to improve transfusion safety, transparency, and accountability, these workstreams represent a coordinated national effort to strengthen governance, workforce capability, digital infrastructure, and clinical standards across the transfusion pathway. The following summaries outline the remit, progress, and future direction of each subgroup supporting this agenda.

- 7a(i) – Tranexamic Acid Subgroup: Update surgical checklists nationally to include the use of tranexamic acid (TXA) in procedures to reduce blood loss. Work includes defining operations needing TXA use, promoting standardisation, engaging stakeholders, and preparing for a new national audit in perioperative care.
- 7a(iii) – Benchmarking Subgroup: Develop transfusion benchmarking criteria and integrate them into national dashboards like Model Health. This includes updating NICE guidance, setting inspection criteria for CQC, standardising NHSBT data, and initiating a national audit and benchmarking process.
- 7b – Transfusion 2024 (T2024) Subgroup: Redesign the transfusion system with better governance, leadership, digital connectivity, and workforce planning. Five key pillars are being developed: governance, quality improvement, digital interoperability, workforce, and research & development. ’ is being finalised for June publication.
- 7c – Staffing Subgroup: Address workforce capacity by modelling safe staffing levels and investing in leadership roles across transfusion services. This includes funded leadership posts and developing a standardised workforce model drawing on existing frameworks like SHOT and United Kingdom Transfusion Laboratory Collaborative (UKTLC).
- 7d – Training Subgroup: Update e-learning and professional curricula across disciplines (medical, nursing, AHPs) to reflect new blood safety standards. A gap analysis is underway, alongside mapping training resources. Scope is limited pending clarity on funding.
- 7e – SHOT Recommendations Subgroup: Formalise transfusion safety standards and governance frameworks, enabling regulatory monitoring (e.g. via CQC). This includes updating SHOT standards, improving reporting of transfusion incidents, and undertaking health economic analysis to drive compliance and improvement at ICB level.
- 7f – Digital, Data and Outcomes Subgroup: Design a national digital architecture to support transfusion safety. Work includes pathway and systems mapping, developing delivery plans, and learning from existing electronic blood management systems (e.g., Oxford, Barts). It will incorporate data integration and pathology interoperability. Dependent on future funding for full rollout.

11.2. The breadth and depth of activity under Recommendation 7 reflect a serious and sustained commitment to addressing the systemic failings that have historically undermined patient safety in transfusion care. As these subgroups continue to progress their deliverables, it is vital that we maintain momentum, ensure meaningful engagement with those infected and affected, and embed transparency and accountability at every level of implementation. This work must not only honour the legacy of the Inquiry but also set a lasting standard for safety, trust, and equity in the delivery of care.

12. **IBI Memorial Art Project Plan**

12.1. NHS Blood and Transplant is developing a permanent memorial at its Filton Head Office to honour those affected by the Infected Blood Scandal. The memorial will serve as a space for remembrance, reflection, and organisational learning, reinforcing our commitment to safety, transparency, and accountability.

12.2. The project is being developed through a phased approach, including stakeholder engagement, artist selection, and co-designed production. Individuals infected and affected, families, support organisations, and NHSBT staff are at the heart of this process, ensuring the final piece reflects lived experiences and collective memory.

12.3. Through this initiative, NHSBT seeks to embed the lessons of the Inquiry into its culture and provide a lasting tribute that acknowledges the profound human cost of historic failures in transfusion safety.

13. **Closing remarks**

13.1. The Infected Blood Inquiry stands as one of the most searing chapters in the history of UK healthcare, and its final report demands not just reflection, but resolute action. NHS Blood and Transplant has embraced this challenge with humility, urgency, and determination, engaging openly with the Inquiry, acknowledging past failings, and implementing robust reforms. From driving national change under Recommendation 7 to championing a compassionate culture of candour and co-design, NHSBT’s response is both systemic and human centred.

13.2. Our internal governance, stakeholder partnerships, and Four Nations collaborations offer assurance that this is not a transient compliance exercise but a deep-rooted commitment to enduring transformation.

13.3. As the national and political landscape evolves, we remain steadfast: guided by the voices of those infected and affected, and resolute in our duty to restore trust, safeguard future generations, and honour the legacy of this Inquiry, not merely with words, but with meaningful, measurable action.

14. References

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15. Acknowledgements

15.1. The development of this paper has been informed and strengthened by the valuable insights and leadership of colleagues across NHS Blood and Transplant.
We wish to acknowledge:

- Louise Sherliker, Programme Director, Transfusion 2024 Programme – Transfusion
- Maggie Pacheco, Chief Nurse for Programmes and Transformation, NHS Blood

We would like to acknowledge all colleagues working in NHSBT ensuring safety is the priority of the organisation and leading the inquiry recommendations internally and externally.

Colleagues working in NHSBT who have been affected and are helping us on this cultural journey to ensure lessons are learnt.