Developments in vCJD

12.32 pm

The Secretary of State for Health (Dr. John Reid): With permission, Mr. Speaker, I should like to make a further statement about the action that Government are taking following a blood transfusion incident involving variant Creutzfeldt-Jakob Disease—CJD. On 17 December last year, I informed the House about the implications of the incident and gave an undertaking to keep it informed of any major developments. As you will know from our conversation last night, Mr. Speaker, I regret that an inaccurate press report appeared before I was able to make this statement to the House. I believe that it has been replicated in another inaccurate press report this morning.

The House may recall that my Department had become aware of a patient who had contracted variant CJD after receiving a transfusion of blood from a donor who went on to develop variant CJD himself. That is a possible, not a proven, causal connection. I told the House that a further 15 patients had been identified who had received transfusions from donors who had gone on to develop variant CJD. I said in my statement of last December that the Health Protection Agency, working with the National Blood Service, was in the process of contacting the individuals concerned. I can now report that all surviving individuals have been-contacted and informed about the circumstances of their case.

As on previous occasions when we have become aware of new information about blood and variant CJD, we have ensured that action has been taken on a precautionary basis to reduce the risk of a transmission of the disease. I stress that we are acting on a precautionary basis—the basis on which we have introduced a range of measures since 1997. For instance, since 1998 we have ensured that blood products are made only from plasma imported from countries that are free of, or have very few cases of, variant CJD. We introduced leucodepletion—removal of the white cells— of all blood for transfusion from 31 October 1999. Two years ago, in 2002, we instructed the National Blood Service to use only imported fresh frozen plasma for the treatment of children born after 1996. That will come into effect for newborn children this month, and will be extended to older children as soon as is practicable.

In the light of the transfusion incident that I reported last December, the chief medical officer asked the expert Advisory Committee on the Microbiological Safety of Blood and Tissues for Transplantation to consider whether there was a need to take any further measures on a precautionary basis. That request was made with the proviso that such measures should not have an unmanageable adverse impact on the safety or availability of blood. We are therefore talking about a balance of risk, given that, with a need for about 800,000 transfusions and 3 million blood components a year, the dangers of a shortage of blood are obvious to all.

Our experts met on 22 January to discuss a number of options for further strengthening the protection of the blood supply in addition to those that I outlined to the House in December. On the basis of all the information available, and taking a precautionary approach, our experts concluded that the United Kingdom should exclude from donating blood people who have previously received transfusions of whole blood components since January 1980. They also advised that additional measures should be introduced to improve further the effectiveness of the use of blood in hospitals.

I have accepted the chief medical officer's advice to accept that recommendation of the advisory committee. The group of people excluded from donating blood will therefore be limited to those who confirm that they have received a transfusion in the UK since 1 January 1980. It is generally accepted that there would have been no exposure to BSE—bovine spongiform encephalopathy—in the UK before that date.

I stress that the risk attaching to that group of blood donors is uncertain, but we are taking those measures as a precaution because the risk may be slightly higher among that group than among the population as a whole. Excluding those donors will inevitably lead to a reduction in the supply of blood available for transfusions. Although the National Blood Service estimates a loss of 52,000 donors, I am pleased to report that it has put in place measures to help to compensate for those losses, and hospitals are being encouraged to make the best possible use of blood. In the meantime, I should like to take the opportunity to thank the blood donors in the group affected by the change for their contribution towards saving and improving patients' lives.

At the meeting on 22 January, the Advisory Committee on the Microbiological Safety of Blood and Tissues for Transplantation acknowledged that a period of some weeks would be needed to allow the blood services to put in hand the preparation of communication material for donors and the setting up of training programmes for blood service staff. It recommended 5 April as the date for implementation, and the National Blood Service asked us to time our public announcement to coincide with a point three weeks before implementation. That is why I am making this statement to the House today. Those steps are being put in motion as I speak.

The advice of the Advisory Committee on the Microbiological Safety of Blood and Tissues for Transplantation and the National Blood Service is that we should identify people who have received a previous blood transfusion by self-reporting, using questionnaire screening, when they come forward to give blood. That action is being implemented now. Another group of potential donors will be people who had an operation in the past but are unsure whether they had a blood transfusion at that time. I have asked the advisory committee to consider whether any further action is required as part of the general review of the measures, and to report back to me.

Earlier in this statement, I mentioned that this process was about balancing risks. I now turn briefly to the other part of the process, which involves ensuring that blood in hospitals is put to the best possible use. I consider blood that has been donated voluntarily to be a precious resource for our health service. We therefore have a responsibility to donors and patients alike to ensure that it is used to the best possible effect. That said, it is clear that the best-used blood is often the unit of blood that is not used when it is not needed. I am, therefore, concerned that blood transfusions should be made only where there is a clear clinical need.

[Dr. John Reid]

It has been widely acknowledged that more blood is ordered and more is used than is clinically necessary. Considerable efforts have been made over the past five years to encourage more efficient use of blood in clinical practice. In 2002, all four of the United Kingdom's chief medical officers launched an initiative to ensure that the "better blood transfusion" strategy is an integral part of NHS care, to make blood transfusion safer, to avoid unnecessary use of blood in clinical practice and to provide better information to patients and to the public. We have seen good progress in taking this initiative forward.

I am pleased to report that NHS trusts have been introducing improved arrangements to oversee all aspects of transfusion, and developing protocols for transfusion practice, based on national guidelines. Work is also being undertaken in a number of other key areas such as the development of additional guidelines for trusts on the resources needed to implement "better blood transfusion" and the establishment of the role of specialist practitioners of transfusion. While this progress is encouraging, we cannot be complacent. The expected loss of supply as a result of today's announcement means that we need to increase our efforts in the more appropriate use of blood. The chief medical officer is producing a revised approach to push forward the "better blood transfusion" strategy.

I hope that my statement has provided the House with a clear indication of the path that we have chosen and why we have chosen it. I would like to end by stressing two things. First, as I said last December, we are following a highly precautionary approach. I understand that people may have concerns about the implications of this announcement, but I would emphasise again that this action is being taken because of an uncertain but slight risk. People should, indeed, continue to have a blood transfusion when it is really necessary. Any slight risk associated with receiving blood must be balanced against the significant risk of not receiving that blood when it is most needed.

My second point is that, particularly at this time, people who can do so should continue to donate blood. Blood donation is a safe procedure and people should continue to donate blood regularly. We place great value on those who already donate and would welcome new donors. I am sure that the whole House is deeply grateful to all of them.

Mr. Andrew Lansley (South Cambridgeshire) (Con): I am grateful to the Secretary of State for giving me the opportunity to see his statement in advance. I am sure that hon. Members are also grateful to him for returning to the House to give further details, which he undertook to do on 17 December. His statement will come as no great surprise, in the light of some of the research that has been published since his December statement. I am particularly aware, for example, that in *The Lancet* of 6 February, Llewelyn et al reported on the surveys of patients identified by the national CJD surveillance unit as receiving blood transfusions. Looking particularly at the case that the Secretary of State highlighted in his December statement, they concluded:

"The chance of observing a case of vCJD in a recipient in the absence of transfusion transmitted infection is about 1 in 15,000 to 1 in 30,000."

So, it clearly must be right, in the light of such an analysis, to proceed on the basis that blood transfusion was the source of infection in the case in question. Indeed, Herzog and others, in *The Lancet* of the same date, considered the risk of intravenous transmission, concluding that it should be treated on the same precautionary basis as the avoidance of consumption of infected beef products.

The case in question, which the Secretary of State told the House about on 17 December, arose from a blood transfusion in 1996. The precautionary process of leucodepletion was instigated, as he said, in 1999, so the first question that arises is, what has been the relevance and effectiveness of that process? The particular case in question does not tell us whether leucodepletion has succeeded in reducing or even removing the risk of infectivity being introduced through blood transfusions. What conclusions, if any, has he and his advisers reached on the effectiveness of that process over the last four and a half years?

Turning to the measures that the Secretary of State has announced, I am aware that he says that the 5 April date is intended to give the National Blood Service time to be able to respond. Will he confirm that it will also, presumably, allow an accelerated call to donors, should that be necessary? I understand that the blood service may have about a week's supply, which is, in the circumstances, a very healthy stock of blood to have available, but it needs to be replenished continuously. Therefore, it is important to ensure that there is no drop-off in donations, even in the short run.

Can the Secretary of State confirm, as he did previously, that there has been advance co-ordination with the Scottish and Welsh Administrations? I understand that the National Blood Service looks after England and north Wales, but clearly there are separate arrangements in Wales, Scotland and Northern Ireland. Perhaps he can confirm that those Administrations are taking parallel measures.

Can the Secretary of State also explain the intentions in relation to those who have transfusions in future? Presumably, those who have had transfusions since 1980 will be excluded, but the logic of his statement is that those who have transfusions only after 5 April this year will not be excluded, because they, by definition, will receive blood that we have made as safe as we can make it.

The Secretary of State talked about the measures that the chief medical officer is taking for a revised approach on "better blood transfusion". I do not wish to be difficult with the right hon. Gentleman, but I have to say that he described a process. He did not describe any outcomes, so perhaps he will tell us what progress has been made in reducing the use of blood products in the national health service to the minimum level that is clinically necessary, because we need to compare that progress inside the NHS with a reducing profile of blood donations.

The figures that I have received suggest that 2.38 million units were donated in 2001–02 and 2.365 million in 2002–03, while 2.31 million units is the estimate for this financial year and that for next year is 2.275 million. That is a 1.5 to 2 per cent. reduction year on year in the number of blood donations. What the Secretary of State has described today represents a 3.2 per cent. reduction

in the donor base, so this year, other things being equal, there might be a 4 to 5 per cent. reduction in blood donation.

In those circumstances, it is important either for the marketing campaign to be able to compensate for that reduction—presumably, the Secretary of State knows that there is no certainty about that—or for NHS use of blood donations to make additional progress. However, there is no measure in the right hon. Gentleman statement of the progress made up to now.

What further research is the Secretary of State putting in hand? I understand that he has taken advice from the Advisory Committee on theMicrobiological Safety of Blood and Tissues for Transplantation, but when I asked him recently about advice from the Spongiform Encephalopathy Advisory Committee he said that that body would be included, as others would. SEAC has particular expertise in the infectivity and transmission of BSE. We know that, so far, 146 variant CJD cases have been identified, so information is progressively being established about the characteristics of persons infected with new variant CJD and conclusions can be drawn. At some point, it will be necessary to balance the harm that could be done by such highly precautionary measures—even if it could be mitigated—against the unknown benefits of a highly precautionary approach.

In that context, in the past disposable instruments were used for tonsillectomies. Known harm clearly resulted from the practice for an unknown and unquantifiable benefit, and that decision had to be reversed. I would hate to reach the position where harm resulted from a persistently highly precautionary approach.

The Secretary of State said that the use of imported fresh frozen plasma that is virally inactivated is to be extended to older children. That development was first announced in August 2002, with the intention that such plasma would be used from the end of 2003. The right hon. Gentleman is now saying that virally inactivated fresh frozen plasma will be used for newborn children. Presumably a timetable exists for extending that use to children born since January 1996. When does the Secretary of State anticipate that timetable will, as a matter of some importance, be completed?

The right hon. Gentleman did not mention the infectivity of urine-derived products. In the past, the Department has said that it does not acknowledge any such evidence, but, in *The Journal of Biological Chemistry* in 2001, Shaked and others suggested that there was such a route of infectivity. If highly precautionary approaches are sought, perhaps the Secretary of State will comment on his attitude to that aspect.

I entirely share the right hon. Gentleman's regret at newspaper stories this morning and would not wish the Government to proceed other than on the basis of scientific evidence. Continuing research is needed because a highly precautionary approach is being taken in the absence of evidence about the true root of infectivity. If the Secretary of State is right and the public listen carefully, they will recognise that that is the right way to proceed. Blood is a vital resource for the NHS and we greatly value those persons who donate it. Blood must be used efficiently and effectively, but we must also encourage people to give blood to the NHS in the hope that that will meet the health service's continuing needs.

Dr. Reid: I thank the hon. Gentleman for his comments and particularly for his reference to the manner of publication and reporting. His reaction, as we would expect, was responsible. I hope that any reporting of this issue will be sober and non-sensational.

The hon. Gentleman referred to a series of publications and produced some statistical evidence. I will not comment on their substance, but I agree that a range of statistical evidence has been placed in the public domain, albeit not of a causal nature. We proceed with caution, despite the fact that there is no proven causal relationship between the description I reported in December of a possible link between someone who had donated blood and someone who had received blood.

At the time when leucodepletion came into effect, our experts believed that the only source of infectivity was through white cells. Leucodepletion is the removal of white cells from the plasma. More recent research suggests that there could be infectivity in other blood components, which is why we are taking further action. As the hon. Gentleman knows, we are guided by experts. We believe that leucodepletion has been effective and efficient in countering risks. I am certainly not aware of any evidence to the contrary.

The hon. Gentleman referred to the chief medical officer's "better blood transfusion" strategy, which is currently being reinforced. Hospitals are encouraged to run pre-operation assessment clinics and to advise patients of the various alternatives. Hospitals are also encouraged to use the technology that allows doctors to rescue and give blood back to patients during an operation. That technology is readily available and should be used when a patient needs more than two units of blood.

It is too early to make an overall assessment of the complete effectiveness or otherwise of the strategy but we continually monitor it and believe that it is making an improvement. When we have completed a comprehensive and robust assessment, we will place that information in the public domain.

The hon. Gentleman expressed the hope that the three weeks before 5 April will be used, at least in part, to encourage people to donate blood to compensate for any effect that today's statement may have. I share his hope, which is part of the reason for giving the blood service proper time to produce publications and circulars before this statement.

The hon. Gentleman is correct in stating that current blood stocks are relatively high—from memory, we have 62,000 units. This morning, I spoke with, among others, the manager of the National Blood Service, Dr. Angela Robinson, and with individuals in Scotland. My hon. Friend the Minister of State spoke to our colleagues in Wales yesterday. We confirm that we shall do everything possible to ensure that the level of blood donations is maintained.

The decision to import fresh frozen plasma from the United States to treat certain groups was taken to reduce the possible risk of variant CJD. There have been no reported cases of vCJD in the United States and we thought it important not to introduce different risks

[Dr. Reid]

with this initiative. Viral inactivation of US-derived fresh frozen plasma was therefore introduced in this country.

We hope to complete by the end of this year our plans for ensuring that all children are treated using the fresh frozen plasma method. We hope that that timetable will not slip.

My hon. Friend the Minister responded to a recent question on urinary infection. There is no evidence of urinary infection occurring—although, as we adopt a precautionary approach, we obviously keep an open mind. I cannot report the specific contents of the discussions with the spongiform encephalopathy expert group, but I will write to the hon. Gentleman on that point.

Mr. David Hinchliffe (Wakefield) (Lab): Over the years, I have met a number of families whose members have suffered from variant CJD. The view commonly held is that Governments have not been as open and frank about the problem as might have been hoped. I want to place on record my appreciation of the fact that the Secretary of State addressed that concern in his statement before Christmas and in his statement today. Those who have had to deal with this terrible problem in relation to family members will also appreciate the fact that the Government have been open and honest and have come to the House as soon as possible to give the information that has been available.

I want to press the Secretary of State on one point. He has referred to the fact that there will be some reliance on self-reporting by future blood donors about whether they have had transfusions since 1980. My experience of self-reporting in the NHS is that it is somewhat unreliable on occasions, and I would welcome his comments on whether we have the capacity in relation to electronic records to ensure that when there is no self-reporting of previous transfusions, that fact is comprehensively checked before individuals are allowed to donate.

Dr. Reid: I give my hon. Friend a straight answer: we do not have that capacity in relation to records; otherwise, we would not be relying on the normal method of self-reporting. It is not an entirely proactive dependency, because when people currently go to donate blood, they are screened in relation to a range of issues and materials, and that is when the questioning will take place. That leaves an outstanding question, as my hon. Friend says, as some people may not intentionally deceive but may be unable to remember, perhaps in relation to the circumstances of being operated on, or may be ignorant as to whether they received blood. I have therefore asked the expert group to consider further what might be done in that respect. All of this information is considered on the balance of risk.

I make no apology for stressing once again that no proven, causal connection has yet been established between blood donation and the blood recipient, in relation to the transfer by blood of variant CJD. We are taking a highly precautionary approach, however, in relation both to being as open as possible when information is given to us and disseminating it as quickly as possible, and in attempting to minimise any possibility of avenues remaining that we have not closed off.

Mr. Paul Burstow (Sutton and Cheam) (LD): First, may I thank the Secretary of State for his courtesy in allowing sight of the statement well in advance, which has provided a chance to reflect on the issues that he has brought to the House's attention? He has done that in a timely fashion, for which I am very grateful.

The Secretary of State says that he is taking a highly precautionary approach. Clearly, securing the supply of blood for transfusion is a key concern. Can he therefore amplify that part of his statement on supply, and tell us what measures he is taking now to safeguard it? What plans does he have, immediately and in the longer term, to increase the numbers of blood donors, not least because, at the moment, only about six in every 100 people in this country donate blood? Is the National Institute for Clinical Excellence to be involved in any way in undertaking work on the use of alternatives to transfusion, such as erythropoietin and the use of patients' own blood? Can he comment on the timeline that has been discussed in respect of making available US-sourced blood plasma for older children, which we hear will be by the end of the year? What about other at-risk groups, however, such as haemophiliacs?

Can the Secretary of State say what assessment has been made of the future availability and safety of non-UK sourced blood plasma? The right hon. Gentleman has referred to the report and work being done by the chief medical officer. Can he tell us when he expects the revised approach to the blood transfusion strategy to be published, and whether that strategy revision will include a more co-ordinated approach, involving the National Patient Safety Agency, in order to reduce risks? In particular, what plans does he have to deal with concern about the risk of the re-use of surgical instruments after brain biopsies, and is new guidance planned in respect of that, to deal not only with those cases in which vCJD has been diagnosed but in other cases?

I understand that the Department is currently undertaking work on a risk assessment of possible vCJD infection in large pools of plasma and the effects of dilution. Can the right hon. Gentleman he tell us when that work will be concluded and when the results will be published?

Finally, can the Secretary of State say what support is offered to those affected donors to whom he has referred today, and to others who might be concerned? Will there be more than just leaflets and information? For example, will other services and support be offered in those cases in which it might seem appropriate?

The Secretary of State is absolutely right: blood is a precious resource; we must do everything possible to safeguard the supply in this country; and we must applaud those who give, and encourage more to do so.

Dr. Reid: On the question of whether support will be available, I certainly hope that it will be, not only from the National Blood Service but from NHS Direct and other parts of the NHS. As for the expert group, which it is looking, almost incident by incident, at each of those

dependent on blood plasma, many cases need to be examined. Obviously, the risk in those cases is even less than the low risk that we have discussed today, because the nature of plasma is that it is a reservoir normally constituted from plasma from a range of people rather than from one person. Nevertheless, great efforts are being made by the expert incident group to examine that risk and to see how it can reassure itself and any recipients as quickly as possible. I cannot give him a finish date for that—he will understand that it is laborious even compared with some of the other laborious work in connection with this matter—but I am sure that it is being done as fast as possible and always in a manner that is commensurate with getting the information correct.

The hon. Gentleman mentioned the question of stocks. As I said earlier, stocks are pretty healthy at present. The exclusions that I have mentioned today will, it is estimated—it is not a hard and fast number—reduce the number of blood donors by about 3.2 per cent. and the number of donations by about 3.6 per cent. In absolute numbers, that is about 52,000 people, who would give about 56,000 donations. That is comparable with the annual net reduction, and with extra publicity and extra effort, we can make sure that that stock is maintained.

In relation to the timeline on children, the only information that I can give the hon. Gentleman is what I said earlier: it will happen at the end of the year. We do not believe that any problem exists with the US-derived plasma that we have received. In common with the hon. Gentleman, I thank those who donate blood.

Mr. Tom Clarke (Coatbridge and Chryston) (Lab): I thank my right hon. Friend for his carefully considered and sensitive statement. In common with my hon. Friend the Member for Wakefield (Mr. Hinchliffe), I remind him about those of us who have families in our constituencies who have had to deal with the dreadful trauma of vCJD over a number of years, and who have now formed a network in Scotland, England, Wales and even Northern Ireland. Those families are only too happy to offer whatever experience that they can and to be consulted by my right hon. Friend the Secretary of State and others. They, too, will greatly welcome what he has had to say about research and blood transfusions and his appeal that people should continue to make blood donations.

Dr. Reid: Yes, indeed. I know that my right hon. Friend has taken a great deal of interest in and given a great deal of support to those who have found themselves in difficult circumstances because of this issue. Of course, I have spoken already to our counterparts in Scotland—I spoke to the Minister there this morning. I may, however, have given the wrong impression—I understand that the Under-Secretary of State for Health, my hon. Friend the Member for Welwyn Hatfield (Miss Johnson), was unable to contact the Minister in Wales last night, but I know that our officials have been in close touch throughout. This issue that does not recognise national borders within the United Kingdom, and obviously, we will work closely together on the matter.

Lady Hermon (North Down) (UUP): For the benefit of those who may be alarmed by his statement, will the Secretary of State comment on improvements in treatment of those with vCJD? Will he also reflect on the courageous decision of his hon. Friend the Member for Kilmarnock and Loudoun (Mr. Browne), who, as the then Minister responsible for health in the Northern Ireland Office, authorised a new technique for the treatment of a young man in Belfast whose condition then improved?

Dr. Reid: Yes indeed. I recall that case. While we are not entirely convinced that the treatment is truly effective, we did understand the anxiety that people would feel should there appear to be a form of treatment available that we were not testing, and we decided to carry out a pilot involving an English strategic health authority. This is a very difficult disease to come to terms with, and some of its implications are clear even from the screening technique mentioned by my hon. Friend the Member for Wakefield (Mr. Hinchliffe). There is, in fact, no test that can be applied before symptoms appear. Nevertheless, we continue to pursue treatments that might prove effective.

Dr. Brian Iddon (Bolton, South-East) (Lab): My concern is for the 15 or so individuals identified in the statement. Some have already contracted NHS blood transfusion-borne diseases such as hepatitis C, and others still require blood transfusions. Can my right hon. Friend assure us that that small number of people will continue to be monitored closely, and that if they require medical advice they will receive the best available from the NHS anywhere in the country?

Dr. Reid: Yes, I can. As my hon. Friend says, 15 recipients were identified. One is now deceased, although as far as we know there is no connection with vCJD. A further recipient has been discovered since then, in January. We do continue to monitor all those people closely. My hon. Friend is right: they deserve the support of the NHS, which must itself monitor their conditions. I promise him that that will happen.

Mr. Mark Francois (Rayleigh) (Con): The Secretary of State mentioned the importance of maintaining adequate stocks. In that context, may I raise an operational point? The right hon. Gentleman will know that the National Blood Service now employs call centres to remind donors to turn up for sessions. I understand, however, that problems have been caused when the message has not been passed on to teams going out to collect blood. When that happens, more donors turn up than the service would normally prepare for. That places tremendous strain on staff running the sessions, and also means that donors who are not covered by the new booked-appointment system must wait for an inordinate amount of time. Some become disillusioned and go home.

Next time the right hon. Gentleman has discussions with the chief executive of the NBS, will he raise that problem? If liaison between call centres and teams collecting blood is improved, staff will not be under such pressure and donors—whom we all applaud—will not become disillusioned.

Dr. Reid: We are trying to modernise and improve the National Blood Service, along with every other part of

[Dr. Reid]

the NHS. In view of what I have said today, it is particularly important for us to maintain the utmost effectiveness in terms of logistics and such matters as collection, and I shall ensure that the hon. Gentleman's comments are brought to the attention of those in the blood service.

Mr. Dai Havard (Merthyr Tydfil and Rhymney) (Lab): As my right hon. Friend will know, I have been concerned for some time about the supply of blood and its security. I am also concerned about the quality of care and the use of blood for the largest group of recipients, cancer patients.

We had the same discussion last time my right hon. Friend made a statement. I know that NICE is considering the use of alternatives, and that it is also being considered by the All Wales Medicines Strategy Group; but will my right hon. Friend ensure that not just an incremental change but a step change is involved, and that alternatives are immediately used as the default for cancer patients when that is possible? If that happens, my right hon. Friend need not face a crisis in blood supply. However, I echo his call for people to give blood.

Dr. Reid: I know of my hon. Friend's interest. EPO, in particular, is an alternative to blood transfusion, especially for cancer patients suffering from anaemia following chemotherapy.

My hon. Friend has done a great deal of research, and I know of the benefits that he believes this will bring to cancer patients. I also know of the knock-on effects for future supplies of blood, and for the NHS generally in terms of potential savings and bed bays, which my hon. Friend has mentioned in the past.

My hon. Friend has made a strong case for EPO, but I know he will understand that that is only one side of the argument. Some argue that EPO may only be useful to a minority of cancer patients, and may not be effective enough to be used as a standard treatment in most cases. We have asked NICE to look into the matter. It will consult on the draft scope for its appraisal by June, and the final guidance is expected to be published by the end of next year. I hope that the appraisal will be objective, and will assess various points of view.

Mr. Roger Williams (Brecon and Radnorshire) (LD): As the Secretary of State will know, the BSE outbreak and the appearance of vCJD in humans has caused a great deal of financial cost and human sorrow. Part of the financial cost has been caused by the need to invoke the precautionary principle, which is always expensive, because we do not have the fundamental scientific knowledge about the infective agent, its transmission and the way in which it carries infection. Is the Secretary of State satisfied that we are investing enough in fundamental research? Is there a balance to be struck between that investment and the cost of invoking the precautionary principle?

Dr. Reid: The pursuit of knowledge in this as in every other area is costly. Taxation is a finite resource, and there is an almost infinite demand on it. The other night I met some people whose children had cystic fibrosis, and then met others to discuss motor neurone disease. That illustrated the extent of the demand. I think, however, that we are investing as much in scientific research as is commensurate with need—some £500 million or £600 million. The Medical Research Council is investing another £500 million. We always want more, but we ascribe to this matter a degree of seriousness that is commensurate with the investigations that are taking place. That is why I have come to the House twice in the last four months to report on what some may consider relatively minor steps. Given the importance of the issue, I think it as well to be open and let all Members know what we are doing.

Mr. Henry Bellingham (North-West Norfolk) (Con): The Secretary of State said that he believed that blood transfusions should only be given in cases of clear clinical need. That struck me as a rather strange observation. Surely no blood transfusion should be given unless there is a clear clinical need. Is the Secretary of State saying that some transfusions have been unnecessary, or that medical technology is advancing?

Dr. Reid: I am saying that, although we have healthy stocks now, it is more important than ever for us to ensure that blood is being used efficiently. Indeed, the chief medical officer's strategy lately has been to inform all involved in blood transfusions that they should be given only when absolutely medically necessary. Blood is an extremely precious resource. I do not suggest for a moment that people are being comprehensively profligate in their use or expenditure of blood in operations, but we have shown in the past when seeking efficiency that we can cut down on the use of blood without cutting down on good medical practice.

Dr. Evan Harris (Oxford, West and Abingdon) (LD): I would like to ask the Secretary of State about the 15 patients who are potentially in a contactable group in respect of the risk of contracting CJD. How is he handling them? Are they on a confidential database from which they are not allowed to remove their names, as suggested by the CJD incidence panel report of October 2001? What was the result of the consultation that took place to a deadline of January 2002 on how that group was to be dealt with? What are the implications for that group in terms of being kept on a register? Indeed, what are the implications for the many more patients who are possibly exposed to a lower risk through pooled products? There does not appear to have been any further documents from the incidence panel following the consultation.

Dr. Reid: To put it simply, those people are being fully supported and fully informed. As I have said, 14 of the original 15 recipients identified are alive. An additional one was discovered in January. Five of those received leucodepleted red cells after 1999. The earliest transfusion involved in those cases was in 1993 and the latest one was in 2001. I mentioned during the previous statement that the National Blood Service was trying to trace all the patients concerned. It has now done so and the Health Protection Agency has arranged for them to be contacted.

Without going into any individual's details, I can tell the hon. Gentleman that, in conjunction with each recipient's doctor, the HPA intends to undertake a review of how the advice was communicated to each patient and to try to ensure that access is provided to expert counselling and to appropriate follow-up health checks. In response to the questions about the two reports that were published some two years before I became Secretary of State, I have to tell the hon. Gentleman honestly that I do not know the answer to his question, but I will write to him about that if I can.

Points of Order

1.22 pm

Clare Short (Birmingham, Ladywood) (Lab): On a point of order, Mr. Speaker. I rise to raise a point of order about a misleading report published today by the Select Committee on Defence entitled "Lessons of Iraq". Paragraph 358 of the report states:

"It has also been suggested that DfID's"—

the Department for International Development—

"role in post-conflict planning was constrained by the attitude of the then Secretary of State towards the prospect of military action. Although our witness from DfID denied that this was the case, we remain to be convinced."

That assertion is completely false. I think that it is very bad practice indeed, as well as rather rude, for a Select Committee that could have asked me to provide evidence on that question to fail to do so and then to insert into its report a statement that is so inaccurate and misleading.

The reality is that DFID pressed the Ministry of Defence to prepare for its Geneva convention and Hague regulations responsibilities because, at the end of a conflict, in the absence of order, the occupying power has responsibility for immediate humanitarian needs. Those preparations were made and food and other supplies ordered and put in place shortly before military action began.

DFID also worked with the United Nations, the Red Cross, the World Bank, the International Monetary Fund, suitable non-governmental organisations and many countries that opposed the rush to war, so that we were fully prepared to support humanitarian relief as soon as there was order, and to support reconstruction efforts as soon as a UN mandate was put in place. Unfortunately, the UN and the United States State Department, which had made preparations for reconstruction, were pushed aside by the Pentagon, which took over the lead for reconstruction in Iraq—

Mr. Speaker: Order. The right hon. Lady is now making a personal statement. It is a point of order that she has raised, so I have to rule on that point of order. I have to tell her that the Chair does not have any responsibility for the content of reports from Select Committees. She may wish to take the matter up with the Chairman of the Committee.

Angus Robertson (Moray) (SNP): On a point of order, Mr. Speaker. I seek your advice about the rules of the House relating to Ministers making comments ahead of the Budget. At oral questions earlier, the Secretary of State for Scotland confirmed that he was opposed to the introduction of a windfall tax on the financial services industry, yet he would not say whether he supported the expensive introduction of fraud-prone strip stamps on whisky bottles. While it is clearly a matter for him whether he wants to support the whisky industry and its workers, can you confirm that no rules of the House bar Ministers from giving their opinions during debates or questions ahead of the Budget?

Mr. Speaker: My understanding is that there are conventions regarding Ministers and the lead-up to the Budget. They are not rules of the House but they are