hep001

RESTRICTED - POLICY

Dr Metters
Mr Heppell
Mr Shaw

From Roger Scofield

Date 9 December 1994

GRO-C

1. Mr Perry 12/12
2. Mr Ong

GRO-C

12.12.

copies
Ms Roughton PS Perm Sec
Ms Probert PS CE
Dr Harvey PS CMO
Mr Shaw DCA
Dr Winyard DMed
Dr Bourdillon HC(M)
Mr Roberts Sol C
Dr Rejman HC(M)1
Dr Nicholas HP(M)
Dr Wight HEF(M)
Mr Dobson FCIA FLIP
Mr Kenny CA QUAC
Miss Mithani HP(A)1
Mr Sharpe HP(A)3
Mr Waterhouse ASPU
Mr Kelly CA OPU2
Miss Sandell HP(A)1c
Mr Burrage CA OPU2

Mr Dobson,
2 points:
- re N, obviously not yet clear what this will involve; and we will have the NIH (and other) precedent to draw on
- I'd appreciate a quick word, to include Bill, about what the finance options are. We are likely to be asked to respond quickly

GRO-C

12/12.

12 DEC 1994

HEPATITIS C

Synopsis

1 There has been increased interest in hepatitis C recently and we can expect the campaign for compensation for those infected through NHS treatment to be stepped up over the next few months. This note provides a short situation report and considers some handling implications.

Background

2 Over the past few weeks Hepatitis C has moved from being a problem on the horizon to a highly political and volatile policy issue. There has been increasing media interest, with a Panorama programme being prepared for screening in early January. Those claiming compensation and their lawyers are mounting a campaign for Government action. We have had a stream of PQs, EDMs and PO cases and the pressure is building up.

3 The hepatitis campaign comes on top of:

a) the NBA's concerted efforts to rebuild the levels of blood supply. This includes a series of advertisements and Ministerial interviews to give blood donation a high profile; and

b) a determined campaign by staff and Trade Unions against the NBA's rationalisation programme for the transfusion service. The consultation period ended 25 October and the NBA are considering the many responses.

Meanwhile there are mass meetings this weekend, an adjournment debate next week and a mass picket of the MPs who have transfusion centres in their constituencies or who are supported by the unions affected.

4 The combined effect of these campaigns has placed a heavy load on the NBA as well as on Departmental staff. We need to manage the Department's ongoing response pro-actively in order to bring this issue to resolution.

The Department's response to hepatitis

5 The Permanent Secretary held a meeting 25 November to review the Department's advice to Ministers in respect to claims for compensation for those infected with Hepatitis C following blood transfusions or treatment with blood products. On the basis of the experience of HIV it was important to think ahead how this campaign might develop and to decide in advance what positive action might be taken and to develop a robust and defensible line for Ministers.

6 A number of actions arose:

i) I would submit to Ministers, as part of the briefing for their oral PQs on the subject, a reasoned argument as to why we regard the case of those infected with hepatitis C through blood transfusions differently from those infected with HIV in a similar manner.

ii) It was noted that SOLC still needed to explore whether the Government had been negligent, although it was sensible in the meantime to assume it had not been.

iii) We needed to pursue immediately a positive strategy in respect of haemophiliacs and others who might have been infected with Hep C.

iv) In the longer term I would consider the elements that might make up a fall-back position.

v) Finally the issue remains to be resolved where within the Department "post-Banks" the focal point for a policy on non-negligent harm should rest.

Briefing for PQs

7 The first action has been completed and PS(H) took an oral question on Hep C compensation 6 December. This has been followed by a number of written PQs. The line taken has been that those infected by HIV through medical treatment were a special category through:

i) the nature of the HIV infection which was believed to be invariably fatal;

ii) the significant lifestyle implications of HIV;

iii) in the case of the infected haemophilia patients the

problems of HIV were superimposed on the health, social and financial disadvantages they already suffered as a result of their hereditary haemophilia.

Action that can be taken by Department

8 There are a number of specific actions which need to be considered. These include:

i) undertaking whatever research may be appropriate to determine the aetiology of the disease and its treatment/management.

ii) drawing up and publishing good practice guidance on treatment and ensuring that all affected have proper access to treatment facilities;

iii) determining whether there are ways of identifying those who have been infected (eg. by using "look back" procedures) so that they may be notified and any prophylactic action taken or treatment given. The Advisory Committee on the Microbiological Safety of Blood and Tissue for Transplantation (MSBT) will be considering a proposal to introduce such action UK-wide at its meeting 15 December. It will need to advise on the best way to do this and the groups on which to focus, as well as consider the ethical issues involved. Ministers will need to decide in the light of their advice, the cost of such a programme and the practical implications whether to give the go-ahead. Tom Kelly has advised Private Offices of this development.

iv) supporting any self-help initiatives (eg. through S64 funding) We have already made the first payment of a project grant to the Haemophilia Society to help fund a programme they are setting up to identify the best way to help society members who are affected).

Handling

9 It is important to clarify who is responsible for individual aspects of Hepatitis C. I have addressed this minute to Dr Metters because of his responsibility for the MSBT; to Mr Heppell since OPU still formerly work to him on HIV litigation matters and to John Shaw as my line manager. As I see it:

i) The responsibility for hepatitis issues is shared amongst a number of policy divisions, including the following:

CA OPU Roger Scofield and HC(M)1 Dr Rejman for blood borne diseases and associated compensation claims and safety of the blood supply (although this may move post Banks?).

HP(A)1 Miss Mithani and HP(M) Dr Nicholas for hepatitis as an infectious disease.

ii) Other divisions having an interest in aspects of hepatitis C, include:

ASPU Mr Waterhouse for liver services

HP(A)3 Mr Sharpe for any implications Ministers decisions on hepatitis C might have on settlement of the CJD claims (and vice versa). There may be others.

iii) The Banks Report recommends that general policy on claims for harm caused by NHS treatment should be located in the NHS Executive along with issues such as complaints and consumerism. This would suggest CA QUAC. As far as I know no decision has been taken on this yet.

10 Although CA OPU and HC(M)1 have taken the lead so far, it could be argued that those responsible for hepatitis as a condition should carry the torch. I should be glad of any comments from addressees which might clarify their own specific interest and contribution into the overall response.

Next Steps

11 I am circulating a draft paper to colleagues describing in much greater detail the package of initiatives that the Department can take short of an ex gratia payment scheme. The intention is that when completed ~~this should form the basis~~ of a submission to TOTO/Ministers for a comprehensive Governmental response.

12 A separate submission will be sent to Ministers before the Christmas break following the MSBT's advice on "look back".

Line to Take

13 Meanwhile Ministers have been advised to take the line that the Government has no plans to make any payments to those infected with Hep C as a result of treatment.

R M T Scofield
CA OPU
EH303 Ext GRO-C