EXHIBIT "WITN3094001/26"

This is the exhibit marked "WITN3094001/1" referred to in the witness statement of Debra Anne Pollard dated 7 May 2019

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PATIENT PRIORITY ORDER –RECOMBINANT CLOTTING FACTORS

STATEMENT BY THE RECOMBINANT CLOTTING FACTORS WORKING GROUP

The Department of Health has made available £13m in 2003/04, £21.7m in 2004/05 and £53.4m in 2005/06 to phase in the provision of recombinant clotting factors for the estimated 1500 haemophilia patients aged 22 and above not currently receiving recombinant. The Recombinant Clotting Factors Working Group has been set up by the Department to advise on the phasing process. Members include haemophilia doctors, public health doctors, patients and nurses and local NHS managers as well as Department of Health officials.

The level of funding available in the first two years means that not all patients can be moved to recombinant initially and that a phasing process is required. The group therefore considered ways this might be done and looked at two options:

- phasing by age group, starting with the youngest. This was the approach followed in Scotland and Wales where patients are now all treated with recombinant.

- giving first priority to groups that might be seen to present a 'special case', ie those infected with HIV or with hepatitis C or those exposed to plasma products traced to a variant CJD donor.

The Group's first objective was to agree on a set of principles that could be used to assess these options as a basis for prioritising. It was agreed that prioritising must be as equitable as possible, with an objective and transparent justification and should be practical to implement with minimum delay.

The group discussed the case put forward by the Birchgrove Group for prioritising HIV/HCV co-infected people to receive recombinant first. On the basis of initial estimates, it was agreed that the level of funding available in year one would probably not be sufficient to place all people infected with HIV/HCV on recombinant until the second year of the phasing process. Moreover, the group had strong reservations about using HIV status as the basis for eligibility for recombinant when there was no accepted clinical case for this.

The group felt that it would be difficult to justify prioritising this group of patients above those infected with hepatitis C alone or those exposed to plasma products traced to a vCJD donor, all of whom could also make a case.

Overall, therefore, the group concluded that phasing in by age banding offered the most equitable approach as all groups of patients, not only those with HIV/HCV co-infection, would start to benefit immediately.

May 2003