Witness Name: Rt Hon Jeremy Hunt
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INFECTED BLOOD INQUIRY

FIRST WRITTEN STATEMENT OF THE RT HON JEREMY HUNT MP

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Section 0: Preface

I, Jeremy Hunt will say as follows:-

0.1. I am a former Secretary of State for Health. I make this statement pursuant to 'Rule 9' requests from the Inquiry dated 12 April 2022 and 22 April 2022, which have asked me questions, primarily regarding my period in office at the Department of Health ('DH').

Opening Comments

0.2. I would like to begin my witness statement by making a few brief opening comments.

0.3. This inquiry is about a historic injustice which I was acutely conscious of from the outset, following contact in 2007 with my constituent named Mike Dorricott who was himself a victim of the Contaminated Blood scandal. Neither he nor I then had any sense that I might go on to be Health Secretary. I met him, I believe for the second time, in 2014 when I was Health Secretary and he came to tell me what he believed would be a fair final settlement, in anticipation of the publication of the Penrose Inquiry report. But the meeting was tinged with great sadness because he also told me that he had been given a terminal diagnosis a week earlier. He then moved to the Lake District where he died the following year. It will forever remain on my conscience that I did not come close to delivering justice to Mike and his family whilst he was alive.

0.4. When I did become Health Secretary it was made clear to me that the Treasury would not support an inquiry because of the potential cost to the taxpayer which (taking into account any decisions on financial support which might follow, such as a recommendation for a compensation scheme similar to that in place in Ireland) could amount to billions of pounds. I did not therefore pursue the issue and followed the official government 'line' in correspondence with all campaigners.

0.5. However, the publication of the Penrose report in late March 2015 made it imperative for the government to do more. I was aware that the sums of money likely to be available would not be anything like enough to meet the expectations of families, but made it clear to No. 10 that anything less than £100m would be an insult. In the end a settlement of that order was agreed.

0.6. In 2017, just five weeks after the Conservatives had been returned to office but having lost their majority, Prime Minister Theresa May was going to have to respond to a Parliamentary Question on the issue. I sensed an opportunity to change the government position. I have no doubt that it was because of the impression made on me by Mike Dorricott over many years. I had felt unhappy about the government position throughout my time in office and thought this could be the moment, with the government distracted and weakened by the election result, to secure justice. I knew that from her response to the Hillsborough families as Home Secretary Theresa May had a strong sense of duty to those whose voices were shut out by the system, but do not know if she consulted the Treasury before making her decision to hold a public inquiry, which to her great credit she did.

Section 1 : Introduction

Q1: Career Overview

1.1. My name is Jeremy Hunt. I was Secretary of State for Health between 6 September 2012 and 9 July 2018. My date of birth is GRO-C 1966. My address is known to the Inquiry.

1.2. After leaving University I went to work for a management consultancy firm before going to Japan for two years where I taught English and learnt Japanese. On my return to the UK, I set up my own educational publishing business, Hotcourses, which I no longer own, and a charity to help AIDS orphans in Africa.

1.3. I have been the Conservative Member of Parliament for South West Surrey since May 2005.

1.4. In December 2005 I was appointed Shadow Minister for Disabled People and in July 2007 was appointed to the Shadow Cabinet as Shadow Secretary of State for Culture Media and Sport. After the 2010 General Election I was appointed Secretary of State for Culture, Olympics, Media and Sport. From September 2012 to July 2018, I was Secretary of State for Health.

1.5. In July 2018, I was appointed Secretary of State for Foreign and Commonwealth Affairs, a position I held until July 2019. I was elected as Chair of the House of Commons Health and Social Care Select Committee in January 2020, a position I still currently hold.

Shadow Minister for Disabled People

1.6. I have been asked to outline my role and responsibilities as Shadow Minister for Disabled People between 2005 and 2007. This was part of the Conservative Shadow Work and Pensions team led by Philip Hammond, then the Member of Parliament for Runnymede and Weybridge and Shadow Secretary of State. My role was to shadow the Minister for Disabled People, who at the time was Anne McGuire, the Member of Parliament for Stirling. I was therefore responsible for Conservative Party policy on issues facing disabled people. I focused primarily on the simplification of the benefits system for disabled people and individual social care budgets. I regularly asked questions of the government on these issues and met with disabled people and their representative organisations. However, I do not remember either being contacted by or meeting with any of those affected by the subjects of this Inquiry whilst in this role except as a constituency MP.

Q2: Positions in government

2.1. As outlined above, the positions I held in government were as follows:-

12 May 2010 - 6 September 2012	Secretary of State for Culture, Olympics Media and Sport
6 September 2012 – 8 January 2018	Secretary of State for Health
8 January 2018 – 9 July 2018	Secretary of State for Health and Social Care
9 July 2018 – 24 July 2019	Secretary of State for Foreign and Commonwealth Affairs

Q3: Role and responsibilities as Secretary of State

3.1. As Secretary of State for Health (and then Secretary of State for Health and Social Care) between 2012 and 2018, I held overall responsibility for the work of the Department, including financial control and oversight of NHS delivery and performance and, latterly, oversight of social care policy.

3.2. I ran the Department in a highly delegated manner. I focused primarily on safety and quality issues, but at different times in my period in office my priorities also included dementia, mental health, maternity, technology and integration issues. I also led on the management of any major crisis, often responding in Parliament and to the media on topical issues of the day. I delegated the day-to-day management of all other issues to my ministerial team, only getting involved if they required my decision, input, or advice.

NHS Finances

3.3. The backdrop to many of the issues being considered by the Inquiry was the poor state of DH finances throughout my time in office. Most of our money was ringfenced and transferred directly to the NHS for frontline services.

3.4. When the new Coalition government came into office in May 2010, it faced an economic crisis and implemented an 'austerity' policy in response.

3.5. Settlements for the NHS over these years were protected from the most difficult effects of austerity, with a large measure of 'protected funding' secured first by my predecessor, Andrew Lansley (who held the office from 11 May 2010 until 4 September 2012) and then by me. According to the Department's 2012 – 2013 Annual Report:

> *"The 2010 Spending Review protected healthcare funding in real terms over the four years period to 2014/15, with growth in cash funding set to increase by £12.7 billion by 2014-15 compared to 2010/11. The 2013 Spending Round, announced in June 2013, confirmed that the Government will continue to increase health funding in real terms in 2015-16, with a further increase of £2.1 billion in cash terms.*
>
> *However, the NHS faces rapidly rising demand for services from an aging population, an increase in the number of people living with multiple long-term conditions, and the continuing need to fund new technologies and drugs. The Department believes that to achieve these demands the NHS will need to deliver and re-invest up to £20 billion in efficiency savings by 2014-15, whilst continuing to drive up the quality of the services it provides."*

3.5. The pressures on the NHS can be seen, for example, from the fact that the national 'NHS tariff', which determines the price paid for treatments and packages of care, was reduced annually from 2010-2011 to 2015-2016, in an effective real-terms cut of 3.8% per annum. Providers were expected to make efficiency savings to compensate, but there was widespread failure to attain the savings that would have been needed. By 2014-2015, NHS provider accounts were running a deficit of approximately £1.5 billion; by the following year this had increased to approximately £2.45 billion. By 2015-2016, it was apparent that this was not sustainable, and in that year the Department exceeded its HM Treasury Departmental Expenditure Limit controls, going into deficit (principally due to the increases in NHS provider deficits beyond planned expectations). Furthermore, as the Annual Report for 2015 – 2016 explained:

> *"116. In recent years, NHS providers have experienced increasing financial pressures from new drugs and treatments, safer staffing*

> *requirements and growing demand for health services as a consequence of an ageing and growing population.*
>
> *117. NHS provider deficits represent a 'pressure' on the RDEL [ie Revenue Departmental Expenditure Limits] that requires offsetting 'savings' elsewhere in the Departmental group to ensure spending is contained within the overall expenditure control…."*

3.6. The greatest part of the Departmental health budget goes to the NHS (i.e., NHSE England): in 2015-2016, some £101 billion from an overall allocation of £114.5 billion in revenue and £3.7 billion capital (DH administration accounting for £3.1 billion). See the figure below, taken from the 2015-2016 Departmental accounts: (see 'a flow chart of funding in the health and care system, 2015-16', at my [WITN3499002]).

3.7. In the Spending Review of November 2015, I managed to secure an increase in the overall settlement for the NHS of £10 billion in real terms, allowing (for example) a modest increase in tariff prices for the first time. According to the Annual Report for 2015- 2016:

> *"As a result of the 2015 Spending Review, annual NHS funding will be £10 billion higher in real terms by 2020-21 than in 2014-15; with £3.8 billion of this increase provided to the NHS in 2016-17, which includes the introduction of a £1.8 billion Sustainability and Transformation Fund to support providers to move to a financially sustainable footing, allowing the NHS the space to transform services. This, alongside additional measures such as targeted growth and the impact of the new tariff, should ensure the sector achieves financial balance in 2016-17."*

3.8. However, this settlement increase was based on a requirement, from the Treasury, for me to make real cuts in that part of the DH budget that was not earmarked for NHSE and frontline NHS services. The central DH allocation included not only the funding for bodies such as Public Health England, but also the funding allocated for support of those infected by contaminated blood or blood products. The additional money was to enable investment in NHSE's plan, the Five Year Forward View (October 2014); but it was not matched by an increase in the DH allocation – quite the opposite.

3.9. I make these points not to justify or excuse the time it took to secure justice for families affected by the scandal, but because they represent the background to any attempts to secure either increases in the funding given to those infected with viruses by NHS blood or blood products, or to consideration of a public inquiry.

DH Ministerial Team

3.10. As Secretary of State, I was supported by a number of junior ministers, as follows:

a) Norman Lamb, Minister of State for Care and Support (06 Sep 2012 – 8 May 2015);

b) Anna Soubry, Parliamentary Under Secretary for Public Health (06 Sep 2012 – 07 Oct 2013);

c) Daniel Poulter, Parliamentary Under Secretary for Health (06 Sep 2012 – 30 Mar 2015);

d) Earl Howe, Parliamentary Under Secretary for Quality (he was in post prior to my start – 11 May 2015);

e) Jane Ellison, Parliamentary Under Secretary for Public Health (07 Oct 2013 – 15 Jul 2016);

f) George Freeman, Parliamentary Under Secretary for Life Sciences (15 Jul 2014 – 17 Jul 2016);

g) Alistair Burt, Minister of State for Community and Social Care (08 May 2015 – 13 Jul 2016);

h) Ben Gummer, Parliamentary Under Secretary for Care Quality (14 May 2015 – 14 Jul 2016);

i) Lord Prior of Brampton, Parliamentary Under Secretary for NHS Productivity (14 May 2015 – 21 Dec 2016);

j) Philip Dunne, Minister of State (16 Jul 2016 – 09 Jan 2018);

k) Nicola Blackwood, Parliamentary Under Secretary (17 Jul 2016 – 03 May 2017; she would later return as Parliamentary Under Secretary in 2019);

l) David Mowat, Parliamentary Under Secretary (17 Jul 2016 – 03 May 2017);

m) Lord O'Shaughnessy, Parliamentary Under Secretary for Health (21 Dec 2016 – 31 Dec 2018);

n) Steve Brine, Parliamentary Under Secretary (14 Jun 2017 – 25 Mar 2019);

o) Jackie Doyle-Price, Parliamentary Under Secretary, Care and Mental Health (14 Jun 2017 – 26 Jul 2019);

p) Steve Barclay, Minister of State (09 Jan 2018 – 16 Nov 2018);

q) Caroline Dinenage, Minister of State (09 Jan 2018 – 13 February 2020);

3.11. At the beginning of my term of office, I believe that Anna Soubry was responsible for blood-related issues, including matters relating to the financial support of those infected by HIV and Hepatitis C by blood or blood products. I attach the Table of Ministerial Portfolios from September 2012 [DHSC5221811].

3.12. On 7 October 2013, Anna Soubry was replaced by Jane Ellison MP, who remained in post until 15 July 2016. Lord Prior of Brampton then took up responsibility for these issues until 21 December 2016 and was replaced by Lord O'Shaughnessy.

3.13. Jackie Doyle-Price then took office on 14 June 2017 and remained in post until 26 July 2019 (by then serving in the DHSC). She took up responsibility for the blood policy area, as far as I can recall.

3.14. I have not listed all the other ministerial changes as they are probably less directly relevant to the matters covered by this statement, although other ministers will have had some involvement from time to time, especially when necessary to respond to debates, including in the House of Lords.

3.15. The reality of my role as Secretary of State was that the detailed consideration of many of the issues covered by this Statement were considered by the Parliamentary Under Secretary of State of the time, who would come to me periodically to update me verbally on the issues and any progress being made.

Q4: Involvement with Patient Safety Watch

4.1. I have been asked to describe my involvement with the charity Patient Safety Watch, my role in its establishment and reasons for its establishment, and any issues relevant to the Inquiry's Terms of Reference which came to my attention in the course of my work with Patient Safety Watch.

4.2. I established Patient Safety Watch in September 2019 to carry out research into the levels of preventable harm in healthcare systems and therefore campaign to improve patient safety. I was one of three founding Trustees. Our work is focused on establishing, with our research partners at Imperial College, just how much avoidable harm occurs within the NHS in England. Our research looks at avoidable harm caused by day-to-day medical error, rather than that caused by administrative or policy decisions (such as those that may have contributed to the contaminated blood scandal). It is not looking, nor does it have plans to look, at the issues covered by this Inquiry nor have any issues relevant to the Inquiry's Terms of Reference come to my attention in my capacity as founder and Trustee of Patient Safety Watch although we do frequently come across the tendency of modern health systems to underplay, misrepresent or cover up patient harm and death.

4.3. In a very broad sense, our Trustees will obviously be interested in any analysis of why that happened in this case, if it did, and any recommendations, if any, that the Inquiry makes regarding the prevention of similar scandals happening in the future.

Q5: Chair of Health and Social Care Select Committee

5.1. I have been the Chair of the Health and Social Care Committee from 29 January 2020 to the present day.

5.2. The Select Committee is a cross party committee of 11 MPs (6 Conservative including myself, 4 Labour and 1 SNP) who are responsible for scrutinising the work of the Department of Health and Social Care and its associated public bodies. We examine government policy, spending and administration on behalf of the electorate and the House of Commons. As Chair I am responsible for chairing our public evidence sessions and our private meetings in which we discuss the inquiries we will hold and subsequent reports we publish.

5.3. In my time as Chair, we have not held an inquiry related to the issues of interest to this Inquiry, nor have we discussed this issue in any of our meetings. The clerks of the Committee have informed me that I have not received any correspondence from those affected by contaminated blood. They have informed me that I received correspondence from the Paymaster General with various updates on the terms of reference for this Inquiry, and that I was copied into a letter from Minister Argar regarding the Blood Safety and Quality Framework Outline Agreement. In February 2021, I also received a request to meet to discuss inquiries more generally from Brian Stanton and Deirdre Domingo. I declined this request because it was not relevant to any of the inquiries that the Select Committee was undertaking at that time.

Q6: Committees, associations, parties, societies and group membership

6.1. I have been asked to set out my membership (past or present) of, or my involvement (past or present) with, any committees, associations, parties, societies or groups relevant to the Inquiry's Terms of Reference, including the dates of my membership and the nature of my involvement.

6.2. I am not aware of any such memberships.

Q7: Business or private interests

7.1. I have been asked to provide details of any business or private interests I have or have had which are relevant to the Inquiry's Terms of Reference.

7.2. I am not aware of any such interests.

Q8: Involvement with other inquiries, investigations or criminal or civil litigation

8.1. I have been asked to confirm whether I have provided evidence to, or have been involved in, any other inquiries, investigations or criminal or civil litigation in relation to human immunodeficiency virus ("HIV") and/or hepatitis B virus ("HBV") and/or hepatitis C virus ("HCV") infections and/or variant Creutzfeldt-Jakob disease ("vCJD") in blood and/or blood products.

8.2. I have not been involved with such inquiries or investigations.

Section 2: The Department of Health

Q9: Responsibility for matters relating to blood, blood products and financial assistance

9.1. I have been asked to describe, in general terms, what responsibility I had as Secretary of State for Health for matters relating to blood and blood products and for decisions regarding financial assistance for those infected with HIV, HCV and/or HBV, as a result of treatment by the NHS.

9.2. In general terms: responsibility for these issues lay with the Parliamentary Under Secretary for Public Health, as I have outlined below. The times when specific issues were brought to me have been further described in this statement, as far as I can recollect them or as they appear from documents shown to me.

Q10: Ministers within the Department of Health with responsibility for blood, blood products and financial assistance

10.1. The Parliamentary Under Secretary of State, generally the Parliamentary Under Secretary of State for Public Health, had Ministerial responsibility for matters related to blood and blood products, including the structure and scope of the financial support schemes administered by the Alliance House Organisations ('AHOs').

10.2. As noted already above, during my time as Secretary of State, the following individuals held that position: Anna Soubry, Jane Ellison, Lord Prior of Brampton, Lord O'Shaughnessy and Jackie Doyle-Price. The role of the Parliamentary Under Secretary of State included replying to correspondence, responding to Parliamentary questions, leading and responding to Parliamentary debates and undertaking meetings with myself and other ministers, as well as MPs, policy officials, civil servants and others.

10.3. My memory now is that whilst I had discussions with all the ministers responsible for the issue, it was Jane Ellison with whom I had the most extensive discussions; I can also remember some discussions with Ben Gummer.

Q11: Senior Civil Servants within the Department of Health with responsibility for blood, blood products and financial assistance

11.1. I have been asked for the names of the senior civil servants within DH with whom I principally dealt, or from whom I received advice, in relation to blood and blood products, the risks of infection from blood or blood products, and the provision of financial support for those infected with HIV, HCV or HBV as a result of NHS treatment.

11.2. I do not recall any particular names. The ministers with particular responsibility in this area would have received briefings and submissions from officials and then briefed me themselves.

Q12: How information and issues were brought to my attention in the Department of Health

12.1. I have been asked to describe how, as Secretary of State for Health, information and issues would be brought to my attention and how effective the system was.

12.2. The Secretary of State for Health is responsible for the NHS, an organisation which, with 1.4 million employees, is the largest employer in Europe. In England, fairly uniquely, the state is responsible not just for the provision of healthcare (ensuring everyone can access good care) but for the delivery of it through hospitals that are largely state-owned. Health regularly tops the list as the most important issue for voters, so it is of huge Parliamentary interest as well.

12.3. As a result of the breadth of these areas of responsibility, I believed it was only possible to do that job effectively with a high degree of delegation to junior ministers on all issues other than a few priority areas where I hoped to make immediate change, such as spending round negotiations, the quality and safety of care or preventing a winter crisis. By 'delegation' I meant not just meeting outside interest groups and giving speeches to conferences, but also engaging with the policy issues and making recommendations as to what should happen. The vast majority of the time I would accept any such recommendations on the basis that a junior minister had engaged with the detail of an issue which I had not. This was what happened on issues relating to the Contaminated Blood scandal until the first weeks of Theresa May's premiership when I sensed a moment to make a personal intervention.

12.4. In short it was my decision whether to delegate, what to delegate and whom to delegate to. The Department was then punctilious about implementing that process.

Section 3: The financial support schemes

General

Q13: Knowledge of the circumstances of those infected with HIV, HCV and/or HBV as a result of NHS treatment

13.1. I have been asked, upon becoming Secretary of State for Health, what I knew about "the circumstances in which thousands of individuals had been infected with HIV, HCV and/or HBV as a result of treatment by the NHS."

13.2. At the time, the information and knowledge that I had was limited to what I had gathered from Mike Dorricott, my constituent who was a victim of the Contaminated Blood scandal. I have referred to him in my opening comments.

13.3. One of the documents that the Inquiry has referred me to is [DHSC5080237]. This appears to be a draft letter to me from Anna Soubry MP (the Parliamentary Under-Secretary for Public Health), in which she responds to an email which I sent her in October 2012 in my capacity as a constituency MP. The original email underlying this exchange was from Mike Dorricott to me on 14 October 2012. He noted that I had recently started as Secretary of State and asked me what I was planning to do to resolve the outstanding issues surrounding the infection of hemophiliacs with contaminated blood / blood products [WITN3499003]. I forwarded that email to Claire Stoneham, who was my Principal Private Secretary, explaining that I had been in contact with Mike Dorricott for some time. I asked Claire Stoneham to investigate and respond back to me. It appears the email from Mike Dorricott was logged as requiring a ministerial response. In her response, Anna Soubry referred to the system of support and in particular to the Skipton Fund and the Caxton Foundation.

13.4. I wrote to Anna Soubry on behalf of Mike Dorricott in my capacity as a constituency MP - a convention that I was advised to follow by the Department to avoid conflict between my government and constituency role. Mike Dorricott also asked me for information and feedback about Anna Soubry's meeting, on 29 November 2012, with campaigners and members of the expert group that advised the 2010 review into the financial support schemes, and I also passed that request on to Anna Soubry. I found the system in which letters sent to me by constituents were passed on to other ministers to reply to unsatisfactory, so later changed it to me making direct replies. However, the content of those replies was still based on Departmental advice and would not therefore have been different.

Q13a: Understanding and knowledge of AHOs

13.5. I have been further asked what my understanding and state of knowledge regarding the AHOs was when I became Secretary of State for Health in 2012 and what information I was provided with about AHOs after I assumed the role.

13.6. I do not remember being provided with any substantial information on this topic when I took up office. I was briefed on the issues that required immediate decisions (such as the Francis Inquiry), but given little or no information about matters that were delegated to junior ministers. Information provided for the Secretary of State would have been very limited, due to the range and scale of the matters handled by DH. I have been shown the Public Health briefing for New Ministers dated 10 September 2012 [DHSC6725752]. This stated (p15 of 19) that "*A number of funds provide support for those affected*" and (p16 of 19) that *"There is lobbying by campaigners, directly and in Parliament, for greater support for those infected with hepatitis C via contaminated blood. PS(PH) is due to meet campaigners in Autumn 2012 to discuss the evidence base for the payments scheme."* I understand that this related to the evidence that informed the 2010 review decisions and announcements made by Andrew Lansley in early 2011. I do not believe that I would have reviewed this briefing, which was designed for the minister with the Public Health brief, PS(PH).

13.7. The Inquiry has referred me to [DHSC6736736], which appears to be a draft of a reply by an official, to a letter written to me as the Secretary of State. The draft represents a response to a letter about the work of 'Tainted Blood' from an individual – but who is not clear. I should explain that generally, letters from members of the public or organisations, written to the Secretary of State, would be answered by officials, and neither the letter nor the reply would be seen by me. (There were different conventions for other letters, e.g. those from MPs which would receive a Ministerial response and those from Privy Counsellors where drafts would be topped and tailed by the Secretary of State). This was thought to be a necessary response given the volume of correspondence received. According to DHSC's Annual Report and Accounts for 2017-2018, for example, in that year ministers and the Department received some 32,346 letters and emails. However, in order to make sure I was properly aware of concerns about NHS care, I did ask to see personally a letter from a member of the public each day, which I responded to with a handwritten reply. That letter was selected by the Department. To my knowledge, these did not include infected blood cases.

Q14: Consideration to financial support to those infected with HBV

14.1. I have been asked what if any consideration I gave during my time in office to the provision of financial support to those infected with HBV in consequence of treatment with blood or blood products.

14.2. I do not remember specific discussions of the issue of HBV infection and its consequences, and I have not been shown any documents to suggest that the issue was raised.

Q15: Meetings with Chair and/or Trustees of AHOs

15.1. I have been asked whether I ever met with the Chair and/or Trustees of any of the AHOs and if so, to describe the details of those meetings.

15.2. I do not have any recollection of meetings with the Chairs or Trustees of these organisations and I suspect that any contact was handled by more junior ministers and officials.

Q16: Working relationship between AHOs and the Department of Health

16.1. I have been asked what knowledge I had of the working relationship between the AHOs and DH during my time in the Department. I have further been asked for my views on detailed issues such as whether I considered the AHOs to be independent of the government; or whether it was, or would have been, acceptable to DH for the AHOs to campaign/lobby for a change in government policy to benefit their beneficiaries.

16.2. I do not believe that I was sufficiently involved in these areas of policy to have formed a view on these issues. I can see, having reviewed the documents for this statement, that work was done whilst I was Secretary of State, on the reform of the various schemes run by the AHOs, and this is discussed in more detail below.

16.3. The Inquiry has referred to the Report of the All-Party Parliamentary Group on Haemophilia and Contaminated Blood ('the APPG'), *"Inquiry into the current support for those affected by the contaminated blood scandal in the UK"* published in January 2015 [RLIT0000031]. I have been provided with a copy of the report by the Inquiry. However, I do not believe that I would have seen a copy of the report at the time. The report, and any response to it, would have been handled by Jane Ellison, whose role it was to reach a considered judgment on these issues.

16.4. The Inquiry has drawn my attention to the passages at pages 80-92 of the report, which are concerned with the management, funding and appeals system for the three charities. I understand from the report that the three "Alliance House" charities were the Caxton Foundation, the Macfarlane Trust and the Eileen Trust; whereas the MFET and the Skipton Fund were private companies. The two private companies provided lump-sum, non-discretionary payments to their beneficiaries, who were those directly infected following treatment with NHS blood products. The MFET supported HIV infected people and the Skipton Fund supported people infected with HCV (pages 34-36, APPG report). The three charities provided various kinds of support to those affected ('primary beneficiaries') and their carers, partners and dependents ('secondary beneficiaries'). The support available from these charities was discretionary, meaning that the charities had discretion as to the amount and type of support they provided and the eligibility criteria for assessing it. The Macfarlane Trust supported people with haemophilia infected with HIV following the use of NHS blood factor concentrate, and their families. The Eileen Trust supported those who had been infected with HIV through blood transfusions who did not have

haemophilia. The Caxton Foundation supported those infected with HCV and their families. (Pages 38-39, APPG report).

16.5. The belief of the authors of the APPG report was that the charities had a *"conflict of interest between fighting for their beneficiaries and satisfying their funders"* (DH) (page 81, APPG report). The authors stated that the conflict of interest arose because, on one hand, the charities were supposed to be independent, *"completely free under the law to advocate for their beneficiaries and highlight gaps in provision"*, but on the other hand, DH was the sole funder of the charities, which according to the authors led to *"a feeling among many campaigners, beneficiaries and even trustees themselves that the Trusts act more as conduits to the Department of Health than charitable organisations"*. The view of the authors of the APPG report was that DH *"should have no influence over the management of the charities"*, including the appointment of trustees, and that it should have *"less discretion as to the funding it allocates to the charities"*.

16.6. I have been asked by the Inquiry if I agreed with the description in the APPG report, that the AHOs had a conflict of interest between fighting for their beneficiaries and satisfying their funders. I did not form a view on this matter at the time for the reasons that I have explained, but looking at the matter now I agree that they would not have had a free hand to campaign publicly for extra funding given their exclusive dependence on DH for their funding needs.

Q17: Contact with beneficiaries of the AHOs

17.1. I have been asked what contact I and others in ministerial positions at DH (insofar as I am aware) had with the beneficiaries of the AHOs, including formal forums for contact between DH and those communities. I have been asked about any *ad hoc* contact that I had.

17.2. I cannot remember any direct contact with beneficiaries. I have explained why this would have been a matter for the Parliamentary Under Secretary of State for Public Health and her team. I believe that there were a number of meetings organised, but I would not have been aware of the details at the time.

Q17a: Letter from the Haemophilia Society of 15 October 2012

17.3. I have been referred to a letter of 15 October 2012 to me from Mr James of the Haemophilia Society. This referred to *"a number of issues relating to the on-going financial and social care needs of those people affected by contaminated blood"* and which asked me to confirm the forum in which they could raise such issues with government and offered to meet with me to discuss the issues [DHSC6762159]. I have been asked how I responded to this letter.

17.4. The letter noted that I was "aware from my constituent" of the "*devastating impact of contaminated NHS blood and blood products from the 1970s and 1980s and of the recommendations of Lord Archer's Independent Inquiry".* I have explained my personal connection with Mike Dorricott above.

17.5. I have been provided with a letter of 26 November 2012 from Norman Lamb, who replied to Mr James [WITN3499004]. Norman Lamb noted he was replying as the minister responsible for policy on long-term conditions. He noted that he did not believe it necessary to have a formal arrangement to enable discussion of matters pertaining to the five ex-gratia financial assistance schemes and encouraged Mr James to build on the existing positive relationship the Haemophilia Society had with officials, where specific concerns could be raised. It seems the letter from Mr James was passed to Mr Lamb for his reply and it is unlikely I would have seen it.

Q18: Knowledge and understanding of needs of beneficiaries of the AHOs

18.1. I have been asked what my knowledge and understanding of the needs of the beneficiaries of the AHOs was during my time at DH.

18.2. I have referred above to my constituent, Mike Dorricott and his correspondence with me. But in general, I had to rely on my junior ministers, assisted by officials, to build up a detailed picture of needs and understanding during my period in office.

Q19: Meeting with campaigners in 2014

19.1. I have been referred to the evidence provided to the Inquiry by Ann Dorricott [WITN1196006] and the transcript of her oral evidence on 21 June 2019 regarding a meeting I and Jane Ellison had with a number of campaigners (including the late Mike Dorricott) in around February 2014 to discuss what would be a fair financial settlement for the victims of contaminated blood.

19.2. I have been asked to set out my own recollection of that meeting and what, if any, steps I took following the meeting to address the concerns and proposals raised.

19.3. First, I would like to say that I knew and respected Mike greatly. I considered him to be a decent and fair man, a brave campaigner and someone of whom I had the highest opinion - as well as sympathy for his terrible plight. As with most of my constituents, we were on first name terms.

19.4. I am not sure what prompted this meeting. Looking back now, I had at first thought that it was prompted by publication of the Penrose Inquiry report, but I understand that this was not published until March 2015. However, I have also been reminded that in a debate in the House of Commons on 15 January 2015,

Jane Ellison said that when she came into office (which was in October 2013), she was told that the report was expected in June 2014. She also made it clear that the government was expecting to see recommendations on financial support from Lord Penrose, and that these would be taken into account in scheme reform. So, it is possible that the meeting was linked to expecting the report from Lord Penrose, even if this eventually took another year to be published.

19.5. My recollection of the meeting is consistent with the account given by Mrs Dorricott, although I do not recall the exact exchange of words to which she refers. I have not been given a copy of any note of the meeting. In relation to the accusation that I did not "*sort it out*", I have already mentioned my real sorrow that I did not achieve justice for Mike and his family when he was alive. I have described, in this statement, what I was able to do: supporting scheme reform by the provision of an additional £125 million, and, in 2017, securing a Public Inquiry.

Q20: Tensions between the beneficiary community and AHOs

20.1. I have been asked whether I was aware of any tensions between the beneficiary community and any of the AHOs, or of any concerns held by the beneficiary community about the AHOs or the parameters of the financial support schemes.

20.2. I was aware that the status quo was not satisfactory, and that the government would need to do more, essentially by finding more money, but I did not know any more details.

20.3. The Inquiry has referred me to two letters from Glenn Wilkinson of the Contaminated Blood Campaign, in which Glenn Wilkinson expressed the organisation's discontent with the AHOs, in particular the trustees of the Caxton Foundation and the system of provision of financial support [WITN2050100 and WITN2050104]. I do not believe that I would have seen these letters, and think

that they would have been handled by officials or junior ministers, so my knowledge of Glenn Wilkinson would have been very limited.

20.4. The Inquiry has also referred me to two letters from me, which are replies to letters sent to me from Nick Brown MP about one of his constituents, Ms Carol Grayson. I replied personally to these letters, as Nick Brown was a Privy Counsellor. I would have reviewed the draft answers before signing them, but would have relied on the drafters to ensure accuracy, at least unless there was something that alerted me to an issue. I see that they referred to what was being done to reform the schemes.

Effectiveness of the AHOs

Q21: Letter from Elizabeth Boyd and Russell Mishcon of 12 February 2014

21.1. I have been referred to a letter of 12 February 2014 to me from Elizabeth Boyd and Russell Mishcon, former trustees of the Macfarlane Trust ("MFT"), which raised concerns about the way the MFT was being administered by its chairman and chief executive [WITN1122048]. I have been asked what if any, advice I received regarding the allegations made in that letter and what if any action I or DH took in response.

21.2. I have been shown a copy of a brief letter sent by the Parliamentary Under Secretary in reply [WITN3499005]. Jane Ellison wrote that:

> *"I appreciate you writing to us with your concerns. However, as you know, the Trust, whilst funded by the Department of Health, is an independent charity, and has its own governance arrangements. Whilst the Department, and ministers, can make decisions about the overall funding of the Trust, they cannot direct the Trust on its policies, provided they are in keeping with the objects as set out in the Trust Deed. I note that you intend to raise the governance matters that concern you with the Charity Commission, which is the appropriate body to consider these matters."*

21.3. I have also been referred to an internal note dated 1 April 2014 (which I would not have seen at the time) which refers to the Charity Commission having *"decided not to take on Ms Boyd's case"* [WITN3499006].

21.4. I have been told that no further documents have been located.

21.5. I cannot remember being made aware of this correspondence, and this is consistent with it being handled by Jane Ellison as the responsible Minister.

Q22: Letter from MFT beneficiaries of 26 February 2014

22.1. I have been referred to a copy of a letter of 26 February 2014 from MFT beneficiaries declaring no confidence in the MFT and demanding that the MFT should be closed down [WITN5594002]. The letter seems to be a circular, widely copied including to me. I have been asked what if any advice I received regarding the allegations made in that letter and what if any action I or DH took in response. I am not aware (or cannot remember) being told of this issue and would have expected any response to have been handled by Jane Ellison.

Q23: APPG on Haemophilia and Contaminated Blood Report of January 2015

23.1. I have been referred to the report of the APPG on Haemophilia and Contaminated Blood titled '*Inquiry into the current support for those affected by the contaminated blood scandal in the UK'* of January 2015 [RLIT0000031]. I have been asked specifically whether I saw the APPG report at the time; and if so, what, if any, response I took.

23.2. I have already explained that I do not recall the APPG report, and that its handling would have been delegated. This is consistent with the correspondence below.

23.3. The Inquiry has referred me to [MACF0000059_047], which is a letter to Jane Ellison from the Chief Executive of the Haemophilia Society, dated 10 February 2015, responding to the publication of the APPG report, as well as the back-bench debate on 15 January 2015, which Jane Ellison attended. The letter voiced unhappiness not only about the level of DH support, but also with the staff of the AHOs. It expressed the firm view of the Haemophilia Society that the five trusts were *"not fit for purpose"* and that *"they should be disbanded, and a new mechanism of support created, including a completely different team of people to administer future support"*. Although I was copied into this letter, this does not mean that I would have seen it, and I expect that Jane Ellison would have responded.

23.4. There was a great deal of anger and discontent amongst the beneficiary community expressed in the documents provided to me, directed not only at DH but at the MFT. So, in addition to the letter of 10 February 2015 that I have referred to above, I have been shown:

a) The MFT's subsequent response to the letter of 10 February [MACF0000059_087], refuting some of the allegations made, and specifically the allegation that Jan Barlow and Roger Evans had suggested that the government should delay responding to the Penrose Inquiry in the hope that more victims would have died, so that future pay-outs would be reduced;

b) A press release from Tainted Blood, dated 25 February 2015 [MACF0000022_027], reproducing a press statement by Alistair Burt MP. He called for an inquiry into the MFT and encouraged the government to announce a review of the system.

23.5. I do not remember being shown this correspondence, but I can remember that Alistair Burt talked to me persuasively and with characteristic compassion about this issue before he became a minister; equally, I understood that he sought meetings with Anna Soubry. Indeed, even before talking to him, I was aware of

the anger and disappointment of campaigners, but felt severely constrained as to what I could do to resolve the issue. At the time of the press release, he was a back-bencher, but on 8 May 2015, he became a Minister of State within DH. He was not responsible for blood policies (his responsibilities covered areas such as adult social care, local government, mental health and primary care). But I would expect that he carried his concerns into his new post, and I am sure that his views would have contributed to my sense that the status quo was not acceptable, fair or just. The steps that were being taken to secure reform are set out below.

Q24: Department of Health's remit to intervene with AHOs

24.1. I have been asked whether DH had the remit to intervene if concerns were raised about the effectiveness of the AHOs and whether it did do so.

24.2. I do not think that I would have been in a position to take an informed view on how the government might have intervened. As is set out further below, the proposals for improvement were centred on replacing the AHOs, rather than intervening in them.

Q25: The running of AHOs

25.1. I have been asked whether I considered that the AHOs were well run. I don't think I had a particular view on this, as responsibility for overseeing them rested with Jane Ellison. I of course knew the overall situation was unsatisfactory and unjust, but do not remember specifically the issue of the quality or competence of AHO leadership being raised with me.

Funding of AHOs

Q26: Process of budgeting and funding AHOs

26.1. I have been asked to set out my understanding of the processes by which DH budgeted for and provided funding to the AHOs and what involvement I had in those processes.

26.2. However, I do not think that this was a matter in which I had any real involvement, at any level of detail. Issues regarding funding would only have come to me for decision or substantive input when there was a question about whether or not funding should continue or levels should change significantly, as I believed they should post-Penrose. I have already explained how constrained the central DH budget was, and how it was generally under pressure in order to maintain the NHS spend.

26.3. My involvement was in the broader political decisions that led to the announcement by David Cameron and myself, in March 2015, of an additional £25 million; and then the additional £100 million that the Department found, for the proposal in the scheme reform consultation. Although the £100 million was a large sum, the only way the Department could afford it was by spreading it over four years.

26.4. In addition to this:

a) I have set out at Q28 below the submissions addressed to me as well as the Parliamentary Under Secretary in 2012/13 on the subject of the charities' reserves;

b) Looking at the documents that have been provided to me for the purpose of this statement, I can also see that in January 2014, a submission was sent to both Jane Ellison and to me that – in addition to discussing possible scheme reforms - recommended that there should be no uplift

in the charities' allocations for 2014/2015 (see [WITN3499013] and para 33.11 below);

but as I have explained, I have no memories of being involved in these decisions. I think it likely that the submissions were copied to my Office for information, but decision-making handled by the more junior minister.

Q27: Changes to the process of allocating funding

27.1. I have been asked whether the process by which DH allocated funding to the AHOs changed over the time I was involved and if so, how and whether there were problems with this process.

27.2. I think that those more closely involved in the AHO funding would be better placed to answer this question.

Q28: Consideration to the approach to take regarding AHO financial reserves

28.1. The Inquiry has noted that in 2012-2013 I considered the approach to take regarding the AHOs' financial reserves. I have been asked what my view of this issue was and what decision was taken.

28.2. As I have explained further below, I have no memory of being involved in decision-making on this issue. But I can see from the papers that have been shown to me for the purpose of this statement that a submission was sent to the Parliamentary Under Secretary and to myself on 6 December 2012 [DHSC5007810]. In this, Ben Cole, of the Blood Policy team, recommended that the MFT should have its funding allocation reduced by £1m in 2013/14 and £1m in 2014/15 and be asked to make up the shortfall from its reserve (which stood at £4m). The Eileen Trust, which held a reserve of £155,000, should not receive any further allocation for approximately two years, until it had paid down its reserve. Ben Cole noted that this was a sensitive subject, but argued against

the need for the charities to retain reserves. The recommended option for the MFT would have left it with £2m of its £4m reserve; by contrast he suggested that the Eileen Trust did not need to retain a reserve as what it had was very small and it had not spent its full allocation in either of the two last financial years.

28.3. In terms of the Trusts' independence, the legal view was that DH had no powers to instruct the MFT about its reserve, or its size, but "as sole funder" DH could refuse or reduce funding until the reserves had been paid down.

28.4. Although I have no memory of seeing these documents, I note for the sake of completeness that:

a) on 12 December 2012, the Parliamentary Under Secretary requested further advice from Ben Cole on the implications of the proposals on Hepatitis C sufferers [DHSC6750915]; and

b) a reply was received on 18 December 2012, advising on the position of the Caxton Foundation [WITN3499007].

28.5. Of more direct relevance, a subsequent email dated 4 February 2013 from Ben Cole [DHSC5244801] stated that further information had been received from the MFT which was causing officials to review their advice; he asked that ministers' decisions be deferred.

28.6. It appears that an amended submission was sent on 28 February 2013 [DHSC5102926], although the document seems to be incorrectly dated as 2012 rather than 2013. The submission now recommended that the MFT and Eileen Trust allocations should not be reduced to take account of the reserves held. The submission referred to information having been received from the MFT about how it had started to spend down its reserve, as well as advice from DH Finance that the 2013/14 budgets for the MFT and Eileen Trust were *"affordable within the overall DH envelope"* and advice from DH Legal Services.

28.7. At [DHSC5896073] is a note dated 19 March 2013 from my Assistant Private Secretary to Ben Cole, thanking him for his submission *"which both PS(PH) and SofS have seen. Ministers are content with the recommendation in para 5 – that the allocations to Macfarlane and Eileen Trust are not reduced."* There had, therefore, been a change of approach since the first submission and the Trust budgets were maintained rather than reduced. However, I cannot now remember this discussion and the minute recording the decision from my office could just as easily refer to a special adviser having seen the submission on my behalf.

Q28a: Letter of 10 December 2012 from Graham Evans MP

28.8. I have been referred to a letter of 10 December 2012 from Graham Evans MP, in which I was asked why stage 1 and stage 2 HCV patients did not receive the same amount of help, with stage 1 patients having access solely to discretionary support from the Caxton Foundation and not regular payments [DHSC6757757]. I have been asked what information I was provided with about this issue; what view I reached and what steps, if any, I took in response.

28.9. I cannot remember this correspondence. I have now been provided with a copy of a letter which is probably the letter that Anna Soubry sent in reply to Graham Evans and his constituent [WITN3499008]. This is how I would have expected the correspondence to be handled.

Q29: Requests from the AHOs for increases to their funding allocation

29.1. I have been referred to correspondence between the AHOs and DH that shows that requests were made to increase their funding allocation [MACF0000026_088, MACF0000062_001, AHOH0000001, CAXT0000110_089, MACF0000061_067 & MACF0000061_066]. I have been

asked whether these requests were escalated to me; what the criteria for escalation was; what the decision-making process in relation to such requests was; if there was, in my view, anything the AHOs failed to show or do when trying to persuade DH to increase their allocation; whether the decisions not to accede to requests for increased allocation related to budgetary constraints at the time; and who had the final say on whether or not to increase the allocation.

29.2. The IBI have provided two letters from Dr Ailsa Wight (Deputy Director, Infectious Diseases and Blood Policy). The first is dated, 21 February 2014, and is addressed to Roger Evans (Macfarlane Trust), regarding the Trust's case for increased funding for 2014/15 [MACF0000062_001]. The letter indicates that she was unable to confirm the MFT allocation for 2014/15 because *"Ministers were still considering the overall apportionment of spend across the whole of the health system"* and that ministers had decided that it was *"not the right time for an uplift in allocation"*, whilst the review of the financial support system was being considered, after the Westminster Hall debate on the topic on 29 October 2013. I have also been provided with a letter from Dr Wight dated 19 February 2014 that is in the same terms, but addressed to Ann Lloyd of the Caxton Foundation [CAXT0000110_089], as well as a copy of the Caxton Foundation business case for 2014/2015 [AHOH0000001].

29.3. Additionally, the Inquiry has provided me with correspondence from the following financial year in relation to the MFT:

a) [MACF0000061_067], a letter from Roger Evans (Macfarlane Trust) to Dr Rowena Jecock (Blood Safety and Supply, DH) in relation to the Macfarlane Trust's financial position and the budget allocation for 2015/2016. I note that this appears to be the final version of [MACF0000026_088]. The letter notes that the business case for increased funding for the previous year had been rejected and that the MFT were having to fund operational shortfalls by spending down their reserves; something which could continue for a further two financial years but not thereafter.

b) The letter in reply from Rowena Jecock, dated 11 December 2014 [MACF0000061_066].

29.4. None of this is correspondence that I saw at the time, to the best of my knowledge. I have also explained the limited involvement I had in funding allocation decisions in respect of the AHOs, as well as the tight financial constraints that applied, in respect of DH funding, across these years.

Q30: Whether the MFT and Caxton Fund were adequately funded

30.1. I have been asked whether I considered at that time, or now, that the MFT and the Caxton Fund were adequately funded or underfunded. I do not recall being asked about or considering this issue in any detail at the time. As I have explained already above, matters relating to the funding of each year's allocation to these charities would have been delegated. I was, however, aware of the general injustice of the whole situation and I have explained what I was able to do to increase the overall funds available.

Q31: Announcement of £25 million funds by David Cameron on 25 March 2015

31.1. The Penrose Inquiry report was published on 25 March 2015. On the same day, David Cameron made a statement in which he announced that a further £25 million would be made available to support any transitional arrangements to a different payment system that might be necessary in responding fully to Lord Penrose's recommendations.

31.2. I also made a Written Ministerial Statement ('WMS') [MACF0000022_045], saying:

> *"... there have been continued criticisms of the system, as reflected in the reports produced earlier this year by my right hon. Friend the Member*

for North East Bedfordshire (Alistair Burt) and by the all-party parliamentary group (APPG) for haemophilia …

... The challenge for any future Government will be to identify the most appropriate way of targeting financial assistance, while ensuring that any system can be responsive to medical advances and is sustainable for Government in financial terms.

... We had hoped to consult during this Parliament on reforming the ex-gratia financial assistance schemes, considering, among other options, a system based on some form of individual assessment. However, I felt that it was important to consider fully Lord Penrose's report before any such consultation. Given its publication today, we clearly are not in a position to launch a consultation, on one of the last sitting days of this Parliament.

… it will be for the next Government to consider all of Lord Penrose's findings, I would hope and fully expect proposals for improving the current complex payment system to be brought forward, with other UK health departments.

… I will be allocating up to an additional one-off £25 million from the Department of Health's 2015-16 budget allocation to support any transitional arrangements to a different payment system that might be necessary in responding fully to Lord Penrose's recommendations."

31.3. I have been asked what I understood the £25 million announced by David Cameron on 25 March 2015 to be for. In particular, I have been asked whether it was the intention of the Government that it would be spent in 2015-2016; whether it was in fact spent then; if not, why not; when the funds were allocated and to what; and whether it was restricted to English beneficiaries.

31.4. I have addressed the history of the schemes' reform in more detail below, from Q33 onwards. The additional £25 million had been agreed by me in the summer of 2014. As will be apparent from the below regarding the actions taken on the reform of the schemes, the use of the £25 million was bound up with the decision of the wider reform of the schemes. It was ultimately used, alongside the £100 million over the Spending Review period, for the creation of the reformed scheme. It was intended for supporting the reform of the "English"

part of the scheme, rather than the commitments of the Devolved Administrations, consistently with the fact that I had agreed to fund it from the DH contingencies fund.

Q32: Knowledge or involvement with decisions relating to the AHOs and their funding

32.1. I have nothing further to add in relation to the AHOs and decisions regarding their funding. As I have explained already, these matters were delegated to a junior Minister.

Section 4: Reform of the Payment Schemes

Chronology of Schemes' Reform

33.1. I have been asked a series of questions about reforms of the payment schemes.

33.2. I have first set out the background to the announcements made in 2015, as it appears from the documents that have now been supplied to me for the purpose of this statement – this is not indicative of my level of involvement at the time.

2013

33.3. It is apparent that Anna Soubry (Parliamentary Under Secretary) expressed dissatisfaction with the existing system of financial support during a meeting with the APPG on 17 April 2013 and asked for a meeting with officials. In a lengthy discussion paper for her, officials subsequently drew up four broad options to consider with respect to reform [WITN3499009] and she met with officials to discuss the options. I do not recall being at that meeting but it seems that I or my Private Office must have had some involvement in discussions, as

the submission of 11 July 2013 (see below) refers to me seeking advice on a possible option.

33.4. The result of this was a submission dated 11 July 2013 addressed to Anna Soubry and to me. Ben Cole, of the Blood Safety and Supply team, provided interim advice on the replacement of the payment schemes. Ben Cole noted that Anna Soubry had requested advice on "*replacing the current system with a no fault Quantum damages-based compensation scheme. [She] also asked for advice on a tariff-based system.*" He further noted that I (SofS) had subsequently asked for advice on a system of equal sized annual payments for all infected individuals.

33.5. The submission sought agreement on the 'success criteria' as to what future reform would be. It noted the approximate cost of three options:

a) Option 1 – a system of equal annual payments for all infected rising to £25,000 per annum, which was estimated as costing £2.1 billion over the lifetime of the schemes;

b) Option 2 - a quantum-based system which was estimated as costing £2.3 billion over the life of the schemes; and

c) Option C - a tariff-based system which was estimated as costing £1.4 billion over the life of the schemes.

33.6. Ben Cole stated that the equal annual payments option and quantum-based system were unaffordable under current DH budgets (running to the end of 2015/16) and that it would be unlikely that HM Treasury would grant any request for additional funding. The tariff-based system was noted as being potentially fundable from within existing budgets; however, Ben Cole noted that further work would need to be done to re-prioritise existing DH budgets. He also warned that higher costs in the longer term would require HM Treasury's agreement [WITN3499010]. Ministers were asked for their response.

33.7. In a submission of 13 September 2013 officials then provided advice on options to enhance financial support that might be affordable within current DH budgets for the remainder of the current Spending Review period. It was suggested that "*Within these [financial] constraints, it is likely that there would be a maximum of £10m per year available in addition to the current projected annual spend on the payment schemes.*" The recommendation was to enhance discretionary funding and provide new regular lower level payments to those least well-served by the scheme [WITN3499011].

33.8. I do not have any recollection of what was agreed by Ms Soubry as a result of these submissions, and cannot remember being personally involved. However, in October 2013 Ms Soubry was replaced by Jane Ellison. Jane Ellison met with officials on 16 October and decided that she wanted to see advice on wider range of options (according to the submission of 2 December, below; this also reminds me that she responded to a Westminster Hall debate on the topic of blood infections on 29 October 2013, when the subject of an inquiry was raised).

33.9. The submission from Ben Cole to Jane Ellison and to me dated 2 December 2013 also noted that on 14 November 2013, the Prime Minister, David Cameron, met with Alistair Burt and campaigners. The Prime Minister "*stated that there were issues regarding the system of financial support for those affected, which should be looked at again*" [WITN3499012]. The submission set out a number of options, but warned that *"Expenditure of this level cannot be funded within existing DH budgets without fundamental reprioritisation including the NHS budget, or without additional resources from HMT".* It also reminded the Minister that a systematic review, by experts, of the effects of HCV had been commissioned to underpin decision-making; subsequent submissions noted that this was due to report at about the same time as Lord Penrose in the summer (i.e., it was then thought that Lord Penrose would report by summer 2014 instead of March 2015 as subsequently transpired).

33.10. Officials asked Ministers to provide a steer on the options, but I do not recollect being involved and believe that this remained with Jane Ellison.

2014

33.11. In a further submission to Jane Ellison and me dated 31 January 2014, Ben Cole provided further advice. It is apparent that Jane Ellison had asked for indicative costs estimates for potential scenarios regarding the reform of the schemes, *"as a basis for your discussions with fellow Ministers*" (which reinforces my view that she was driving discussion, to that point). He noted the inconsistent nature of the existing schemes: *"Some payments appear to be made in recognition of the fact of infection, while others provide on-going support, or to compensate for loss. Payment levels are for the most part arbitrary, and, with some exceptions, not based on any assessment of impact or need."* But he also noted that the high costs of reforms to the scheme could not be met through existing DH budgets and noted the severe pressure on central budgets (see paragraph 12). He recommended further advice be provided by officials on reform within the existing budget envelope, and consultation by Jane Ellison with the Devolved Administrations. A meeting was set up with Alex Neill MSP in February [WITN3499013].

33.12. A submission dated 30 May 2014 to Jane Ellison, but copied to all other ministers and the CMO [WITN3499014], set out an update on the possible reforms. Ms Balabanoff provided an update on work on the possible restructuring and retargeting of financial support; the proposal was that there should be a single, non-charitable organisation. An assessment of the work needed to dismantle the existing structures was in hand. Following discussions with Alex Neill MSP in February, consultation with the Devolved Administrations was recommended; there was a recognition of the desirability of maintaining a consistent approach across the UK. Ms Balabanoff also noted that the submission was one of two submissions being sent that week for ministers on contaminated blood issues, the other being the plans for early release of documents to The National Archive.

Agreement to provide an additional £25 million from DH 'contingencies'

33.13. By June 2014 David Cameron had indicated that he would like an additional £25 million added as a one-off sum with respect to the payment schemes; DH was asked about how that money should be used [WITN3499015].

33.14. The funding for this was to come from DH; so, by 8 July 2014 I had agreed that additional funding of £25 million could be made available in 2014/2015 from my "contingency pot", for those covered by the English schemes. To the best of my memory, this "pot" consisted of £50 million, so allocating half of this was a sizeable commitment. A subsequent submission dated 8 July 2014 sent to Jane Ellison (and copied to me) referred to this agreement (see paragraph 14), although officials warned that Treasury approval would still be needed for an "exceptional case" for an extension to the ex-gratia schemes and there were concerns about the "vfm" (value for money) of proposals. It is apparent from this submission that Jane Ellison was now working with officials for proposals to spend this additional £25 million. Proposals at this stage centred around a combination of (i) a 'lump sum choice' – a one-off payment for exiting the schemes and (ii) additional support to those severely affected by Hepatitis C at 'Stage 1', but there was also work on assessing whether funding could be used to secure accelerated access to the new Hepatitis C treatments (see para 17) [WITN3499016].

33.15. In agreeing that the sum of £25 million could be taken from the DH contingency fund, I think that I was trying to respond as positively as I could to a need that I accepted, whilst being constrained by the financial realities that were set out in (for example) the submission of 31 January 2014 which has been summarised above. But I was also conscious – see my letter to the PM in June 2015 - that this would only go a limited way to securing meaningful reform.

33.16. I believe that the spend was subsequently agreed for 2015/2016, rather than 2014/2015, when the consultation did not proceed in 2014; see the announcement made by the PM in March 2015.

33.17. By 29 October 2014, a business case for reform was being developed [WITN3499017] and Jane Ellison met with the Chairs/Directors of the various schemes in November 2014, to plan for system reform. By this stage a draft consultation document had been prepared [WITN3499018]. A submission asking for clearance of the consultation process was sent to Jane Ellison (copied to Will Jones in my Private Office) on 14 November 2014 [WITN3499019]. A draft letter to the Health Ministers of the Devolved Administrations was included. The hope was that the 12-week consultation process could be completed before the General Election of 7 May 2015. In the event the consultation process was delayed, possibly out of a desire to wait for the Penrose Inquiry report which was expected to comment on issues of financial support, as well as the need to study the work that had been published by the APPG on 14 January 2015 (see the response of Jane Ellison to the Parliamentary debate held on 15 January 2015).

33.18. In January 2015 a letter before claim was received by Leigh Day solicitors highlighting the inequalities between those suffering with HCV and those suffering with HIV.

33.19. On 25 March 2015, Lord Penrose's report was published. On the same day the Prime Minister offered an apology for what had happened and announced the additional £25 million of funds, replying to Mr Stewart MP by saying:

> *"My hon. Friend is absolutely right to raise this, with the Penrose report being published today. I can do all of the three things he asks for. I know that many Members on all sides of this House have raised the question of infected blood, and I have spoken about how constituents have been to my surgeries. While it will be for the next Government to take account of these findings, it is right that we use this moment to recognise the pain and the suffering experienced by people as a result of this tragedy. It is difficult to imagine the feelings of unfairness that people must feel at*

being infected with something like hepatitis C or HIV as a result of a totally unrelated treatment within the NHS. To each and every one of those people, I would like to say sorry on behalf of the Government for something that should not have happened.

No amount of money can ever fully make up for what did happen, but it is vital that we move as soon as possible to improve the way that payments are made to those infected by this blood. I can confirm today that the Government will provide up to £25 million in 2015-16 to support any transitional arrangements to a better payments system. I commit that, if I am Prime Minister in May, we will respond to the findings of this report as a matter of priority."

33.20. I laid a written ministerial statement on the same day [MACF0000022_045], which referred to Lord Penrose's report and included the following:

"... Whilst it will be for the next Government to consider all of Lord Penrose's findings, I would hope and fully expect proposals for improving the current complex payment system to be brought forward, with other UK Health Departments. In the meantime I am pleased to announce that I will be allocating up to an additional one-off £25million from the Department of Health's 2015/16 budget allocation to support any transitional arrangements to a different payment system that might be necessary in responding fully to Lord Penrose's recommendations. We intend this to provide assurances to those affected by these tragic events that we have heard their concerns and are making provision to reform the system.

Finally I can formally announce that, in line with our consistent policy of openness, we are now preparing for transfer to the National Archive remaining Department of Health documents relating to blood safety for the period from 1986 to 1995. These documents, which will be open for public scrutiny, will be followed by subsequent tranches of documents covering later years.

Whilst I recognise that this statement does not immediately fulfil the desires of all who campaign on this matter, I hope that it signposts this Government's positive direction on these matters."

33.21. Thereafter, Parliament was dissolved (on 30 March) and on 7 May 2015, a General Election was held. David Cameron retained office, now with a small majority, and I was reappointed as the Secretary of State for Health.

33.22. Jane Ellison also continued in office, and continued to work on proposals for reform of the schemes. I have been referred to a submission to her dated 1

June 2015 (copied to my Office), which set out the "*options and estimates for using extra money over and above the additional £25m already allocated in 2015/16 … This would be contingent upon additional money being agreed by HMT, and cannot be met from within existing DH budget*s" [WITN3499020]. I note that the submission says, at para 2, that *"SofS has asked you to recommend a way forward on this issue*", which would reflect my delegation of this issue to Jane Ellison.

Q33: Letter to the Prime Minister of 30 June 2015

33.23. The results of these discussions was that on 30 June 2015, as I set out below, I wrote to the Prime Minister regarding the proposed government response to the Penrose inquiry and outlined three options for next steps in the reform of the AHOs [CABO0000163_003, see also CABO0000163_002 & CABO0000164_002].

33.24. In my letter, I noted the widespread criticism of the system of financial payments in place at that time by those infected and affected. In particular I noted the confusing structure of the current schemes with discretionary charitable payments and outdated funding structures that apportioned money to some who were ostensibly well and little to many who were ill. I outlined three options for next steps in the reform of the AHOs which were being considered at that time.

33.25. The first was the '*Austerity option: £25m'*: to use the £25 million already allocated to offer final payments *"to buy bereaved spouses and partners out of the existing scheme"*. I noted at that time only 10% of spouses received regular payments, but under this option all would receive a payment of around £20,000 to exit the scheme. I explained however that whilst the 90% of families who at that time got nothing would benefit, campaigners would be furious at this option.

33.26. The second option: '*Minimum scheme likely to satisfy the majority of sufferers: £480m'* was for payments to be offered, not just to bereaved families, but to existing sufferers in order to buy them out of the scheme, with payments at around £50,000 for each bereaved family and £100,000 for each infected person. I noted that this option would close down the payment schemes, which would after 5 years result in no further funding being needed. I also noted that a new HCV treatment had then recently become available, but the NHS accelerated treatment programme, as it then stood, would have meant that only 800 of the infected blood cohort would be eligible, leaving 2,500 with no early access to the programme. I explained that under this option, if implemented, all of those 2,500 people would get access via private treatment to the new treatments. I also noted the financial context in DH at that time: we were still in the process of identifying £22 billion of savings to the health budget. As such, I explained that this option was not affordable for DH and would have to be funded by additional resources from the centre.

33.27. The third option: '*Maximum possible within DH budget constraints: £125m'* proposed that DH would find an additional £100 million from its existing budget to fund accelerated access to the new Hepatitis C treatment for all those in the early stages of the disease; so the primary focus would be on securing effective treatment. That additional £100 million would be on top of the ongoing costs of the payment schemes, and would be taken from DH funds rather than the NHS allocation. I noted that this option would be unlikely to satisfy campaigners, but that it was in my view the fairest option, at least given the financial restraints in place at that time. With respect to this option, I explained that I had received advice that there was very little that could be achieved with the existing DH budget. Further, that if DH were to find additional resources, it would take longer to identify the £22 billion in savings we were required to do and harder to 'balance our books' over the following two years when pressures would be particularly acute.

33.28. With respect to this letter, I have been asked by the Inquiry: what advice I received regarding the proposed response to the Penrose Inquiry and from whom; what options were under consideration in relation to reforming the AHOs at that time; what the key factors which informed that consideration were; and what my preferred option was and why.

33.29. As to this, I have referred in the previous section about the unhappiness of beneficiaries and my understanding, even if it was at a fairly general level, that the status quo was neither acceptable nor fair. I therefore supported Jane Ellison in encouraging the development of a better and fairer scheme.

33.30. It will be apparent to the Inquiry from the chronology above that numerous and very detailed proposals were considered by Jane Ellison in particular, in an attempt to come up with a fairer scheme. The details of the proposals and the advice received would be apparent from those submissions from officials. It is obvious that matters were complicated, not only by the limits on resources but also the concern to ensure that the changes did not reduce existing payments and were not discriminatory.

33.31. As for my own preferred option, it will be apparent from the letter that I supported the option requiring £480 million of funding from HM Treasury, which was correct; see further para 33.34 below.

Response from the Prime Minister

33.32. I have been supplied by the Inquiry with a copy of the submission then sent to the Prime Minister from Clare Macdonald dated 5 July 2015, discussing the options I highlighted in my letter of 30 June 2015 [CABO0000163_002]. This is a No. 10 document and not one that I would have seen at the time. Clare McDonald noted the single recommendation made by Lord Penrose, stating that "*We will accept and implement this recommendation.*"

33.33. She discussed the three options for reform of the support systems, recommending that the "austerity" option of £25m be approved. I was stated as preferring the option requiring £480 million of funding from HM Treasury, which was correct; although given that I knew that HM Treasury would not fund it, in practice I was resigned to the £100/125m option as being the best practicable alternative. However, I wanted the PM to know that it would not satisfy the families.

33.34. However, Clare MacDonald set out reasons why it was thought that the £100m proposal was not satisfactory either, writing "*HMT will not agree to a further £100m from DH underspends when hospital providers are running deficits. The HepC drug will eventually be available [to] everyone as NICE has approved it, but it is being rolled out in a staged way. Jeremy's final option [of] additional money from HMT is clearly not feasible on top of the £8bn of extra funding already agreed for the NHS*".

33.35. The handwritten annotations (which I believe are from David Cameron) indicate that he was not willing to support option 1. This had been presented as involving taking money away from people who currently got it, which was "*hopeless*". Equally, he accepted that "*we don't have £480m lying around*"; essentially, he wanted to see proposals reworking the use of an additional £100m to "*fill in the worse payment gaps*" as well as merging all the charities into one. So, the money was to be used for additional financial support, rather than for focusing on accelerated treatment, as I had proposed.

33.36. An email from my private secretary to officials of 6 July 2015 followed this, noting that the Prime Minister had given a clear steer that he was not prepared to consult or implement a scheme that removed money from groups that currently received it. Further, that he did not think it was feasible to spend an extra £480 million or request additional funding from central reserves for this purpose. He had wanted to progress with reforms to the scheme so that there

was equity between those with HCV and HIV and that DH would meet those costs. Lastly, he did not wish to pursue the option of accelerated HCV treatment [WITN3499021].

33.37. A further submission to the Prime Minister of 13 July 2015 from Clare MacDonald responded to the PM's instructions by outlining *"a different approach to the consultation on reform of support schemes for those affected by contaminated blood."* [CABO0000164_002]. Again, this is not a document that I would have seen at the time. Clare MacDonald noted that the proposed consultation had been redrafted so that the way forward was entirely open and did not specify a preferred government position, so as to stick to the timetable promised by the Prime Minister. It also set out the intention that those who then received support in the old schemes would continue to do so in the reformed system. The submission noted that the commitment to maintain current levels of payments and provide additional funding to those with stage 1 HCV would result in a doubling of the costs of the current scheme and that work would therefore be undertaken to consider the affordability of the new scheme. Lastly it proposed that the £25 million that David Cameron had referred to in his parliamentary speech would be used for the ongoing costs of the scheme and increased payments to some groups, rather than any one-off payments.

33.38. The handwritten annotations on the submission noted that this was "better" but that the proposal was unspecific and therefore would disappoint. It seems that the Prime Minister responded by commenting that there was a need to find a "sum of money" and a "final" move. *"No one is expecting us to solve this, but simply to be a bit more generous."*

33.39. A further email of 15 July 2015, again from my Private Secretary to officials, noted that the Prime Minister considered we could not commit to the upper limit of £480 million in funding and that something closer to, but in excess of, the initial £25 million already identified would be appropriate. It was noted that the £25 million would remain committed to the transition to a better, fairer scheme,

but consideration was to be given to what could be done in the spending review process [WITN3499022].

33.40. My own recollection is that we ultimately settled on the option of making an additional £125m available (including the sum publicly committed in March 2015), with the focus to be on increased financial support, rather than the treatment-focused approach that I had put forward. The detailed options for reform were to be consulted upon. This proposal, for an additional £125m, can be seen in the submissions which followed.

33.41. Thus an email of 30 July 2015 from the Private Secretary for Jane Ellison to officials noted that all money was to come from DH budgets and so three options were to be discussed with No. 10. First, the amalgamation of the current schemes into one with no additional spending. Second, the reform of the schemes into one with an additional £5 million per year for the next five years. Third, the reform of the current schemes into one with an additional £25 million funding a year for the next five years [WITN3499023]. These options were then placed in a submission of 5 August 2015 to Jane Ellison's and my Private Secretaries [WITN3499024]. The submission noted the third option was the least risky as the additional £25 million per annum would be likely to cover the annual payments for the disabled HCV stage 1 individuals.

33.42. I have explained at paragraph 3.7 above how in the Spending Review which concluded in November 2015, I managed to secure an increase in the overall settlement for the NHS of £10 billion in real terms. This was the Review in which we also managed to secure agreement that a further £25 million per year would be allocated from DH central funds to the financial support schemes for those who had been infected, over the next five years (i.e. from 2016/2017 - to 2020/21), making a total of an additional £125 million. Given that, as I explained, the £10 billion settlement increase was based on a requirement, from the Treasury, for me to make real cuts in that part of the DH budget that was not earmarked for NHSE and frontline NHS services, this represented a

major Departmental commitment, even though it fell well short of the more acceptable £480 million I had proposed that would have been possible with the assistance of Treasury funding.

Q34: Commons debate of 20 July 2015 and response to a constituent of 2 June 2015

34.1. I have been referred to the 'Contaminated Blood' debate in the House of Commons, on 20 July 2015 and to the speech of Diana Johnson MP who said: "*on 2 June the Secretary of State for Health wrote to one of his own constituents: 'Any additional resources found for a settlement will be taken away from money spent on direct patient care for patients in the NHS'*" [RLIT0001576]. I have been asked whether I am able to supply, or assist the Inquiry to locate, the letter of 2 June 2015 to which she referred. I have also been asked why, if this was the case, I wrote to a constituent in those terms and why it was the case that any additional resources found for a settlement for beneficiaries and their families would be taken away from money spent on direct patient care for patients in the NHS.

34.2. Regrettably, neither I nor my legal advisors have been able to locate the letter of '2 June' to which Diana Johnson referred. In his response to the question in the debate, Ben Gummer highlighted that the issue of settlement for beneficiaries and their families had to be considered within the bounds of the Spending Review and would come within the parameters of the DH budget. If I did make such a comment in a letter to a constituent, it is to these considerations that I was alluding. I recall that this particular spending review was incredibly tough and I knew that No. 10's position was that there were no further funds, so it was the case - to the anger of campaigners - that any additional funding would have had to come out of DH/NHS budgets.

34.3. Was it fair to say it would affect frontline NHS services? In reality, we simply did not have enough headroom within the non-NHS DH budget allocation to find

the appropriate sums that would have come close to satisfying campaigners (see above). Furthermore, much of the DH budget itself funded frontline care – through, for example, junior doctor salaries funded by Health Education England, and addiction services funded by Public Health England. We were also under constant pressure to find central savings to pass on to the NHS budget – ultimately, all these funds were interlinked.

Q35: Announcement of public consultation on 16 December 2015

35.1. I have been asked what led to the announcement of the public consultation on the reform plans on 16 December 2015 and my involvement in the decision-making process.

35.2. As outlined above, the plan to conduct a consultation on the reformed scheme had been considered since as early as 2014. As I noted in my letter of 30 June 2015 to the Prime Minister, and as is reflected in the submissions of Clare Macdonald of 5 July 2015 and 13 July 2015 [CABO0000163_002, CABO0000163_003 and CABO0000164_002], there had at that time been an intention to conduct a consultation regarding the reform of the AHOs.

35.3. On 16 December 2015 Jane Ellison, in answer to a parliamentary question from Diana Johnson, explained that, despite the best efforts of those involved and the commitments previously given in earlier debates on consulting on the reforms before the end of 2015, the government would not be publishing the consultation until January 2016. I think it had had to await the end of the Spending Review process, and agreement that the additional £100 million would be forthcoming; I have described that process already.

35.4. A submission which is dated 08 January 2015, but must be from January 2016, was sent by Rachel Devlin, Policy Manager of Infectious Diseases and Blood Policy, to Jane Ellison, to me and to the Permanent Secretary. She sought

approval of the final proposals and to the publication of the consultation, following the decision that up to £25 million in additional funds over the five-year Spending Review period would be provided to support reform of the support schemes [WITN3499025]. The writer concluded: "*Whilst we know that some campaigners will be disappointed with the level of funding, we believe that these proposals offer the best package possible within the available funding and the desired parameters.*"

35.5. In January 2016 the consultation document for reform was published and ran until 15 April 2016. The results and response to consultation were published in July 2016 and on 13 July 2016 the Prime Minister announced the response to the consultation and plans for reform.

35.6. I would not have been involved in the details of putting together the consultation proposals or its process and I do not think that I could comment further on its timing, save to say that it followed the decisions on funding that I have described.

Q36: Consultation document of January 2016

36.1. I have been referred to the consultation document on the proposed reforms that was published in January 2016 [WITN3904006]. I have been asked what, if any, involvement I had in formulating the proposed elements of a reformed system and in the consultation process.

36.2. Again, as in my answer to the question above, this is not something that I would have been involved with and this would have been delegated to the junior minister, Jane Ellison.

Q37: Consultation document of January 2016: notice to the Devolved Administrations

37.1. I have been asked what if any prior notice was given to the Devolved Administrations regarding the consultation. I have been referred by the Inquiry to two documents from Northern Irish officials [DHNI0001449] and [DHNI0000756], stating that there had been no effective notice given of the date of the proposed consultation or the details of the proposals.

37.2. These are not documents which I would have seen at the time, and I do not think that I had any involvement in issues relating to the timing or the involvement of the Devolved Administrations. Again, this is a matter that would have been dealt with by junior ministers and officials and I do not recall having any involvement in, or conversation about, the notice given to the Devolved Administrations regarding the consultation.

Q38: The Government response to consultation

38.1. I have been referred to the government's response to the consultation which was published in July 2016 and asked a number of questions about it [WITN3953052].

38.2. I have been asked, first, to what extent the decisions set out in the response document reflected my preferred approach. On this, I would have been following the advice of Jane Ellison and then Lord Prior of Brampton.

38.3. I have then been asked to what extent the consultation responses were used to inform the development of the reformed payment schemes. I cannot comment from my own knowledge on the detail of the use made. But the response document notes the key themes that arose from the consultation, and appears to engage with them. For example, there was support for the principle of a single, simplified scheme.

38.4. Finally, I have been asked what the justifications were for combining the financial support schemes into one single scheme. I would again refer the Inquiry to the response document. The intention was that proposals *'should focus available resource on those whose health is most affected, and that the system of support should be simple, equitable and responsive to individuals'* circumstances'. There was plainly the intention that this would reduce the reported confusion around the schemes and the support they provided, and maximise the funding available to beneficiaries by minimising running costs.

38.5. I understand that the new payments scheme was implemented from December 2016. The element of the scheme that was delayed was the issue of the special appeals process, which became the subject of a further consultation in 2017.

Q39: Further consultation in 2017

39.1. I have been asked why a further consultation was considered necessary in 2017.

39.2. I do not have any real personal recollection of this and believe that by this time (January 2017), the reforms were being handled by Lord O'Shaughnessy, the Parliamentary Under Secretary of State for Health (Lords).

39.3. However, I have been referred by the Inquiry to a number of documents. These show, in essence, that the original proposals in the January 2016 consultation, for individual assessments for those who had stage 1 HCV, to determine the amount of their financial support, had not received support and were reconsidered. A new proposal, for what came to be called the "Special Category Mechanism" ('SCM') was developed to try to fulfill the aim of providing increased support to those who needed it, before stage 2. This was felt to be sufficiently different from the original proposals as to require a further consultation exercise.

39.4. I have been shown:

a) A letter from Lord O'Shaughnessy to the Rt Hon Amber Rudd MP of 20 February 2017 [CABO0000105] which sought the Home Affairs Committee's agreement to publish a new consultation for reforming the financial support system. The letter explained that DH wished to undertake a consultation on the SCM as it was a significant new element of the reforms. The letter also notes that the consultation would cover a range of measures to redistribute the available funding to ensure that the scheme remained within DH's allocated budget for the scheme.

b) A letter to Lord O'Shaughnessy from the Caxton Foundation, on behalf of the five AHOs, of 3 April 2017 [MACF0000061_026]. This noted the conclusion of a meeting held between the AHOs and the BSA (Business Service Authority), that the objective of creating a single scheme administrator could be achieved by transferring oversight to BSA while keeping the team of professionals at Alliance House. The letter also noted that the authors were awaiting details of the future structure of the new organisation that would replace the five AHOs so they could plan for the transition to the new organisation. It noted the need to minimise the continued uncertainty for beneficiaries and anxiety and stress for the AHO staff team;

c) A further letter to Lord O'Shaughnessy from Diana Johnson of 3 April 2017 [CGRA0001031], writing as co-chair of the APPG on Haemophilia and Contaminated Blood. This expressed concern about the planned reforms to the support schemes. In particular it noted a concern that not enough money was being put forward to meet the needs of those in the affected community. Whilst Diana Johnson supported the SCM, she considered it was not right to use such support to make cuts to the rest of the support scheme. She also highlighted concerns about the changes that the proposals were causing for those affected, notably the future of the discretionary budget, the lack of any assurance that no one would be

worse off under the new reforms, interim arrangements for the funding of the discretionary charities and the issue of support for the bereaved;

d) A note from the Infected Blood Policy team of 7 July 2017, which recorded the need for a further consultation in 2017 in response to beneficiaries' call for more clarity about the SCM [DHSC0050028].

39.5. This appears to have been a matter that was being led by Lord O'Shaughnessy and I do not recall any personal involvement in it. However, it is apparent from the above that a decision was reached that a further consultation was needed with respect to the SCM which had become a significant new part of the reforms. I understand that a further consultation took place from 6 March 2017 – 17 April 2017.

Q39a, b: The Outcome of the Consultation and Funding

39.8. I have been asked about:

a) Funding for the consultation proposals (Q39a); and

b) The outcome of the consultation (Q39b).

39.9. I have been referred to a number of documents. Following the history through, it seems that, first, PS(CMH) i.e. Jackie Doyle-Price, took over responsibility for this matter after the General Election of June 2017:

a) On 23 June 2017, a Note was sent by the Infected Blood Policy Team to PS(CMH), seeking approval to publish a consultation response. The proposals consulted on had included removal of the funding uplifts planned for 2018/19 [WITN3499026]; this was to ensure that the scheme remained within the overall funding 'envelope', but this meant that payments would not increase from £15.5k p.a, to £18.5k;

b) At a subsequent meeting with officials, Jackie Doyle-Price asked the team to "*consider the available options if the payment scheme funding*

envelope was increased so that no beneficiaries would receive less money in the reformed scheme";

c) On 7 July 2017, further advice was sent by officials to (in particular) PS(CMH) i.e. Jackie Doyle-Price, about the options for reform [DHSC0050028]; these included options reinstating the annual payment uplift (see paragraph 9 of the Note);

d) On 11 July, she provided her initial views on the options *"ahead of any final decision by SoS on proposed reforms*" [DHSC0050062]. Ms Doyle-Price favoured "Option A", whereby the annual payment uplift and higher amounts of discretionary funding would be reinstated, but no new regular payments would be introduced for bereaved partners. The email noted that this option was, in Jackie Doyle-Price's view, the fairest and would ensure that no particular group lost out financially and that this option, when compared to others, provided this for the lowest cost;

e) A further submission of 11 August 2017 [WITN3499027] to PS(CMH) noted that "*To be able to reinstate the annual payment uplifts in the response to the consultation ….., we need HMT to provide the additional funding*". Officials asked Jackie Doyle-Price to "*agree to start discussions with SofS and No 10*" to enable discussions with HMT with a No. 10 "steer". The submission set out the details of the additional funding needed (see paragraph 4).

39.10. I do not think that I would have seen any of this documentation at the time.

39.11. It is apparent that in response, officials prepared a detailed note for No. 10 (see the email chain of 24 August 2017 to 01 September 2017 involving officials [DHSC0050086].

39.12. A submission to Jackie Doyle-Price dated 12 September 2017 noted that she and "*SofS [had] agreed that discussions should be held with No. 10 to explore options to re-instate annual payment uplifts from 2018/19 (previously*

announced in 2016 but not yet implemented) and to increase the overall level of discretionary funding available. An additional £4-22m per annum would be required from HMT as finance colleagues confirmed that DH does not have the money for this." [DHSC0050103]

39.13. No.10 had responded supporting the uplifts but "*saying they want the uplifts to be funded from DH's existing budget without additional funding from HMT*" and to publish the response to the consultation by 14 September. The finance team were working to identify the funds in the existing budget. Jackie Doyle-Price was therefore asked to confirm she was content with the package of reform in the consultation response provided with the submission. In relation to finance (para 9), the submission noted that options would be presented to me (SofS) *"on the options for cutting other budgets in order to support delivery of the No. 10 Infected Blood commitment".* [DHSC0050103]

39.14. Details of the proposals to be introduced were set out.

39.15. The email exchange at [DHSC0050121] on the contents of a further submission show my response to the suggestion that other options should be cut. The submission noted that "*No 10's requirement to deliver all components of the 2016 scheme from within existing DH budgets results in unfunded costs from 2018/19 for the remainder of the Spending Review, in which existing commitments outside of the NHS mandate substantially exceed the funding available."* My Private Office wanted sections on finance in a further submission to refer, not to options being presented to the SofS for cutting other budgets, but with a more general reference to "*deprioritizing funding in other areas*".

39.16. I have been asked (Q39a) what the nature of that discussion was, what aim I was seeking to achieve and whether I achieved that aim.

39.17. I did not want the funding uplifts to come from cutting existing programmes and sought recognition from No.10 and HM Treasury that the costs would have to be held as an unfunded pressure on the DH budget. HM Treasury had indicated that they would only support the announcement in the consultation response on the basis that DH managed the pressure from within its existing budget. To explain further: an 'unfunded pressure' is a spend for which money has not been allocated. It can sometimes be resolved at the year-end by using underspends in other budgets, but this cannot be guaranteed – and if the underspends do not materialise, then HM Treasury would have to bail you out. I was effectively trying to secure agreement that the centre (HMT) would bear the risk, not DH, as I did not want to cut other agreed programmes. DH went into the financial year 2018/19 with a massive amount of funding pressure. I managed to secure a large additional settlement for DH in the summer of 2018 (£20.5 billion in real terms for the NHS budget, see [WITN3499028]). But I then left DH in July 2018 and ultimately I do not know how DH resolved the issue of this particular unfunded pressure.

39.18. I have further been asked (Q39b) what the outcome of the 2017 consultation was.

39.19. I would defer to Jackie Doyle-Price and officials on the detail of the proposals implemented. The Inquiry will see them set out in the Consultation Response and Equality Impact Assessment that were published on 28 September 2017. I have also referred to the submission to PS(CMH) dated 12 September 2017 [DHSC0050103, p386] which contained Annexes and a draft WMS summarising the changes made (see [DHSC0050103] and following).

Q40: Replacement of AHOs in 2017

40.1. Further to the replacement of the AHOs by four separate and different schemes (the English Infected Blood Support Scheme, the Wales Infected Blood Support Scheme, the Infected Blood Payment Scheme for Northern Ireland and the

Scottish Infected Blood Support Scheme), I have been asked what if any consultation took place with the devolved nations in relation to the replacement of the AHOs with the four new devolved schemes and the significant differences between the four schemes.

40.2. In particular I have been asked what my understanding was, at that time, of the differences between the four schemes; whether I considered those differences to be justified and why; and why steps were not taken to achieve parity between the four schemes.

40.3. There was awareness that there were differences between the schemes in the four nations. In particular, Scotland was providing higher payments, but was not providing annual payments to those with HCV stage 1 as in England. Further, Wales was providing different levels of payments to those proposed in the 2017 consultation, and neither Wales nor Northern Ireland were proposing a SCM [DHSC0050086].

40.4. I do not know what consultation took place with the devolved administrations in relation to the replacement of the AHOs. The detail of this should have been handled by junior ministers within DH and officials. Whilst parity between the devolved schemes would have been desirable, Health functions were devolved and each Administration had constitutional responsibility for its own scheme. Responsibility for the infected blood payment schemes was therefore a matter for each devolved administration, each administration was financially responsible for beneficiaries in its jurisdiction, and parity across the schemes could not be imposed.

Q41: Knowledge of and involvement in decision making on reform of AHOs

41.1. I have been asked, to the extent not already addressed above, to describe my knowledge of, and involvement in, the decision-making regarding the reform of

the payment schemes and their replacement with four separate devolved schemes.

41.2. I have nothing further to add.

Section 5: Public Inquiry

Q42: Consideration to a Public Inquiry 2012-2015

42.1. I have been asked, between 2012 and 2015, what consideration I gave (if any) to calls for a public inquiry and why no inquiry was established.

42.2. My recollection is that during this period, it had been made very clear to me that the Treasury would not accept a public inquiry in any circumstances, because of the risk it would recommend a multi-billion pound settlement. Consequently, I did not pursue calls for a public inquiry as I knew it was not a position I could change. As I have explained in my opening comments, my own view was that a public inquiry was indeed warranted, and so when I sensed, in July 2017, that there was an opening that might persuade the Prime Minister to change the position I took the opportunity to act.

42.3. As can be seen from a note from the Infected Blood Policy team of 7 July 2017 [DHSC0050028] at this point Ministers sought further information on the possibility of establishing a public inquiry. The note records that DH's position up until that time had been that an inquiry would not be in the best interests of the sufferers and their families as it would be costly, delay action to address their concerns, and curtail plans to reform the existing support schemes. Further, it noted that DH had published all relevant information it held on blood safety in line with the Freedom of Information Act 2000 and that there had been two previous inquiries, the Archer Inquiry and Penrose Inquiry in Scotland.

42.4. As can be seen in an email from my Private Office of 10 July 2017 to Sue Gray and individuals from HM Treasury, Cabinet Office, the Wales Office, Scotland Office, No.10 and the Northern Irish Office, which was copied to the permanent secretary [CGRA0001119] it was noted that I had considered Departmental advice on whether to hold an inquiry and had indicated that I was minded to do so, and so, in accordance with the Ministerial Code, I sought to consult the Prime Minister.

Q43: Letter to the Prime Minister of 30 June 2015: Public Inquiry

43.1. I have been referred to my letter to the Prime Minister of 30 June 2015, where I wrote *'Should there be calls for a further inquiry in England, I recommend that they be rejected, as all our documentary evidence will be in the public domain very shortly, and further inquiries would hinder scheme reform'* [CABO0000163_003]. I have been asked why I held that view at that time; what I meant by the statement "*all our documentary evidence will be in the public domain very shortly*" and why I considered that a public inquiry would "*hinder scheme reform*".

43.2. It is difficult to remember why my letter was drafted in that way now, but I would have received advice. However:

a) The submission dated 30 May 2014 to PS(PH) (Jane Ellison), copied to all other ministers at [WITN3499014] made it plain that there were steps being taken to put documents into the National Archives. A further submission of 4 July 2014 to Jane Ellison and me developed this further, noting the steps that would need to be taken to release records to the National Archives with a view to publishing the records to coincide with the publication of the Penrose Inquiry report [WITN3499029]. In my WMS of 25 March 2015, I then announced the transfer of records for the period 1986 – 1995 [MACF0000022_045]. It is apparent that we were trying to make more information available as well as responding to requests for scheme reform;

b) Pragmatically, it would be unlikely that major scheme reform would have been attempted alongside a public inquiry. The more common approach would have been to have let an inquiry examine the issue and to make recommendations, rather than to risk expending time and resources on reforming a scheme which might then be subject to further change. Because I did not believe the government position on an inquiry would change, I was keen to focus energy on improving the schemes. But my note to the Prime Minister was not a full reflection of my position, for the reasons I have stated earlier.

Q43a: Letter to Diana Johnson MP in November 2016

43.3. I have been referred to a letter I wrote, in November 2016, to Diana Johnson in which I explained that I did not support the proposal for the establishment of an independent panel and where I stated that such a panel or a public inquiry "would detract from the work we are doing to support sufferers and their families" [HSOC0029781]. I have been asked to identify the "work" to which I was referring and to explain why I considered that a panel or inquiry would detract from such work.

43.4. As I have explained already above, my recollection is that in 2016 the Treasury were firmly against a public inquiry. In responding to correspondence, I had to defend the public 'line', even though it did not reflect how I felt personally about the importance of improving support offered to victims of the scandal, something most likely to be achieved by a public inquiry. Regarding the phrase "work", I believe that this would have been a reference to the work done by my junior minister and DH officials on scheme reform

Q44: Letter from Vaughan Gething in December 2016

44.1. I have been referred to a letter from Vaughan Gething, the Cabinet Secretary for Health, Well-being and Sport in the Welsh Government, of December 2016 which set out his support for a UK-wide public inquiry [WITN3988003]. I have

been asked to set out what if any steps I took in response to his letter and have been asked to provide a copy of any reply I sent to him.

44.2. In his letter Vaughan Gething notes he had met with the National Assembly Cross Party Group on Haemophilia and Contaminated blood and that his officials had held workshops as part of a consultation on how best to use the money available to assist those affected. He highlighted the strength of feeling from individuals and their families in favour of a UK wide public inquiry, noting that the families sought closure and clarity as to what happened to them. He notes his support for such an inquiry.

44.3. I understand we have been unable to locate the reply that was sent to Vaughan Gething in direct response to this letter, however a note of meetings had by Lord O'Shaughnessy from his private office of 15 March 2017 noted that a telephone conference was held with Vaughan Gething and Lord O'Shaughnessy on 8 March 2017. The note refers to the issue of a public inquiry being raised and that Lord O'Shaughnessy set out my position and that of the Prime Minister on the point [WITN3499030]. A subsequent letter of 23 March 2017 from Vaughan Gething also noted that the issue had been raised regarding a public inquiry and that Lord Shaughnessy had indicated that he was not in a position to take the matter forward [WITN3499031]. Subsequently, and in response to the announcement of a public inquiry in July 2017, I corresponded directly with Vaughan Gething on the issue and noted that we would be consulting with those affected to seek their views on the format and scope of the inquiry [WITN3499032].

Q45: Announcement of a public inquiry in July 2017

45.1. With reference to the Prime Minister's announcement of this public inquiry in July 2017, I have been asked to explain how and why the government's position changed and to set out my own involvement in that process.

45.2. I have addressed these matters already in answering the questions above, as well as in my Opening remarks.

Q46: Establishment of an Inquiry before July 2017

46.1. The Inquiry has reminded me that it has heard evidence from people who were infected and affected, from campaigners and from the former Secretary of State for Health, Lord Fowler, indicating that the government should have established a UK wide public inquiry before it did. I have been asked to set out my present views on this observation.

46.2. I agree entirely. It was not possible to secure an agreement in government to establish a public inquiry, prior to the Prime Minister, Theresa May's, decision to do so in July 2017. I do not believe any representations I could have made would have changed that because the sums likely to be involved would have had to be found by HM Treasury who believed it could not be afforded.

Section 6: Other matters

Q47: Letter from Nick Brown MP in December 2015

47.1. I have been referred to a letter sent by me to the Rt Hon Nick Brown MP in December 2015 [WITN1055155] in which I stated that "this tragedy continues to receive my utmost attention". I have been asked to provide details of the "attention" which I gave.

47.2. In my letter, which is date marked 18 December 2015, I referred to the government's intention to reform the support schemes for those affected and referred to our commitment to undertake a consultation on the reform plans in January 2016.

47.3. I believe that I was referring to the work that had gone into reforming the schemes as well as securing the £125 million spend.

Q48: Involvement in Patient Safety and impact on views

48.1. I have been asked whether my involvement in Patient Safety altered and/or informed my views on infected blood issues and if so how.

48.2. My involvement in Patient Safety has not altered my views on infected blood issues. I saw infected blood as an historic scandal, requiring justice whereas, patient safety campaigning is concerned with preventing avoidable deaths going forward. There are however elements of overlap, notably concerning the regrettable tendency of health establishments to downplay or conceal preventable harm and death.

Q49: Any aspects of government response that could or should have been handled differently

49.1. I have been asked whether there are any aspects of DH's policy-making and/or decision-making regarding the government's response to the tragedy which I consider could or should have been handled differently during my time as Secretary of State.

49.2. Given the constraints on the NHS budget and government finances it is not clear to me that handling the decision-making differently during my time as Secretary of State would have led to a better outcome, even though I recognise that meant a grievous perpetuation of the injustice of the scandal. I do believe that it would have been much better if we could have established a public inquiry earlier and it is a matter of great regret to me that it was not possible to do so. Justice delayed is justice denied - and that justice was denied to Mike Dorricott and many others who will have died before justice is finally done. As Secretary of State for Health during part of that period, I accept that however

proud I was to finally secure a public inquiry, I was also in charge of a system that denied that inquiry for too long.

Q50: Further comments

50.1. I have been asked to provide any further comments on matters that I believe may be of relevance to the Infected Blood Inquiry, having regard to its Terms of Reference.

50.2. I do not have anything further to add.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed. GRO-C .....

Dated.....28/06/22.....