

Witness Name: Claire Foreman

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## **INFECTED BLOOD INQUIRY**

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### **SECOND WRITTEN STATEMENT OF CLAIRE FOREMAN ON BEHALF OF THE NHS COMMISSIONING BOARD (KNOWN AS NHS ENGLAND)**

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I, CLAIRE FOREMAN, Head of Acute Programmes (formerly National Programme of Care Senior Manager) within the Specialised Commissioning Directorate of NHS England, will say as follows:-

1. I make this statement in addition to the statement provided on 14 February 2020 and in response to a Rule 9 request from the Infected Blood Inquiry (“IBI”) on 16<sup>th</sup> January 2020.
2. In producing this statement on behalf of NHS England and NHS Improvement (“NHSE”), I have sought advice from clinical and NHSE colleagues including Professor Graham Foster who acts as NHSE’s National Clinical Lead for Hepatitis C (“HCV”) and Martin Machray, Interim Joint Regional Chief Nurse and Clinical Quality Director at NHS England and Improvement London Region. Martin has acted as the Recovery Director for the NHS since the fire at Grenfell Tower.

#### **How psychological services are commissioned and funded in England.**

**If psychological services are the commissioning responsibility of NHS England or CCGs (either generally, or specifically in relation to those who have been infected with a chronic and serious disease such as HIV or HCV or HBV) please provide details of the services which are commissioned and are available to people who have been so infected, or whose partners or family members have been infected, and who have suffered psychological difficulties as a result.**

3. Mental health services investment has been identified as a priority for the NHS in the Long Term Plan (“LTP”): *“The Long Term Plan makes a renewed commitment to grow investment in mental health services faster than the NHS budget overall for each of the next five years. The NHS in England is already meeting the goal set in the recently launched Lancet Commission on Global Mental Health that high income countries should be spending at least 10% of their health services budget on mental health, and NHS England will be the only major Western health service to have made and sustained such a funding pledge for what will have been eight years by 2023/24. NHS England’s renewed pledge means mental health will receive a growing share of the NHS budget, worth in real terms at least a further £2.3 billion a year by 2023/24. As a result mental health investment will be growing faster over the next five years than over the past five years. It is also the ‘floor’ level of uplift now being set nationally, and we expect it will be further increased by local investment decisions. We will ensure this translates into additional funding for frontline services, including locally agreed spending and delivery plans signed-off by commissioners and providers”.*
4. The LTP sets out investment and improvements in a range of mental health provision for the general population based on the severity of their medical condition. This includes the Improving Access to Psychological Therapies (“IAPT”) programme services for common mental health problems, community based psychological services for people with severe mental illness, and emergency services for people experiencing

mental health crisis. **[WITN3953054]** (full version available at **[WITN3953010]**).

5. The IBI is interested to know where the commissioning responsibility for psychological services (generally for the general population and specifically in relation to those who have been infected with a chronic and serious disease such as HIV or HCV or HBV) resides.
6. In summary, both NHSE and Clinical Commissioning Groups ("CCGs") are the responsible commissioners for psychological services for the general population, with the vast majority of services being commissioned by CCGs. Both are also responsible for commissioning relevant psychological services for those who have been infected with a chronic and serious disease such as HIV, HCV or HBV. Other bodies may also have a role in commissioning psychological services. For example, local authorities commission some community HIV support services. In such cases, individual CCGs or local authorities make individual decisions based on the needs of their local populations.
7. In the paragraphs below, I have set out an overview of the sorts of psychological services commissioned and expected to be available for
  - a) the general population, including those infected and affected through infected blood, and
  - b) people infected with a chronic and serious disease such as HIV or HCV or HBV and their families.
8. All NHS patients can access a wide range of mental health services, depending on the specific issues they are experiencing. The particulars of the presenting symptoms and any underlying condition will determine exactly which services will best meet the person's needs and in turn who is responsible for commissioning them.
9. For all patients, this is best understood by visiting the NHS Choices website for information on mental health services. **[WITN3953055]**

10. Psychological or mental health services range from talking therapies which can be accessed via self-referrals or via a GP referral for stress or anxiety through to medical inpatient care for people with the most serious mental illnesses.
11. The wide range of services available via self or GP referral for dealing with stress and anxiety are generally commissioned by CCGs. Improving Access to Psychological Therapies services (IAPT) are an example. These are typically available to adults and offered locally to patients registered with a GP. The services tend to include talking therapies for people experiencing mild to moderate depression, general anxiety and worry, panic attacks, social anxiety, traumatic memories and obsessive compulsive disorder. The services may also offer help with other problems including anger, eating, and relationship or sexual difficulties. People who access IAPT and other psychological services, will be referred or directed to alternative services if assessment reveals they require a different type of service to meet their needs. This would include where a patient had a more serious condition such as diagnosed psychosis, schizophrenia, Bipolar Affective Disorder or Personality Disorder or was experiencing acute mental health crisis.
12. In addition to the general services on offer, the IAPT programme has produced a range of resources aimed at specific patient groups who have protected characteristics under the Equalities Act such as those from Black and Minority Ethnic Groups (BME), people with learning disabilities, older people and women during the perinatal period. Guides are also produced for veterans, people who misuse alcohol and other drugs, people with medically unexplained symptoms and offenders. These guides can be viewed here: <https://www.england.nhs.uk/ltphimenu/mental-health/iapt-positive-practice-guides-for-targeted-groups/> [WITN3953056]. The guide for people with long term health conditions is of particular relevance here <https://www.uea.ac.uk/documents/246046/11919343/longterm->

13. In addition to these general psychological services, a range of other inpatient or intensive mental health services are commissioned between NHSE and CCGs for more complex conditions. By way of example, these include but are not limited to

a) **General acute mental health beds:** CCGs commission acute mental health beds which are not associated with any secure pathway. These are people who have a primary mental health presentation that requires an inpatient stay but who are not at risk of harming others or themselves.

b) **Adult secure mental health services:** NHSE commissions high, medium and low secure inpatient care and associated non-admitted care including Access Assessment Services and Forensic Outreach and Liaison Services ("FOLS") for those detained under the Mental Health Act. As well as commissioning general mental health beds not on the secure pathway, CCGs commission services for patients on the secure pathway who do not or no longer require high, medium or low secure care or FOLS (page 1 of [WITN3953058])

c) **Adult specialist eating disorder services:** NHSE commissions inpatient care and bespoke care packages providing intensive day care (as an alternative to admission) services provided by Adult Specialist Eating Disorder Centres. CCGs commission multi-disciplinary adult community eating disorder services, which include a 'gate-keeping' function for admission (access assessment); this may also include less intensive day patient services (page 2 of [WITN3953058]).

d) **Neuropsychiatry services:** NHSE commissions assessment and treatment for adult and child patients with neurological diseases and associated severe psychiatric symptoms; or severe and disabling neurological symptoms without identified neurological cause, in named specialist centres. CCGs commission dementia services included within elderly care (page 3 of [WITN3953058]).

14. NHSE is also the responsible commissioner for mental health provision for people in secure and detained settings such as prisons. This responsibility is set out under mandate from the Department for Health & Social Care (“DHSC”) as a part of the National Section 7a agreement between the Secretary of State for Health and NHSE **[WITN3953059]**. This agreement means that NHSE has a specific role to commission the specified public health services and to hold to account providers to ensure that they deliver the contracts that have been agreed. Mental health support in prisons is equivalent to that commissioned in the community, though is governed by a bespoke NHSE service specification taking into account both setting and the patient cohort. Population-level psychological services are available (alongside primary care and other specialist services) as they would be in the community, including relevant psychological services for those who have been infected with a chronic and serious disease. **[WITN3953060]**

15. As I have indicated in my first witness statement, NHSE commissions specialised treatment and care services for people with HIV and HCV and some elements of care for HBV. The scope of this commissioning responsibility is set out in the Manual for prescribed specialised services **[WITN3953061]**.

16. Many patients requiring specialised services for a disease or condition will also have psychological support needs at some point in their care or treatment pathway. Whilst this follows their primary health need (such as liver care), responding to psychological support needs is an important part of a patient’s overall care package. Whilst it is not expected or desirable for each specialised service to have their own dedicated psychological support service, it is expected that all services have in place the necessary links and referral pathways, so patients can be referred to and access the care they need, as determined by the clinical team looking after them. For example, I understand from Professor Foster that the treatment for HCV was, for many years, based upon interferon, which often induced depression. Consequently, most, if not

all, liver units with a significant HCV treatment practice had established pathways to access psychiatric support for their patients.

17. Referral pathways and access to appropriate psychological or psychiatric support is therefore the focus of commissioning from a specialised commissioning perspective. As the needs of each individual is assessed by their clinical team, NHSE service specifications relevant to HIV, HCV and HBV set out this requirement for access to the appropriate level of psychological support but do not specify provision further. [WITN3953062] [WITN3953063] [WITN3953064] [WITN3953065] [WITN3953066] [WITN3953067]

**The Inquiry understands that: (a) in October 2018 NHS England announced funding (of up to £50 million) for a new screening service to be put in place to provide long term support and treatment for people with physical and mental health issues following the Grenfell Tower fire; and (b) a free and confidential NHS service (the Grenfell Health and Wellbeing Service) is available to children and adults affected by the Grenfell Tower fire. Please confirm whether there is any equivalent or similar service in England for people infected or affected in consequence of infected blood or blood products. If so, please provide details of the service(s). If not, please explain why.**

18. The Grenfell Tower incident was one of 5 major incidents that occurred in 2017, the others being the London Bridge and Westminster Bridge terrorist attacks, the tube attack at Parsons Green, and the Manchester Arena terrorist attack. As major incidents, NHSE's responses to these incidents were in the context of its Emergency Preparedness, Resilience and Response ("EPRR") duties under the Civil Contingencies Act (2004). NHSE's approach to EPRR is set out on our website: <https://www.england.nhs.uk/ourwork/epr/> [WITN3953068]

19. NHSE is required to review and respond to major incidents at a national level. This covers both immediate response to an incident (such as

ensuring that ambulances attend the scene and hospital beds are made available to care for affected people) and facilitating NHS resilience in the recovery period following an incident (such as ensuring that other services are not affected for prolonged periods after an incident). Providers and commissioners of NHS funded services must therefore show they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients.

20. In the case of Grenfell (and the other incidents that year), local communities witnessed extreme events likely to result in significant mental health issues, as well as other health problems.

21. In recognition of this, NHSE issued advice to health services about caring for affected people, shortly after the incidents. **[WITN3953069]**

22. This advice encouraged greater vigilance by healthcare professionals and provided a leaflet about coping with stress after a major incident. Individuals were also signposted to use NHS Choices or 111, the usual routes to access relevant health and mental health services.

23. As the Inquiry has noted, NHSE announced on 9<sup>th</sup> October 2018 the services it would put in place for the local community affected by the Grenfell Tower fire: <https://www.england.nhs.uk/2018/10/nhs-to-provide-long-term-screening-service-for-grenfell-community/>

**[WITN3953070]**

24. These additional arrangements were made as part of NHSE's major incident response in enabling the NHS to return to normal as part of the 'recovery' phase and in response to the Prevent Future Deaths report made by the Coroner: <https://www.judiciary.uk/wp-content/uploads/2018/09/Grenfell-Tower-2018-0262.pdf>

**[WITN3953071]**



25. The Coroner's report, directed to NHSE, set out concern that some Grenfell survivors and responders at the scene may have been exposed to significant inhalation of smoke and dust containing toxic substances, and so left at risk of developing health conditions. The report also noted that many of those affected by the incident suffered emotional trauma and harm to their mental health and were therefore likely to need appropriate mental health support.
26. Whilst services for mental health (including post traumatic stress disorder) and respiratory conditions are generally available via the NHS for all patients, the services put in place for Grenfell were therefore in response to the specific and additional needs of the Grenfell community. This was consistent with the principle that NHS patients with equal need should have equal ability to access services, regardless of how those needs arose. In the same way, ill patients with Hepatitis C have been able to access NHS services and treatments on the basis of need, rather than differentially based on how those needs arose.
27. NHSE (otherwise known as the NHS Commissioning Board) came into existence in 2013, and long after it became known that patients had received infected blood. I am unaware of the actions taken by relevant predecessor organisations before that time.
28. I am not aware of any specific Coroner reports, such as that put in place after Grenfell, to prevent future deaths in relation to infected blood. Contracting an infectious disease like HIV or HCV is devastating for everyone infected and affected. General and more tailored psychological services for those with such diseases are in place for all those people infected and affected via the pathways indicated above. I have indicated in paragraphs 16 and 30 the availability and importance of psychological and psychiatric services at the time of previous HCV treatments.

**What scans, blood tests and/or other checks and/or monitoring are, or should be, offered to a person who has been diagnosed with HCV, how often and over what period of time?**

29. Clinicians treating HIV or hepatitis will follow NICE guidance and published clinical guidelines relevant to the condition. Examples of NICE guidance, which in turn references such published consensus clinical guidelines, can be viewed here:

<https://cks.nice.org.uk/hepatitis-b#!scenario:1> [WITN3953072]

<https://cks.nice.org.uk/hepatitis-c#!scenario> [WITN3953073]

<https://cks.nice.org.uk/hiv-infection-and-aids> [WITN3953074]

30. According to Professor Foster, the decision as to what follow up is appropriate for a person with chronic HCV infection should be determined by the local treating physician, in conjunction with the patient, after an informed conversation regarding the risks and benefits of the available options. The monitoring arrangements and recommendations depend upon the available treatments at the time the patient was under review. For example, when interferons were the only treatment option available (which clinicians considered to be of limited effectiveness and prone to side-effects), follow up was very different from the follow up that is now suggested with instant access to effective, side-effect free drugs.

31. For patients who did not wish to take advantage of the treatment options that were available at the time, the majority clinical opinion would support follow up based on the severity of fibrosis. For a patient with cirrhosis, standard follow up would include a review every 6 months with an assessment of liver function by blood tests, including a full blood count, liver function tests and, usually, clotting assessment. A liver cancer screen would be performed with an ultrasound scan and an alfa fetoprotein assessment.

32. For patients without cirrhosis follow up was context dependent and determined by the patient's condition and progression. In a patient who had been stable for many years, with histologically mild disease and near normal liver function tests and who did not wish to undergo therapy, it would be appropriate to adopt a minimalistic approach with an annual, or even two yearly, assessment of liver function with liver function tests and a full blood count. For a patient with evidence of liver fibrosis on liver biopsy and raised liver function tests, a more regular review would be required and this would depend upon the patient's preference. For example, if a patient was not willing to undergo therapy whatever the circumstances, then infrequent review would be reasonable. If a patient chose to defer therapy until either side-effect free drugs were available or until the liver had reached a critical scarring threshold, then regular review, twice a year, with a liver biopsy every few years would be appropriate. At each clinic review it would be usual to perform liver function tests and a full blood count.

33. Repeat viral load testing is considered by clinicians to be of limited value and would not normally be performed.

34. When non-invasive measurements of fibrosis (e.g. transient elastography) became available, many clinicians included an assessment of fibrosis in the regular follow up visits but I am informed by Professor Foster that there is no consensus on the frequency with which these should be performed and, in general, this would be dependent upon the initial degree of fibrosis and the likely progression of disease, dictated by a clinical decision based upon liver function tests and co-morbid factors, such as alcohol intake or diabetes.

**Following successful treatment, such that the person has received a sustained virological response (SVR), what follow up scans, blood tests and/or other checks and/or monitoring are or should be offered, how often and over what period of time?**

35. According to Professor Foster, it is generally recommended that, in the absence of liver cirrhosis, patients with HCV who have cleared the virus with treatment can be discharged from follow up and no routine surveillance is indicated.
36. Many clinicians perform a single repeat check of HCV ribonucleic acid ("RNA") status and liver function 6-12 months after treatment to identify the very rare patients who suffer a late relapse but, in the absence of co-morbidities, no follow up is indicated. For patients with cirrhosis, standard follow up post therapy should include a review every 6 months with an assessment of liver function, by blood tests including a full blood count, liver function tests and, usually, clotting assessment. A liver cancer screen should be performed with an ultrasound scan and an alfa fetoprotein assessment.
37. Follow up and monitoring should clearly be different in the presence of co-morbidities such as fatty liver disease, chronic HBV infection, alcohol misuse or other significant liver disorder. Follow up for the non-hepatic complications of HCV should be determined by the requirements of that particular condition.

#### Timelines for test results

38. As I understand it, the timelines for requesting, processing and reporting blood tests and scan results varies according to several factors. Clinicians would be expected to discuss any testing with patients, including giving an idea of the timescale for the availability of results. Most of the results from the tests conducted for HCV should be available within less than one week and these should be reported back to the requesting clinician. It is generally recognised that the requesting clinician is responsible for reviewing the result and taking appropriate action within an appropriate time frame, usually within a few days of the result being available. For normal results, or those in line with expectations, it is not uncommon for the patient to be informed at the next appointment, although some clinicians do contact patients to inform

them of their test results. If the test is unexpectedly abnormal or reveals a significant clinical change requiring early review, it is the responsibility of the requesting physician to identify the need for urgent action and respond appropriately within a clinically acceptable time frame – for example an ultrasound scan or a blood test showing a possible cancer should prompt urgent action within 2 weeks.

39. If tests are not processed and results not given in the appropriate timescale, patients can report this via the NHS provider's Patient Advice and Liaison Service (PALS) or complaints service in order that the circumstances can be investigated, and appropriate action taken.

Statement of Truth

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

Signed:

**GRO-C**

Dated: 18 February 2020