

## Trust Board -Infected Blood Update December 2025

The previous update in relation to the Infected Blood Inquiry and associated work was provided to Trust Board, on 27 March 2024. This update, summarises key issues of relevance to the Trust between March 2024 and November 2025.

The Infected Blood Inquiry was an independent public statutory Inquiry established to examine the circumstances in which men, women and children treated by national health services in the United Kingdom were given infected blood and infected blood products, in particular in the 1970s and 1980s.

The Inquiry published its final report in May 2024, highlighting multiple areas from which learning and improvement was detailed. It outlined 12 recommendations and 56 sub recommendations. These sit across a wide range of areas within the Department of Health (DOH).

Volume 1, contains a summary which sets out some of the key failings, followed by an overview which provides a chapter-by-chapter summary.

Volume 2, covers people's experiences and provides a detailed account of what happened to children with haemophilia treated at Treloar's, a non-maintained residential and day special school and college for disabled children and young people.

The Report comprises a total of 7 Volumes and can be accessed at <https://www.infectedbloodinquiry.org.uk>

Areas of interest to Belfast Trust include Haemophilia and other Bleeding Disorders, Hepatology, Psychology Services, Red Cell Disorders, as well as Blood Transfusion for those infected and/or affected by contaminated blood or blood products. A number of these areas which are regional services are all hosted within the Trust.

Some areas, which had delivered Services during the Inquiry with temporary, non-recurrent funding, have continued to support this work.

The Psychology post has been recruited on a permanent, 'at risk' basis. This was in recognition of the wider psychological needs of the populations attending Northern Ireland Haemophilia Comprehensive Care Centre (NIHCCC) Team, in conjunction with the evidence base and comments made during the Inquiry. Dedicated specialist confidential support to victims of contaminated blood and those affected in their families continues to be provided.

The administration support for this post, Haemophilia Consultant's 1PA and 0.6 WTE 8B Management Lead post, which are also unfunded, continue to be delivered due to the work created as an outcome of the Inquiry. These relate to claims for compensation coming through to the Trust from the Infected Blood Compensation Authority (IBCA) and regional work plans.

The Victims and Prisoners Act, became law in May 2024 and provided the legal basis for the establishment of the IBCA. IBCA is an arms-length body, operationally

independent from Government, set up to deliver compensation for the victims of this scandal. The Act also obliged the Government to establish a compensation scheme. In August 2024, the Infected Blood Compensation Scheme was established.

IBCA requests asking for additional information, on behalf of the claimants, are being received by a few Clinicians within the Trust, adding a considerable amount of demand to their schedule. Taking them away from other 'core' clinical duties.

Delays have been experienced in the claims process, managed by IBCA. These have been highlighted by those within the infected and affected communities. As a result, Sir Brian Langstaff, Chair of the Infected Blood Inquiry, instigated further Hearings on 7/8 May 2025.

Below is a section from a Witness Statement, which reiterates these points. It makes reference to the support the claimant received from Dr Gary Benson, a Haemophilia Consultant within the Trust and Director of the NIHCCC. It reads:

***"I have had a number of meetings with Dr Gary Benson, Haematologist at The Haemophilia Centre. I have needed his help in respect of my own case. I am in the latest cohort being looked at by IBCA. I have come to realise what a struggle it will be for victims to prove facets of their case. For me, the issue is proving my co-infection with hepatitis B. I of course know my way around medical records and the like. I can also call on the help of clinicians such as Dr Benson. I dread to think how victims without this experience and knowledge will cope."***

*The statement goes on to reference the Belfast centre:*

***"Members and I are very upset at the news that Belfast is not considered to have been one of the centres carrying out unethical research. I find this astonishing. It is well established that Dr Mayne was, along with Professor Bloom in Wales, one of the leading clinicians at the relevant time and that Dr Mayne acted with little if any sense of accountability. I personally know that she was taking blood for liver tests when we were teenagers. She was clearly carrying out some sort of research."***

Those individuals who attended centres, identified as being a centre of 'unethical research', would be eligible for an additional compensation payment.

The report on the recommendations from these Hearings was published 09 July 2025. It can be found on the Infected Blood Inquiry Website, referenced previously.

The other submissions on behalf of the core participants refer to "the delays, lack of consultation, and absence of transparency that characterised the establishment of the Scheme".

This Report explores how the scheme was designed, the structure of compensation awards and the approach to the scheme's delivery. The report provided recommendations across 9 key areas making 26 individual recommendations in total. Fifteen of these recommendations focus on the design of the scheme. The Government is immediately accepting 7 of these recommendations.

Some of the key recommendations are specifically directed to the IBCA. These include, direction in respect of registration and prioritisation within groups, such as

those nearing the end of life, opening the service more widely to other groups than those previously known to the Infected Blood Support Schemes and to be more open and transparent within the Authority. The report can be found on the Infected Blood Inquiry website, as mentioned previously.

Following the publication of the report, IBCA accepted all the recommendations that related to them.

As of 18 November 2025, a total of 3,614 people have been asked to start their claim, 3,418 have started the claim process, 2,777 offers of compensation have been made, totalling £2,159,144,472.80. A total of 2,446 people have had their compensation paid with £1,629,630,690.80 paid in compensation.

IBCA are now opening their service to the first claims for living infected people who have never been compensated.

They also aim to open the service to those representing a deceased infected person, and those affected. This will no doubt, have a further impact on resource required to respond to these requests. This issue and the need for additional resource has been raised directly with IBCA and DOH.

Belfast Trust have received approximately 45 IBCA requests to date, requesting further medical information, to support claims. A standardised process, promoting a 'single point of contact' within the Trust, has been drafted. This will be shared and implemented imminently with key stakeholders.

In April 2025, the Belfast Trust Infected Blood Oversight Group, was re-established.

A key purpose of this Group is to provide assurance to the Trust Board, that actions are being implemented and that gaps/challenges are being recorded and highlighted to commissioners, as necessary.

The Department of Health (NI) has reviewed their Organisational structure and established an Infected Blood Inquiry (IBI) Implementation Team, supporting the central coordination of the implementation of the final IBI Report recommendations. They report to an Inquiries Implementation Programme Management Board (IIPMB), chaired by the Department's Permanent Secretary. An IBI Regional Group has also been re-established. Some of this work is being undertaken alongside other Nations' equivalent teams.

Within Hepatology, Senior Clinical representatives from the home nations (Dr Neil McDougall represents NI), remain unhappy with the inaccurate statements outlined in Recommendation 6 of the Inquiry Report, some of which are at odds with best clinical practice. Efforts have been made to clarify this but the Infected Blood Inquiry will not change the report. Therefore, Clinicians have simply committed to adhering to the best and most up to date clinical guidelines for managing ALL patients with liver fibrosis or cirrhosis.

Our teams remain committed to ensuring where outstanding recommendations remain to be met, that these are highlighted with the associated plans attached.

Other internal groups which are already established or awaiting confirmation of membership include Records Management, Operational groups and a PPI task and finish group. These support a clear, cohesive standardised approach to our record keeping and inclusion of 'meaningful' service user involvement. Staff support sessions have also been delivered before, during and following publication of the final Inquiry report.

A PPI Workshop was delivered on 19 November 2025. Initial feedback from this has been positive.

Such work will require additional funding, to ensure that the learning and implementation of the recommendations is tangible and visible to our service users and carers.

A Moderate Revenue Business Case being drafted, if approved, will address a number of these additional pressures. The 'true' extent of the demand within our Services, in the future is 'unknown', therefore it will be actively monitored and reviewed.