

OFFICIAL SENSITIVE

Infected Blood

Compensation Authority



Policy Forum Minutes
Tuesday 22nd April 2025, 11am
Online

Attendees: Celine McLoughlin (Chair), [GRO-D] Alix Crabtree, [GRO-D] [GRO-D]
[GRO-D] [GRO-D] [GRO-D] Tom Carney, [GRO-D]

Item 1: [GRO-D] updated the group on ExCo policy decisions made in relation to Hep B chronicity and the "indication of intent" to take supplementary route.

Item 2: [GRO-D] talked the group through the Hepatitis B (post-1972) paper and the lack of confidence (based on lack of data relating to probability) in making balance of probabilities decisions on likelihood of infection through receipt of NHS blood or blood products after 1972.

1. Position: where clinicians confirm Hepatitis B from infected blood, we will accept. And our clinical assessor is comfortable making a BoP decision for the period before 1973. This leaves us blocked where there is no clinician confirmation of the cause of an infection after 1972.
2. [GRO-D] set out 3 broad options:
 - a. Wait for the results of the clinical assessor procurement to see if we get access to clinicians that do have the requisite experience of Hep B infections over this period. As no pre-existing schemes existed for HepB, we expect there will be no clinical assessors with experience of making BoP decisions in relation to Hep B. But we may find practitioners with enough experience to make those calls. **Policy forum decided that waiting to see if this yielded the outcome we wanted is not acceptable on its own as an action.**
 - b. Build the evidence base around probabilities of Hep B infection through infected blood or blood products after 1972. Starting with a proper literature review, consultation with Hep B experts, and seeking access to non-public datasets that may provide incidence and screening data (including retrospective testing). [GRO-D] **was optimistic about access to data, having had some fruitful conversations about the NHD.** [GRO-D] and [GRO-D] **have been reaching out to Hep B experts.** [GRO-D] and [GRO-D] **expressed their view that this is our preferred approach because it is closest to how the scheme is intended to work. Policy forum decided to pursue this option, and revert to the third option if we are unable to build that evidence base.**
 - c. Establish risk-informed policy positions absent an evidence base. This takes us into the space of likely non-compliance with the legislation - as this option is only relevant if we are unable to establish a balance of probabilities position for a given context and year. [GRO-D] outlined the risks of inconsistency-driven inequity and the need to be rigorous in our determinations and to be prepared to review and top-up as evidence came to light in relation to BoP. [GRO-D]

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recommended engaging with experts on what such indicators and positions might be - so that we might gather any available data in the course of pursuing our preferred option. The group agreed.

3. [GRO-D] made the group aware that we have 7 (at the time) post-1972 Hep B *coinfections* being processed. We needed to decide how to handle these cases whilst waiting for the options above to bear fruit. She set out three options:
- Assume they are eligible, and accept the risk of overpayment.
 - Assume they are not eligible, underpay them (by paying for their recognised mono-infection), and prepare to issue top-up payments to those we learn are eligible when we feel able to make those determinations based on newly acquired BoP data.
 - Pause the claim processing and accept that we will build up a backlog.

[GRO-D] **asked what the pros and cons of the second option were (as it seems the least bad option).** [GRO-D] **said that it would be better to give people the choice to receive at least some money now. The group agreed and chose the second option - underpay them (where people claiming choose that, over waiting) and then use the IBCA-initiated internal review process to top-up their payments if we later deem their Hep B eligible as a coinfection.**

Item 3: [GRO-D] talked the group through the HIV dating paper [REDACTED]

[REDACTED]. She explained that the policy intent was that the blood disorder infection dating provision should *not* be used to undermine the liability window and confer eligibility - because that could mean payments for people decades before HIV existed anywhere in the world. The recommendation is for IBCA to:

- Continue to determine eligibility before infection date. We will only use a pre-1982 infection date where we know someone is eligible and there is evidence of treatment with HIV-infected blood before that date.
- Not automatically assume the start of blood disorder treatment is the infection date for HIV claims where the treatment began before 1982. We will seek evidence.
- Capture coinfection date as a separate field on the declaration form, to recognise that we will take the earlier of the two infection dates into our award calculations. Recording infection dates for HIV and Hepatitis *and* a separate *coinfection* date allows us to avoid the suggestion that we are using an HIV infection date years before HIV, or the Government's liability for HIV, existed.
- [GRO-D] asked what would happen if the CO changes the start of the HIV eligibility. [GRO-D] explained that if in the future the legislation is changed to reflect an earlier HIV date, we would issue top-ups to those who will as a result have been underpaid. That is separate to the question above (and would at least be clearly linked to HIV incidence).

The group agreed to continue with its current approach and with the recommendations above.

ACTIONS

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- Build the evidence based for Hep B after 1973 - literature review, expert consultation, access to data (Could be delivered through the infection dating working group potentiall alix.crabtree@ GRO-C ? Otherwise should be GRO-D GRO-D GRO-D GRO-D GRO-D potentially GRO-D anyone else?)
- Add coinfection date to the declaration form (GRO-D GRO-D)