

# IBCA Lessons Learned from early compensation claims

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In December 2024 the Infected Blood Compensation Authority started making payments as part of a 'private beta' phase. This is where a service is opened up to a small number of users so that the systems and processes can be tested. Learning is then fed back into iterative design of the service to help improve outcomes for users. This is in line with the government's stated policy of [test and learn](#) and HMT's emerging [approach to funding iterative, outcome based services](#).

The process of inviting and handling the first small number of claims has ensured that the service will be fit for purpose as we open it up to more people. Alongside live claims IBCA are continually speaking to people who are eligible to claim to gather feedback on both the process and proposed communications and tools that could form part of a future service.

An initial cohort of 17 were invited to claim in December 24. At the time of writing IBCA has asked 475 people to start their compensation claim, with a further 200 to be asked next week and 100 in each following week. 137 people have received an offer of compensation and 77 people have been paid.

The below summarises lessons learned to date for both the initial 17 and the subsequent invitees to the service, to provide the most up-to-date picture possible.

## 1. Legislation and operational policy

- a. We've found and addressed a small handful of mistakes in the calculation engine before an offer is made. As part of test and learn, our case volumes were sufficiently low for us to maintain triple-checking of declarations and calculations. Without this "start small" approach, we certainly would have had large numbers of award reviews to run and claims to top-up and overpayments to recover. We have learnt by starting small, adapting and improving before we scale up.
- b. We've been able to work with the Cabinet Office policy team to ensure that we understand in depth the policy intent behind each regulation - and from the perspective of operationalising them. This has enabled us to be clear on what is within IBCA's power to define and what is not and where it is the latter get more detail on intent so we are able to explain this where possible whilst still being clear that is regulations and not IBCA policy.
- c. We learned that the legislation, as drafted, prevented us from paying infected bereaved partners' infected claims. This is because the first set of regulations disallowed partial deregistration - if someone were to be paid their Core

compensation as an infected person, they would have to stop receiving their bereaved partner payments too. The second set of regulations has slightly different language within it, and the IBSS have made changes to scheme rules and processes on their side, so that we can now pay infected bereaved partners their infected payments alongside all other registered infected claims.

## **2. Learning from issues on claims**

Private beta allowed us to learn and improve more intensively, and more intentionally, than we otherwise would have. This turned out to be highly valuable.

The application of the scheme rules to many claims is complex, especially where information is missing, and can lead to mistakes if support were not in place. We've been able to respond quickly with policy clarifications, adjustments to guidance, and adjustments to the quality assurance process - so that when we move to scaling the service, these specific problems won't scale with it.

## **3. Additional Evidence**

Within the first claims we worked with people making their claims to access additional information from healthcare professionals. IBCA are managing the contact directly with the relevant healthcare professionals with the aim of speeding up claims.

- a. The biggest source of delay in processing claims, at the moment, is missing evidence. Specifically, the evidence that enables us to run the compensation calculation: year of infection, year of diagnosis (for HIV), and years of changes in infection severity (for hepatitis). IBCA has begun using template documents to make requesting evidence as quick as possible.
- b. A significant proportion of the files we've received from the IBSS hold only some, but not all, of the necessary information for us to calculate compensation. When we start processing a claim, we look at what we hold, and what we still need. We ask the person claiming if they already hold the information themselves - and if they don't, we ask the professionals providing their infection-related care to provide the specific information we need.
- c. When contacting medical professionals to request additional evidence, we have found they frequently seek patient consent to action this request, with limited knowledge of and reluctance to rely on the use of the Victims and Prisoners Act. We were also surprised that some healthcare professionals asked IBCA for payment to provide evidence and have put in place a route to pay for this.
- d. Much of the time waiting for evidence responses can be down to awaiting a consultant signature, when the work to gather the evidence has been done

by a nurse practitioner who is familiar with the patient and their history. As a result we adapted the form to include the signature of other registered healthcare professionals such as Advance Nurse Practitioners.

- e. Hospital stamps are no longer used commonly and should not be requested to confirm the legitimacy of an evidence response.
- f. We also identified the need to put a secure file transfer system in place to make sure that any information shared as part of claims is kept as secure as possible when it is shared. This has meant we can request information from medical professionals directly to support claims, with the consent of the people making claims.
- g. However, we have found that there is no consistent approach or tool in use across the NHS for secure document transfer. This means the method of secure document transfer implemented is new to many clinicians, and they require guidance and support to use it.

#### **4. ID Checks**

Ensuring the identity of people claiming and their representatives is an essential part of fraud mitigation. We learnt on ID that:

- a. Whilst the information supplied by the IBSS enabled us to do a low level of ID checks with people eligible to claim (Knowledge-based verification on name, address and IBSS reference) - This was not sufficient to make a payment of the required value. This meant introducing a higher confidence photo ID check after the claim had started but before payment was made in order to process payments.
- b. However, doing a full ID check at the end of the claim just before their payment was confusing to people, because they have shared all their medical details with us (although we did simpler ID checks at the start of the process). Therefore we have moved full ID checks to the start of the process.
- c. Users are asked to supply a photo of a photo ID and a selfie style photo alongside it. Some users have been confused by the term "selfie" so the language was adjusted accordingly. Since the early cohorts there have been a handful of users who didn't have photo ID so further measures were put in place by working with DWP to allow for ID checks to take place using their network.

#### **5. Claim timings**

Starting small allowed IBCA to understand aspects of operations as follows:

- a. It is currently taking approximately 24 hours direct claim manager time to handle a claim for someone who is infected and is registered on a support scheme. This is helping inform the numbers of claim managers needed to handle all claims.
- b. Average total elapsed claim time (from start of claim to payment made) is around 39 days. There is a wide range within this, with the fastest time for a person to be paid being 5 days. This was a claim processed through the End of Life pathway which commenced on the 14th April. This pathway has already supported 15 people to start their claim immediately, with a further 25 people currently going through the process.
- c. The longest time spent at any claim stage is the evidence gathering stage, followed by the time between offer issued and accepted.
- d. There is an average of 12 days spent at the evidence gathering stage and 7 days for an offer made to acceptance. As well as involvement of clinicians in the evidence stage, the inclusion of legal support has been found to increase the time taken in some cases.

## 6. Website

The IBCA website was published on 9th December 2024 and a Public Calculator, to help people estimate the compensation they may be due, was published on 17th March 2025. Research undertaken to support the design of this part of service has shown:

- a. That a public facing tool to estimate compensation values has helped relieve some of the pressure/anxiety in the community and has provided some reassurance. The team developing the tool hypothesised a risk that people may have been inclined to begin to make future plans based on an estimate before starting their real claim - which was seen as potentially problematic, as an accurate compensation amount can only be fully known once a case has been assessed by a claim manager in a live context. However, user research undertaken as part of the calculator's development has shown that the design of the tool and the content used has mitigated this effectively.
- b. It was important to people to understand *why* IBCA needed different types of evidence to handle their claims, this has been communicated in the estimation tool.

## 7. Receiving and accepting an offer

The initial cohorts invited to the scheme enabled us to test the experience of receiving an offer. This revealed:

- a. People making claims can be confused by the difference between payment routes. They are now described as 'IBCA' and 'Adjusted IBCA' to remove



the reference to IBSS that was included in the regulations, based on feedback from people making claims.

- b. For private beta we were able to work closely with UK Finance (who represent all major UK financial institutions) to ensure that any compensation payments made by IBCA were not flagged as suspicious, or blocked. Absent the carefully negotiated process and communication design here, had we moved straight to delivery at scale we would likely have seen many payments fail, and much claimant distress.
- c. We have also been able to take the time to understand empirically the actual time spent, and the relative value of financial and legal support at different stages in the claim process. We've been able to see how many people are taking it up, and what drives them to do so. These insights help us craft our service journey - and proposal for future financial and legal support - in order to optimise for processing speed, user satisfaction, and value for money.

## **8. How and what to communicate with people making claims**

It is worth recalling participants in the first cohort of 17 volunteered to take part in it, knowing it would be imperfect to start with. This gave us the safe space to test, for example, imperfect letters, emails and calls - so that we could improve their design ahead of time. This reduced the risk of widespread distress in the community due to untested language.

Our research has frequently highlighted the importance of people making claims knowing the steps of making a claim from beginning to end before they start the process.

- a. This learning influenced the service design by shaping the initial call between people making a claim and claim managers. In particular the value of offering video calls for those who choose it to support with building a relationship and those who benefit from visual aids for their memory. This allowed us to build video calling requirements into our telephony platform.
- b. We also heard the need to follow up all calls with a note of the call, again to enable people who particularly struggle with brain fog or memory problems to have a record of the conversation, to ensure that they feel confident about progressing their claim to the next step.
- c. Research was undertaken into the best way to communicate the different kinds of payment options that people can receive when IBCA shares the compensation offer. For example how to compare continuing to receive ongoing support payments from current support schemes or not. This insight informed the specific design of screens displaying this information.
- d. We also found that people wanted to know up-front about the legal and financial support they could be offered. We couldn't provide this initially as

we worked through scaling the offer but as soon as we could we implemented this change. We now include this in the first exchanges.

## **9. Approaches to evidence and dates**

Operating the service at a small scale has helped surface a number of gaps in operational policy, for instance on how we treat particular edge cases relating to dates of infection or change in severity, which we have been able to resolve.

- a. A range of evidence is being used to reflect the change of severity within medical records, rather than requiring e.g. a liver scan in all cases. Where necessary this is referred to a Clinical Advisor who is able to provide expert opinion on the available evidence. Where additional evidence is required to demonstrate a change of severity, IBCA are agreeing with people making claims to directly request that evidence from clinicians to support claims.
- b. IBCA requires a wider range of clinical expertise than that available via the existing clinical advisors associated with IBSS because IBCA compensation is available to people with Hepatitis B. Some of the people who are registered on current schemes have made claims on the basis of a Hep B co-infection. Limited analysis has been done on Hep B eligibility dates (because it was not part of current IBSS eligibility) and clinical advisors are not always familiar with the relevant likely evidence.

## **10. Claim manager operations**

The claim manager experience also benefited from testing different ways of approaching the delivery of the service. They learnt that:

- a. It was beneficial to enable claim managers to role switch. By enabling everyone to participate in drafting emails, operating telephony, and calculating claims, knowledge was shared more quickly. When IBCA was initially stood up a "surge" team was established (led by UKSV) of AOs from the CS surge team operated by HMRC. They were given responsibility for the IBCA inbox and the phone lines but were only given very limited training (via a FAQ). We quickly learned that we needed a much more knowledgeable team and that we needed to build processes around the team in order to make it robust and measure its performance, so we created the resolution centre and resourced it with HEOs who now receive the same comprehensive training as the claim managers
- b. Claim managers required individual licences to specific digital tooling to be able to share claim information with people making claims, and any legal support. This has been met by Egress and Adobe sign, with additional guidance, training and licences required as claim managers onboard.

- c. The team learnt that people making claims expect that claim managers have been able to see their statements to the inquiry (even when they had been anonymous). Claim managers are now guided to seek clarity from the person making a claim on whether they have made a statement (if not clear from initial research) and make it clear that they will not have been able to access it, but ask for a copy if they would like to share.
- d. Claim managers found access to guidance was made challenging by information being held in different places. A new knowledge hub has been scheduled and work is in train to develop a canonical process map with signposting to the relevant information for each stage.
- e. With respect to preparing claims, the team considered having a separate role or team packaging up claim evidence, identifying key information and filling gaps *before* it went to the claim managers. We decided to keep it as a single role and split it out if we found it was needed to avoid building in potentially unnecessary org design complexity. We've learned that this level of preparation is actually valuable and are looking to adjust our model slightly to provide a more substantial claim file and data preparation to claim managers.
- f. Solicitors would want to see the information we held on their clients and we didn't have a means to share it at the onset so implemented a secure file sharing platform Egress to enable this.
- g. As per point 1c we discovered a requirement for the need for individuals to be able to deregister with IBSS. We assumed it would be a straightforward process but the work uncovered a disconnect between Devolved Administration policy and operation teams for the blood support schemes. We had to rapidly establish working relationships and agree on a process between us. This has developed into close working relationships and an Operational working group is now in place coordinating change across IBCA and the IBSS schemes.