Infected Blood Inquiry Response:

Expert Group work programme

25 January 2024

Contents

Infected Blood Inquiry Compensation Framework: Expert Group (EG) work programme

1. Confidentiality

Please note this work is of a highly sensitive and confidential manner. All members of Expert Group (EG) and Technical Working Group (TWG) will be subject to confidentiality arrangements and have agreed clear Terms of Reference.

Should you be approached by external actors such as the media in relation to the Inquiry or expert group, you should direct journalists to the Cabinet Office Press Office (pressoffice@cabinetoffice.gov.uk).

2. Introduction

The Infected Blood Inquiry, chaired by Sir Brian Langstaff, was set up to examine the circumstances that led to individuals being given contaminated blood and blood products in the UK.

On 15 December 2022, Minister for the Cabinet Office confirmed the Government's acceptance of Sir Robert Francis's recommendation that there is in his view a moral case for compensation to be paid. Sir Robert Francis compensation framework study can be found here:
https://www.gov.uk/government/publications/infected-blood-compensation-framework-study-terms-of-reference

The Government also accepted in full Sir Brian Langstaff's first interim report recommendation to pay infected and bereaved partner beneficiaries of the UK infected blood support schemes, and those who join in the future, an interim payment of £100,000. These were paid in by the end of October 2023 to meet the Government commitment.

The Inquiry is due to publish its final report on 20 May 2024 and the Government has committed to responding 25 sitting days following the report's publication. The Cabinet Office Policy Response team is leading on the Government's response to the Inquiry Second Interim Report and work is currently ongoing in consideration of the complex and wide range of factors set out in the second interim report.

In addition, the Government is appointing clinical, legal and social care experts to form an EG to advise the Cabinet Office on detailed technical considerations of the Inquiry's recommendations. The Minister for the Cabinet Office announced this in parliament in December 2023. This will ensure the Government has the relevant expertise to make informed choices in responding to the Inquiry's recommendations on compensation. The EG work will be short-term and carried out within 3 months with the possibility of extending up to 6 months if required.

3. Expert Group Membership

The Expert Group (EG) consists of:

- Chair: Responsible for and accountable to HMG for the advice produced by the experts. Also responsible for the oversight and management of other members of the expert group.

- Professor Sir Jonathan Montgomery

- Clinical experts: Specialists in the relevant infections to help define the infections, the symptoms, the stages of progression and degrees of severity of the relevant infections.
  - Professor Jane Anderson - Experience in HIV
  - Dr Ahmed Elsharkawy - Experience in Hepatitis B and Hepatitis C
  - Professor Graham Foster - Experience in Hepatitis C and HIV
  - Professor Patrick Kennedy - Experience in all Hepatitis infections

- Legal experts: Specialists in clinical negligence and/or personal injury litigation to help develop a compensation framework based on the relevant infections and severities.
  - Browne Jacobson LLP

- We currently do not have social care experts but will be utilising expertise within DHSC's social care network and where applicable via Browne Jacobson LLP.

4. Governance of the Expert Group and Technical Working Group

The EG advisers will work closely with officials to the work programme outlined in section 10. The EG will be utilised to test Cabinet Office officials' policy and cost assumptions in order to refine the modelling and develop a potential compensation framework.

The Technical Working Group (TWG), initially established by DHSC in 2023, will now be established and led by Cabinet Office officials. This forum will continue to quality assure any work undertaken by officials following input from the EG to refine existing policy and cost analysis and develop a potential compensation framework. The TWG consists of officials from Cabinet Office, Department of Health and Social Care (DHSC), HM Treasury (HMT), Government Legal Department (GLD), NHS Business Service Authority (NHSBSA), Government Actuaries Department (GAD) and NHS Resolution. There may be a requirement for EG to also participate in the TWG depending on the subject matter to be discussed.

The input of the EG will inform policy advice led by Cabinet Office officials on the design of a potential compensation scheme. All final decisions on the design and scope of a potential compensation scheme will need to be agreed by Ministers, HMT and No10.

5. Key principles for and approach to compensation

No decisions on a potential compensation scheme have been made. The policy and cost analysis done to date is reliant on a large number of highly uncertain assumptions, many of which are working assumptions and some of which are assumptions underpinned by available data. Work is ongoing to improve the quality of assumptions and this is where EG will play an important role in refining those assumptions.

In developing a potential compensation scheme, and as outlined in the Inquiry Second Interim Report and the Sir Robert Francis Compensation Study[4], the following objectives have been identified:

- The scheme must deliver compensation rapidly to the groups agreed by HMG, following receipt of the final report;
- The scheme is trusted by the community (and seen as a preferred route over seeking redress through the courts);

- There is minimal time, effort and stress for eligible parties to participate in the scheme. To achieve this, the scheme should have a simple and sensitive application process (re-traumatisation recognised and avoided, and where an applicant is already a member of an existing scheme that should satisfy eligibility) with advice and support for applicants not registered on scheme.

6. Expert group work programme

There remain a number of outstanding core questions on the design and scope of the scheme which the EG will be asked to provide views on to support policy and cost modelling. Ultimately this work will inform decisions on exactly **who** will receive compensation, and **what** compensation those cohorts will receive.

This document sets out the core work programme for the EG. This includes an overview of technical questions for experts and core policy documents and analytical data packages for review.

Analytical data package summary will be presented by DHSC.

7. Outputs

Following input from EG, the outputs produced by officials in the Cabinet Office will be a clear set of eligibility criteria and a compensation framework with clearly defined categories and award levels, which have been tested by clinical, social care, legal experts and across government via the TWG. Following ministerial and No10 agreement, this eligibility criteria and framework can then be utilised by the scheme assessors in order to assess and award claims as appropriate.

8. Background reading material

- Reference documents including public reports, inquiry response parliamentary statements and useful links can be found here Link
- Analytical data package can be found here Link
- Summary of legal advice to date can be found here Link

9. Work Programme overview

Work Block 1: Defining the eligibility criteria and Infection

Phase 1: Defining eligibility

Objective:*To define and quantify the potential eligible infected and affected groups for redress and evidence required to establish eligibility*

- Develop clinical and legal definitions for the potential eligible infected and affected groups
- Identify eligible modes of transmission e.g. transfusions, needles, tissue transfer
- Identify, if suitable, cut-off-dates for eligible infections e.g. when effective screening was introduced

Phase 2: Understanding the infections and severities

Objective: *To define the severity assessment categories for each eligible infection, including care requirements, and appropriate required medical evidence.*

- Defining the infection symptoms, infection progression and severity bands
- Defining the impacts on day to day life
- Defining the care requirements

Work Block 2: Identifying and defining potential Heads of Loss as recommended by Sir Brian Langstaff

Objective: To define the different categories of damages and the amounts of potential compensation to be paid, including defining the two novel heads of loss as recommended in the inquiry's second interim report. There may be a requirement to develop case studies to distinguish between the damages awarded under common law vs Sir Brian Langstaff recommendations.

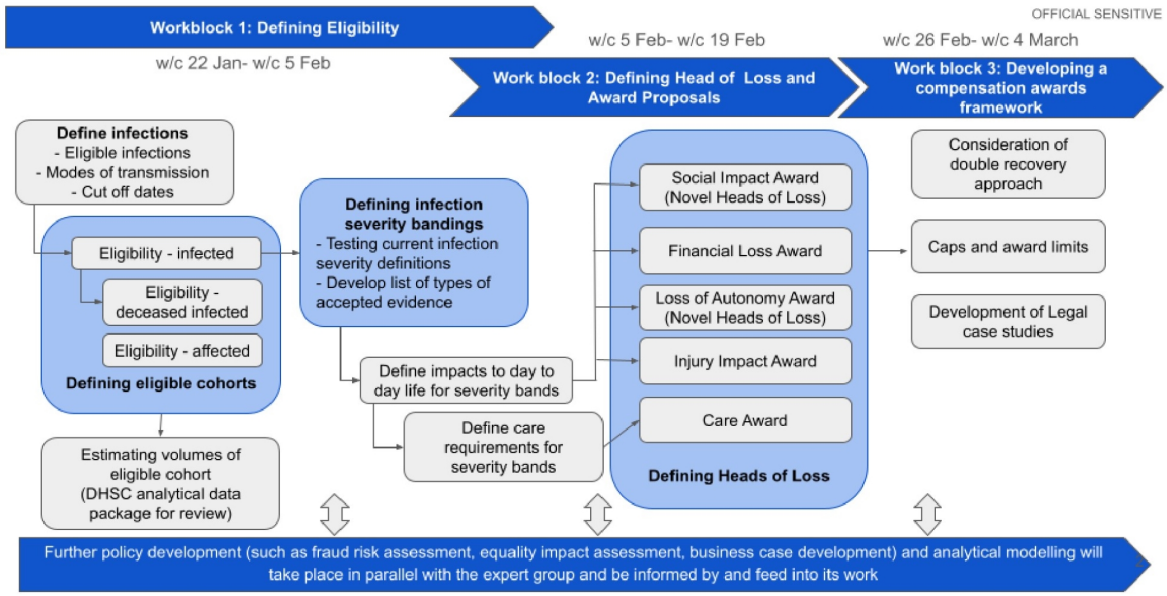
- Financial loss
- Injury Impact
- Care award
- Social Impact award -Novel head of loss
- Loss of Autonomy award - Novel head of loss

Work Block 3: Developing a Compensation Awards Framework

Phase 1: Development of a compensation skeleton framework for case worker assessment

Objective: To design a potential compensation framework model to be used by a scheme)

Work programme overview:



10. Work programme- technical work package

Work Block 1 - Phase 1

Objective: *To define the potential eligible infected and affected groups for redress and evidence required to link an affected to infected case*

Work Block 1: Defining the eligibility criteria and infections (Phase 1)	
Topic	**Defining eligibility criteria**
Background and reading material	Inquiry Second Interim Report recommendations: 1,2,3,4 Sir Robert Francis's compensation study recommendations: 2,3,5 **<u>Relevant Infections in scope as recommended by the inquiry</u>** Human Immunodeficiency Viruses (HIV), Hepatitis C (HCV), Chronic Hepatitis B (HBV) and Hepatitis D (HDV) **<u>Current Infected Blood Support Schemes eligibility</u>** The following is a summary of the eligible beneficiary categories used by the current infected blood support schemes: ● Infected - those historically infected with HCV from NHS blood or blood products or tissue prior to September 1991; ● Infected - those historically infected with HIV from NHS blood or blood products or tissue predominantly prior to October 1985 (Scottish Infected Blood Support Scheme (SIBSS) & Northern Ireland Infected Blood Support Scheme (NIBSS) cut-off date is 17 February 1992; Wales Infected Blood Support Scheme (WIBSS) is February 1992, but acknowledges unlikely after Autumn 1985); ● Infected - those secondarily infected with HCV and/or HIV by an infected person falling into the above categories (via sexual transmission, from mother to baby or accidental needlestick injury); ● Infected - the estates of those infected in the above categories who have died; ● Affected - spouses, civil partners and long-term partners of a deceased beneficiary (who were living together at the time the beneficiary died); and ● Affected - dependent children (usually as a component to payments for one of the other categories). ● Natural clearers - The current support schemes do not accept natural clearers if the claimant cannot prove they had Hep C for more than 6 months and has since cleared it. **Mode of transmission:** Current recognised methods of primary direct infection are listed below: ● blood transfusion, that is: the transfusion of whole blood, or components of blood e.g. red cells, platelets or plasma;

- tissue transfer - infected through transplants.
- infection through treatment with blood products e.g. Factor VIII.

Cut off dates when effective screening was introduced: The current support schemes use the following cut off dates:

- **HIV infection:** All NHS blood in the UK was being screened for HIV from October 1985 onwards so it is very unlikely, although not impossible, patients would have received HIV through infected NHS blood after October 1985. SIBSS & NIBSS use a cut-off date of 17 February 1992 and WIBSS use February 1992. England Infected Blood Support Scheme (EIBSS) does not adopt a fixed cut-off date but acknowledges infections are very unlikely to have occurred after October 1985.

- **HCV infection:** Donor screening for HCV was introduced in the UK on 1 September 1991. Consequently, eligibility for current compensation schemes define the eligible as those historically infected with HCV from NHS blood or blood products or tissue prior to September 1991. However the Inquiry's Second Interim Report noted a number of infections after this date.

Sir Brian Langstaff's / Inquiry and Sir Robert Francis's Recommendations

Eligible infections: Eligibility for current support schemes is limited to those infected with HIV and HCV. However, the Inquiry's Second Interim Report recommends the scheme also offers redress to those infected with HBV, limited to chronic HBV unless the infection has resulted in a fatality in the acute period.

Affected Groups: A key part of a potential compensation scheme will be defining the cohorts of the affected who are eligible to claim compensation. The affected being a group of people who have been impacted (physically or psychologically) as a result of their relationship with the infected individuals. Recommendation 4 of the Second Interim Report sets out the different cohorts of the affected, to include spouses, children, parents, siblings, providers of care, members of the family or friends. However, the inquiry report noted that the estates of the affected should not be eligible to claim compensation as previously recommended by Sir Francis..

Sir Robert Francis's Compensation Study (2.19) noted there are likely to be individuals who have been seriously affected because of their relationship with an infected person, particularly the psychological distress due to the closeness of their relationship with the infected. If discretion were to be applied, the criteria by which the discretion should be exercised are difficult to define, not only because of the wide variation of family and social circumstances, but because the entitlement to compensation under the scheme may extend beyond the normal limits of recoverable damages for personal injury. Sir Robert Francis suggested that the limit of entitlement could be defined as extending to a person who:

- Is a member of an infected person's family or a long term friend of the infected person;

	● Has since the onset of the infection maintained a close relationship with the infected person for a continuous period of at least two years; ● Has in fact suffered a mental or physical injury as a result of the infection or its consequences. **Secondary Infected Persons**: The Second Interim Report recommends that this condition should be met if the applicant was infected by transmission of the infection (e.g. via sexual transmission, from mother to baby or accidental needlestick injury); from an infected person who is or would have met the conditions for eligibility for a directly infected person. **Cut Off Dates:** Sir Robert Francis's report and the Inquiry Second Interim Report recommends eligibility should be dependent on cause of infection not date and recommended a similar approach to cut off dates as indicated by the statement on the EIBSS website as far as HIV infection after 1985 is concerned. A previous judicial review (Challis- CO/3319/2020, judgement) challenged the decision to maintain the cut-off date for HCV infections (September 1991) pending the outcome of the Infected Blood Inquiry. The courts ruled it was not irrational for SofS to take the view that any reconsideration of the eligibility criteria should wait for the findings and recommendations of the Inquiry and the case was dismissed. A reconsideration of eligibility, including cut off dates, was therefore envisaged by the courts as part of any response to the Inquiry recommendations. **Policy Questions** Reflecting on the advice of the expert group, the key policy questions Cabinet Office officials will be working towards answering are: ● *Which infections and under what circumstances should infected individuals be eligible for compensation?* ○ Should chronic HBV be included as an eligible infected group? If it is included, under which circumstances would someone be eligible? ● *Which affected groups should be eligible for compensation?* ○ How do we define eligible affected groups including minimum cohabitation for blood relatives? ○ Should non-blood relatives (e.g. friends, in-laws) be eligible on a discretionary basis? ● *What evidence would be required to prove infected and affected eligibility?*
Questions for expert group	**Infected- eligible infections** **Clinicians :** ● Which of the relevant infections can naturally clear within 6 months? ● How would you define a serious chronic HBV infection? ● Can HDV only develop in an individual infected with HBV and if so what is the impact?

Cut-off dates when effective screening was introduced

Clinicians :

- What is the likelihood HIV contaminated blood or blood products were still prevalent in the system after effective UK wide screening was introduced in October 1985? Is there a date for when there was certainty that contaminated blood products had been removed from the system entirely?
- What is the likelihood HCV contaminated blood or blood products were still prevalent in the system after effective UK wide screening was introduced in September 1991? Is there a date for when there was certainty that contaminated blood products had been removed from the system entirely?
- What is the likelihood HBV contaminated blood or blood products were still prevalent in the system after effective UK wide screening was introduced in December 1972? Is there a date for when there was certainty that contaminated blood products had been removed from the system entirely?
- What cut-off date, if any, would be considered appropriate for people infected with HCV by someone who was infected through treatment with NHS blood or blood products (secondary infected)?
- What cut-off date, if any, would be considered appropriate for people infected with HIV by someone who was infected through treatment with NHS blood or blood products (secondary infected)?
- What cut-off date, if any, would be considered appropriate for people infected with HBV by someone who was infected through treatment with NHS blood or blood products (secondary infected)?

Affected Groups:

GRO-D

	GRO-D
	GRO-D
	GRO-D

	Mode of Transmission **Clinicians:** • Current recognised methods of primary direct infection are listed below, depending on disease type, how likely is it to become infected through the different methods,how quickly are the symptoms noticeable and what are they? a) blood transfusion, that is: the transfusion of whole blood, red cells, platelets or plasma; b) tissue transfer; c) infection through treatment with blood products d) Needlestick injury **Evidence**: **GRO-D** **Clinicians**: • What medical evidence could we expect individuals to provide to evidence an eligible infection? • What medical evidence could we expect affected applicants to provide to evidence the infection of an eligible deceased individual?
Ask to expert group	• Review of questions listed above • Review detailed COLA legal instruction on policy work to date • Review of current eligibility definitions in illustrative draft compensation framework

Work Block 1- Phase 2

Objective: *To define the severity assessment categories for each eligible infection, including care requirements, and appropriate required medical evidence.)*

Work Block 1: Defining the eligibility criteria and infections (Phase 2)	
Topic	**Understanding the infections and severities**
Questions for expert group	**HCV and HIV:** **Clinicians :** ● Would you consider the infection categories listed below as an appropriate way to define the severity of a HCV and HIV infection? o For Living infected: Acute, Mild chronic, Moderate chronic, Severe chronic o For Deceased infected: Acute, Mild chronic, Moderate chronic, Severe chronic, infection deceased (died from infection) ● What evidence might be captured in a patient's medical record or what evidence would a treating clinician be able to provide to support an infection severity assessment? ● Is it possible for a clinician to predict progression across bands to support a final award status? What evidence is required for this? ● Where infection was listed as a contributing factor on a death certificate can it be assumed an individual's infection was chronic severe? ● Can an HIV infection be acute? If so, is this still feasible for an infection acquired through receiving infected blood or blood products? (ideally, we would appreciate an indication of the proportion that might have been acute) ● For each of HIV-only, HCV-only and Co-infected: a) How quickly do those who do develop symptoms with chronic infection progress through the stages of severity? b) Do we have any indication of how many people an infected person is likely to infect? c) Will there be a difference in severity for someone who has been infected via NHS treatment with blood and blood products vs those who were infected via intercourse or via breastfeeding/gestation? ● What is the typical severity and progression of HCV/HIV with and without treatment? ● What is the treatment for HCV/HIV? How has this changed since the 1970s/80s and what impact would this change of treatment have on the daily life of someone infected? ● How would a co-infection with HIV and HCV affect the progression and severity of each condition? Would co-infection affect the treatment offered to an individual?

HBV and HDV

Clinicians :

- Would you expect to see significant differences in the severity of symptoms for chronic HBV patients? If yes, what would these severity bandings be?
- At what severity of HBV can HDV develop? How would infection with HDV impact on the prognosis, severity and treatment of the HBV infected individual?
- What medical evidence could a clinician provide to evidence the severity of an HBV or HDV infection?
- What is the treatment for HBV? How has this changed since the 1970s/80s?

Natural clearers

Clinicians:

- What are the symptoms of natural clearers for the relevant infections and can they be cleared, if so how quickly?
- Can natural clearers be tested for having had the infection if the infection has been cleared within or after 6 months?
- What is the reasonable proportion expected to clear HCV? (25%, range of 15-40%)?
- What proportion of those that do and do not clear the HCV will show symptoms?
- Are those who don't clear a virus (and haven't yet shown symptoms) any less likely to pass on the infection than those who have cleared the virus?

All infections (HIV, HCV and HBV, HDV)

GRO-D

Social care & clinicians:

- What is the profile of care requirements over time for each severity rating of HIV, HCV, HBV, HDV for the infected and co-infected? How much of this care is likely to be provided at home, hospital and nursing home?

Ask to expert group	• Review of questions listed above • Review infection severity assessment table in the illustrative draft compensation framework

Work Block 2: **Identifying and defining potential Heads of Loss**

Objective: *To define the different categories of damages and the amounts of potential compensation to be paid to individual claimants, including defining the two novel heads of loss.*

Work Block 2: Identifying and defining potential Heads of Loss (Overview)	
Topic	**Heads of Loss Overview**

Background and reading material	Inquiry Second Interim Report recommendations: 5, 6, 7, 8, 10 Sir Robert Francis Compensation Study recommendations: 7, 8, 9,10, 11, 12, 13 **Background** The Inquiry Second Interim Report recommends that compensation is allocated to the following categories of loss: 1. **Injury Impact Award-**for past and future physical and mental injury, emotional distress and injury to feelings caused by the infection and treatments for it, or (whilst not being personally infected) being affected by them or by the death of an eligible infected person (including, as part of this, an award for loss of society of the deceased); 2. **Social Impact Award** *(novel head of loss)*- for past and future social consequences of the infection including stigma and social isolation; 3. **Autonomy Award** *(partially novel head of loss)*- as additional redress for the distress and suffering caused by the impact of the disease, including interference with family and private life, including where relevant: personal autonomy, loss of marriage/partnership prospects, loss of chance to have children. It should include sums for the aggravated distress caused by interferences in their autonomy and private life such as lack of informed consent, lack of sufficient information about the risks of treatment, and about diagnosis, treatment and testing, or being the subject of research without their informed consent. It should include the effects of lack of candour and inadequate responses by authority. 4. **Care Award**- for the future care needs of the eligible infected person, and to compensate for past losses in respect of care necessitated by their infection (to be paid directly to the infected person where they have paid for care, and/or directly to an affected person who has provided care); and 5. **Financial Loss Award**- for past and future financial losses suffered as a result of the infection. Sir Robert Francis' Compensation Study references two additional categories for affected persons 'Bereavement Award and Bereaved Family Loss Award' and 'Family Care Award' which are merged with the Care Award and Financial Loss Award respectively in the Inquiry Second Interim Report: ● Family care award, available where a Care Award is not made to the eligible infected person directly, for care provided free of charge to the infected person or likely to be provided by them in the future. ● Bereavement award and Family loss award to the eligible affected persons in the event of the death of the relevant eligible infected person by reason of the disease, for the loss of financial benefits they would have enjoyed but for the death. The Inquiry Second Interim Report states *'that the range of potential awards for the impact should be determined by an independent advisory panel of legal experts, taking account of but not limited by current practice in courts and tribunals across the UK' (*Recommendation 5, part c)

	Policy Questions The policy intent of this section will be to define the different heads of loss in the compensation scheme. The key policy questions Cabinet Office officials will be working towards answering are: ● How should heads of loss be applied to each eligible infection and severity banding? ● What level of award would eligible infected and affected claimants recover at common law?
Questions for expert group	**GRO-D**

	GRO-D
Ask to expert group	• Review questions above • Review detailed COLA legal instruction on policy work to date • Review DHSC analytical data package - latest average award assumptions and DHSC analytical award pack

Topic	Injury Impact Award
Background and reading material	Inquiry Second Interim Report recommendations: 6, 10 (further detail on p.44-46) Sir Robert Francis Compensation Study recommendations: 7, 8, 9,13 Definitions of compensation **Inquiry Second Interim Report injury impact award for infected and affected:** *for past and future physical and mental injury, emotional distress and injury to feelings caused by the infection and treatments for it, or (whilst not being personally infected) being affected by them or by the death of an eligible infected person (including, as part of this, an award for loss of society of the deceased)* **Infected injury impact award (Sir Robert Francis's report)**: *Redress for the past and future physical and mental injury caused by the infection and its consequences to the infected person.* **Affected injury impact award (Sir Robert Francis's report):** *payable to eligible affected persons for physical or mental injury caused by their experience of the relevant conditions or death of the relevant infected person, where such injury was a clinically or psychologically recognised consequence of close and established association with the infected person.* ***Bereavement Award*** **(Sir Robert Francis's report)***: payable to defined family members or their equivalent when the death of the deceased has been caused by the infection or its consequences.* • The Inquiry Second Interim Report suggests that stated psychological distress from a given applicant should be credited in the absence of sound reasons to the contrary (p. 44).

	• Sir Robert Francis's Compensation Study provides an illustrative framework for the Impact Award (p.103) • Sir Robert Francis noted that as the award is a lifetime award, the severity must be judged over the expected lifetime of the eligible person, not merely by their current condition. **Affected** • The Inquiry Second Interim Report suggests that affected persons should receive an Injury Impact award as part of their compensation package. The report notes this should not be thought of as novel for the affected as County Courts and employment tribunals have made awards of this nature and Parliament has repeatedly recognised that "injury to feelings" at least in the context of discrimination (without a diagnosis of psychiatric injury) may be compensated. The report also suggests that from case law, the banding of experiences is common practice (i.e from mild, moderate, severe). • The Inquiry Second Interim report also suggests an award for bereavement should form part of an Injury Impact award. Recognising an affected person as having a claim in their own right means that the calculation of appropriate compensation for them should not be dictated by the fatal injury legislation specific to any of the three jurisdictions.
Questions for expert group	**GRO-D** **Infected** **GRO-D** **Clinical/Legal**

- What are the pros and cons for each of the infected, the scheme administrators and the public purse of compensation under an injury impact award being structured as follows ?
  - A tariff system based on type of disease and severity
  - Or, an initial baseline or flat rate which then requires further assessment on an individual basis to enable an infected person to receive an uplift (e.g. additional funds) over and above the baseline or flat rate
- What factors and medical evidence should be considered in reviewing eligibility for an uplift to any baseline or flat rate injury impact award for an infected individual?
  - Should age at which infection occurred be considered in an uplift value for injury impact (i.e the younger the infected individual the higher the uplift)
  - Medical proof of mental injury i.e. (use of NHS/ private mental health services)
  - Would a statement of truth be acceptable if medical records cannot be found?
  - Medical proof of further/secondary conditions that are clearly linked to the original infection

- **Co-infection**:How could Injury Impact awards for co-infected individuals be calculated? Options include awards following a formula (e.g. Sir Robert Francis's report suggested that an infected person be awarded either (1) 100% of the impact injury award in relation to the disease that is more highly compensated for (e.g. attracts a higher award under the compensation scheme) and, in addition, (2) 50% of the injury impact award that would be awarded under the compensation scheme for the injury that would attract a lower award); or, alternatively, there could be a tariff for each category of disease where it is a co-infection- (the tariff would be lower than if the disease was not as a result of co-infection)? What would be the advantages and disadvantages of each option outlined for each of the infected, scheme administrators and the public purse? Do you have any further ideas for alternative means of calculating injury impact awards where an infected is co-infected?

Affected

GRO-D

Awards

GRO-D

	GRO-D
Ask to expert group	• Review questions above • Review detailed COLA legal instruction on policy work to date • Review DHSC analytical data package - latest average award assumptions and DHSC analytical award pack

Topic	**Financial Loss**
Background and reading material	Inquiry Second Interim Report recommendations: 6,7,8,10,11,13 Sir Robert Francis Compensation Study recommendations: 8,9,10,13,15 Definitions of compensation **Inquiry Second Interim Report Financial Loss Award for infected and affected:** F*or past and future financial losses suffered as a result of the infection. This award should be given on an assessed basis, as Sir Robert suggests, whereas the other awards should be given by adopting a "banded" approach.* **Financial Loss Award (Sir Robert Francis's report)**: *Redress for the past and future financial losses incurred by the infected person caused by the infection.* **Bereaved Family Financial Loss Award (Sir Robert Francis's report):** *for defined family members or their equivalent, to reflect the financial benefits payable only in respect of losses of financial benefits they would have enjoyed but for the death of the deceased infected person.* **Background**

	• The Inquiry Second Interim Report and Sir Robert Francis's Compensation Study both support the notion that compensation from previous support schemes should not be considered or offset against the financial loss award including those from the Alliance House Organisations. However the Inquiry Second Interim Report suggests that future support payments should be taken into account in respect of future loss calculations under the compensation scheme. • The Inquiry and Compensation Study both support the idea that periodic payments should be made to account for loss of income for as long as the applicant is alive and that annual payments should also be made to the bereaved.
Questions for expert group	**Clinicians:** • How likely is it that a claimant will deteriorate in a way that the assumptions for each disease/ level of severity does not predict? **GRO-D** **GRO-D**
Ask to expert group	• Review questions above • Review detailed COLA legal instruction on policy work to date

	• Review DHSC analytical data package - latest average award assumptions and DHSC analytical award pack

Topic	Care requirements and compensation
Background and reading material	Inquiry Second Interim Report recommendations: 6, 10, Sir Robert Francis Compensation Study recommendations: 8, 9 Definitions of compensation **Inquiry Second Interim Report injury care award for infected and affected:** *for the future care needs of the eligible infected person, and to compensate for past losses in respect of care necessitated by their infection (to be paid directly to the infected person where they have paid for care, and/or directly to an affected person who has provided care); and* **Care award (Sir Robert Francis's report)**: *Redress for the past and future cost of paid for (private) treatment, care, and the value of gratuitous care received by infected person in the past and/or 93 Infected Blood Compensation Study likely to be required in the future, subject to an equivalent Family Care Award not having been made (see below).* **Family Care Award (Sir Robert Francis's report)**: *where a Care Award has not been made to the infected person, redress payable to defined family members or their equivalent, for care provided free of charge to the infected person in the past and likely to be provided in the future.* • The Care Award would be to compensate for both past and future costs of care. • In Sir Robert Francis's Compensation Study, Sir Robert Francis recommends a separate Family Care Award for the affected for those where the relevant infected claimant has not applied for a care award. • This award should reimburse for both previous professional and gratuitous care. ○ The recommendation in both reports is that recompense for gratuitous care should be valued by reference to what it would have cost commercially. • He also advises that the attendance allowance should be deducted from this award unless the disability for which it is granted is unrelated to the infection. • Both reports argue for a lump sum for past care and the option of a periodic payment or annual periodical payments for future care.

Questions for expert group	**Clinical and social care** ● What is the profile of care requirements over time for each infection severity band? How much of this care is likely to be provided at home, hospital and nursing home? ● For future care costs, the Inquiry Second Interim Report recommends that a banding approach should be used if possible – such that an infected person may rightly recover their anticipated costs as part of their own claim. Beyond infection severity, do any additional factors need to be taken into account in estimating future care costs? **Social care** ● How many hours of care, both paid and gratuitous, would someone an infected individual in each infection severity banding agreed under work block 1 require. Current assumption is the severity bandings will be: a) Acute symptoms? b) Mild chronic symptoms? c) Moderate chronic symptoms? d) Severe chronic symptoms? o If possible, how would the care requirements outlined above differ in the 1970s/1980s? ● Is severity of illness the key factor determining cost of care? If not,why not, and what is/are the key factor(s)? **GRO-D** **Statisticians**

	• If it is assumed that there will be the option of lump sum payment for future care, how many years of payment should be assumed for each group on the tariff (assuming that the tariff factors for disease and severity) ○ How does age factor into these assumptions and would it be useful to include age as a factor for to future payments tariff **Clinicians, Legal, Statisticians and Social Care:** What are the advantages and disadvantages for awarding annual payments for future loss payments as opposed to a lump sum payment? Would there be any legal risk with either approach?
Ask to expert group	• Review questions above • Review detailed COLA legal instruction on policy work to date • Review DHSC analytical data package - latest average award assumptions and DHSC analytical award pack

Topic	Social Impact
Background and reading material	Inquiry Second Interim Report recommendations: 6, 10 Sir Robert Francis Compensation Study recommendations: 8,9 Definitions of compensation **Inquiry Second Interim Report injury impact award for infected and affected:** *for past and future social consequences of the infection including stigma and social isolation, loss of educational opportunity, and loss of congenial employment;* **Social Impact Award (Sir Robert Francis's report):** *Redress for the past and future social consequences of being infected including in particular the stigma and social isolation attached to these infections; and, an award for eligible affected persons for the stigma and adverse social consequences of being associated with an eligible infected person.* The Compensation Study recommends that this award should be on a lump sum tariff based system. There is limited insight on the Social Impact Award in the Inquiry Second Interim Report. For further information on the inability to form a marriage/ long term relationship and loss of chance to have children uplifts please see the Compensation Study, Lines 2.44&2.45, p. 25.

	There is no dedicated section on Social Impact in the Inquiry Second Interim Report
Questions for expert group	**Clinicians, Legal and Social Care:** ● The Compensation Study suggests that tariffs should align with the severity of disease as it is assumed that this correlates with social impact. Does social impact and stigma correlate with infection severity? Would a flat rate award for all severities of an eligible infection or a tariff based on factors other than severity of symptoms be more appropriate? o Should the year of diagnosis be an additional consideration within a given tariff for Social Impact due to the higher levels of stigma faced by those who were infected earlier? How much weighting should the year of diagnosis have? ● While acknowledging that all infections would have a significant social impact, is it valid to assume that HIV would have had the greatest social impact of the infections/illness included in this scheme? ● What are the advantages and disadvantages of the recommendation in the Compensation Study which suggests that social impact award for co-infected claimants should receive 100% of the payment from the disease that is more highly compensated for and 50% for the lesser paying award **GRO-D**
Ask to expert group	● Review questions above ● Review detailed COLA legal instruction on policy work to date ● Review DHSC analytical data package - latest average award assumptions and DHSC analytical award pack

Topic	Autonomy Award
Background and reading material	Inquiry Second Interim Report recommendations: 6, 7, 10 Sir Robert Francis Compensation Study recommendations: 7, 8, 9 <u>Definitions of compensation</u> **Inquiry Second Interim Report injury impact award for infected and affected:** *as additional redress for the distress and suffering caused by the impact of the disease, including interference with family and private life, including where relevant: personal autonomy, loss of marriage/partnership prospects, loss of chance to have children. It should include sums for the aggravated distress caused by interferences in their autonomy and private life such as lack of informed consent, lack of sufficient information about the risks of treatment, and about diagnosis, treatment and testing, or being the subject of research without their informed consent. It should include the effects of lack of candour and inadequate responses by authority.* **Autonomy Award (Sir Robert Francis's report):** *Additional redress for the aggravation of the distress and suffering caused by the impact, as recognised in the impact award, caused by interference with the right to family life, the right to personal autonomy, absence of informed consent to the administration of blood or blood products, failure in candour with regard to infections and their cause, testing and screening, and any other instance of wrongful interference with the right of the individual to control over their own life.* **Exemplary damages:** This is the term conventionally used to describe a non-compensatory award of damages designed to mark the court's disapproval of outrageous conduct. The Inquiry Second Interim Report noted 'exemplary damages' would not be appropriate to include in a compensation scheme which aims to process compensation claims without unnecessary delay. This would not however prevent someone who wishes to bring a claim which is, or includes a claim, for exemplary damages before the courts. Note: The Second Interim Report references the loss of choice to have children in this award which the Sir Robert Francis Compensation Study covers in the Social Impact Award (see related questions in the table above).
Questions for expert group	**Clinical and Social Care** ● What personal loss of autonomy impacts might you expect for each infection and severity? Can this be assumed across all individuals in an infection severity banding or do other factors take greater precedence e.g age infection started?

	GRO-D
Ask to expert group	• Review questions above • Review detailed COLA legal instruction on legal policy work to date • Review DHSC analytical data package - latest average award assumptions and DHSC analytical award pack

Work Block 3: Developing a Compensation Awards Framework

Objective: *To understand recommended compensation or tariff values for potential eligible group and design a framework award model)*

Work Block 3: Developing a Compensation Awards Framework	
Topic	**Development of a Tariff skeleton framework for case worker assessment**
Background and reading material	Inquiry Second Interim Report recommendations: 8 Sir Robert Francis Compensation Study recommendations: 10 This work block will focus on bringing together the advice and recommendations of work block 1 and 2 into a tangible compensation framework proposal and consideration of operational technicalities. Technical questions will be developed as the expert group moves through work blocks 1 and 2. **Policy Questions** The key policy questions Cabinet Office officials will be working towards answering are: ● What caps and award limits should we set for infected and affected groups? ● What is our approach to double recovery? What past and future payments will be considered in double recovery? ● What is the operational strategy for bringing the compensation scheme online? Do we want to prioritise applications from designated groups of claimants e.g the infected ● Should payments be backdated for infected individuals previously unregistered with an infected blood support scheme (IBSS)? To note, this work block may extend beyond the initial 3 month expert group contract period and will remain under review
Questions for expert group	**GRO-D**

Ask to expert group	