

Infected Blood Compensation Scheme Technical Expert Group

Roundtable background paper: Severe Psychological Harm

24 February 2026

The purpose of this roundtable is to facilitate targeted engagement with key organisations and charity representatives of the infected blood community to help inform the TEG's advice to the Government. The TEG is seeking a fuller understanding of how severe psychological harm can be recognised within the Scheme's structure.

This paper provides the specific questions that will be discussed at the upcoming virtual roundtable regarding severe psychological harm.

The paper also provides background on the Infected Blood Compensation Scheme structure, and outlines the principles guiding the advice that the Infected Blood Compensation Scheme Technical Expert Group (TEG) has been asked to provide.

1. Recognition of psychological harm in the compensation scheme

a. Core Awards

The Scheme acknowledges that everyone will have suffered psychological harm alongside the physical impacts of infection. Therefore the scheme provides compensation as part of all core awards, with no separate or specific evidence of psychological and psychiatric harm required. This is to acknowledge clearly that everyone will have suffered this category of harm. There is, therefore, no requirement to show that people have received psychiatric treatment or psychological therapy when people apply for the core awards.

Compensation for financial loss is also automatic in the core award. For chronic hepatitis (Level 2) it is calculated on the assumption that people will experience a 40% loss of earning capacity (for example being able to work only for three days a week). No evidence is required to show that this is caused by the infection. The connection between the infection and lost income is inferred from the fact that we know that people experienced psychological and physical symptoms that impacted significantly on their everyday lives, including their ability to work.

b. Severe Health Condition Awards

Severe Health Condition Awards provide for increased care and financial loss awards for categories of circumstances where the assumptions on which core awards are calculated are likely to be insufficient to compensate for the impacts of infections. The tariff-based approach that Sir Brian Langstaff's reports on compensation proposed means that awards cannot be precisely tailored to individual circumstances but need to provide broad justice for most people. Some degree of categorisation is necessary for such a tariff-based scheme to work.

It is known that some people with Hepatitis C, Hepatitis B, and HIV experience neurocognitive impairments and behavioural disorders and in relation to these a SHC

provides for increased care awards in defined cases of long-term severe neurocognitive impairment (based on a social services needs ((or equivalent)) assessment and financial loss (up to 100%).

For the separate Severe Psychiatric Conditions award, the previous Expert Group advised that where there was a diagnosis of a potentially serious disorder that had such an impact on people that they required specialist psychiatric treatment for a prolonged period, and where the impact prevented them from working, then the supplementary Severe Health Condition Award should be based on 100% financial loss. This loss is regarded by the scheme as permanent if the eligibility conditions are met. Even if a person's mental health improves with treatment, a history of specialist psychiatric treatment can itself be stigmatising and impair employment prospects.

The Inquiry's recommendation, set out in full below, was to accept a formulation-based opinion from a psychology professional as equivalent to a psychiatric diagnosis and remove the requirement for having had, or to be currently receiving, consultant-led psychiatric treatment. The TEG is reviewing/considering how to make this approach compatible with the structure of the scheme.

Currently the need for consultant-led treatment distinguishes the level of severity assumed as part of the core and supplementary awards whereby greater severity assumes 100% inability to work. The psychiatric diagnoses that comprise part of the current eligibility criteria include depressive and anxiety disorders that can have a wide range of impacts. In itself, the diagnosis does not always serve as a proxy for impacts on the ability to work that lead to financial loss, which is the aspect of the compensation scheme addressed by this Severe Health Condition Award. For example, depression is a common mental disorder and will have been widely experienced. It is therefore recognised in the core award. Sometimes, however, the impact of depression is much more severe and can require prolonged specialist treatment or even hospital admission. In such cases, the financial loss will be greater than the core award recognises. Some criterion is needed that serves as a proxy for severity of the impacts in order to identify those whose financial loss will be greater than 40%.

Applying the principle that the Scheme should not require evidence that could not reasonably be expected to be available to applicants, the Scheme proposed receipt of specialist treatment because it was anticipated that this would be recorded in health records.

A formulation-based opinion is the product of a process of discussion between a psychological professional and client in order to inform a treatment plan. It may include a description of symptoms and their potential severity, factors that have led to the condition and triggers as well as their impact on an individual's life (e.g. ability to work). A formulation can include reference to diagnostic criteria if relevant and appropriate but is unlikely to provide a specific diagnosis. A formal assessment of symptoms using standardised tools indicating severity may also have been used. This might give some comparison with impacts on different populations. In itself, the fact that an assessment has taken place does not indicate any level of harm, although this may be apparent from the documentation of the process.

The TEG has previously received advice that an intense and time-consuming individual assessment process would be required if formulation based opinions were to be used in the compensation scheme. This would depart from the principles on which the tariff-based scheme is built. This informed our initial advice to the Government. The TEG would like to understand from the roundtable participants how likely it is that people already have access to contemporaneous formulation based assessments that have described psychological impacts that were having similar impact on day to day function to the current diagnoses of psychiatric impacts beyond those recognised in the core awards. No specific evidence of psychological harm is required in the core awards, as this is assumed to be associated with the infections. For a severe psychological harm award, however, there needs to be evidence that the level of psychological harm that has prevented the individual from actively participating in daily living, family life and regular employment, greater than already recognised. If the use of a formulation-based opinion was to be integrated into the Severe Psychiatric Condition, there would also be an implication that treatment was unlikely to enable people to return to work.

2. Roundtable objective

The TEG hopes that roundtable participants might assist by identifying the categories of evidence that will reasonably be accessible to people, would include an assessment of psychological impact that shows it goes beyond a 40% loss of the ability to work, without involving disproportionate intrusion or inquiry into people's lives.

Questions for the roundtable:

1. How common is it for people's mental health to have been formally assessed by psychological professionals?
2. What evidence is likely to be available to show that people's mental health has been affected by their infections in ways that led to them suffering a greater loss of the ability to work than is recognised by the core awards?
3. Given that many people have been unable to access specialist treatment for psychological and psychiatric difficulties, how could the risk that Severe Health Condition awards could exacerbate inequities be reduced?
4. How might the ways in which psychological harm is recognised in the Scheme be better explained? Could the use of language from the lived experience help the Government explain this better?

The following provides information on the structure of the scheme, the format of the roundtables, the TEG's initial advice, and the TEG's approach to reviewing the responses to the Government's consultation.

3. Infected Blood Inquiry recommendation

In March 2025, the Infected Blood Inquiry announced its intention to publish an additional report to "consider the timeliness and adequacy of the Government's response on compensation". The Inquiry published its [Additional Report](#) in July 2025 which made a number of recommendations for the Infected Blood Compensation Authority (IBCA) and the Government in relation to the operation and design of the Scheme. It did not suggest that the

structure of the scheme should be altered so its recommendations were for additions and modifications to 'build constructively on the scheme as it is' rather than fundamental change as this would cause inevitable delays in compensation being paid.

The recommendation regarding severe psychological harm from the Inquiry's Additional Report is:

"The approach of the Infected Blood Psychology Service is adopted so that both a diagnosis made by a psychiatric professional and a formulation-based opinion of all qualified psychological and counselling professionals are accepted as sufficient evidence of severe psychological harm and that such evidence should qualify a person for a supplementary Severe Health Condition award without the additional need to demonstrate a period of consultant-led secondary mental health treatment or assessment/treatment as an inpatient."

4. The role of the Technical Expert group and roundtables

The TEG has been asked to advise the Government on practical aspects of the recommendations made in the Inquiry's Additional Report. Decision-making on policy is a matter for the Government. The TEG is therefore concerned with:

- Identifying options for implementing the Inquiry's recommendations within this scope.
- Advising the Government on the practicalities and implications of each option.

In accordance with our [Terms of Reference](#), we are able to undertake targeted engagement with members of the infected blood community in order to complete our work programme. This does not replace the formal public consultation that the Government has undertaken. Nor does it delegate the TEG's advisory responsibilities, for which it remains responsible and accountable.

This engagement will be focused on the scope of the Additional Report and has the following purposes:

- To enable testing of emerging TEG thinking, ensuring that the TEG advice is informed by lived experience and wider professional views
- To increase transparency about the TEG work process to ensure that the rationale and thinking in relation to all recommendations are available for scrutiny.

5. Roundtable format and process

Format: The TEG will convene a virtual roundtable to discuss an aspect of the Inquiry recommendations.

This roundtable will focus on severe psychological harm. The size is aimed to enable a full and open discussion focussed on the work programme of the TEG.

Further roundtables will be convened this year to refine the TEG's initial advice on recommendations concerning the recognition of the impacts of interferon treatment and the

supplementary route for affected persons. Each roundtable will be supported by a background paper on the specific recommendation to be discussed.

Attendees: The participants of the roundtables will be as follows:

- Chair - Professor Sir Jonathan Montgomery
- Approximately seven key organisations and charity representatives per roundtable
- Members of the TEG
- Cabinet Office officials will attend for the purpose of making a record of the meeting but are not part of the TEG.

Role of community participants: Following introductions, each community participant will have the opportunity to make a short statement of views before the questions identified by the TEG in this paper are raised. There will be no interruption to these contributions save to keep to the allotted time. The chair will then introduce the specific questions that have been identified in the paper and seek views on those questions if they have not already been stated. The aim is to ensure that each participant is able to contribute with an equal voice.

Where matters are raised that are outside of the scope of the TEG's terms of reference, this will be drawn to participants' attention so that they can consider submitting them to the wider public consultation.

Role of the TEG members: Following introductions, TEG members will be invited to listen without interruption or comment. Any questions (which are likely to be for clarification) will be raised via the Chair rather than from individual TEG members. The TEG Chair will endeavor to address questions from invited participants to the extent that they fall within the group's Terms of Reference. However, definitive answers may not be available until the TEG has concluded its work.

Written responses to the TEG: The TEG recognises that this issue affects a broad range of people across the community. In addition to the roundtables, the TEG invites written responses from key representatives in the community (see Annex A) to the questions in the background paper. This is separate to the consultation held by the Government. Responses to the TEG background paper can be sent to ibcs.teg@cabinetoffice.gov.uk.

So that responses can be considered ahead of the TEG's final advice, please provide written responses by **10 March (two weeks after the roundtable)**.

All responses from representatives will be shared with TEG members alongside a thematic summary prepared by the Cabinet Office which will be published at the conclusion of the series of roundtables.

Transparency: This paper is being made public as a commitment to transparency and will be provided to invited contributors ahead of the meeting.

Following the roundtable, a record of the discussion will be shared with participants to check for accuracy. Issues raised in written responses will be collated into a thematic summary that will be considered by the TEG. The record of the discussion at the roundtable and the report

on written responses will be publicly released alongside the final report presenting the TEG's considered advice. Minutes of TEG meetings that discuss the roundtables and consider the written responses will also be published.

Confidentiality: For the purpose of transparency, a list of participants and a record of the key points discussed will be published, but it will not attribute opinions to specific participants. We hope this will help facilitate trust between participants and promote open conversation on sensitive topics.

The content, ideas, and key takeaways discussed during the roundtables can still be freely used and shared by participants; however attendees are asked not to disclose the identity or affiliation of the speakers.

6. Policy Background

This section outlines some key elements of the Compensation Scheme that provide the context for the TEG's work programme. The TEG will aim to give advice that builds on the fundamental structure of the Scheme.

6.1 Compensation scheme structure

The Infected Blood Compensation Scheme adopts the five heads of awards for infected people proposed by the Inquiry:

- **Injury award:** This award recognises the physical and mental injury, emotional distress and injury to feelings that may have been caused or will in future be felt as a result of: infected blood and/or related medical treatments; the death of an infected person; the likely death of a loved one in the future.
- **Social Impact award:** This award recognises the past and future social consequences that people with blood-borne infections may have suffered (e.g. stigma and social isolation).
- **Autonomy award:** This award recognises the distress and suffering caused by the impact of disease, including interference with family and private life (e.g. loss of marriage or partnership, loss of opportunity to have children).
- **Care award:** This award recognises the past and future care needs and associated costs for infected people.
- **Financial Loss award:** This award recognises the past and future financial losses suffered as a result of infection. This includes both financial loss and loss of services (e.g. providing childcare).

The Scheme has two routes: the **core route** (offered to everyone eligible) and the **supplementary route** (for exceptional cases where greater compensation for financial loss and care costs is necessary).

The reports from the previous [Infected Blood Inquiry Response Expert Group](#) advised on the amounts that would be indicated by reference to judicial guidelines and court decisions, although not limited by them.

A full overview of the scheme can be accessed [here](#). A high level overview of the scheme can be accessed [here](#) (please note this does not reflect the amendments from the third set of regulations).

6.2 Technical Expert Group Advice

The TEG engaged the leads of the Infected Blood Psychological Service (IBPS) to review the Inquiry's recommendation. The TEG's initial advice to the Government is based on the following:

- While formulations guide treatment, they do not provide clear, reliable markers of severity or assess the impact on earning capacity or care needs in the way required for a tariff-based scheme.
- Defining award criteria based on formulations would require new individual clinical psychological assessments for all applicants, which is not possible within a tariff-based scheme.
- The TEG has advised that severe psychological harm for those with Hepatitis B or C could instead be covered by the proposed changes to the Special Category Mechanism (SCM) award, as SCM criteria already include a review of mental health concerns and their impact on daily life.

6.3 Proposal in consultation

The Government accepted the need for change in July 2025 and committed to consulting on the level of psychological harm and the evidence needed for eligibility. The current proposal is that the Scheme provides compensation for a range of mental health issues:

1. Core Route: For psychological harm suffered by all infected people.
2. SCM Severe Health Condition Award: For those whose mental health issues require more compensation than the core route but do not meet the "severe psychiatric disorder" threshold.
3. Severe Psychiatric Disorder Severe Health Condition Award: For the most severe harms requiring intensive specialist treatment.

The consultation asked:

1. The majority of victims of the infected blood scandal have suffered psychological harm. The Scheme compensates for this in three ways, depending on the severity of harm suffered:
 - **Core route**
 - **New proposed Severe Health Condition award for SCM**
 - **Severe Health Condition award for severe psychiatric disorders**

Across these three different awards, are the mental health effects of infection or treatment fully covered by the compensation offered? If you answered no, what other mental health issues do you think the Scheme should consider?

2. To qualify for the Severe Health Condition award for severe psychiatric disorders, infected people must currently provide a report from a consultant psychiatrist

confirming a diagnosis and causation, alongside evidence of extensive treatment (a six-month period of consultant-led secondary care, inpatient admission, or section under the Mental Health Act). Care awards for those eligible for this category of supplementary award would be at low care (£23,424 per annum) for those years when the relevant conditions were met that were not already attracting this level of payment or higher under the core award. This band equates to 16.5 hours per week consisting of 6 hours per week domestic support and 1.5 hours per day personal care. For a 100% financial loss award there had to be provision of evidence that the applicant was unable to return to work after diagnosis of Severe Health Condition.

What other pre-existing evidence could the Scheme ask applicants to provide to demonstrate severe psychological harm, similar to the Severe Health Condition award for Severe Psychiatric Disorders?

6.4 Principles of evidence to support a tariff based scheme

The TEG will apply the principles of evidence that were identified in its predecessor's work in order to promote consistency. These principles are:

- **Accessibility:** Accessible to claimants (and assessors) means that only information that is reasonably expected to be available if requested should be sought to establish eligibility.
- **Assessability:** Evidence must be suitable for use by the Infected Blood Compensation Authority (IBCA) to determine eligibility or entitlement without significant further inquiry or assessment in line with principles of a tariff based scheme.
- **Verifiability:** Evidence must be verifiable to maintain the integrity of the scheme.
- **Proportionality:** No more intrusion into people's privacy should be sought than is required to ensure that they receive the compensation to which they are entitled.

6.5 Review of issues raised in consultation responses

The Government will consider all responses submitted to the public consultation and will publish a response within 12 weeks of its closing. The work of the TEG in advising the Government is separate from this process. However, the TEG has asked for an indication of the points raised in response to the two consultation questions. This is so that the TEG can consider whether the issues raised should lead us to advise that the Government amend the proposal outlined in the consultation.

TEG advice will be only one aspect of the considerations that the Government will take into account. We have therefore considered what our approach should be as a 'technical expert group' when the evidence about the impact takes many different forms, including lived experience, reports in professional literature, and the experience of members of the TEG. We intend to be transparent about the basis, and therefore also the limitations, of our advice. In the following paragraphs we set out our tentative view of the proper role of the TEG. We may refine this in the light of the discussions at the roundtables and associated written submissions.

The TEG will discuss the mental health issues identified in the consultation responses and consider if it is able to say whether and where the range of issues is covered in the Government's proposal. The TEG will review the consultation responses and consider whether it is possible to utilise other types of pre-existing evidence to demonstrate severe psychological harm with equivalent impacts or care needs and financial loss to those covered by the Severe Health Condition Award for Severe Psychiatric Disorders.

Next steps

A record of the meeting will be drawn up by the Cabinet Office and circulated to all attendees to check for accuracy. This will be made public alongside the advice from the TEG. Written responses will be collated and reported to the TEG. This will also be made public alongside the advice from the TEG. The TEG will discuss what it has learnt alongside other information, including relevant responses to the Government's consultation. A minute of these discussions will be published alongside its advice as with all TEG meetings.

The TEG may approach individual participants for further clarification of points raised. If this happens, the focus and outcomes of such exchanges will be recorded in an agreed note that can be made public alongside the advice from the TEG.

Annex A:

List of key representative organisations and charities in the infected blood community whom are invited to comment on the background paper via correspondence:

- [The Birchgrove Group](#)
- Blood Friends (formerly North West England Support Group)
- [Bloodloss Families](#)
- British Liver Trust
- [Contaminated Blood Campaign](#)
- Contaminated Blood Women
- [Contaminated Whole Blood](#)
- [Factor 8](#)
- [Families of Deceased Infected Blood Victims UK](#)
- [The Fatherless Generation](#)
- [The Forgotten Few](#)
- Former Treloar's School Pupils
- [Friends and Families of Haemophilia Northern Ireland](#)
- Haemophilia Action UK
- [Haemophilia Northern Ireland](#)
- [Haemophilia Scotland](#)
- [Haemophilia Society](#)
- [Haemophilia Wales](#)
- [Haemosexual](#)
- [The Hepatitis B Trust](#)
- [The Hepatitis C Trust](#)

- Individual campaigner for estates, women and carers
- Manor House Group
- Mono-HCV Infected Haemophiliacs
- Positive Women
- Misdiagnosed Victims
- [Scottish Infected Blood Forum](#)
- [Terrence Higgins Trust](#)
- [UK Thalassaemia Society](#)
- [Tainted Blood](#)
- Tainted Blood Parents
- Tainted Blood Widows and Bereaved Partners
- Independent Widows
- HaemAffected
- Independent Longstanding Campaigners