Northern Ireland Assembly

Committee for Justice

OFFICIAL REPORT (Hansard)

Troubles Permanent Disablement Payment Scheme: Capita

7 October 2021

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Mervyn Storey (Chairperson)
Ms Sinéad Ennis (Deputy Chairperson)
Mr Doug Beattie
Ms Sinéad Bradley
Ms Jemma Dolan
Mr Robin Newton
Miss Rachel Woods

Witnesses:

Dr Shah Faisal	Capita
Mr Brendan Flynn	Capita
Mr Antony King	Capita

The Chairperson (Mr Storey): I welcome, in person, Mr Antony King, managing director of Capita health and welfare; Mr Brendan Flynn, the Northern Ireland client engagement director of Capita health and welfare; and Dr Shah Faisal, chief medical officer of Capita health and welfare. I thank the three gentlemen for their help in preparing for today's meeting. Thank you for the correspondence that you sent to us previously, your engagement with the Committee to date and your presence this afternoon. It is very much appreciated. I advise everyone that the session will be reported by Hansard, and a transcript will be published on the Committee's web page.

I will invite Mr King to make some brief opening remarks highlighting any particular issues that he wishes to draw to the Committee's attention in relation to the role of Capita in the Troubles permanent disablement payment scheme. Before we proceed, however, I want the Capita representatives to know that a very useful informal meeting took place yesterday with the president of the Victims' Payments Board, Mr Justice McAlinden, during which he outlined the role of the board, how the process will work, the safeguards to prevent any re-traumatisation of victims and the board's accountability arrangements. A note of that meeting will be circulated to Committee members later. It is only right that we inform you that that meeting took place. I found it extremely useful, and I look forward to this engagement this afternoon.

I will hand over to Antony, after which members should indicate to me whether they have any questions.

Mr Antony King (Capita): Good afternoon, Mr Chairman and Committee members. Thank you for the opportunity to make some brief opening remarks. Before I do that, I thought that it might be helpful to expand on the roles that we three play in Capita. As managing director for health and welfare, I have ultimate accountability and responsibility for all the work that Capita does across those sectors. Dr

Shah Faisal, as chief medical officer, is responsible for all matters clinical across health and welfare. Brendan has been heavily involved on the ground with the Troubles permanent disablement payment scheme since the beginning and will continue to be so in the coming months.

I thank the Committee for the opportunity to talk to you. We strongly believe that the transparency in governance around this Committee is important to maintain confidence in the scheme, so the opportunity to answer your questions and address any concerns is welcome. This does not have to be a one-time date. We are more than happy to come back in the coming months to talk about progress as the scheme rolls out. You are all very welcome to come to our offices or talk to us individually at any time about any concerns that you have.

This scheme is hugely important for those who have been affected by the Troubles and the conflict in Northern Ireland and, indeed, across the UK. For that reason, we have put those people at the heart of the scheme's design, and we will continue to do so as we roll it out. We designed the scheme in collaboration with the Department of Justice and the Victims' Payments Board. We also had extensive conversations with the representative groups for the victims of the Troubles/conflict over the last few months. I would very much like to say thank you to those groups for the way in which they engaged with us. That has been incredibly helpful.

In designing the scheme, we looked at similar schemes across the world to ensure that we took the best practice from them. We had input from leading academics from the universities in Northern Ireland, and from further afield, such as Harvard University in the States. The output of that is, we believe, a scheme that is compliant with the regulations, sympathetic, inclusive and easy to access.

Where are we today? I am pleased to be able to say that, this week, we received the first cases from the Department for our team of assessors to look at. Those assessors are public servants, typically from the NHS, who have chosen to work with Capita. They bring their professional background and qualifications to the scheme, and we have put them through intensive, specialised training to make sure that they are fully equipped to support those in need.

Now that the scheme is up and running, we are clear that ongoing transparency in governance is important, as I mentioned. To that end, I think that, in July, the Committee talked about the possibility of an external review of the scheme. We would very much welcome that. In our experience, external reviews have been really good at identifying areas for improvement and, indeed, reinforcing best practice. If the Committee decides that it would like to progress an external review, we will give it our full support.

Obviously, this scheme cannot reverse the trauma, upset and pain that have been caused by the Troubles and conflict over recent years. What it can do, to some extent, is, through financial recognition, help to alleviate some of that suffering. Our job is to play an important part in the scheme. The Committee has my word that we will make sure that help gets to those who need it most.

The Chairperson (Mr Storey): Thank you very much, Antony. I welcome your indicating that you are willing to return and continue to engage with the Committee. The issue that, sadly, brought about the need for this pension provision, this payment scheme, underscores the sensitivity, hurt, pain and anguish of years of unnecessary violence and trouble in our country.

Given the sensitivity with which the applicants have engaged with this process, their past and the worry, as Mr Justice McAlinden referred to yesterday, about ensuring that even an issue like selecting the location in which to meet them is done in a sensitive way, what assurance can you give us that that same sensitivity will prevail in the staff who will deal with and process these assessments? I have been at pains to state that there is no read-across between this scheme and any other scheme. It is for other Committees to probe and ask questions about how other schemes were or were not successful. This is a new scheme, and we want to ensure collectively — the Executive Office Committee, this Committee, the Department, the panel and everybody involved, including, I suspect, you — that this works to the best possible standard.

Mr King: I completely agree, Mr Chairperson, and I am very happy to give the assurance that we will do everything that we can to make sure that we deal with all cases and all individuals with great sensitivity. I will let Brendan pick up on the detail in a moment, if that is OK.

The Chairperson (Mr Storey): Yes.

Mr King: We have some quite significant safeguards and checks and balances in the system, and we have the training that I mentioned earlier. We have the specialist training, and we have the sensitive approach that we will take to choosing the method of assessment. Where possible, that will be through using medical evidence directly from other parts of the NHS. We absolutely encourage any applicant to bring along a companion to any face-to-face meeting to help them to go through the process. Mr Chairperson, I will let Brendan fill in some of the detail.

Mr Brendan Flynn (Capita): Thank you, Antony. Good afternoon, Chairman and members. We acknowledge that this is an exceptionally sensitive time for people who are applying to the scheme. We are acutely aware that we have to ensure that as many as possible of the applications that come to us are dealt with as a paper-based assessment, alleviating the need for any face-to-face consultations. Our primary goal will be to make sure that we can complete as many as possible using a paper-based assessment approach, as Antony mentioned. Where, as a last resort, we need to meet people face to face, we will seek to do that in the most appropriate location. That will be in their home or, potentially, in one of our assessment centres. As part of the process of determining the correct location, one of our clinical assessors will review the entire case. We appreciate that things like location are important. For instance, the last thing that we want to do is to ask someone to travel to a location that may take them past the place where an incident occurred. We have built those safeguards into the process.

The staff whom we are employing on the scheme are all healthcare professionals. They are absolutely dedicated and wedded to the principles of the scheme. As part of the training that Antony mentioned, we have engaged with the WAVE Trauma Centre, and it has designed and delivered an intense 10-hour trauma awareness programme. It is broken into four sessions over the four weeks of training, and we are keeping that at the centre of what we do. We genuinely care about the individuals who are coming through the process, and I believe that the safeguards are there. We are happy to provide any further detail that might be needed for your reassurance.

Dr Shah Faisal (Capita): As head of the clinical team, I can add that we have recruited to the team psychiatric specialists and a specialist medical adviser whose backgrounds are in disability assessment medicine. The same principles will apply to the scheme as apply when there is a complex or complicated case in an NHS hospital. The hospital will have a multidisciplinary team (MDT) meeting, and we have established an MDT that will help the clinical assessors and their managers by discussing any complex cases to make sure that an applicant gets absolutely the correct outcome from their assessment.

The Chairperson (Mr Storey): We will go to members' questions shortly. We noticed from the correspondence that it was determined that the clinical assessors needed to undergo a practical and a written assessment. What was the pass rate among those who took part in that?

Mr Flynn: The first two cohorts of trainees came out of training last week. I am pleased to say that, of the 14 staff who started the training process, only one fell by the wayside. All the others passed through the training successfully. The feedback that we received — we have shared it with the Department, and we are more than happy to share it with you — at the end of the training from those trainees was a real credit to the team who designed and delivered it. One person commented that it was the best training that they had received throughout their nursing career. Comments from the other trainees were of a very similar nature. I am delighted to say that they all made the grade. We will audit 100% of the cases that they write as they complete disability assessments. We have made sure that we have trained them to the appropriate level, but we will continue to audit them for a period of at least six months because, although they have passed out of training, they have not yet proven that they are at the standard that we require. Once they get to that standard, we will implement a structured rolling audit process. To reassure everyone that quality is right at the top of our list, we will select a statistically valid sample of cases every month to keep an eye on.

Ms S Bradley: I appreciate your presentation. One of my main concerns, as it is for others, is the re-traumatising of victims. I am delighted that we are speaking about this today and that we have moved to a point at which we are looking at the detail and talking about the recruitment and training that have happened. I have been reassured by some of the comments about the level of understanding that there is of the sensitivities around this.

When the applications are being sifted through, is an attempt made to understand the applicant and their needs and to match them to the most suitable clinical assessor, who may have a particular specialism and be mindful of psychological trauma etc? Added to that, although great effort may be

invested in making sure that the clinical assessors are at all times sensitive to the needs of applicants and victims, are training mechanisms in place for all those who will be in contact with them? Individual stories may carry significant dates or times in the year when things are difficult to manage. The applicant may be having a difficult period, and it would be remiss of somebody in an admin role, for example, to simply send out an appointment on a date that should have been pencilled out or reserved as being not a good date to contact them. I really want to know about the level of consideration that has been given to truly understanding the applicants and the weight of the trauma that they may be carrying.

Mr King: I will reply initially and then hand over to Shah to talk about the clinical training. I completely understand and share your concern. If we start re-traumatising people as a result of the scheme, we really are failing in our job. I promise that we are very aware of this. All our recruits have a degree of mental health experience, which is important. We will have training for our wider staff as well.

Dr Faisal: On re-traumatisation, one thing that Capita will not do as part of the scheme is diagnose psychiatric conditions. It is when a consultant, specialist or doctor, as part of a diagnostic assessment, goes into more depth about how someone sustained the trauma and asks about what actually happened that bad memories of that time can be brought back.

We will work on a working diagnosis provided to us by the specialist as part of the claim that the applicant submits. If that diagnosis is not available in the process of what we call the initial review, our assessors will go through all the clinical context that has been provided by the applicant, to seek that diagnosis. Once we get that information, and the diagnosis is available to us, our number-one priority is to undertake a paper-based assessment so that the claimant will not have to come into contact with an assessor or go through any re-traumatisation.

If we need to do a face-to-face assessment, whether in the clinic, at home, virtually by video or by telephone consultation, the clinical assessor will be aware of any risks and any safeguards that are required for that applicant. We have embedded in the training the interpersonal skills, sensitivity and empathy that assessors need to show. They all come from a clinical background. As mentioned, most will have background experience in mental health, and, for those who do not have such experience, our training covers really well all the conditions that the applicants are likely to have been suffering from: whether post-traumatic stress disorder or complex post-traumatic stress disorder, it is all covered in the training.

Our aim is to minimise the risk of re-traumatisation. The clinical assessors are not required to talk specifically about the incident. Rather, they will talk about the diagnosis, the symptoms that the applicant gets and how those impact on their day-to-day life. That will enable the clinical assessor to reach a decision on the degree of disablement, and they can complete a robust report for the Victims' Payments Board to enable it to make a decision.

Mr Flynn: Ms Bradley, I will come in with a couple of answers to some of the points that you made.

Each individual application will be allocated to a clinical assessor who will look at the case and consider all the information that is available. If healthcare professionals have been involved in the care of the applicant, and we do not have evidence from an individual healthcare practitioner, we will reach out to them. We have committed to the president of the board that, if we have the contact details for other healthcare professionals, we will reach out to them to gather evidence. We will make sure that as much evidence as possible is available to us before we make any decisions about the case. The clinical assessor will then determine the best route to assess that individual's disability. We are able to do the vast majority of those assessments on paper. Where we need to see an individual face to face, there are, as we mentioned, safeguards in place.

The clinical assessors are not on their own. They are not just left to determine these cases for themselves. A senior clinical governance team, under Dr Faisal, will provide coaching and mentoring. If somebody has a particularly difficult, complex case — the applicant may have expressed complex physical or psychological difficulties — they can go to the senior clinical governance team, and, if that team needs any further support, we have established a multidisciplinary senior clinical panel that includes senior psychiatrists, psychotherapists and a broad range of disability medicine specialists.

Lots of safeguards are in place. We have worked closely in collaboration with academics and clinicians in the trauma space so as to be acutely aware of the difficult traumas that people have experienced. Hopefully, that gives you some reassurance that we have robust processes in place.

Mr King: Brendan, will you comment briefly on the training of the admin staff?

Mr Flynn: As part of the service that we will provide, we have established an enquiry centre so that we can support applicants who may need to know where their case is. We might need to see some applicants face to face. They might need to call us to say, "This is a particularly sensitive date", "This is a sensitive time" or "I am uncomfortable in that location". We have established a team of experienced enquiry centre agents. They will also receive training in trauma awareness so that they can be very sensitive in how they handle those telephone calls and, as you rightly say, the interactions with people who may be feeling vulnerable and anxious as they go through the application process.

Ms S Bradley: Thank you. I have one final point. Some applicants may have had previous connections with Capita and been through assessments. We all know very well the stories about assessments not being reflected in reports. I am curious to know this: if an applicant felt reassured by the fact that they could record a face-to-face assessment, if there had to be one, would there be any objection to such a recording from the clinical assessor?

Mr King: At the moment, the recording is not part of the scheme, but we are discussing that with the Department of Justice. We are encouraging everybody to bring a companion in the event that they need to have a face-to-face assessment. Whilst a recording is currently not available to them, we make sure that someone is there who can provide that level of reassurance that the assessment is reflected in the report.

Ms S Bradley: Sorry; I did not mean that Capita would make the recording available. What advice is given to clinical assessors in the event that an applicant chooses to record a face-to-face assessment? Is it to proceed with that assessment?

Mr King: Brendan, do you mind answering that one?

Mr Flynn: As Antony says, we are discussing the matter with the Department of Justice. There is an element of balance to it. Typically, with those types of things, you look to get a master version of the recording that can be shared with both parties. We do not yet have agreements or a process in place for that. We are not instructing our staff one way or the other. It is a matter of individual preference for the clinical assessors. If they felt uncomfortable about being recorded, hopefully, their wish not to be recorded would be respected. The key thing is that we are in conversation with the Department about it. There are some data protection sensitivities in that area. We are committed to getting a solution in place with the Department.

Ms S Bradley: Thank you. Chair, I would like it noted that my prime concern is ensuring that the applicant feels comfortable. The clinical assessor is there in a professional capacity. Their whole focus, therefore, should be on making everything about the face-to-face assessment as comfortable and as safe as possible for the applicant.

Thank you for your answers.

Ms Ennis: Thanks, Antony, Brendan and Shah. The note that we received from you was very useful. Much of what I had intended to tease out has been covered in your answers to earlier questions. I want to double-check something: are you saying that, in the first instance, Capita healthcare professionals will accept support letters from a person's clinical psychologist or counsellor confirming that the applicant has a PTSD diagnosis as the result of a conflict-related trauma?

Mr King: Yes, that is right. Our last resort is to do a face-to-face assessment. As we said, we absolutely want to try to do the majority of assessments through the use of medical evidence, phone calls to healthcare professionals and so on. Yes, that is the case.

Ms Ennis: How will you manage the fact that a number of the applicants have physical and psychological injuries that date back to the 1960s and 1970s? What will be deemed acceptable evidence if they have difficulties in acquiring their medical records from that period?

Mr King: We have had to consider that challenge in the design of the scheme. I will ask Brendan to pick up on the detail.

Mr Flynn: We acknowledge the fact that a lot of the people who apply to the scheme may have been injured a long time ago. It is essential that we are able to help them and facilitate their application to the scheme. To support that, we have had conversations with the Department, the Department of Health and the BMA GP council about access to medical records. We acknowledge that the standard of recording of injuries has changed over time. There may be very good, detailed evidence in more recent files, but, as you say, if you go back to the late sixties and early seventies, the information may be sparse. We recognise that as a challenge that we need to work to overcome.

You mentioned the diagnosis piece. Diagnosis is really important to the scheme, and I will ask Dr Faisal to touch on that in a moment. In layman's terms — I am not a clinician — the clinical assessors have to identify the injury. In order to do that, particularly in psychological cases, we need a diagnosis. That could be a formal diagnosis from a consultant psychiatrist or a consultant clinical psychologist. That would be very formal and clearly evidenced in the medical records. We recognise, however, that a lot of people who have been injured in the Troubles/conflict may not have had access to that level of care. We have agreed with the president of the board that we can use a working diagnosis identified by another healthcare professional who has been involved in the care of that injured individual. That is probably a good point for me to hand over to Dr Faisal to help you to understand what a working diagnosis is and how we will identify it.

Dr Faisal: In a historical case, going back to the sixties or seventies, for example, someone who had suffered depression as a result of a Troubles-related incident may have gone to their GP, whose thinking was, "Your symptoms are suggestive of depression or another psychiatric condition, but it is not confirmed. However, I will start treating you with antidepressants". That is the working diagnosis. If the medication made them feel better or otherwise helped them, they may not have sought more help from that point onward, but they may have continued to take the medication. That degree of information from GP records will be sufficient for us to accept it as a diagnosed condition and to process the assessment further.

Ms Ennis: That is useful, because it answered my next question on the evidence threshold and the level of evidence that would be required. Thank you very much.

Miss Woods: Thank you very much for your attendance today. A lot has been covered already, and I appreciate the Chair's statement at the start about not reading across from one payment scheme to another. Naturally, however, that will happen, given the public interest in the personal independence payment (PIP). I have a number of questions that stem from the process and from answers that you have given to other Committee members.

My first question is about the ability to bring a companion to assessments, which I fully appreciate. Can you guarantee that companions will be allowed into an assessment centre or into somebody's living room, should that be their preferred place? I have had experience of being told to sit outside during a different assessment because there were not enough chairs. Will the applicant have to nominate the companion on a form and give a heads-up to Capita that somebody else will be there, or will that be accepted on the day?

Mr King: I give you the assurance that companions will be accepted under any circumstances. I apologise if you have had a different experience with a different benefit; that is not good, and I will be happy to look into it if you want to talk to me about it outside the meeting. For the level of detail that you asked for on the application process, I will pass over to Brendan.

Mr Flynn: Thank you for your question, Miss Woods. We absolutely encourage all applicants to get support and to bring companions with them. The scheme is unique and novel. It is entirely different from any other scheme. It is founded on different regulations and principles, and it is for a different purpose. We are acutely aware of the sensitive nature of the scheme. People have already been traumatised enough, and we definitely do not want to add to that. We encourage that companions come along, and there is no need to notify us in advance of the name of a companion. Potentially, the only exception to that is where we might do a telephone assessment or a virtual assessment, much like the StarLeaf system that we are on now. Those solutions are all in place, and the Department has encouraged us to make those other methods available.

In order to facilitate being able to get a companion joined on a phone call or a video call, we would welcome getting their contact details in advance. We will have an enquiry centre, so if anyone has any concerns, we would encourage them to give us a call, and we will be more than happy to facilitate changes to appointment times, locations or methods of assessment, if someone is uncomfortable with

what is being proposed. It is about putting the victims at the centre of what we are trying to do and giving them control over how the assessment process operates.

Miss Woods: Thank you, I appreciate that answer.

When it comes to medical evidence and current evidence that GPs or other healthcare professionals may hold on an applicant, do the healthcare professionals have to provide evidence to Capita? Are they mandated to do so? I am, perhaps, comparing apples with oranges, but will the GP factual report (GPFR) forms be a similar process to how medical information is requested?

Mr King: I do not believe that we can compel them. Brendan?

Dr Faisal: Can I take this?

Mr Flynn: May I come in first, Shah? The board has the power in the regulations to compel individuals and organisations to provide evidence, but I do not think that we will be relying on that. I am, perhaps, stealing Dr Faisal's point here. His team has designed a medical factual report, which is different from what has been used for other benefits. As we say, this is a very different scheme. It provides for very targeted questions. We have worked directly with the GP council in Northern Ireland, which has been amazing in facilitating us. It has helped to design the form. Indeed, we were in communication with the GP council today about sending out some further correspondence to the 330 or so GP surgeries in Northern Ireland. We are working really closely with GPs, and we are encouraging them to complete the forms and get them back to us.

Finally, we encourage anyone who is applying to send in any evidence that they already have. Please do not go to your GP or the hospital. If you have evidence in your possession, please send it to us, along with the contact details for people who have been involved in your care. We guarantee that we will reach out to those healthcare professionals, and we will attempt to obtain that information on your behalf. Please do not worry; if you do not have it, give us the contact details, and we will look after that for you. I am sorry, Dr Faisal.

Dr Faisal: You have explained it really well. I just wanted to reiterate that the medical factual report that we have on this scheme is very specific to the needs of the applicant, and it asks specific questions that will help our clinical assessors to identify the injury, the diagnosis and the restriction. If they answer all the questions, it will enable us to write more paper-based assessments.

Miss Woods: Thank you very much. I appreciate getting a very clear answer about the process.

Finally, thank you for the briefing note that was provided to the Committee. It was very detailed. It states:

> *"Throughout the application process our Clinical Assessors will be required to ... Determine the percentage of permanent disablement".*

That raises a number of questions for us. How does one calculate a percentage? Does that mean that the disablement scheme will, essentially, be about point-scoring percentages? If it is based on percentages, does that determine eligibility? Is that a direct read-across? Does 68% equate to a certain payment? How does that work? Is there an existing precedent for assessments such as this in terms of percentages of permanent disability?

Mr King: Brendan, are you OK to answer that?

Mr Flynn: This is a very complex area, and I will do my best to simplify it. The regulations require that the clinical assessors provide the board with a robust and clearly justified report on the percentage of permanent disablement attributable to a Troubles-related injury. The regulations are detailed in how that must be done. As you say, the disability must be expressed in a percentage. The percentage must be in a multiple of 10. It is simple mathematical rounding: if it is five or above, it is the next highest multiple of 10. However, there is the exception of any disability that is 14% and above: 14% becomes 20%. The threshold for entitlement is 14%, which will be expressed as 20%.

You are right to point out that that is complex. The regulations point to a table of prescribed disabilities. It is a table that appears in the Social Security (General Benefit) Regulations 1982. That is

called up in the regulations. It provides a detailed table of percentage disability for certain types of physical injury. It is detailed. I encourage anyone who is involved in the scheme to take a quick look at it to get a feeling of how percentage disability is built up.

That table and the social security Act 1992 do not include psychological injury. There is no table for psychological injury. In our early conversations when preparing for this scheme, that was one of our major areas of focus. It was an area that was flagged by the victims groups. The Victims and Survivors Service (VSS) provided us with a detailed paper that it put together with the victims sector. It expressed their concerns around psychological disability and how it would be determined as a percentage. We then engaged with leading academics from Queen's, Ulster University and, as Antony mentioned, Harvard University and Capita's senior clinical team, including Dr Faisal and our senior medical officer. We put together a detailed literature review, which looked at many similar schemes across the world where people had suffered traumatic injuries. As a part of that process and working with Queen's, in particular, a detailed psychological framework has been devised, which helps clinicians to understand how certain disabilities caused by psychological injury can express themselves. It is very complex, and I am not a clinician, so I will ask Dr Faisal to talk about the psychological injury framework and how it is used in the assessment process.

Dr Faisal: As Brendan mentioned, we worked with specialists in the field and people with experience and background in disability assessment medicine. The psychological assessment framework evaluates the level of disablement by taking into consideration the diagnosis, the severity, the symptoms that the applicants are suffering from, and the impact that it has on their social life, occupational health and day-to-day activities. All of that is taken into consideration. The findings that the clinical assessor will have at the time of the assessment, be that from a mental-state examination or a cognitive-state examination, will be combined with that and put on the scale defined in the psychological assessment framework. That will determine whether the person is 20% or 30% disabled, for instance. That is how it will work.

Miss Woods: Thank you, both. I know that I said that that was me, Chair, but you will always get another question from me. Following on from that and related to it, the percentage disablement is expressed in multiples of 10. Does that directly correlate with the amount paid? Finally, is there an appeals process?

Mr King: There is definitely an appeals process. Brendan, will you talk about the correlation?

Mr Flynn: I believe that to be the case within the regulations, although I should point out to Miss Woods that we are not involved in determining the level of payment; we simply provide the report that gives the degree of disability.

As I have said, it is a very complex area. We recognise that many people will have physical and psychological injuries. The clinical assessors have to be able to determine what level of those injuries is attributable to either a single Troubles-related incident or multiple Troubles-related incidents. That is made more complex by the fact that people may have had pre-existing conditions or may have conditions post that. That is a really complex area for us to get into the detail of. We believe that we have a competent and capable team and that we have the ability to do this very well. We are giving the clinical assessors space to work through these cases in detail. We are looking for support from everyone. We want to continue to engage with the victims sector. As Antony said, we would welcome conversations with the Committee as the scheme proceeds, particularly if members have any concerns. If there are things that you want clarified or points that you want to raise, please reach out to us. We would really appreciate that input.

Dr Faisal: May I just add to the appeals piece? There is an option for the applicants to appeal against an outcome if they are not happy with it. Before that, however, when a clinical assessor completes the report, it goes through a rigorous internal audit and quality assurance process. When the report is submitted to the Victims' Payments Board, if a panel member is not happy with the content or has concerns about the quality of the report, the board can send the report back to us and our senior clinical team will have the opportunity to look into that report and respond to them. Before an applicant appeals, that process is embedded.

Miss Woods: Thank you very much for your attendance and your answers.

The Chairperson (Mr Storey): Thanks, Rachel. On that point, Dr Faisal, will the report be shared with the applicant, either in some circumstances or in all circumstances, before it is submitted to the Victims' Payments Board?

Dr Faisal: The applicant can request a copy of the report from the Victims' Payments Board. When we complete the report, we will submit it to the board.

The Chairperson (Mr Storey): You submit it to the board. Can the applicant apply for sight of the report at that stage?

Dr Faisal: Yes. Once the board makes its decision, the applicant can apply for that.

Mr Beattie: Thank you to Antony, Brendan and Shah. It is a complicated piece of work that you have to do. I accept that. We have talked a lot about the applicants. May I ask a couple of questions about process, please?

This probably falls to you, Brendan. Can I get a sense of who the clinical assessors are? When I say, "Who are they?", I mean, "Where are they from?". I get that they have a particular background, but where do they come from and how many are there?

Mr Flynn: Thank you, Mr Beattie. I am happy to answer your question. As I mentioned to the Chair, we have recruited the first two cohorts of clinical assessors, so there are 14 clinical assessors. A total of 34 clinical assessors have been offered and accepted roles with us. They will go through training cohorts over the coming weeks.

We are looking ahead to recruitment next year. As a slight side point, I say that we have been working off forecasts provided by the Government Actuary's Department. There is a low-level forecast, mid-range forecast and higher-level forecast. At the moment, we are recruiting towards the higher end of the forecast. We keep that under review with the Department on a fortnightly basis, because we obviously do not want to over-recruit. At the moment, however, there is no great certainty around the volume of applications.

When it comes to the location, our staff are predominantly based in Northern Ireland. We recognise, however, that there are victims who were injured elsewhere in the UK or who were injured in Northern Ireland but are now resident elsewhere in the UK. We have a very good geographical dispersal across the north and south of GB. We also acknowledge that there will be applications from outside the UK. We will be looking at those on a case-by-case basis. We have established that we will be able to do virtual or telephone-based assessments for anyone in the EU. We will be able to do that by telephone or video link. Outside of that, I am aware that there are applications in from as far afield as Canada at the moment. We need to look at the information governance processes around how we facilitate those. I assure you that we are dealing with those on a case-by-case basis.

Mr Beattie: Thank you for that, Brendan. You have partly answered where I was going with that question. How do we make sure that the clinical assessors understand the very different societal issues impacting an applicant who is in Northern Ireland compared with an applicant who may well be in England or further afield? The societal issues that affect an applicant from here are very different from those that affect an applicant in England.

Bearing that in mind, some applicants may well have a huge level of mental distress around who they talk to. For example, some of our applicants may be wary of talking to a GP, because they do not know their background. I apologise if I have missed this, but will you outline the vetting process for the assessors? Is it just an Access NI check? What happens further afield?

Mr Flynn: Thank you again. That is another important point. Primarily, the staff in the clinical assessor role are all registered healthcare professionals. They will have to maintain their registration with their governing body throughout their period of employment providing clinical assessments. Before they can come into Capita, they have to go through baseline personnel security standard vetting, as mentioned. They then have to receive counter terrorist check (CTC) clearance. Everyone will have CTC clearance.

We are acutely aware of the sensitivities around it and around some of the different populations of people who will be applying to the scheme. To give an example, I met the chief executive of the Royal Ulster Constabulary George Cross – Police Service of Northern Ireland Benevolent Fund earlier this

week. He was very clear in expressing to us his concerns for the population of people whom he represents and, as you said, the potential issues around trust and who has access to their information and evidence.

I assure you that we have very good processes in place with the Department about what information comes into our space. We really only want to know information that helps us to understand how somebody's disability affects them, as Dr Faisal said. We are less interested in how they were injured, unless it puts how their injury impacts them into context. I assure you that we take it very seriously. Handling personal data very sensitively is one of the principles of the scheme, so please be assured that we are committed to doing that.

Mr Beattie: Thank you. You said that all clinical assessors will have CTC clearance. I take it that all senior clinical governance team members will also have CTC or developed vetting (DV) clearance in some shape or form. Will you confirm that?

There was a question about the appeals process. I accept that there will be an appeals process, but how does an applicant go about starting the appeals process? I am looking at the high-level applicant journey that you set out, and, after step 3 on that applicant's journey, the applicant might feel that he has an issue and think that things are not going right or that he has not given the information. What does that applicant do to appeal in order to re-engage with or restart the process or to appeal what has been done so far?

Mr Flynn: You are absolutely right about CTC clearance. Everyone who has access to personal data will have CTC clearance. I will not have access to personal data, but I also have CTC clearance. Anyone in our operation who reports to me will also have CTC clearance. That includes people who provide IT support. They do not directly have access to personal data, but they potentially could have access. They do not need to access personal data as part of their job, but everyone who could access it will have CTC clearance.

I need to make it really clear that the appeals process is a matter for the board and not for Capita. I am sure that the president will advise you that he sees himself as judicially independent on that. To the best of my memory, the regulations say that, after the board has made its determination and notified the applicant of the outcome, there is a period of 12 months. I will correct that, Chair, if I am incorrect. I think that there is a period of 12 months during which the applicant can make an appeal to the board. The board will establish an appeals panel, under the guidance of the president, and will make a determination about how to proceed. The board could request a second healthcare assessment, or it could determine the appeal based on the evidence that it has. It is a matter for the board.

Mr Beattie: Thank you.

The Chairperson (Mr Storey): I decided to look up the regulations and legalities on all this for our information. Part 7 of the Victims' Payments Regulations 2020 is very useful, as it sets out the assessment of cases where disablement worsens, the appeals process, the termination of appeals, the timescale and so on. It is very useful in providing the context for appeals, which, undoubtedly, will become an issue.

Before I go to Jemma and then Robin, Sinéad, I think, had a question about how long, from minimum to maximum, an applicant's journey should take.

Mr King: That is a tricky question to answer.

The Chairperson (Mr Storey): Sinéad normally asks tricky questions.

Mr King: It is tricky, because we very much deal with applications on a case-by-case basis to make sure that we get them right. We have some targets in the work that we are doing on our side, which Brendan can give more detail on. We can probably give broad ranges, but it is done very much on a case-by-case basis to make sure that we have all the available evidence to make the right decision.

Mr Flynn: Antony is right to point out that there are particular challenges. Again, one of the principles of the scheme is that the board should make its determination without delay. We are conscious of that. At this point, we do not really know what the quality of the applications will be. Will they come fully formed and with all the detail that is needed to determine the percentage of disability, or will we have

to request further evidence from other healthcare professionals? We do not have a sense of that at this point.

We recognise that some cases will be done fairly quickly, because we are working closely with the victims sector and we talk to them on more or less a weekly basis about what makes good supporting evidence and how to present applications so that they can be processed quickly. We are also aware that, because we are seeing their applications come in now, there are individuals who have put together their application by themselves without any support. Those applications may not be as detailed as we would like; they do not have enough information for us to be able to give the board a robust report. They will probably take us a bit longer, but we will work through them individually.

I will add that the board has the ability to prioritise certain cases based on, for example, age or whether somebody is terminally ill. We have committed to processing those cases as a priority, so that may lead to some other cases taking a little longer.

Apologies for a bit of a vague answer. At this point, all I can say is that we are committed to processing the cases without delay, and quality is our primary goal.

Mr King: It is probably a very good question that we will be happy to come back to talk to you about as the scheme progresses. It will certainly become clearer as we get more applications in.

Ms Dolan: Thank you to the panel. You will be glad to know that that question was one of mine, so you will not need to answer it again.

My only other question is: will there be a limit on the number of assessments Capita's healthcare professionals can carry out in one day? Is there a target that they have to meet?

Mr King: We do not have a firm target, but we have to base the scheme on some volumetrics. At the moment, we have assumed that it will be one assessment per day, but we will keep that under review as the scheme progresses.

Ms Dolan: OK. That is fair enough. That is all my questions, so thank you for that.

Mr Newton: I thank the witnesses for coming. Doug Beattie asked my question about the appeals process, which certainly sounds fine at this moment in time. My second was asked by Sinéad, so I am content at this stage, Chair.

The Chairperson (Mr Storey): I will conclude by asking how clear you are in your organisation about the accountability that allows it to deliver the contract? Is Capita clear on who is ultimately responsibility at a departmental level? We want to be as open and transparent with you as I believe you have been with us prior to the meeting and today. I very much welcome your commitment to continue to engage with us. We have given a commitment to victims' organisations that, in our public role and through our legal responsibilities as a Statutory Committee, we will do all that we can to be of assistance.

We have had an issue and tried to tease it out. The meeting with Mr Justice McAlinden yesterday helped us to get an understanding of the role of the Executive Office Committee and our role as the Justice Committee. Where does the contract that you have to deliver the scheme sit? Is it with the Department of Justice or the Executive Office, or where do you think that it sits?

Mr King: With the Department.

The Chairperson (Mr Storey): Of Justice?

Mr King: Of Justice, absolutely.

Mr Flynn: We are also aware of the tripartite nature of arrangements around the scheme, but we are very clear that, contractually, we are accountable to the Department of Justice. Also, we are in no doubt whatsoever that the president of the board is scrutinising every step that we take. With the board being an arm's-length body of the Executive Office, there is a line in there. Ultimately, of course, we are accountable to the victims of the Troubles, and we want to make sure that we deliver the scheme properly for them.

The Chairperson (Mr Storey): That is an appropriate note on which to end. At the centre of this are those who have been affected by the past and the actions that others took in our past. We want to ensure that they are kept at the centre of all that we do on this. We welcome, and we will take up your offer of, continuing engagement.

If there are further queries or questions, Brendan, we will undoubtedly come back to you as the local point of contact. I also thank Antony and Dr Faisal for taking the time to come over to Northern Ireland to be here today and for your presentations. Thank you for your attendance today.