

Public Accounts Committee

Oral evidence: Revising health assessments for disability benefits, HC 1337

Thursday 6 July 2023

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Public Accounts Committee Members present: Sir Geoffrey Clifton-Brown (Chair); Olivia Blake; Mr Jonathan Djanogly; Mrs Flick Drummond; Peter Grant; Anne Marie Morris.

Work and Pensions Committee Member present: Sir Stephen Timms, Chair.

Gareth Davies, Comptroller and Auditor General, Joshua Reddaway, Director, National Audit Office, and Marius Gallaher, Alternate Treasury Officer of Accounts, HM Treasury, were in attendance.

Questions 1 to 76

Witnesses

I: Peter Schofield CB, Permanent Secretary, Department for Work and Pensions; James Bolton, Senior Responsible Owner, Health Transformation Programme, Department for Work and Pensions; Katie Farrington, Director General, Disability, Health and Pensions, Department for Work and Pensions.

Written evidence from witnesses:

– [Add names of witnesses and hyperlink to submissions]

Report by the Comptroller and Auditor General

Transforming health assessments for disability benefits (HC 1512)

Examination of witnesses

Witnesses: Peter Schofield, James Bolton and Katie Farrington.

Chair: Welcome to the Public Accounts Committee on Thursday 6 July. This morning we are covering the very technical subject of transforming health assessments for disability benefits. In 2021-22, the Department for Work and Pensions spent £63.1 billion on a range of benefits to support people with a disability or health condition. In 2018, the Department announced plans to improve the way it manages the process of health assessments for disability and incapacity benefits, which it is implementing through its health transformation programme.

The Department aims to make the health assessment process simpler, more user-friendly, easier to navigate and more joined up for claimants, while delivering better value for money for the taxpayer. The transformation will cover around 3.9 million people currently receiving employment and support allowance, universal credit and personal independent payments, although the health transformation programme estimates that the numbers will rise from 4.8 million to 5.8 million in 2025-26.

Today, we will be taking an inquisitorial approach, questioning witnesses on the aims, risk management and measures of the success of the programme. Above all, we will want to examine whether this ambitious plan is realistic and deliverable. I am pleased to be able to welcome Peter Schofield, the permanent secretary at the Department for Work and Pensions—a regular at this Committee—and, for his debut, James Bolton, the senior responsible owner for the health transformation programme. James, I think you have been the SRO since the reset in 2019—is that correct?

Peter Schofield: Dr Bolton took over in 2019, after the reset. Details of the reset are set out in the Report.

Chair: Brilliant. Finally, Katie Farrington is the director general for disability, health and pensions at the Department. You are all very welcome indeed; thank you for coming. Before we go any further, I must ask members of the Committee whether they have any interests to declare.

Olivia Blake: I am chair of the all-party parliamentary group for SEND, and a vice-chair of the APPG on eating disorders and the APPG on ADHD—those are separate APPGs, to be clear.



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Chair: Thank you very much. Any other declarations? No. Thank you.

I also welcome this morning—we are very pleased to have him with us—Sir Stephen Timms, who as everybody knows is Chair of the Work and Pensions Committee. You are very welcome; we are very grateful to have you. Without any further ado, I will transfer to you for questioning.

Q1 **Sir Stephen Timms:** Thank you very much for welcoming me, Sir Geoffrey. I apologise for having to leave the meeting just before 11. Good morning, Peter, Katie and James. First, Peter, what difference will benefit claimants experience once this health assessment programme has been completed?

Peter Schofield: There is quite a lot of detail in the Report, but I can take the Committee through it. Stepping back, we are conscious of the fact that, as the Chair said, 4 million people rely on this benefit each and every day. It makes such a difference in enabling people to live independent lives and to live with their health conditions, but I have always wanted to make this system work better.

We will be seeking to do a number of things through this programme. For a start, one of the elements we are testing quite heavily at the moment through our health transformation area is the way we use case management, because so many customers find it confusing that they deal with lots of different organisations as they go from application through to assessment, and through to final decision. One of the things we are trying with the health transformation area is to have a case manager who gets in touch with the customer early on in the process, explains what the benefit involves and the process; then, as the application is considered, talks them through the evidence that might be appropriate, and at the end of the process explains the decision. That will be one really important element addressing some of the things I hear about when I talk to customers about the benefit.

Another thing we are working through at the moment and that we are seeking to roll out during the course of next year is an online application system: PIP apply online. It is working on small numbers of cases at the moment, but we will be rolling it out through next year. The PIP2 form is a 33-page form, and it is complex. We will not completely replace the paper version—those who want to use the paper version will still be able to use it— but the online system will enable people to be taken through the collection of evidence in a more intuitive way. It will also enable us, in time, to use the information from the assessment form to think about how we can tailor the service going forward. At the moment, the form is effectively scanned when it arrives, and it has to be read from start to finish, along with all the other evidence the assessor gets, whereas we are seeking to enable a bit of machine learning to support the whole process and to eventually pull the evidence together in a form that enables the assessor to make the decision more easily. Potentially, one of the things we are testing is the ability to use specialist assessors. That might help us to direct a claim to where it needs to go.



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There are two more things we are looking at. We are seeking to speed up the whole process from end to end. You will see in the Report that there is quite a range in customers' experiences. Often that is for good reason—some customers need more time to fill in the form or pull the evidence together; maybe they want to have time to have a family member with them when they fill in the application or some other support—but we want to get the overall time down from end to end.

The final thing is to place all we are doing with the health transformation programme into a wider set of reforms. You will have seen the White Paper on health and disability that was published in March. We know that a sizeable minority of customers on these benefits are not working but would like to work. We are seeking to help through the benefits system alongside everything else. We are thinking about occupational health with employers and the way that the NHS works to support people to move into work—if they have a health condition—to stay in work and to succeed in work. This is part of a wider set of reforms.

Q2 Sir Stephen Timms: I will pick up some of those points in a moment, if I may. I think this is probably a question for Katie. The contractors at the moment have the capacity, we understand, for an estimated 2 million assessments per year, but you think that we will be above that level of demand in a couple of years' time. How will you cope with that extra demand?

Peter Schofield: You are right that Katie should respond, but two things I would say are that we have seen this increasing, and the number of assessors that the assessment providers have been able to have since 2015 has almost doubled. Also during this time, we have seen the Scotland PIP cases being devolved and replaced in Scotland by the adult disability payment, so there is some reduction in numbers as a result. That said, there is a big increase in demand, and we are seeing that through the PIP system at the moment. Katie, do you want to add to that?

Katie Farrington: I can add a couple of things. You are right that at the moment, we are seeing about 2 million claims per year. The contracts procured volumes are based on our forecasts at that time, but we are constantly updating our forecasts; we do it every quarter. We have seen high demand, as Peter says. The contracts we have procured have the flexibility to increase volume. They also have the flexibility to pivot volume from one assessment to another if we are seeing more PIP claims than claims for the work capability assessment. The other thing we have done, which the Report sets out in some detail, is that where we have had high demand, we have chosen to focus on new claims in order to ensure that we get people the money they are entitled to, and we hold existing claims in payment until we have additional capacity to get to them.

Q3 Sir Stephen Timms: Are you confident that they will be able to get additional capacity when they need it? Are there people around that they can recruit to do this job?



Peter Schofield: I will not suggest anything other than that this is a challenge. It has been a challenge for the assessment providers. It is one of the reasons why, when we have looked at whether this is something that we would want to take in-house, we have always decided that it is better to be led by health providers who have this as an expertise. We actively manage the relationship with the health assessment providers, and they have responded. We have made changes to the way that the system works in order to facilitate their ability to recruit and retain health professionals. I cannot say anything other than that it is a constant challenge. We work with them to help them succeed. So far, they have managed to do that.

Q4 **Sir Stephen Timms:** There is a risk to quality if this does get more difficult in the next few years.

Peter Schofield: As the Report sets out, we have actively managed quality over the last few years and seen a big improvement in quality, but it is something that we have to keep a close eye on. We do not want them to recruit people who cannot deliver quality assessments. We are not seeing that at the moment, but we need to avoid it.

Q5 **Sir Stephen Timms:** You are aiming in the programme to both reduce the costs and improve the experience for claimants. Can you sum up for us how you think you can do both of those things at the same time?

Peter Schofield: A number of elements are set out in paragraph 2.15 of the Report. Dr Bolton can say a bit more about the detail, but there are several elements. One is that we are looking at whether more automated processes can take out the cost of scanning documents, reading documents, post and all that goes with that. There is a sizeable cost associated just with that. Introducing the PIP online system could improve that. As we improve the underlying systems behind that, it will make a difference. That is part of it.

We think that by being better at the decision making up front, we could reduce the effort involved in mandatory reconsiderations down the track, and that could be part of it. In the health transformation area, that is one of the things that we will be testing over a period of time to see whether that is something that we will see in reality. James, do you want to say a little bit more about some of the other elements to the benefits?

Q6 **Sir Stephen Timms:** Before that, on the distinction between the functional assessment service and the health assessment service, how will savings come from those two?

Peter Schofield: Okay. The ones that we have set out in the Report at paragraph 2.15, which come to about £1.3 billion, relate to the health assessment service. What we are also seeing is one of the things that we have done for the functional assessment service—an interim service that we are introducing from 2024 to 2029, which is basically very similar to what we do at the moment, but with one assessor in each geographic region doing both work capability assessments and health assessments for PIP. One of the things we are seeing is part of that.



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We have opened up the market. Instead of relying on the provider to bring their own IT in, we have bought the IT and we have seen as part of the bidding process for the contracts, which take effect from next year, new bidders coming in. There is more competitive tension in that contracting process, and that is part of the FAS business case. On the business case for the interim solution, that has made a bit of a difference there.

Q7 Sir Stephen Timms: You bought the IT for the whole country?

Peter Schofield: Previously, there were lots of different bits of computer infrastructure in the whole system. For the assessment bit of the process—for PIP specifically—Atos and Capita currently provide that service and the IT, and have been providing the service for many years. We were concerned that the fact that providers had to bring their own IT for that bit of the service would stop other bidders from coming in. We felt that by buying the IT and making it available to whoever bid, that would increase the competitive tension in the process, and we have seen new bidders come in—in fact, a new provider has been awarded the lot in the south-east of England.

Q8 Chair: Could I just ask you to clarify that? When a new provider comes in, Atos or Capita has to provide IT. Do the new bidders have to pay for that?

Peter Schofield: James, do you want to say a little bit about how it works?

James Bolton: Let me briefly explain the existing service. At the moment, the Department provides the IT service on which work capability assessments are done. That is a single provider across the entire country. The IT provider is Atos, and those assessments are currently delivered by Maximus. That is the process and system that we use now. As Peter has said, for personal independence payments, we currently have two separate providers across the country, Atos and Capita, who have each produced their own IT service. The Department has recently procured an IT system, similar to the work capability assessment one, that will do personal independence payments across the country. For this new set of contracts that are due to start next year, the Department said, "When you come in, we will give you a region. We will provide you with the IT, and then you are to provide the service using that IT." As Peter said, it has lowered the barriers to market entry and increased the competitive tension.

Peter Schofield: The numbers you see in here include the cost, for us, of paying for the FAS IT system. The providers do not pay for that, but we have had more providers who are willing to come and do the assessment, because they have not had to find the IT to do the PIP bit on their own.

Q9 Sir Stephen Timms: So you are going to get some savings from the functional assessment service, and then further savings when the health assessment service takes over. Is that right?

Peter Schofield: Yes. The savings seen in paragraph 2.15 of the Report are related to the strategic outline business case for the HAS service.

Q10 Sir Stephen Timms: What will the savings be from the interim FAS service?

Peter Schofield: Have we got those numbers, James?

James Bolton: Yes, though they are not in the National Audit Office Report. We have a separate business case, so we have done it in two parts. The first part, as we have highlighted, is reissuing these contracts. It is having single geographical lots and giving us the basis to go on and do the further transformation. That has a separate business case—separate from the programme business case—to allow us to build and continue the service. That will be finalised when we finish signing the contracts, so I don't think I am at liberty to put the information in the public domain today, but clearly we can share it with the Committee. The full business case will be finalised once we have all those contracts in place and we have signed it. That will go for approval, and we expect to save some money as a consequence of bringing the costs down.

Q11 Sir Stephen Timms: It would be helpful to see those figures if you are able to let us have them. At the moment, I do not think we know when the work capability assessment will be scrapped, as the White Paper proposes. I do not think we know how decisions are going to be made about benefit awards for people who are too ill to work, but who are not disabled or eligible for PIP, at least not under the current PIP eligibility criteria. Do you know how those decisions will be made, or is the policy still to be determined?

Peter Schofield: As you will be aware, those are policies set out in the White Paper, but the timing, particularly for the removal of the work capability assessment, relies on new primary legislation. We do not know the timetable for that, but we do know that it is the Government's intention to do that, so we have worked through how you can build flexibility into the programme going forward to enable us to manage that. The main impact of that will be to take significant volumes out of the assessment service requirement, but the way that we are probably going to implement this—obviously, this is subject to primary legislation—is to do this for new claims first and gradually roll that out. When you think about the management of the contracts and the assessment volumes going through the system, we can manage that effectively with providers with the flexibility that we already have built into the contracts between 2024 and 2029.

Q12 Sir Stephen Timms: When do you need certainty in order to achieve the programme timetable that you have set out so far? I suppose the question is: by when do you need that legislation to be in place?

Peter Schofield: There is a number of key milestones in the programme. Probably the main one that is relevant to that is around 2027. In 2027, we will be needing two things. We will need to have decided whether, beyond 2029, we want the assessments to be provided by an outsourced provider.



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We always have up until now, for the reasons I described earlier, but that is a decision that will need to be made. If we are going to outsource, we will need to articulate at that point what we want to buy, and set out the invitation to tender. That will then give us a year to run a procurement process, up until about 2028, and a year for a transition through to the new HAS contracts to run in 2029. That is probably the best way of describing the milestones.

Q13 Sir Stephen Timms: How will you convince claimants that the assessment decisions are right? As you know, there is lots of anxiety about this at the moment. How will this all help?

Peter Schofield: It goes back to what I was saying earlier, really. This is where I think case management will help quite a lot, going forward. As I say, it is something that we are testing, but so far it seems to work well. It is about actually having someone a customer can talk to who is the face of DWP. As you go through the process, you can explain to them up front what PIP is for and what sorts of condition it is there to support. Sometimes there is quite a lot of misunderstanding about the fact that it is a functional benefit related to your daily living and the support that you need, as opposed to being related to a particular medical diagnosis.

That is the first thing. The second thing is having someone who can help with the whole process of what evidence is relevant and can help you to upload and think about the right evidence as you go along. You get a sense that you have had the opportunity to tell everything that you need to tell to the assessment service—to DWP, if I can put it that way—to enable an accurate decision to be made.

Then there is the call at the end of the process. I was talking to some of the case managers in the health transformation area only this week about how that call sometimes goes, when you are phoning to say, “I’m sorry—actually the decision is that it is a nil award.” Customers would be disappointed by that, and obviously there will be the opportunity to appeal through a mandatory consideration and then ultimately to a tribunal if they want, but people appreciate the fact that they have been talked through it: “This is why the decision was made. These were the things that were taken into account.”

Obviously there is also the opportunity to say at various points, “Look, have we missed anything? Is there anything that we should be aware of?” I am conscious that some of our customers have fluctuating conditions. It may be that at the point they have the health assessment their symptoms are, happily, less severe, but there will be moments where the symptoms are worse and we need to take that into account. That is one of the things we are looking at in terms of health records as part of the assessment. We could come on to that.

Q14 Sir Stephen Timms: As you know, at the moment it is not unusual for people to read the report of their assessment and think, “This must be



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about somebody different. This doesn't bear any relation to what actually happened." The Work and Pensions Committee recently called for assessments to be recorded by default. That would provide a means to learn from errors and to correct them when they occur. All the contractors support that idea. Why has the Department rejected that recommendation?

Peter Schofield: I know that you have recently written to the Minister about that, and I think you have given the Minister until the end of the month to reply, so I should leave the Minister to reply to that. I know that your Committee has looked at this in a lot of detail and collected a lot of evidence. I should say, so the Public Accounts Committee is aware, that all the assessment providers allow and provide for assessments to be recorded, but it is on the basis that the customer asks for it, and actually relatively few customers ever do. I think the debate that you have been having with the Minister is whether it should be something that is an opt-out, so it is by default unless you say, "I really don't want to be recorded," or the other way around.

Q15 **Sir Stephen Timms:** I think Frank Field's Committee recommended the same thing and the Department said no. It seems to me that it would provide a mechanism for trying to understand what is going wrong with so many of these assessments at the moment. Does it worry you that 15% of PIP decisions that do not award the highest rate end up being overturned either on mandatory recommendation or on appeal? That seems a big proportion.

Peter Schofield: There are two things. I go back to what I said at the beginning: I would like part of this to involve us getting the decision right the first time more of the time, and spending more time up front to get the decision right the first time. Figure 8 in the Report is a rather good table. It has the numbers—I applaud the NAO for it.

Sir Stephen Timms: It is a kind of flowchart, isn't it?

Peter Schofield: Yes. Colleagues may have seen it.

Sir Stephen Timms: It looks quite complicated.

Peter Schofield: It does look quite complicated, but I found it very helpful as a way of illustrating the different routes that customers go through. Over a four-year period, out of just over 2 million cases, there were 84,000 that ultimately got through the DWP process, including mandatory reconsiderations, and then the answer was overturned on appeal at the very end. That is about 4%.

You are right that you have to add the cases in which we did not get the decision right the first time, but we caught it again in the mandatory reconsideration. Just so colleagues on the Committee are aware, if the customer receives a decision from DWP that they are not happy with, they have the opportunity to have another decision maker within DWP look at the case all over again. That is called a mandatory reconsideration. That picks up a number of cases in which the first decision was not right. When



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you add that on, you get to the 12% or 15%, depending on the denominator that the NAO Report has.

I am glad that we have these processes. I would like to get more decisions right the first time, but I am conscious of what the Report itself says about the fact that these are decisions in which there is inevitably a degree of judgment involved. This is not like an income replacement benefit, where you can look at what someone earned or did not earn and say, "Okay. There is a mathematical formula. This is what you are owed." It is not like the state pension where you can look at the national insurance contribution record and say, "This is what you are entitled to."

Take PIP, for example. You have to go through 12 specific descriptors. You have to understand the way in which a particular health condition or disability is affecting someone's daily living or mobility. I was with an assessor only the other day, and the whole assessment took 1 hour and 45 minutes. A huge amount of time went into it, but you can sometimes look at the same situation and take a different judgment. It is rarely because new evidence is provided late in the journey, but sometimes it is because the condition has fluctuated over time. Sometimes, when it comes to a tribunal, the case is put more clearly or the questions are answered in a different way, and you suddenly see the picture more clearly than earlier in the process when it was missed.

I do think that what we are trying to do with the health transformation areas is to do more to make it clearer up front what it is that customers need to be telling us, what we are looking for and what evidence is relevant to help us to get the decision right first time. But I do think it is good that there are opportunities to look again at the judgment, given that clearly there is a subjectivity to it.

- Q16 **Sir Stephen Timms:** There clearly must be. Finally, you made the point at the beginning that you hoped to reduce the time it takes to get a PIP assessment. Ideally, how long should it take? What would you like to get that period down to?

Peter Schofield: It has come down very considerably, from the peak in the pandemic to about 14 weeks—actually, in the latest data that we published for April it was 13 weeks, so it is coming down. I am giving you a slightly vague answer, in part because we are testing what is possible through the health transformation area. I am confident that the online application process will help, because until now we allowed a month for customers to return—

- Q17 **Sir Stephen Timms:** Can you get it down to eight?

Peter Schofield: We do in some cases.

- Q18 **Sir Stephen Timms:** It does vary hugely, doesn't it?

Peter Schofield: It does vary hugely. The things that we can control are the things that we can do once the application has come to us: speed up the assessment process, get the decisions made quickly, remove the use of paper and streamline things like that.



But you also have to give time for the customer to be able to do the things that the customer needs to do. Sometimes you have a customer with mental health conditions who, for whatever reason, misses the assessment, so we have to re-book that. Sometimes, quite understandably, you have a customer who wants to have someone with them when they fill in the application or when they have the assessment, but that person is not free at a particular moment. You could certainly get some of the applications down to eight weeks, but you would always have those customers for whom a longer journey is the right thing.

Q19 Sir Stephen Timms: It is down to 13. What would you like it to get down to?

Peter Schofield: I think I am not going to give you an answer, Sir Stephen, because it is something I want to do a bit more work on through the health transformation area. We are developing the outline business case for spring next year, and there should be more about it in there.

Q20 Anne Marie Morris: Can we take a little time to look at the transforming functional health assessments programme? What you have taken on is a very ambitious programme that will take 11 years and is effectively trying to balance external contractors, what you do in the Department and a huge amount of change, never mind your new IT projects. That is an awful lot to manage, so the Department will have to have a laser-like focus on that transformation, or else it is going to get sidetracked by the day to day.

How are you going to do that? Clearly there will always be the short-term pressures of the day to day, not least moving from the legacy contract that has been extended to the new, while at the same time managing this transformation process. How are you going to deal with that?

Peter Schofield: That is a very, very good question, because this is a challenging programme, as the NAO has set out. Indeed, I would say that we made a mistake early on in the programme, between 2018 and 2019, when we thought that we could try to do the transformation as part of the procurement of the new contracts. We realised—this goes to your point about what you can do in the day to day versus the transformation—that the procurement timetables simply would not allow that.

What we have done is what is implied, I suppose, by the obverse of your question: to separate out the day to day from the transformation for as long as we need to in order to get the transformation journey understood, optimised and ready to roll out.

Q21 Anne Marie Morris: How long will that be? How will you know when you do not need to, and how are you going to allocate resource? Moving people from focusing on this to focusing on that is difficult.

Peter Schofield: Exactly. Let me take you through some of the key milestones. From next year, when the existing contracts expire, we have the new functional assessment service. That is being delivered by a range of providers—some new, some existing—and those contracts are in the process of being let. I described that as similar to what we do at the

moment, but with the combination of the health assessment service and the work capability assessment provided by one provider rather than two in each geographical area.

- Q22 Anne Marie Morris:** Presumably you will also have the challenge that you have a different group of contractors—some the same, some different. There will be some cases on a legacy system for a contractor who is no longer one of your contractors, so you are going to have to deal with what happens to that particular claimant and their journey, given that their existing contractor is now out of the picture.

Peter Schofield: I imagine that the assessors move across on a sort of TUPE, so you have a lot of the same people moving across. We have talked about the IT systems and how they work already; that is in a good place and ready to go. We have de-risked the business-as-usual service between 2024 and 2029 with these new contracts, which are being let out as we speak. That is the first thing.

The second thing to say is that we then wanted to look at radical changes to the way we deliver, as I said in answer to Sir Stephen earlier. But we are doing that separately, in a kind of sealed set of transformation areas. There are two of them at the moment, and specific postcodes in London and Birmingham are being referred to that different way of doing things, just a few at a time.

We are trying new ways of doing things, trying out the case management route, and trying out the approach of having the health assessor and case manager working together in the same place. That means that where the case manager who is making the decision has a question, they can often go over to the next-door desk and say, "You did the assessment for this person. I'm a little confused by this. Can you explain this? Can we talk through this particular condition?", or whatever is required. When you do these things in a small place and on a small scale, you can try lots of different things, and as we do that, we have an evaluation strategy to enable us to work out, as we are trying different things, what is working and what isn't.

By 2026, we need to be ready to scale that up to about 20% of the country. With the contracts we have with the interim providers, we have allowed space for us to try what we will have learned through our health transformation areas. We will have the space to be able to try that out on a bigger scale, to give us the confidence to be able by 2027, if we decide to contract out, to set out the invitation to tender to describe the new service, which will then be operational from 2029.

So for at least 80% of the country, not a lot will change between now and 2029, other than the things I was describing to Sir Stephen. But in the meantime, separately, we are trying out a radically different way of doing this, to give us confidence that we can roll that out across the country from 2029 onwards.

- Q23 Anne Marie Morris:** I love IT, but it usually goes wrong. You say that



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you now have a standard that should, in theory, make life easier because all the contractors are going to use the same system, and you are in the process of letting. When you actually have let contracts, have you done some sort of risk analysis as to whether that is going to be seamless? What steps can you put in place so that when the IT for one provider does not work for some reason or there is a glitch, you have a way of getting in there and fixing it?

Peter Schofield: I like IT as well, but I have talked to this Committee before about the huge scale of digital work within DWP across the board and the transformations that we are doing elsewhere as well, which are heavily reliant on digital change and data. To reassure you, hopefully, the bit of IT that we are buying now for 2024 to 2029 is something that is already being run—used—by one of the contractors, so we know it works. We are just owning it to enable new providers coming in not to need their own IT; they can come in and take what already works.

Q24 **Anne Marie Morris:** If one contractor's IT system goes down, is there any mechanism so that DWP can provide some sort of cross-support? It is your system, effectively, that you are asking them to use, so you have control of it. If for some reason, for one contractor, the system goes down and you have a lot of claimants and cannot process anything, is there a mechanism, given that the same system is being used across all the contractors, to try to—

Peter Schofield: Is there resilience to rely on each other?

Anne Marie Morris: Yes.

Peter Schofield: James, do you want to come in?

James Bolton: Sure. For work capability assessments, it is obviously a system and service we have been running for some time now. Atos are providing that IT for us. The Department is acting as the integrator, which is one of the challenges the NAO set out for us—I think it is the third in its list—so we are very alive to this issue. In the IT contract, as with any IT contract, we have standards about how long we expect the service to be up and how quickly we get back on top of things if it goes down. As I say, the service has been up and running for years now, so we would expect the service to come back online very quickly should there be any outage.

Peter Schofield: For most of our systems across DWP, there is a lot of failsafe support to move across—if something goes down, you have a back-up—and we would run that system. In everything that we run, we have those back-up systems.

Q25 **Anne Marie Morris:** Let us move to what I describe as your sandbox. Effectively, you have this fascinating place where you have locked your team in and they are going to do nothing but look at transformation. That is going to be really challenging, because success will depend on whether you ask the right questions and pick the right data so that by the time you get to the 80%, or whatever it is, you have a realistic picture of how this is going to roll out.



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You have started out with London and Birmingham. What made you believe that those particular postcodes were right, were relevant and gave you the variety that you are going to need to deal with across the country, to give you at least a first indication as to whether the new sandbox ideas are going to work?

Peter Schofield: James might want to come in and talk about why it was those two sites. They are examples; they give us the opportunity to try out different ways of working, but that will not be enough. That is why we need to scale up after 2026 and do this elsewhere. That will give us more of a representative sample.

I am not going to pretend that we have a representative sample just in these postcodes in north-west London and Handsworth in Birmingham. We are trying to work out a radical new way of working by having case managers and health assessors together in the same room. That is a much more joined-up approach to how we operate. We are thinking from first principles about the whole process, from applying and assessment to decision and telling the claimant what the outcome is. We are looking at whether there is an improved way of streamlining that whole process. That is what we are trying out, and we are already seeing very promising results. James, do you want to say a bit about why it was those two sites?

James Bolton: Very briefly. Before the programme, the Department had always had a couple of in-house sites in Birmingham and London. We took the opportunity to take those on board, expand them and use them as the transformation area to begin with. As Peter highlights, we will need to get a wider range. On your question about the range of customers and whether we have tested it, an important part of the service will be that scaling. We will try it in a number of different areas and make sure that as part of our evaluation strategy we are taking a wide range of customer types from across the country.

Q26 **Mrs Drummond:** I just want to ask about the dates in figure 10. You said that it would be 20% by 2026, but your figures say 2025. I just want to query that. You are still talking about 2029 but, from what you were saying, you seem to be slipping already. I assume these figures are right; I am looking at page 35. You said that 20% of new claimants would be processed by 2025, but you mentioned a minute ago that it would be 2026. You might be able to catch up before 2029, but—

Peter Schofield: By 2027, I need to be able to articulate what the requirements of the invitation to contract to tender are going to be. Working back from that, I need to have got to a point at least by 2026 where I have scaled up across the country. We need to work back from that. We will scale it up as soon as we possibly can. I should just double-check with James that I am not misinterpreting the difference between 2025 and 2026.

James Bolton: No, that's right.

Peter Schofield: We will do it as soon as we can, but we have to be doing it by 2026 in order to meet the 2027 date.



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Mrs Drummond: You say 100% by 2026, but a minute ago you said it was only 20%. I just want to clarify that.

Peter Schofield: Under the existing contracts, we will only ever get to 20% scaling up, and we need to have done that by 2026. In the new contracts, we only get to 100% after 2029.

Joshua Reddaway: Sorry, it should say 100% of new claimants.

Mrs Drummond: So by 2026 it should be 100% of new claimants. Thank you; I just wanted to clarify that.

Q27 **Chair:** Could I ask an associated question, Mr Schofield? I think I heard you say much earlier in the hearing that you still have to decide whether by 2027 you want to bring the thing in-house, or whether you want to continue with the outsourcing. Given that you will have done all this work, and given the problems you outlined earlier of getting the number of health assessors and everything else, is it conceivable that you will ever want to bring it back in-house, or is that just to keep pressure on the contractors?

Peter Schofield: Oh, I couldn't admit that in a hearing. I am conscious that I always need to keep that as an option. You are right that the reasons why I have not done it up until now are still likely to be around in 2027, but it always needs to be an option. In theory, transformation is easier if you have control over everything and you don't have a contract between you and the delivery of the service. We have had to weigh that up, and we have always weighed it up in a way that has suggested that the assessments need to be delivered through outsourced providers, and that that is the best way to do it, given the risks I described. We have a programme that allows for that and works around these key commercial timetables, but allows us, as Ms Morris was saying, to develop, separately and entirely in-house—in a sandbox, as it were—that transformed service. That would give us confidence to roll that out across the country, when we are ready, through a new set of outsourced contracts, which would go to tender in 2027, so that there could be transformation from 2029.

Q28 **Chair:** I hope I am not mis-portraying the situation, but there is a slight fuzziness over the dates. Perhaps this is a question for Dr Bolton; I do not know. This Committee has known of numerous transformation programmes where the existing contractor was both the legacy contractor and a new contractor. How will you keep the contractor to their obligations on the legacy system—in other words, get these assessments through in a timely manner, and not just let them drift while awaiting the new system?

Peter Schofield: We have a very effective contract management team, which is separate from Dr Bolton's team. It runs the business-as-usual contract management of our health assessors. They are very active. They sample some of the reports; they check on quality. You will see from the Report—I think in figure 4—the way that quality has improved as we have become more active in the way we have managed those contracts. That contract management team will be there, I can assure the Committee,



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working away and driving high-quality performance and speedy turnaround throughout this process up until 2029, when these new contracts come to an end.

Chair: Thank you. That is very helpful.

- Q29 **Anne Marie Morris:** Given that this is will be a process of growth—you will move from, first, London and Birmingham, towards '26—and you have a significant number of cases going through this sandbox, which has become rather more than a sandbox, how will you work out which postcodes to bring in when? How will you assess, given the lessons you will have learned from the first chunk, which ones you need to bring in? What are the complexities you have not yet looked at? If you are to grow this, it will need to be in a thoughtful way; you cannot just add the postcode next door. My supplementary question is: how will you ensure that those claimants in the sandbox—you will have real data; they are real people and real cases—still get a good service, given that they are subject to a trial?

Peter Schofield: James might want to talk through exactly how we are doing that. I would add to your list—if that is all right—the constant challenge of monitoring whether we are delivering the improved service, day in, day out, for these new claimants in the sandbox to ensure that we are on track to deliver the business case.

This is not something that is new to the Department—rolling out a new, transformed service. After all, that is what we had to do with universal credit; we started out in a jobcentre in, I think—it was before my time—Sutton. We were trying out lots of different ways of working in one jobcentre, then we rolled it out to a number of other jobcentres in south London. Then we picked other places. We were scaling up; from 2017 onwards, we were doing 50 jobcentres or more a month, when we had optimised the service.

We are doing something similar even now in our “move to UC” programme, which looks at how we lift legacy customers. We started out in Bolton, and we moved to other areas. Again, we were trying to ensure that what we find is representative of the issues that different types of customers may face. It is hopefully reassuring that this is something the Department has done before successfully, and it is learning from that. James, do you want to say a little about how you intend to scale from 2% to 20%, which I think is the question Ms Morris asked?

James Bolton: I am very happy to. There are a couple of elements to that. First, we will be awarding contracts later this year. Then we will need to work with the providers on what the best areas are. The programme has a substantial research and evaluation team as well. A really important part of their role will be working to tell us what their requirements are, how we get a representative sample, what size it needs to be, what areas of the country it needs to cover, and whether we can assure ourselves that the information that we get from it will give us the answers that we need.



A combination of those two things will be ready for when we start to expand, as we go into next year and the new contracts are in place.

- Q30 **Anne Marie Morris:** What is there to help the guinea pig clients—if I can call them that—in the sandbox, so that if something is not working, somebody picks it up and resolves the issue, and the claimant in the sandbox does not end up disadvantaged?

Peter Schofield: In the early stages, when there are relatively few customers being supported in this way, there is a lot of support around. A lot of very senior folk are looking at each and every case as it comes through. As there is active management through a case manager, in a way that we don't have through the BAU system, we are able to pick up and address issues quickly. The whole point of this is to learn from what is going on and what works, but also learn very quickly if something is not working, so that we can put it right. There is a huge amount of oversight, case by case, to enable us to pick up on the things that are going well, but also anything that is going wrong. James, is there anything you want to add?

James Bolton: Very briefly, the National Audit Office called this out as one of its challenges—challenge 6. Paragraph 22 highlights that “DWP told us it has a very low tolerance for allowing different outcomes and tests a sample of decisions”. We are being very careful with all the customers that come through, as Peter highlighted, to ensure that we are applying the legislation in a consistent way, that we are providing the same standard of service, and that our outcomes are the right outcomes for those customers.

- Q31 **Anne Marie Morris:** That is helpful. In the end, this will have to be a programme that is picked up and run under the new HAS, rather than FAS. You will need to take contractors on the journey, albeit that you do not know whether they will be the ones to whom you let the contract. They will be able to take in some learning under the new FAS, which is not quite the same as what is going on in the sandbox, but there needs to be some mutuality and sharing of experiences; otherwise, you might lose some of the mutual learning, and make it more difficult to jump between FAS and HAS.

Peter Schofield: Exactly. Obviously, this requires a partnership approach. A lot of this is about the relationships at work in the contract. There is a contract between us and the provider, but there is flexibility in there. The NAO has suggested, and we are looking at, how we can build in incentives to support that, which I think is a really good suggestion.

So much of this is around the relationships, and how we manage them locally and nationally with our contractors. They will want to be part of the future. They will want to be able to demonstrate that they have understood the way the optimised system is working, to give them success in the contract awards for 2029. There is an incentive for them in that. A lot of this is around how we manage through existing contracts, taking on

board some of the suggestions from the NAO on things like incentives. James, is there anything you want to add to that?

James Bolton: No, I think that is absolutely right, Peter.

Q32 **Anne Marie Morris:** Let's move on to how you will measure the benefits. You have some KPIs and metrics. Do you feel that they are adequate to ensure that you get the time and cost reductions, and the increase in satisfaction? I think there are some question marks in the NAO Report as to whether what you have is fit for purpose. How will you do that? Will you improve, and try to embellish, your KPIs and metrics? How will you ensure that this is fit for purpose, and that we do not land up with what happened between 2018 and 2019, when you suddenly realised you were going in the wrong direction? That was quite an expensive deviation.

Peter Schofield: It's a good point. First, we published our evaluation strategy in May. We wanted to be very open about how we are doing that and the approach we are taking. As you say, figure 13 in the Report on page 43 sets out the sorts of key performance indicators that we are looking for. You will see that of the nine areas, there is one where we have not yet identified the right data to collect. That is for "Customer query resolved at first contact", which, for the reasons I described in the earlier conversation, is an important part of knowing that this customer journey is improving. I have really been quite open about the fact that we need that, but we have not yet resolved exactly where that data is coming from and how we draw that together. We have time, but this is something we know we need to do.

The second element is this: we have the data, but are we clear about which metric really matters and needs to be monitored as we go along? There is the area that I just talked about, where we do not have the data, and two areas where we have the data but are not yet fully decided on exactly what the right metric is. Again, we have time, but not a lot of time, to get this right. That relates to our evaluation strategy and how, over the course of the next three years, we monitor the way that the health transformation area is working and whether it is genuinely reducing customer journey times effectively. Is it genuinely resolving issues at first contact? As we try different things, how do we quickly identify, "This one worked. Right, let's bake it into the long-term system," or "This one we've tried, and it didn't work"?

To give you a very specific example, a great question is: when is the best time for the case manager to get involved in a case? When someone first applies? Further down the track, after an assessor has first had a look? Obviously there is a balance to be struck here on the additional cost. The more involved a case manager gets earlier on in the process, the more costly it is; we would need more case managers for any number of cases, but it may give more assurance to the customer up front. It may help the customer provide the right sort of evidence earlier. It might make the decision better. It is a matter of trying different ways of applying case management in practice. This is quite detailed, but I want to give you a sense of the sophisticated way we have to go about making a decision



about, "Okay, the optimised experience for a customer is this, and it looks like this. We know this is the best balance between outcomes and costs, and that it is something we can scale up." Does that help?

- Q33 **Anne Marie Morris:** It is helpful, but what you are talking to me about is improving the process—I totally get that. You need to be measuring outcomes, not just outputs and processes. My concern is that these KPIs and the metrics do not really encapsulate outcome, with the outputs, if you like, then linked to those outcomes.

The other thing I found confusing about figure 13, but it may just be the way it has been presented, is that there are some key things you want to do. You want to keep the cost down. If you had the KPIs, with maybe some of the outputs, and then the outcome under that bucket, that would have been helpful. Likewise, when it comes to improvement in customer satisfaction and journey, there are all sorts of outputs, but the outcome measure is not there. There are about three different buckets of things that you want to achieve. Like that, I would have found it much easier to understand, and would feel that I could hold you to account for delivering the change in a way that will really deliver the outcome that you want. Is that something you might review, if it is not entirely baked?

Peter Schofield: No, because the business case is due to be finished in spring 2024. At that point, we will publish it with my accounting officer assessment. I think you are right about how we link some of these input/output metrics with outcomes. Going back to the objectives that we talked about at the beginning of the hearing, at the heart of this is making a difference in outcomes for individuals' lives, making the right decision first time, increasing trust and understanding of the process, and helping more people into work, as well as reducing the cost of delivering the assessment.

- Q34 **Anne Marie Morris:** My final question is about transparency, business cases and the accounting officer assessment. I appreciate that you live in a complex world. There are a number of business cases that need to be put forward for the whole programme and for individual bits of the programme, and then the accounting officer assessment is clearly mission-critical. Given that the programme is such a big part of the GMPP, I would have thought that there must have been an accounting officer assessment some while ago, before it was ever entered as one of the main projects. Why is it that we still haven't seen, as a matter of transparency and openness, what the criteria are, so we can help you as a critical friend to get this right, and so we can see that the very substantial sums of money are being well spent?

Peter Schofield: There is a very specific technical answer to your question, which is that the guidance from the Treasury was changed in March to say that accounting officer assessments for GMPP programmes should be published at the earliest decision-making process. Up until now, it had been at the point of the outline business case. We are all on track for the outline business case to be published this coming spring, and the accounting officer assessment related to that will be published at the same



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time. That is what we are set to do, and that is based on the guidance that applied at the time. I am sorry that, as you say, it is a complex world.

We have sought to be transparent throughout. My annual report and accounts were published today. It is a thick document, and it is as detailed as ever on this programme along with all our other major programmes. Every year, the Infrastructure and Projects Authority publishes its annual review, which includes this programme. There have also been written ministerial statements at various points throughout the process. We have sought to be as transparent as possible. Given all the change that you see reflected here, and I think the NAO Report is also a good exercise in explaining what we are doing at the current point, the right thing to do is move forward and do the outline business case for next spring with the accounting officer assessment. I am sure you will have me back to talk more about that.

Anne Marie Morris: You're right.

Q35 **Chair:** We will—you can be assured of that.

Mr Schofield, I am going to bring in Mr Grant in a minute, but your answer on the role of the assessor and the caseworker set me thinking about how the process was going to work. You may not be aware of this but to give you an example, we had a hearing on the DVLA. What we found was that people were applying perfectly satisfactorily online, but once it came to complex medical questions, they were going back to a paper-based system. You said earlier that you wanted to use AI and so on to try to streamline the process. How will you ensure that you are able to communicate with other Government Departments to be able to do that?

Peter Schofield: The starting point is to make better use of our own data, to be honest. The particular issue I was describing was the fact that at the moment, an applicant will provide a huge amount of evidence, but it will all be paper-based. Even if it comes in online, it will be scanned. It will be effectively a picture that we can look at, not characters that we can recognise and do something with. So the starting point is to make better use of the data that comes to us anyway, which will enable us to give the more tailored service that I was describing to Sir Stephen.

We are particularly thinking about how to draw out evidence from a whole load of different sources. You could have evidence from GPs or from other types of health assessments that aren't necessarily part of the process, but it is all very relevant and can help us to make the decision. So we are thinking about how to draw all of that together in a sensible way, potentially using AI. We don't know how that would operate in practice, but it could be used to help structure the evidence in a way that helps the assessor get quickly to the points that really matter for the decision that is being made. That is the particular point I was making, but you are right; there is a huge opportunity and we are looking at that across the whole of DWP.



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There is a huge opportunity to work more closely with other parts of Government and use data from different sources to improve the way we deliver services. A classic example, which the Committee will be aware of, is working with HMRC on earnings data and universal credit. Every month, the HMRC feed will tell DWP how much someone in employment has earned if they are on universal credit. We can then calculate from that how much universal credit they are entitled to. It all happens automatically and payment goes straight out the door. And that is a great example of where it can work well. We need to learn from that and do more.

Obviously, different Departments have different systems. There are all sorts of issues related to that around things like security and compatibility. But you can imagine that the Cabinet Office are holding our feet to the fire in terms of helping us to look at how we join up more effectively all across the civil service to deliver better services to customers.

Q36 Peter Grant: I apologise to the witnesses for missing the start of the session; I was needed in the Chamber earlier on. Mr Schofield, given the difficulties that you have described in having to deal with all these different contractors, why have you outsourced it? Why didn't you just bring the whole thing in-house?

Peter Schofield: This was a point we discussed a bit earlier. This is something that we review; we review it very carefully on a regular basis. There is actually a Cabinet Office tool called a delivery model assessment, which we use to help us to work this through, so it is quite a structured process. The result of that assessment—James may want to say a bit more about this in a minute—was that the risks were too great for us to try to do this in-house and to manage this alongside everything else that we do. If you think about the challenge of, as the Report says, sometimes 2 million assessments a year, it is a huge operational challenge. As the Report also says, at the heart of the challenge is recruiting and retaining healthcare professionals. Our assessment was that we would find that difficult to do in the context of things like civil service pay and pay structures, and things like being able to offer a career path and a career plan for people coming in, encouraging them to think that this is something that they would want to do, and motivating people. That is just not a skillset—that recruitment, retention, management skillset—that we have.

Q37 Peter Grant: So how come Social Security Scotland have been able to do it? They have insourced all their assessments. What is it that they are doing right that is beyond the DWP?

Peter Schofield: As you say, they are doing that and we work very closely with them as cases have moved from PIP to the adult disability payment. As I say, we work closely with them. We will see how they get on.

As I said earlier, I am not saying we would never do it, because it is always something that we need to keep open as an option. But we think



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there are big challenges. If Social Security Scotland are successful, and I wish them well and I'll do everything I can to support them, and if they find a way of doing this that I haven't really thought about—obviously, they are on a smaller scale than we are—that is something that we need to learn from.

- Q38 **Peter Grant:** You referred earlier to figure 4 on page 23 of the NAO Report, which shows the percentage of health assessment reports that were graded as unacceptable from 2015 to 2022. You described it as showing an improvement in performance. It is the case, though, isn't it, that that graph is based on how good or bad the report was? It doesn't tell us anything about how good or bad the underlying assessment and decision making was, does it?

Peter Schofield: I might bring Katie in on this, because we are doing a lot of work here. This is based on the sampling that I was talking about a little bit earlier and this has shown the impact of very effective contract management, I would say, because it tells a very good story. Katie may want to say more about that.

Related to that, and getting to the heart of your question, Mr Grant, is the quality of decision making. I don't know whether you were in the meeting when we were talking about figure 8 and what that tells us about decision making down the track. Katie, do you want to say a little bit about the work we are doing with contractors to improve quality across the piece?

Katie Farrington: You are quite right that figure 4 in the Report shows the way we audit the quality of reports, and what it shows is a trajectory over time, where we have seen consistent improvement and also lessening of variation between the different contractors. That is just one piece of data that reflects some of the ways in which we are working with our providers.

There are other information points. This report also gives us our customer satisfaction data. We look at that for the different benefit lines, and the Government—the Cabinet Office rather than the DWP—publish KPIs for the PIP contracts, looking at customer satisfaction scores for both providers who supply the PIP contract, and they are both rated as good. So we have seen improvement—there is an improving trajectory—but, as Peter says, this is just one bit of data.

- Q39 **Peter Grant:** You say that information is published. If I want to look at an assessment of the accuracy of the decision making by each of your private contractors, where can I get that information?

Katie Farrington: We don't publish that data.

- Q40 **Peter Grant:** Why not?

Peter Schofield: We have data in figure 8: if you want to know about accuracy—the proportion we get right first time, second time, third time—it tells you that. That is what we have here, and it is very consistent across the providers. The top right number in figure 8 shows the decisions, after having come to DWP first decision and DWP second decision, that



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then get overturned and appealed. Over a four-year period, that works out at 84,000 out of 2 million, which is about 4%.

- Q41 **Peter Grant:** I am sure most MPs and a lot of members of the public would be interested to see how often each of the private contractors, which are paid taxpayer money to take these decisions, gets it right first time.

Peter Schofield: Sorry, but I need to be clear about this. The contractor does not make the decision; the decision is made by DWP. The contractor produces an assessment report, the quality of which is graded in the way Katie has described.

- Q42 **Peter Grant:** Do you assess how often the decision has to be overturned at a later stage because it emerges that what the contractor put in the report was not accurate?

Before the hearing, our Committee Chair, Dame Meg Hillier, wrote to all MPs asking if there were any cases they wanted to raise. I have one from my constituency neighbour, Wendy Chamberlain. She had a case where an assessment report contained significant factual inaccuracies but it was difficult to persuade DWP that they were inaccurate. Several months later, the decision was overturned, but Wendy Chamberlain's constituent was owed over £3,000 in arrears. Had the decision not been overturned, they would have been losing £150 per week in benefits that they were entitled to.

When the contractors get these assessments wrong, it is seriously damaging to the interests of the people we are supposed to be looking after, so why aren't you publishing more detailed information so that members of the public who are declined—and who all too often are the victims of these contractors—can see which contractors are delivering and which are not?

Peter Schofield: First of all, I am so sorry to hear about that case. I am glad it was resolved in the end.

The quality measure is a measure of all the things you described. Ultimately, the decision is made by a decision maker within DWP. We are trying as part of the health transformation programme to improve the way we bring those two together, and I have seen that in one of our health transformation areas, as I was describing to the Committee earlier: bringing together the health assessor and the decision maker—the case manager—in the same team and the same place enables us to be much better in making sure there is effective understanding about the nature of the issue, the nature of the circumstance for the individual, and how that plays out in their daily life and their mobility and what the right decision is—in awarding PIP, say, in that particular case. All the issues you describe are captured by the quality data published in this report.

- Q43 **Peter Grant:** What do you think is the explanation for the fact that, as far as I can see, Social Security Scotland outperforms the DWP on every single measure of service user satisfaction? The civil service people survey 2022 asked people working in the organisation what they actually



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thought about it. On every single measure, staff working for Social Security Scotland gave a markedly, and sometimes spectacularly, more positive view of their organisation than those working for you at DWP. We should bear in mind that these are often exactly the same people who transferred over recently. In some areas, employee engagement is up from 60% to 78%, while the outcome for leadership and managing change is up from less than 50% in DWP to over two thirds in Social Security Scotland. How do you explain such a dramatic difference when it is the same people performing more or less the same service for the same members of the public? What is different about what they are doing in Scotland?

Peter Schofield: We both have the same mission and we are working together. As I said earlier, I have a very good relationship with colleagues in Scotland. We work closely with them and with the team in Social Security Scotland. They are doing things differently, and we want to learn from that. If it plays out in better outcomes for customers, we need to learn from it. They are trying different things, as we are in our health transformation areas. I have not measured staff satisfaction in the health transformation areas, but the team I have met there feel very motivated about what they are doing and the opportunity to do things differently. We often see that with new teams who are doing things in a different way and are able to see the way they work impacting for the benefit of customers; we see an improvement there. And that is exactly the sense of mission I want to bring across to the whole DWP. That is why this programme is so important for me and for all of us, from a leadership perspective. We know we have to improve, we want to improve, the way this service works, and we are on a journey.

Q44 **Peter Grant:** I will ask one final question, if I may. In the discussions that I know you have with your counterparts at Social Security Scotland, are they telling you the same as they are telling Ministers in the Scottish Parliament and MPs in Scotland, which is that they are struck by how often people who transfer to them from DWP are remarking within days what a refreshing change it is to be working in an organisation where nobody is in any doubt whatsoever that they are there to service the public? A lot of them did not feel that that was the message they were being given while working for the DWP. Are colleagues in Social Security Scotland telling you that in the same way as they are telling MPs and MSPs?

Peter Schofield: To be honest, I have not heard them say that to me, but if they are saying that, I will ask them a bit more about what they are doing. I know, when it comes to our teams in Scotland within the DWP, we have fabulous inspirational leaders in Scotland who are leading our teams, and people feel incredibly motivated there. But we want everyone to feel motivated in what they do and to feel that connection to purpose, because what we do really matters. We know that. What we do can change lives for good. Just as we lead out our teams and think about how we are changing the organisation for the future, so we need to be helping each of us to achieve our potential, as an organisation and as individuals, with the skills

and capabilities we need. It is part of an overall civil service modernisation agenda that is being led out across the whole civil service.

Chair: Thank you, Mr Grant. Olivia Blake, you have been very patient; thank you.

Q45 **Olivia Blake:** Thank you, Chair. I would just like to go into a bit more detail about the challenges on implementation. My first question is to Dr Bolton. How will you continue to manage the programme and what differences there will be in that management now that you have established the test areas and need to get on with testing?

Peter Schofield: James, do you want to come in? What I would say is that this programme is going through an evolution over time. Dr Bolton came in in 2019 as part of a refreshed leadership team. The governance of the programme board itself is changing over time as well, and will need to in order to reflect the changing challenges that you are describing. James, do you want to say a bit more about how we are running the programme and how that is evolving?

James Bolton: Absolutely. I am very happy to; thank you. We talked earlier about outcomes. The programme has five big strategic outcomes. We want to improve trust. We want to be more efficient. We want to help our customers to find employment support where that is relevant to them. We want to improve the experience that they are having, which includes things like journey time, which we have talked about. We have talked also a lot about data. Those are our big five strategic outcomes.

In terms of what will be different at different points, the NAO, in paragraph 13 of their Report, have three different phases. We have touched on this already today, but the first phase, which goes into next year, will see the new providers that have that single geographic contract. We have talked about the online application for PIP service that we are bringing in. And we are going to start to gather data and use that in different ways—again, as we have touched on.

To your question, you have talked a lot about what the second stage—phase two, as the NAO calls it—talks about. We are going to see a number of changes over that period of time, all the way up to 2029. We are going to see the Department move its existing service so that we are starting to use the service that we are building across the Department. We will see customers being orientated to PIP Apply. We have done some research with customers around whether it would be useful, as they are applying for PIP, just to understand the entitlement criteria. We have been working with them to see what the best way is to show them this information and playing that back to them.

As I said, we want the online channel across the country. We want to begin tailoring journeys. We have touched on this a little bit already today, regarding how we make sure that the customers receive the right support at the right time, the challenges that we see with different customers and making sure they get the support they need, and all of that.



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A really important part of this, which we will be building over the next stage, will be around just making sure that it is much more transparent. Again, we touched on trust and how you build trust in a Department and a service. I think one of the really important parts of that will be transparency.

- Q46 **Olivia Blake:** Okay. Just going back to the testing part of the programme, if there has not been sufficient testing and you do not have enough data, will you continue to roll out the HAS or will you delay if you do not have the base?

James Bolton: Inevitably, we need to keep the service safe and we will only expand at a rate that is safe. We have talked about the health transformation areas and where we are now, and being ready to move those into the provider. We have a set of exit criteria—a number of things that we want to be ready before we start to do that.

Having done that—again, we talked about 20%, but it is actually up to 20%. The programme has always been very clear. We will do enough through the evaluation and understand what we need to do. But again we have different exit points. We are being very clear within the programme on what needs to be ready, what quality needs to be like, what sort of service we are providing to our providers, and we will not continue to expand the service unless it is safe to do so and it meets our exit criteria.

- Q47 **Olivia Blake:** Ms Farrington, if the testing produces things that you were not expecting or things that were not what you wanted to see, what will you do in that circumstance?

Peter Schofield: Shall I come in first? It may be one for Dr Bolton as well.

This is about trying to develop a transformed service that, as James says, is safe, and will deliver and be effective at what we want it to do. The rate at which we roll it out will be determined by how successfully we progress through the health transformation areas.

We have set out in the strategic outline business case what we think we could achieve, but it will only be in the outline business case that we will set out a bit more detail about those benefits and what we think we will get to.

Ultimately, if there is a limit to how much transformation we can deliver, then we will issue the contracts for 2029 based on what we know we can deliver. If transformation is not successful to the degree we want, then we will issue contracts that have less transformation in.

We know we can issue contracts that can deliver the service; the question is how much improvement we can deliver and set out that we are confident we can deliver in time for 2027.

- Q48 **Olivia Blake:** I guess it does not necessarily have to be a negative. What if there are more positives to the testing? How would you ramp it up, so



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that people are not experiencing a bad service compared with a much improved one?

Peter Schofield: That is a good point. I hope that we are in that circumstance; it will be great if we are.

It is one of the limitations in the contract for the interim period between 2024 and 2029. We have negotiated the space to be able to offer the transformed service to the maximum of 20%—I think that is right. So it is capped out at 20% without some contractual change between now and 2029.

Q49 **Olivia Blake:** Would that be fair to people going through it and how would you manage the challenge from anyone who was going through one system when you have evidence that the other system is much more beneficial?

Peter Schofield: This comes back to the whole point about how you ensure consistency in outcomes between the two systems and it is a point brought out very clearly in the NAO Report. As the NAO Report says and as Dr Bolton said a bit earlier, we have very, very low tolerance for inconsistency between the two services. And as I said in my answer to Sir Geoffrey, in the way that we currently manage really effectively the performance of the contractors, we will do the same for both the contractors and understanding the outcomes from our health transformation areas, to make sure that we can identify any inconsistency that is developing and really clamp down on it, and avoid a difference in outcomes. Obviously, we want the experience in the health transformation area to be better, but a difference in outcomes is not something that we can tolerate, really.

Olivia Blake: Ms Farrington, do you have anything to add?

Katie Farrington: Just to add to what Peter has said, the assessments that we are delivering are the same ones whether we are delivering them in FAS or in HAS. They are on the same legal basis, they are under the same clinical standards and we are under the same oversight.

At the moment, in our transformation area, when we have made a decision in-house, we then check it with our decision makers who work on the BAU service. So we are very confident that we have consistency there. To the point you are making—whether we can allow learning to move in both directions—I think we absolutely would like to make sure that happens.

Q50 **Olivia Blake:** Moving on—I am on my first set of questions—Dr Bolton, how clear are you about what each stage will look like for the health assessment service over its development? We have talked about the different stages, so I just wondered whether you could be a bit clearer about what you are expecting it to look like at this stage.

Peter Schofield: James, do you want to go through the key milestones that we talked about?



James Bolton: Absolutely. We talked earlier about the phases in NAO Report paragraph 2.10. There are three quite big phases there. In the programme, we have quite a lot more detail behind that, as you might imagine, and we recognise and are working to a number of different key phases.

At the moment, there are five main ones. The one that we are in at the moment we are calling building the foundations. That is these new contracts that I have talked about, and making PIP available online, which is something that our customers told us was a real priority for them, so we brought it in early and are making sure that that is national, rather than just contained within the programme.

Our second phase, as Peter talked to earlier, is just improving the service. That is really about test and learn and trying out these different things. There are quite a lot of things in the White Paper that we have not really touched on, but a lot of those will form part of the programme. There are things that we are looking to test and, where that testing is successful, implement.

We then move into scaling the service. That is about really building up the numbers and getting the representative sample, as we touched on earlier, before we then start this phase of transitioning—so, moving it into a national phase—before whatever then happens in 2029 in terms of future contracts.

Q51 **Olivia Blake:** Just to quickly follow up on that, we have mentioned what I suppose you could call the interim operating models. Will that all be included in the business case that you are putting forward, so that we know, between now and 2029, what the interim measures will look like? Will it be published within that, for transparency?

James Bolton: On challenge 4, paragraph 20 of the NAO Report highlights that we have a target operating model and an interim operating model. Clearly, a number of interim operating models will be built as we go through this phase. They are constantly changing, so I do not think that we usually put them in the public domain, but we are having a lot of stakeholder engagement. We are running regular workshops, bringing in representative groups, and bringing in individuals. We are talking them through what the service is looking like and working with them to help them design that. So we are being transparent in that way.

Q52 **Chair:** Can I stop you there, Dr Bolton? There is some concern that relatively little is known about this programme at the moment by the groups that are going to be affected, and yet here we are, only a year off a business case, and the actual transformation starts only a year on from that. What programmes do you have in the Department to make sure that more-affected groups are better informed?

Peter Schofield: This is really important for us. There are two levels, and I will get James to say a bit more about this. One is how we are connected to representative groups—maybe charities and those groups that support many of our customers who are going through the process. A second thing



is, as we develop particularly things like the user interface or the new IT experience, how we are doing that in a way that understands what users will find helpful, in a really close way, so that they can affect and influence the way that, for example, screens will come up in the process online. So there are two different levels. Do you want to describe both of those and how we are engaging with stakeholders in particular?

James Bolton: Thank you, Peter. This goes to challenge 7 in the NAO Report, around stakeholder buy-in. We are working on three different levels. We have a national stakeholder strategy. We have held 18 workshops so far, with over 72 different organisations represented, and we are continuing to hold them. We have got one coming up soon specifically looking at this new apply-for-PIP service, which we are looking to make national next year, to show where we have got to and to gather any thoughts on that.

Then is then a kind of more regional approach. Where we have had our transformation areas, we have been engaging locally with groups in those areas and MPs within those areas, and we will continue to do that as we expand.

Then we come right down to an individual level. As we are building these services, we bring customers in, we show them what we are building, we ask them what their needs and their requirements are, and we use that to shape the service and how it is designed. I think I touched on an example earlier where for the new apply service, we ask customers, "Well, do you want to be clear on the eligibility criteria? Would that be helpful? What level of information do you want?" We use behavioural scientists to help us do that and create that portal, which we will see when it goes live later this year.

- Q53 **Chair:** Given the numbers that are involved that I outlined in my introduction, is there any plan to have a sort of national Government information programme to inform people of all of this? It is all very well involving individual stakeholders and individual groups, but there will be an awful lot of people out there who may not even yet have needed to apply but may, in their circumstances, want to apply in the future. They need to be aware of it.

Peter Schofield: This is something we should look at as we scale this service up. We have a couple of years before we are doing that, but we should play that into our wider consideration about how we communicate with our customers and the campaigns that we run. It is something we should work through, and part of what we will do as part of the user engagement work is, "What are the sorts of things that users found helpful to know before they first applied for PIP or universal credit?"

Chair: Sorry to have interrupted you, Ms Blake.

- Q54 **Olivia Blake:** No, it's okay. Just building on the stakeholder questions, because I think it is a very important point, how confident are you that the stakeholders that you have engaged so far are fully behind the



transformation that you want to see?

James Bolton: It is a very good question. We have had very positive feedback on the workshops that we have been running. For example, when we have asked people who have been to those, 89% said they are likely to recommend them to others as well. We are able to show that real change. We can show examples of where the service is evolving and changing in response to that feedback. There is always more you can do, as Peter highlighted, and we are very open to hearing people's views to continue to expose that and to continue to improve the service. It is, at the end of the day, a customer-centred service and that is what needs to drive the design.

Q55 **Olivia Blake:** And are you involving customers within the design?

James Bolton: Absolutely, yes. We have our digital design teams. They have a whole range of customers who have said they would be willing to work with us. We call on them regularly, bring them in, show them what it looks like, and ask them what their needs are. They actually help us design individual elements of the service right down to the wording on the screen and how you navigate through. I have some good examples, if that would be helpful, of just how we have taken some of that feedback on board.

Q56 **Olivia Blake:** Maybe in writing, because I am a bit conscious of the time. I have just one question, because this has not always been got right: are you ensuring that anything that is digital is going to be fully workable with assistive technologies?

James Bolton: Absolutely. Accessibility is very high on our list. We have a team dedicated just to looking at accessibility as we build in the service.

Q57 **Olivia Blake:** Ms Farrington, do you feel able to be a bit more open and transparent about the programme now that we have got the White Paper?

Peter Schofield: I think the link to the White Paper is a really important point to get across to the Committee.

Katie Farrington: I think the NAO said in its Report that we had taken a decision that we really wanted to communicate about the White Paper, first and foremost, as our big transformation. That was published in March, and the change that that is trying to achieve is to reflect the challenge that we have had back from people that they go through the work capability assessment and they feel that they have to show how sick they are, and they then get very little support to get into work. And yet, as Peter said earlier, there is actually quite a big group of those people who would like to try work, but are worried about doing so because they think they may need to go through the assessment process all over again or they may lose their benefits. So that is the really big change.

The health transformation programme will be the vehicle to deliver that big reform in the staged way that Peter described earlier, starting with legislation in the next Parliament. We want to be communicating about the



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health transformation programme at all the different levels you are describing.

One other thing that may be worth adding is that it is important that we work with partners who work directly with customers—people such as Citizens Advice who are directly giving advice to customers claiming these benefits—and making sure they have the right information and that we are reflecting their feedback.

- Q58 Olivia Blake:** The second challenge the NAO highlighted was about integration of services. This question is probably best for you, Mr Schofield. How will you incentivise the contractors to help you to deliver on the transformation you are seeking?

Peter Schofield: As you say, challenge 2 on page 47 of the Report sets it out quite well. The first thing to say is that this integration of services is not new for us; we do it already on the work capability assessment system, for example, where we already provide the IT. What we need to be able to do is manage that with a number of providers, rather than just the one at the moment. It is about building on that capability.

The other thing I would say is that a lot of this relates to making sure that we have identified the risk and started to address it by putting mitigations in place. The business case already assumes that we build a bigger capability to manage the integration between the various contracts, improving both on the contract management side and in terms of the digital support, so that is baked in. We have recognised the challenge, we have experience to build from and we have put in place the plans to build the capability to manage those risks.

- Q59 Olivia Blake:** Do you feel you have the right skills and people within the integration office with the experience to do that role well? On this Committee, we constantly ask what lessons have been learned from other major projects, so on integration in particular, what lessons are you bringing to this from what we have seen that has not gone quite so well before?

Peter Schofield: As you can imagine, there is a lot of sharing of experience among the programme and project delivery profession across the civil service. The examples set out in figure 15 are ones that we draw on. They relate in particular to the challenge of sometimes not recognising that there is an integration risk that needs to be managed until you are too far down the track. As I say, we have learned from that, in part because it is something we do already, and in part because we have experience of it. We have good capabilities that we can build from. We are not creating skillsets and professional expertise within DWP that have not existed there before. We have great commercial teams, great contract management teams and really good digital teams. When you already have that capability, it is more straightforward to build up from it and to grow, rather than to create it from scratch. We are in a good place in that respect.

- Q60 Olivia Blake:** So you are not concerned, as other Departments have



been, about difficulty in engaging those skills and getting people with the right talents for this particular element?

Peter Schofield: I do not want you to get any sense—any sense—of complacency at all on this, because it is a huge challenge, and recruiting and retaining skilled people, particularly from scarce professional backgrounds, is always a challenge within the civil service. It is something we constantly do across DWP more broadly. I am never complacent, but I want to give the Committee confidence that we have recognised the challenge. The NAO brought it out brilliantly in their Report, and we are managing it. We have the plans in place to build the capability we need to manage that.

- Q61 **Olivia Blake:** From the Report it seems to me that it may have been a mistake to rely on standard contracts that needed to specify requirements, rather than alternative forms of developing contracts. Do you agree? Is that a lesson learned from the initial stages of the programme?

Peter Schofield: The lesson to be learned from the initial stage of the programme was that it was an attempt to try to transform and articulate the new requirement in time for a contract that was due to start in 2021, and those commercial timetables were just far too optimistic. I know why we did it—we were really keen to improve the service—but it was just too difficult to do in the timetable that we had. I think that is the main lesson that we learned there.

The NAO brought out, as you set out, a challenge in terms of the contracts for the period between 2024 and 2029. That is also to the point that Ms Morris was raising, around the fact that we need to be collaborating and having a constructive, supportive relationship with contractors. Could we build some of that requirement into the contract? It is difficult to do when you do not actually know at the point of writing the contract what exactly it is that you want them to do, but I think some suggestions in the NAO Report, for example about incentives, are really sensible ones for us to be working through and taking away.

- Q62 **Chair:** I think Ms Blake was getting to the heart of it there. If you don't know exactly what you want them to do, why are you using the standard contract rather than a more bespoke contract? A standard contract will make you set out at the beginning what it is you want to achieve. Even when you are writing it, you know you are going to need to vary it. Why not use a more bespoke contract?

Peter Schofield: Because for the vast majority of what we want the FAS suppliers to do, we know what it is. Basically, it is, in the interim, the sort of business-as-usual element. We want them to drive forward and deliver the health assessments and the work capability assessments as we do now. But what we then want to do, as we grow the size of the health transformation areas, is to be working with suppliers to think about how we build capacity and take those centres in to scale up the health transformation area. The requirement there is to let go of some space and some places. That is built into the contract. Then there is the question



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about whether some things are coming out of the health transformation area that we might, early on, before we get to 2029, bring into business as usual.

James might want to say a bit more. We felt that was too difficult to write up front, because we had not clearly identified what it is that we would want them to do, and we wanted to focus on the BAU and the 80% at least, throughout the period to 2029.

There are some suggestions. I regard them as things you can add rather than any suggestion from the NAO about a fundamentally different approach.

James Bolton: I agree with what Peter has said. In terms of the next set of contracts, we have talked about that solid baseline, moving the operating model to a place where it is ready for the future transformation. That is exactly what they allow us to do. They are bringing services together. They are helping us realise some advantages of doing that.

As Peter highlights, we have the hooks in the contract to do the transformational things we need, so we can get that 20% in there within those existing contracts. They are exactly the right tool for what we need for this phase.

There is an interesting question of whether we should outsource in 2029 and what kind of commercial arrangement we might need for that, because that might look different. We have begun a piece of work thinking about what the right commercial strategy is from that point onwards.

Q63 **Olivia Blake:** Do you think that approach is a bit inflexible?

Peter Schofield: I think we have got the flexibility we need.

Q64 **Olivia Blake:** Okay. We might have to agree to disagree.

Dr Bolton, could you outline a bit more the key dependencies of this programme with other programmes that you are running and other governmental projects that are ongoing in the Department? How are those risks viewed, and how are you managing that risk?

Peter Schofield: Before James gets into that, there is a point from my perspective as well. At the same time as we are building out service by service and transforming services, there are common things that need to be done across the whole infrastructure of DWP.

There is a programme referred to in the NAO Report: the strategic reference architecture programme. That is something where we are developing common components that can be used by a variety of services all across DWP. It is one of those areas where you have to be delivering in time so that the health transformation programme is able to use those that are relevant at the right time. There is a big management challenge to be done outside the programme, but looking across DWP as a whole, led out by my chief digital and information officer, who we recently recruited.



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That is one of the big elements, and it is brought out really well in the NAO Report. I am looking at what I often call the vertical service-by-service and the horizontal common componentry. That is one of the really important interdependencies that we are managing strongly over the coming period. That is one element. James?

James Bolton: Absolutely—that is a really key one for us. It is that dependency on some of the other digital services. It will be on the providers when we are looking to expand the service, and we will be working with them. It will be things like operational readiness.

A programme of this size obviously has a large number of dependencies. I point the Committee towards paragraph 19, where the NAO highlights that we have identified our dependencies and are monitoring them at programme board. As part of that, we have been thinking about what happens if one of these dependencies is not ready on time, so we have been developing some scenario planning that will inform our next business case. There will be some flexibility in that should any of these dependencies not be realised. As I said, the NAO Report says that we are handling our dependencies and thinking about scenarios should any of them become problematic.

Q65 **Olivia Blake:** Are you confident that you have horizon-scanned for every dependency?

James Bolton: Well, the NAO has said that, and we believe that. There are always what we call black swans—things that you can never predict, which are unknown and unknowable. Covid was a good example of something that we were not expecting, and the programme had to change its plans as a consequence. There will always be those things.

Q66 **Olivia Blake:** Moving on to data and the evidence that you need to assist the transformation, you mentioned earlier the 5.8 million claims that have been predicted. Do you feel—we have asked other Departments this in the past—that you are able to access cross-Government data from DfE, DLUHC and the NHS so that you have a real understanding of the need in the medium to long term, or do you think you could have more input from those Departments to help your understanding of need?

Peter Schofield: I was reflecting on that very good question on supported housing that you asked me when I was here last time, Ms Blake. I digress, but it was about thinking about the need for particular types of supported housing. You asked whether, when predicting demand, you can use data from PIP to help local councils think about the strategic need in their areas. I thought that was an interesting challenge. It is the sort of challenge that we need to reflect on in answering the question that Sir Geoffrey asked earlier about sharing data and understanding how we can learn from each other. Some great examples have already been described, in terms of HMRC. James, do you want to say a bit about the health service side of things and the records there? Clearly, when making a decision on PIP, drawing on the best medical evidence really matters.



James Bolton: Absolutely. Getting evidence to support these cases has always been very challenging. We touched on appeals earlier, and we know that sometimes new evidence comes up that changes the case. A question that the programme is asking itself is, "How do we get that information early?"

The other part of the challenge, of course, is that there is a lot of information out there. If you go to the NHS, they have a lot of clinical information, but often what we need is to understand how health conditions affect customers on a day-to-day basis. We do not need to understand a specific diagnosis, a medication regime and so on.

It is an area that we are actively looking at. We have been fortunate that we just had a new programme board chair start, who used to be the deputy chief medical adviser over in what was the Department of Health. We are looking at this area very closely, and we will draw on her experience to see what we can do. Obviously we do not want to burden the NHS either, so how can we identify relevant information and get to it earlier?

We believe our customers can help us with that, too. We have talked quite a lot about this new online portal, where you can apply for PIP. That allows customers, if they have some information they think might be relevant for us, to take their phone out, take a picture of it, upload it as part of the service, and go back and add more information as it goes along. That is just one of a number of ways we are trying to create ways into the service. It may not just be customers; we may be able to do it for other groups as well, so they can provide us with relevant information so we can make those decisions.

Q67 Olivia Blake: Okay. The follow-up to that is: how will you use aggregate data to help you plan the service in future more effectively?

James Bolton: We understand that data and getting the right information is key to this. The programme has already made some strides in this area. One of the five key strategic priorities that I talked about earlier was data. Already, within the Department, you can see that the service for work capability assessment is slightly separate from the service for the personal independence payment, yet it is often the same customers having to provide information more than once. In our transformation areas we have already begun to bring those together. I was talking to the health professionals there the other day, and they said, "It is fantastic. Suddenly we have a much more holistic view of what is going on with this individual." That is just one way that we are beginning to use data.

We talked earlier about the fact that a lot of the information provided to us is still on paper. It is very hard to start moving that information around, and it is much slower. It is also not accessible or understandable by a service. We believe that by putting things online, and by having more data about our customers that is actually accessible, we can start to do things such as routing cases a bit more sensibly.



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There are things in the business case around whether we can make things more effective. Can we, for example, identify people who may be more at risk, those who may need a quicker decision or an intervention at an earlier stage, and those for whom it is very clear what the decision is and we have sufficient information? Can we flag those cases up?

- Q68 **Olivia Blake:** This is a very specific question, but given that the form is pretty much free-flowing text at the moment, and given that you are moving to an online system for PIP, would you consider doing more of a rating of need so that people could put themselves on a scale of one to five or one to 10, for example? That is what GPs do, and it is standardised in medical practices. Would you consider changing the way you ask the questions?

James Bolton: The short answer is absolutely. The slightly longer answer is that, with the version we are putting online, we are trying a little bit of that. If you look at the questions we are asking on mobility in the online form, we are trying to get a bit more into the detail on how far people can walk, in a way that the paper form does not. Now that we have got it online and people can start to make their claims, we can begin to iterate that, we can understand the information that customers are providing us and that we need in order to make those decisions, and we can continue to refine the form—so yes.

- Q69 **Olivia Blake:** Ms Farrington, when can we expect to see a full baseline for the programme against which we can judge whether there has been an improvement to the service?

Katie Farrington: Our intention is to revise the programme plan to reflect the detailed implementation of White Paper reforms, and to publish that in the spring, as Peter said, together with the summary of the accounting officer assessment. In terms of delivery, we will continue to publish journey times for PIP, as we do now. That gets published quarterly. You will continue to see the same sort of journey time data that you see now.

Could I add to the answer that Dr Bolton gave on data? In terms of predicting aggregate future demand, we work closely with the Department of Health and Social Care in particular, looking at the prevalence of different conditions. We also work closely with the Department for Education, looking at, for example, the prevalence of autism and mental health conditions among young people. I think that was partly what you were getting at on forecasting demand.

- Q70 **Olivia Blake:** Confidence in the numbers you have is the underlying point. Data in general seems to have been a bit of a challenge. You have not really set out the data you need for the programme before you started developing the health assessment service and letting contracts for the functional assessment service. Do you have any reflections on why that was not the case and what could be done in future to ensure that you are setting those things out more clearly from an earlier point?

Peter Schofield: I will push back a little bit on that. We have published the evaluation strategy, as the Report recognises. Figure 8 sets out what



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we have got already, which is most of the data for eight of the nine key indicators. We are developing many of the metrics further.

The key point is starting with the outcomes that we want to achieve. The classic one is around customer first contact. It is not figure 8; it is figure 13 on page 43 of the Report. We said that customer query resolved at first contact was something that really mattered to us.

We did not immediately have the data that we need, but I do not want the fact that we do not immediately have the data to stop us focusing on something that really matters. The challenge is to go and find out how we can get the data, so I think that is the right way round. You will hold us to account because we will publish the outline business case in the spring, which should be able to fill in much more of these gaps.

- Q71 Olivia Blake:** Ms Farrington, was there a problem with the data that prevented you from being a bit more transparent with the current capability assessment process? It seems from the outside that that might be one of the cases that has not been very transparent on the current numbers.

Katie Farrington: No, I wouldn't say that. We publish data on the work capability assessment that is part of the employment and support allowance. That gets published quarterly. The unique thing about the work capability assessment is that it forms part of our universal credit service. We published some data on the WCA about a month ago—on 8 June, I think—and we intend to continue publishing that data.

- Q72 Olivia Blake:** The final part of my questioning is about policy uncertainty in the longer term, and how you are going to be able to deliver both long-term transformation and flexibility within the system if there are significant changes between now and 2029. For example, a change in Government could be a big disrupter to you. Mr Schofield, could you outline how you plan around those issues and challenges?

Peter Schofield: I will turn to Katie in a second, but the starting point, as I said at the beginning, is that we see the health transformation programme as part of a wider set of reforms, which are set out in the White Paper. This really matters. This is a way of delivering some of the changes in the White Paper—for example, removing the work capability assessment—so some of it has to be programmed in. However, to answer Sir Stephen's question, we do not know exactly when primary legislation might come along to enable us to implement some of that. That is one element of it. Katie, do you want to say more about how we are keeping flexibility in this as part of being prepared for policy change?

Katie Farrington: Thank you; it is a good question. As Peter said, the way we intend to implement this is to take legislation early in the next Parliament, and then implement it very much in a staged way. We would start with new claims only and roll it out geographically. We said in the White Paper that we would start that process from 2026-27, and then we would get to what you might call the stock of existing claims to transition over the people already on our system from 2029.



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We are confident that we can deliver that within the health transformation programme as we have designed it. As I said, we are now working through the absolute detail of the implementation and refreshing our business case for publication in the spring. We are confident that we can deliver that. However, as Peter said, this legislation will have to go through in the next Parliament, and obviously we all have to be able and ready to respond to the decisions that Parliament makes.

Q73 Olivia Blake: We have touched on this, so I think the answer will be that you are confident—but how confident are you that the flexibility you have built into the programme will be sufficient for adaptation in the future?

Peter Schofield: I feel you have already given me my answer: I am confident but not complacent. With all these things there is some uncertainty. James talked about what we call black swans—what we do not know that might happen further along the line. We have tried to bake plenty of flexibility into these contracts, but they last from 2024 to 2029. There is much more flexibility for whatever lies ahead beyond 2029. By 2027, if we are outsourcing, we will need to be in a position to be able to specify what that outsource requirement is.

Similarly to my answer to Sir Stephen, I think that 2027 will be an important point if there is very significant change that might need to be implemented beyond 2029. We would need to know and be able to reflect it in the invitations to tender at that stage, assuming we go with an outsource model at that point.

Q74 Olivia Blake: I have a final specific question on progressive diseases. I have spoken to plenty of organisations in this space around MS, MND and other conditions that want to know whether you will be reflecting on the necessity of regularity. How often will people have to reapply for things? If they have already met the top threshold, is it necessary to review, if we know that there will be a degradation of their condition? I wanted to put that on the table and ask that question; I know it is a bit policy-focused, but it is process-based as well.

Peter Schofield: It is a really good point. You will have people whose health conditions sadly deteriorate, and we might not pick it up for a while until there is a reassessment, unless the customer reports that. They might have been entitled to an additional payment for PIP, for example, because of that.

I mentioned at the beginning that our annual report and accounts have just been published. In them, you will see data about overpayment and underpayment. One of the biggest elements of underpayment in our benefits system is PIP, where people may have had a deterioration in their condition and have not come forward to let us know. That is something that we are conscious of and want to be able to address. The health transformation programme might be a way of helping us to do that, but there are other ways to help us pick up on this important issue. The statistics suggest that there are a lot of people who might be missing out



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on additional PIP money because of that, so we really want to try to address it.

- Q75 **Chair:** I have a couple of questions to mop up at the end, if I may—perhaps for you, Mr Schofield, or indeed for Dr Bolton; I do not mind. Can I take you to paragraph 13 of the summary, and particularly to the sub-paragraph on phase 2? It lists five massive tasks that you have to do to develop an interim IT system, and an IT system to manage the work capability assessment. In parallel with those, you will “continue to develop the new Health Assessment Service”, you aim to “increase the volume of claims processed” and you plan to “import good practice”. That is a massive work programme. Do you have the capacity and skills in your Department at the moment to undertake that?

Peter Schofield: It is a good challenge, and one that we are consciously looking at in the context of everything else that the Government are asking of DWP. We play a vital role in so many different parts of Government activity and we are determined to play our part, but as well as delivering all the things we are being asked to do around the labour market—for example in jobcentres; there is fantastic work going on across DWP, all set out in our annual report and accounts—we have always sought to protect and safeguard the resourcing for our key transformation programmes. This is one, and the continuing roll-out of universal credit through the move to UC programme is another. The work we are doing to improve our buildings is yet another.

There is some of the modernisation that we have talked about in this Committee—modernising the way we deliver the state pension, for example, is part of that. We have ensured in our departmental plan that we have safeguarded investment in that. We have great people leading these programmes, including Dr Bolton, who are fully trained and are graduates of the Government’s major projects leadership academy. We are prioritising that, but we know that we constantly need to manage across all the pressures and asks on DWP across the piece. That is what I spend a lot of my time doing.

- Q76 **Chair:** No doubt we will return to some of that when we do the session on your report and accounts.

Finally—you have carried a lot of the burden today, Mr Schofield, so I do not mind if Dr Bolton answers this—you would not expect to come to the Public Accounts Committee without getting a question about the overall figures. Basically, the net saving is made up of the £1.26 billion cost of transformation, as set out in figure 12, against the £2.6 billion set out in paragraph 2.15. If you look at paragraph 2.15, it looks like the figures for the savings you will be making are quite optimistic. How confident are you on those figures?

Peter Schofield: This will be refreshed in the outline business case for next spring with my accounting officer summary assessment, so we will come back to it. As I said to Ms Morris, I know that you will hold me to account in the next iteration as well.



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We are confident, because the system costs a lot to deliver, so small improvements save quite a lot of money, and we can see quite a lot of improvements already through the health transformation area. I think the challenge for us will be the point that I think Ms Morris brought out in her questions around investment up front delivering outcomes down the track and whether we do indeed deliver not just those savings in paragraph 2.15, but the wider benefits in paragraph 2.16 as well.

At the heart of this is not just supporting some of the most vulnerable people in our country to live independently, but helping and encouraging those who can to live an independent life, which involves some ability to work as well. We know that when that happens it has financial benefits, but it also has an economic benefit for the country, social benefits and benefits for the health and wellbeing of the individual. This is part of a wider story, and we need to be able to demonstrate not just those financial savings and efficiency improvements, but the savings and benefits that come from changing people's lives for good. I want to give the Committee a real sense that that is at the heart of what we are trying to do here as a Department.

Chair: We really appreciate what you do in your Department. You are looking after some of the most vulnerable people in society, and it is a valuable piece of work that you do.

It has been a pretty technical inquiry today, and you have answered with huge expertise. Thank you very much, all three of you, for your time and for coming before us today. We will publish our Report in the autumn, but the uncorrected transcript of this session will be up in the next two or three days.