HOUSE OF COMMONS

Work and Pensions Committee

Oral evidence: Employment and Support Allowance and Work Capability Assessments, HC 1212

Wednesday 14 May 2014

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Members present: Dame Anne Begg (Chair), Debbie Abrahams, Graham Evans, Sheila Gilmore, Glenda Jackson, Kwasi Kwarteng, Nigel Mills, Anne-Marie Morris, Teresa Pearce, Mr Michael Thornton, Dame Angela Watkinson

Questions 183 – 280

Witness: **Professor Malcolm Harrington CBE**, gave evidence.

Q183 Chair: Thank you for coming along this morning, Professor Harrington. You have appeared in front of this Committee a few times over the years and it is nice to see you back. Hopefully, you can be a bit more reflective this time, as you are not as directly involved in the reviews as you were, but you do know the ins and outs of the operation of ESA and the Work Capability Assessment, so we are grateful that you are here this morning.

In the reviews that you wrote, you argued that the Work Capability Assessment should be retained and improved, stating that you had no evidence to suggest that the whole system should be scrapped. Do you still stand by that view?

Professor Harrington: We need a Work Capability Assessment of some sort. I do not think the principle is wrong; I just think that, when I started, there was something wrong at every stage of the process. I thought it was impersonal, mechanistic and lacked transparency and there was poor communication, both between the parties taking part in the assessment and to the claimant.

If they say, "Scrap it," you have to say, "And what are you going to replace it with?" I have not heard anybody come up with a very good system that would be better than the current system, although the way in which the current system operates is still not good enough.

Q184 Chair: The various things that you have just mentioned—it's being mechanistic and the way that people are made to feel or the way that they are questioned—are still complained of. We were in Newcastle yesterday speaking to claimants, and they are still reporting exactly the same criticisms today as they were when you did your first review.

Professor Harrington: I know. They said it to me too, even though I have not done it for the last year, but up until I finished it was clear that, on the ground, in some parts, it was no better. I think the decision makers and the people working inside the Department made a serious effort to improve the way in which they did their bit. I wanted the decision maker to be centre stage on this, because I did not trust Atos to get a sufficiently good assessment done, but the fact that there seems to be no improvement at all, I find very disappointing.

Q185 Nigel Mills: Do you think it is just Atos that are not capable of doing this, or do you think that it may just not be possible for any private sector provider to make this work?

Professor Harrington: Have you watched it in process and actually seen one of these assessments go on?

Nigel Mills: I have seen a video of one.

Professor Harrington: They are very boring to do. You are asking supposedly highly qualified people to do a very boring job and some of them admit that they are not actually looking at these people—they are not caring for them, they are processing them. The danger is that the quality of the people who do that will not be of the optimum.

The private sector has a financial interest in doing this and I think we ought to look seriously at alternatives to the private contractor. I talked to Kate Green a bit about this, just kicking around ideas about whether the provident associations and the charities, with their medical advisers and a process of triage, could not actually get a better job done than we currently have with a private contractor doing it.

Now Atos has walked away, the question is which other private contractor are you going to use? G4S and Serco are two possibilities, but they are under investigation for fraud at the moment, I believe, and there is Capita. The fact remains, I think, that Atos is the biggest game in town in terms of the number of people who do this work, and the Government have got themselves into quite a problem over it.

Q186 Chair: If somebody else was to take over the contract, presumably a lot of the staff who presently work for Atos would just simply move across to any new contractor, whether state-run or private, simply because you could not start from scratch and train up assessors from scratch.

Professor Harrington: Yes, you could. You can bring tears to the eyes of some of the old lags inside the Department if you talk about the Benefits Agency medical service, which was an in-house service. It was still operating in Northern Ireland until a couple of years ago, and it worked very well in Belfast; then, Northern Ireland went over to Atos instead. If you talk to the people, you hear how you had the doctors working just down the corridor from the decision makers and the people doing something else; they all knew each other and talked to each other and it seemed to work a lot better—but there is no point in crying over spilled milk. We are not going back to a Benefits Agency medical service, so we have to use somebody, and it does not appear to me that the people who are just in it as private contractors are necessarily doing a good job.

Q187 Sheila Gilmore: This is perhaps a historical point now, but it keeps coming up in debate and you might care to clarify. It is the issue of whether the migration of IB claimants

should have gone ahead in the way it did. I think the then Minister had said that you supported it going ahead when it did, and *The Guardian* then reported you as having said that you had not. This keeps coming up.

Professor Harrington: Yes, can I clarify this, once and for all? In my first year—before the first report, that is—I said to Chris Grayling that, left to my own devices, I would prefer it if they postponed the IB migration until I had got at least one review in, so they could just deal with the new claimants and would not be confused by another group of people coming in—a completely different group of people, as you well know. He did not say no; it was just obvious that it was a political done deal and they were going to go ahead and do the IB migration whatever.

I think that the confusion has come up because, two years later, I visited one of the pilot areas for IB migration, Aberdeen, and I thought the decision makers up there were doing a good job. When I went back and had one of my regular meetings with Chris Grayling, he said, "I understand you've been to Aberdeen," and I said, "Yes, and it appears that the decision makers can handle it." That must be the interpretation behind "Harrington said it's all right." I would not have done it then, but they had done it, and certainly in Aberdeen, one of the pilots, it seemed to work okay and not to cause that much trouble. It has caused a lot of trouble elsewhere. I think that is where the confusion lay. I do not think anyone could say that the Minister lied to Parliament or anything like that.

Sheila Gilmore: I just thought it might be helpful.

Professor Harrington: Is that clear?

Sheila Gilmore: Yes, that is very helpful.

Professor Harrington: There was a two-year gap between the two things.

Q188 Chair: Knowing Aberdeen, obviously, it did work reasonably well there as a pilot, but that was because there is low unemployment, a low claimant count and there were not the intractable problems you had elsewhere in a deindustrialised area, which Aberdeen most certainly is not. I think it was chosen because it was quite a contrast to Burnley, where it was quite a different picture.

Professor Harrington: Yes, and I think that is the issue of looking at the pilots and thinking it is going to work like that elsewhere. In Wrexham, they do a lot of piloting of different bits and pieces, but there is nobody at Wrexham telling them how many decisions they have to make in a day. They were getting away, with some of the changes they were making, with maybe three decisions in a day when the norm is 10 to 12.

Q189 Glenda Jackson: If I just take you back to when you were paraphrasing slightly and you said that you believed WCA was necessary and a good thing to have—you keep saying that certain things have worked well. I am not clear why you thought the Work Capability Assessment was a good thing; with what desired outcome? If it is working well, what is the desired outcome that says it is working well?

Professor Harrington: I think—I believe, anyway—you have to have some assessment of people who say they are incapable of work as a result of ill health, to assess what degree of ill health and what degree of work capability they have, and to decide what you do with them: whether, in fact, you just give them money and park them in this support group because they

are really not going to get well; then there are people who are clearly fit and ought to go out and get a job if they can get a job; and then there are those in the middle. It has always been a sort of rag-bag—sorry for the terminology, but they never really decided what they wanted to do with this group in the middle. Some of these people, with help, could get into the position of being employed with adjustments to their work. Some are going to be in a deteriorating condition, like Parkinson's, and are never going to work, so why don't we just make that decision now and give them the support they need?

Going back to your question, in assessment of work capability, I think the country needs to decide what benefits should be given to people and what benefits should not be given to people. If you do that, then how you actually make that assessment is the real question to me. Doing it the way the DWP are doing it at the moment, using outside contractors and a computerised system, does not work well.

Q190 Glenda Jackson: If it could be altered or adapted to deal exclusively with that middle group of people, would that be better?

Professor Harrington: Yes, I think then you would have to have semi-specialised individuals to deal with some of the groups, like people with mental health and learning disabilities. Those assessors ought to have some degree of training specifically in that.

Q191 Glenda Jackson: Well, actually, with respect, are there not three requirements? One is to accept up front that there are people who will never be capable of work, for a variety of reasons.

Professor Harrington: Yes.

Q192 Glenda Jackson: And on the other hand there are people who are physically fit for work, but in some instances they may need help to actually get into work. Then the central one is a version of WCA with more specialised examiners.

Professor Harrington: Yes.

Q193 Glenda Jackson: So what is—again, I go back to the point you made that in certain trials things have worked well—the definition of "working well"?

Professor Harrington: Taking enough time and trouble to assess that individual's individual needs and then taking a reasoned decision that they should go into one particular group or other. At the moment, that is not happening. I want the decision makers to be central to all this. I know the argument inside the Department by some people is: "Well, they're not medically qualified and they can't possibly understand this." There has always been a lay person who made that decision in the Department—we called then an adjudicating officer in the old days—and there is nothing wrong with a lay person making the assessment, given all the evidence they should have. However, all the evidence has not been provided, or it's not being handled properly, and they are making them do this job too quickly, for what I think needs to be step by step.

Towards the end of my three years, when I went to a benefits centre, I was starting off my meetings by saying, "I'm sorry I made your job harder." All these people didn't say,

"Yes, you so-and-so"; they said "You have made it harder, but that's all right because it's more interesting. But we are not given enough time to do each case." I can see the Department's problem here, because that would make it more expensive up front. My argument has always been that if you got it right first time, there would be less people going to appeal, and therefore in the end it would be okay—it's all right for me to say that.

I can see the Department's problem. They really went for it big time in the first two years and then the middle-management inertia set in—"This is already too difficult. We haven't got time to do what Harrington wants us to do, and so we have to fudge some of that." The dedicated team I had in Leeds that was driving a lot of the recommendations was disbanded or downgraded or something, so that sort of disappeared and that momentum went as well.

I think you have all seen this sort of thing in other circumstances. This is not new: somebody comes in with some ideas and the thing tails off after a while. In the third year I was thinking, "What have I really achieved?" I still think the principle of what I was saying was right. The decision makers, who I put at the heart of this thing, also thought it was right. There were people in the Department who thought that Atos were the people to do all this, and other people in the Department said, "We haven't got the time to do all this."

Q194 Glenda Jackson: So essentially the rejection of your ideas from the Department has been based on finance.

Professor Harrington: Well, that's my guess. I wouldn't say that it has been rejected—

Q195 Glenda Jackson: They must have given you a reason.

Professor Harrington: No, it just got slowed up. We could talk at length about the appeals process—that was deliberate slowness on the part of other people—but nobody in the Department, including Chris Grayling, whom I had for nearly three years, ever stopped me putting forward a proposal. They always said they'd be met: some of them have been, some of them haven't, and some are in the process of being trialled. I suppose it is me feeling frustrated and wanting things to move faster.

Chair: We will have more questions on those issues, but I think Dame Angela wants to get in.

Q196 Dame Angela Watkinson: We had a visit to Newcastle yesterday and we heard a lot of stories from individual claimants. A common theme was the experience they had during assessment. You just said that ideally assessors should specialise in a particular field. Some of the people we spoke to said they felt humiliated and demeaned by the process. I am not suggesting that all assessors make people feel like that, but I wonder whether there is too much variation in the calibre and quality of assessors, and whether more training to assure a high standard of assessors would bring a better experience for claimants and a better outcome. Do you think that is part of the problem?

Professor Harrington: Yes, I do. I cannot give you a scientifically proven survey, but that is my anecdotal feeling from going round and talking to people. The quality of the Atos assessors, for example, is very patchy. Where they say they have introduced mental heath champions, I don't know whether that has made any difference. I met one of their mental

health champions, and of course he was very good—well, he would be, wouldn't he: he was the one person I met. It was clear that he was up for the job and that he would do a terrific job in that neck of the woods.

It is an enormous outfit. One of the problems I became more and more aware of is that it is a huge Department with a vast budget trying to manage hundreds of thousands of claimants, and it is very hard to do—I don't know how it does it. When I say, "I think you can do bits of this better", it is not surprising that some of that gets bogged down in the process.

Q197 Sheila Gilmore: It's a huge job, as you suggest. What is your view on the frequency of reassessments? People said yesterday that they are reassessed quite quickly after the original assessment, which must create a volume of work. Do you think that is as essential as it appears to be?

Professor Harrington: I think the frequency of reassessments is illogical. They are not looking at individual cases. Some of those people come back for another assessment when it is clear that they don't need one—they should be parked for longer or whatever, or they haven't gone through the appeal process. There is a system for reassessing them every x number of months, but it does not take into account the individual conditions—we can go back to Parkinson's, for example. The chances are that if you are going to reassess that person, you might as well leave it for quite a long period of time. Unfortunately, the chances are that the person will have deteriorated in that length of time, so why are you then doing another reassessment? Why don't you think about that individual? I know it is deliberately not a diagnosis-based assessment, but for certain diagnoses, such as motor neurone disease, you know what the outcome is going to be, so the clinician has to take that into account, even though they do not use diagnosis alone as the basis for the assessment. We can come on to the business of fluctuation some other time, but it is a very important aspect of the WCA, which is completely ignored by the Department, even post Evidence-based Review.

Q198 Chair: We will come on to the Evidence-based Review. The test is called the Work Capability Assessment, but it strikes me that the last thing that is being assessed is capability for work. What it does assess is whether someone should get the benefit, so it is a benefit entitlement assessment. The second part of the assessment, which should be about getting someone into work and addressing the barriers to work, seems to have been forgotten. Do you agree that it doesn't do what it says on the tin and doesn't give an assessment of someone's capability for work?

Professor Harrington: It is odd, because if you talk about employability, that is different. It depends on where you live and what sorts of skills and advantages you have. If you are a manual worker of 55 who has a really bad back, you have a problem in getting another job because all you have done is manual work. That involves using your back and so that is very difficult. You would have to learn IT skills or something like that to do something completely different.

What we have not got at the moment is a joined-up system between deciding whether somebody is capable for work, it appears, in some form or another, and what sort of job they could do and what alterations would need to be made or what training would be needed to get

them into that position. There are people who work on that aspect of the process but they do not necessarily talk to the people who are doing the Work Capability Assessment—I am not sure if I have answered your question, Chair.

Q199 Chair: Do you think, therefore, that there might be a case for two tests? One test would be a straightforward benefit eligibility, which can be done much more simply and cheaply. It would not need medical assessors at all because it would be a functional test, which is actually what it ends up as. Another assessment of some sort would then look at things such as employability, the individual and the chances they have of getting into work.

Professor Harrington: Yes, you could do that. If you did it that way, you could deal with a lot of these people as a paper exercise in that first stage and, for those who had a potentially more serious problem, get semi-specialised people to do that as a face-to-face assessment, which I think, quite honestly, could be done in the voluntary sector or you could pay people to do some of this work. Lots of general practitioners up and down the country do paper exercises on pension applications in their spare time. I know a number of people who have done that sort of work. You get a pile of papers at home and you do them in the evening. You look through a set of papers and say, "Yes, I'd give them that pension and that pension," and away it goes.

Q200 Chair: That is someone who has been pensioned out of their work through ill health.

Professor Harrington: Yes. So you could start off with a process like that and—this is what I was talking to Kate Green about—if you did, you might decrease the number of people who really need a serious look at and then cut down the number of people who had to be seen, but they would then be seen by people who are more specialised. You would change the system. You would still have a Work Capability Assessment; you just would not necessarily use a standard, automated, IT-based system run by external contractors.

Q201 Chair: So would you say that the WCA, as it stands, is just process-driven?

Professor Harrington: Atos is process-driven. I know people who have applied for jobs with Atos—and shall be nameless. An excellent nurse I knew went through the process, which she said was gum-achingly boring, and at the end the person who was supervising all this said, "I don't think you should come and work for us." The nurse said, "Why not?" The reply was, "You care for people. We are not here to care for people. We are here to process people." If that is the basis of it, it is very difficult to then look at that individual as an individual and see what their individual problems are.

Q202 Chair: The migration pilots in Aberdeen and Burnley were not about whether the WCA was correct or, indeed, whether the people at the other end got into work. It was purely the DWP exercise of managing the volume of numbers and making sure that people were called in at the right time, got the reminder letters and got the decision by telephone and then letter. There was not really a pilot around how the non-process bits would work. Is that fair?

Professor Harrington: I think that's fair. When you look at IB migration—this is one of the reasons I wanted to delay it—they are a completely different group of people from the

new claimants. These are people who have been on benefits for years, sometime decades, and suddenly somebody comes along and says, "I think you're fit for work. Why don't you come and have an assessment?" Your attitude towards that is not going to be very positive.

Q203 Chair: So when you said that you had been to Aberdeen and seen the process work, you literally meant the process—the handling of them—rather than what was happening when they went to Atos for their WCA.

Professor Harrington: Yes, I think you need, at some stage, to have some system—it probably has to be computerised—looking at general questions around ability, but it is the way you handle the individual at the start and the collecting of the additional medical information that you need in quite a lot of cases as well. I felt it was very important for the decision maker, at the end—this makes their job harder—to go back to the claimant and say, "I've looked at all these aspects and I'm minded to put you into this particular category. What have you got to say about that?" Very often, at that stage, it would be, "Well, what about all this evidence?" And they would say, "Okay, bring it in." Then, at least the claimant, at the end of that process, feels that they have had a fair crack of the whip and that somebody has seriously looked at their problem. A lot of people accept a decision that they do not like at that stage if they feel that there has been that degree of administrative justice, or whatever you want to call it.

Q204 Chair: And that would cut down on appeals as well.

Professor Harrington: And that would cut down the appeals.

Q205 Nigel Mills: You could have a system for Work Capability Assessments that is purely judgmental whereby the person doing the examination just says yea or nay, effectively, or you could try to have a system that is objective, with points scoring, from which you try to get consistent decisions across everyone. Are you suggesting that we have perhaps gone too far towards the second of those, and that the system is too rigorous and restrictive and that, actually, you would probably get a better system if you moved at least a bit towards the middle of those two options?

Professor Harrington: I think that that is fair. If you then say to me, "What is the middle of the options," I will have to say, "Well, I will have to go away and think about that," as that is a bit fuzzy in my mind. But it is not working and you cannot have no system at all. You have to have some system of assessment, but it has to be more humane and more individual-focused. To do that, you have to triage the whole mass of people you are dealing with until you get down to that relatively smaller group of people, as you were saying, Chair, who need some serious specialised look at to decide what you are going to do with them.

Q206 Nigel Mills: Is that a role for the decision maker or the assessor? At one level you can say that a consistent, restrictive, rigorous and whatever assessment should be one part of the process, but that should not mean that if you get less than, say, 16 points, that is it. We sense that the decision maker does not often overturn the Atos report. Perhaps we need to—

Professor Harrington: They used not to at all; they used to rubber-stamp the Atos thing, because that was what you were supposed to do. They would think, "These are the experts; that is the end of it, thank you very much," and move on to the next one. Certainly during my time they have been more and more prepared to question that or, if necessary, to have a dialogue with the Atos people.

Paul Litchfield's report suggests that maybe they ought to sit in the same office, or in a near office. One of the Government's responses—I will have to spell it out because it is so ludicrous—was to say, effectively, "Oh, you can't do that." On page 28, paragraph 12, of the response to Litchfield, they say at great lengths how that is unethical, but that is ridiculous because they are talking about the same people. The decision maker will know what is wrong with the individual and will probably have collected the extra medical evidence, and then you have the Atos report in the middle, so where is the ethical clearance problem?

It is in the claimant's interest for both these people to know what is wrong with them. When they rabbit on, saying, "Oh, you couldn't possibly do this," they are really saying, "These people aren't medically qualified and these people are, and never the twain shall meet. You'll never have the right sort of mix." The non-medically qualified people are those who, in the end, have to make the decisions. The closer they work with the other people, the better.

Chair: I will bring Teresa in and then I will move on to our next question with Dame Angela.

Q207Teresa Pearce: Call me simple if you wish, but the idea of having them both together to make a decision about a single person is very good. However, we have heard a lot that if you criticise the decision, Atos will say, "That is not us; that is the decision maker," but the decision maker will say, "We just based it on the Atos report." They both point at each other and no one is taking responsibility. If they were in the same room and made the decision together, that would take responsibility to a place where you could nail it.

Professor Harrington: There is nothing wrong with the people being in the same place—that is an infantile attitude towards those conclusions. The whole purpose of having that sort of process is to learn by your mistakes. As a result of that, you ought to say, "Oh right, I understand now, yes. Of course, he was the one who is medically qualified, so that is fine." Or, the person who is medically qualified could say, "No, I hadn't looked at that aspect, because I don't have the knowledge of what goes on in the world of pensions and security, so I have learned from that," so the next time they come across a similar situation, perhaps they won't make the wrong decision. That is the idea. There is no point in pointing the finger. We all make mistakes. You have to have a system where you can say, "Okay, you made the mistake this time, but next time it may be me."

Q208 Debbie Abrahams: That would improve the quality no end.

Professor Harrington: Exactly. That is the whole purpose.

Chair: I know that some people have questions, but can you hold on to them as they might come up later? I need to move on as we are halfway through the session and we are still on question 2. Question 3 is about the Evidence-based Review.

Q209 Dame Angela Watkinson: Does the process of review, recommendation and reform bode well for the Work Capability Assessment, provided that the Department engages in the process?

Professor Harrington: Yes, I think that is very good. During my first year, and certainly in the second year, a number of the charities said to me that they thought that the descriptors were inadequate for the purpose of assessment. In each of the cases—cancer, mental health and learning disabilities, and fluctuating conditions—I said to them, "Okay. If you don't like it, come up with a better system." And they did. Macmillan came up with a better system for the cancer descriptors, and they were changed. Mind, Mencap and the National Autistic Society went away and looked at the mental health things.

I then thought, "What are you going to do about fluctuating conditions?" I got a group of people together—MS, ME, Arthritis Care, Crohn's and Colitis UK, National Aids Trust and Parkinson's UK—who seemed to me to represent individuals with the greatest likelihood of fluctuations and frequency and severity in their conditions. They went away and produced a report, and I thought that was worth considering. I didn't say more than that. I went back to the Department and said, "They have come up with an alternative assessment that is worth testing against the current assessment, and let's see who wins." That requires money, time and effort, and the Department, to its credit, said that it would do it. I said that I would oversee that with a distinguished group of experts in their field, and they were my steering group. We oversaw the development of the protocols, the changes that had to be made in practice and the execution of the whole process, and we kept in touch with the charities to show them what we were doing as we went along. We then produced a report, which you have seen, and to which the Government have now responded.

That is the mechanism behind it. I think that it worked very well, which I think is the point that you are making, and it should be done more often. Well, I would say that from an academic background, wouldn't I? I may say, "Okay, I don't like this, but I don't know whether it is better than your system. Let's test the one against the other." They did it, and it was a worthwhile exercise.

Q210 Dame Angela Watkinson: So you would say that this semi-structured style of interview should be adopted for the Work Capability Assessment?

Professor Harrington: There are three things that the Government should do that they are not necessarily going to do. They are going to think about the semi-structured interview. Clearly, everybody who went through this process, whether it was the claimant or the assessor, saw that the semi-structured element brought a degree of individuality to that case, which was missing before, so we should go down that line.

The Government have rejected the idea of changing the fluctuation element, which is a big mistake, because there is lots of evidence that fluctuation is very important in the prognosis for people's individual cases, and for their work capability. It was introduced early on in the process—I think in the test that we did—and I don't think that that is the right place for it. Evidence that came back from the data certainly showed that adding that bit towards the end of the process added an extra element to enable you to assess work capability. As you know, some of these conditions vary greatly from month to month, or week to week, and quite dramatically. One week you might be able to work, and another week you cannot work

at all. For the Government to say that there is no need to change the descriptors for fluctuation is wrong.

The Government have also missed a trick over introducing a sliding scale, as I would call it, for the points. I think that one of your colleagues has already mentioned that. Somebody may come back and say, "But I am not well, yet I got no points." I would collect points—we all would probably collect a few points if it was done properly. You have probably got something wrong with you. I have several things wrong with me, so I'd collect points. It may not be points enough to give me the benefit that I want, but the individual then can go away from the system and say, "Well, they did look at me actually, and they gave me five points." They may say, "It is not enough to get what I need," but, psychologically, there is an important point in that. To take it further, why not have a sliding scale for what benefit you get on the basis of the points system? Why have rigid pitches at 15 and 30, so that if you get 14 points, you do not get the benefit, but at 15 you receive it? The Universal Credit is supposed to be run on a sliding scale, isn't it, so why not introduce such a scale for this?

Dame Angela Watkinson: The answers to my other questions were incorporated in that response. Thank you.

Q211 Debbie Abrahams: We had a meeting with Atos in relation to the Evidence-based Review yesterday, and I was concerned about the design of the process. As a former public health academic, and by assimilation, you probably know that the Government are saying that the alternative assessment is less reliable than the original one, and so are suggesting that the addition of descriptors is not helpful.

But in terms of the process, as you are probably aware, they talked about one observer and one assessor doing the original WCA, and then the observer moving into another office with a claimant to do what was meant to be—but certainly not by my definition—a semi-structured interview. I wonder whether you want to comment on that. I just thought that that was bizarre. Instead of having two parallel processes to be able to do some independent comparisons with two separate assessors, it just seemed bizarre in terms of how that had been designed.

Professor Harrington: Well, that was plan A. My scrutiny group and I—all medical academics—sat around a table and decided that, in practical terms, or even in ethical terms, putting these people through two quite separate assessments was going to be hard to do, and we might have a low drop-out rate, particularly among people with mental health and learning disabilities. We settled for this compromise that was likely to give us at least something towards the answer we wanted, without having nobody turning up to do it because it was just too stressful.

Q212 Debbie Abrahams: Were you able to do any sensitivity analysis in terms of the reliability? It is being quoted that the original WCA is 75% more reliable than the alternative assessment.

Professor Harrington: It depended on what criteria you do them on. I don't have the data in front of me, so I cannot answer your question properly, but I think it deserves to be answered properly.

I think it was depending on which way you set some of the criteria—whether the current WCA was better than the alternative assessment—and, by and large, it seemed to be more accurate. When you get down to sensitivity and specificity, there were differences between the two, which I think, as I remember, would suggest that the alternative was better. But in practice, it was not going to make a whole heap of difference, so the researchers in the Department did not put that forward as a means of changing it.

It was an incredibly difficult study to do, actually. As I say, what you have picked up on is absolutely right; that was plan A. A number of other things had to be changed, just in practicalities. Each time, we went back to the charities and said, "Look, we can't do it the way we said we were going to do it. We have to do it this way, and this is why." In the report of the review, they do spell out why they did not do certain things, which would seem otherwise to have been obvious.

The short answer to your question is: I don't know.

Chair: We need to move on. Graham has questions on the delivery of the assessment.

Q213 Graham Evans: Professor Harrington, I am not an academic; I am a business man and have a business background. I always believe that it is about delivery and the right outcomes for clients. The task that we now have is: what lessons are being learned from Atos by the new provider? Have you looked at how Atos was given the original contract, what its mandate was in terms of delivery, and what lessons can be learned? Have you looked at what the original mandate was and what lessons can be learned from that so that when we look at the new provider, the mandate that it is given is perhaps different to Atos's? What lessons do you think we should learn?

Professor Harrington: The short answer to your question is that I cannot answer it, because I am not a business man. The other thing—this is another cop-out—is that my brief was not to tell Atos what to do, but to tell the Department, should they want to get Atos to do it better. I kept saying that, and they didn't, and when they did lean on them, they walked away. I think it was difficult for the Department as well, because if you did lean on them and they did walk away, you would have a big problem on your hands.

So far as Atos was concerned, some of the people I spoke to—certainly the people in the centre—seemed concerned to improve the process. They seemed quite happy with that 4% failure rate—it seemed to be acceptable. The National Audit Office did not think it was tight enough. All I kept saying to the Department was, "I think Atos can do better than this. I think the quality of the work could be better"—going back to what I said before—"the quality of the training for some of these people should be better, and it is your job, DWP, to go back and renegotiate that contract with Atos."

So I did not. Whether I should have is another matter. I do not think it was my brief. So I would then go back to and see what Atos did the following year and go back to the DWP and say, "I still don't think it is good enough," but there was a reluctance to push them too hard, for whatever reason. So I cannot answer your question, but the contract with the new supplier—presumably, a private organisation—has to be looked at much more closely. I think my assessment of it, trying to look at it from a business man's point of view, is that Atos were the biggest game in town and it is going to be very difficult to replace them in numbers and quality.

Q214 Graham Evans: Given your knowledge of Atos and my own experience, when they took on the contract in 2008 I had a feeling they did so not realising the mammoth task or the ability to make money on the contract. It struck me that, as you mentioned earlier, the calibre of the health care professionals was an issue virtually from day one, as was the management and leadership of Atos in dealing with the health care professionals in terms of getting through the workload—they used to come and go as they felt free, was an observation—but also the quality of the health care professionals in terms of mental health. How important do you believe it is that the new provider should have health care professionals who are experienced in mental health issues?

Professor Harrington: I think it is very important. I knew a chap who was head of one part of the negotiating team looking at the DWP contract when Atos got it—the organisation that he worked for can be nameless. He said to me afterwards, "I am so glad we didn't get it, because when we looked at it more closely, we could not have delivered." That may have been what you are implying happened there.

The mental health and learning disability group are the biggest chunk of the hardcore people that we were talking about before, and they require specialist expertise. I am no expert in this, so I had to take advice from people who were, but it is clear that they have special needs in terms of how you understand what their capability is, let alone anything else—they don't even fill the forms in properly. When I went to one Atos assessment, this individual came in with somebody else, and they had no papers with them. The Atos assessor said to me straight away, "Oh, this will be someone with a learning disability," so I said, "What do you mean?" He replied, "Oh, they never bring any paperwork with them," You see, that is not a very good way to start, is it? You have to have that built into it.

It was clear from talking to the mental health champion that I talked to with Atos, an ex-consultant psychiatrist. He was making assessments of some of these people on paper by saying, "If this says 'paranoid schizophrenia' there is no point seeing this individual for an assessment. Right, move it over there." He would say, "This person needs to be seen, but by a specialist," or, "This person can be seen." It should work. They certainly started it, but how successful they were with it, I do not know. You will have to ask the relevant charities whether they thought that their people who had gone through a process with someone with specialised knowledge was better. It happened that at one of the centres I went to the Atos assessor had been a mental health nurse, and he was very good; he really did handle this one particular case extremely well. I could not have handled it as well, because my background, my medical expertise, never ran into that. I would not have managed it as well as this ex-psychiatric nurse, so it does make a difference. They are a very important group of people and they are probably the most difficult group in the whole WCA to deal with.

Q215 Graham Evans: Looking at some of the things you said regarding the caring aspect, you used the example of the nurse who said she was far too caring to work for Atos, but you also mentioned that the actual process is boring and therefore it is questionable about the calibre of the health care professional and it is just process-driven and so on and so forth. Many of us in this room have had constituents come in to see us who have told us they are "fit for work". We are just laymen, but they are clearly not fit for work, with mental illness or long-term disability. We would say, "We don't think you are fit to work." So it is clear that

when they have had those assessments, those people in there are either bored to death or they don't see it in that person. I was just wondering whether it is possible to put something into the system so that when that person walks through that door, they think, "How can I, as a health care professional or a layperson, help them to reach their true potential?" and look at it from an area, region, locality, community or a local economy point of view, knowing what opportunities are out there for those individuals. It may be a public or private sector opportunity. It may be an area of low unemployment. How can we look at that person, even though they may have several points there, and see their true capability, so that with help and support they could get gainful employment? Within the document they fill in, how can they say, "This person collects these points and has these ailments, but I believe that with help and support within this community and this economy they could play a role"? You may need to have some local economy information in a different dimension in that assessment.

Professor Harrington: What you are putting forward is a pretty good alternative to the current system—you could do this job very well. The problem the DWP would put to you is that it would be too expensive: "You are down to individual assessments of individual people with people with specialist knowledge both of the local economy and all the rest of it and we cannot afford to do that." I would say that you can have a system of triage, where you could be doing that for the more difficult cases. There is no reason why if you or somebody sitting next to you is looking at the employability aspect as opposed to the work capability—I keep emphasising the difference between this—you can come out of there with a small number of points saying that you really are capable of doing some work, but in your locality and with your previous skills, no. You would have to be retrained or the work would have to be altered because your condition means you really cannot travel on the bus first thing in the morning. You have colitis or whatever and you can only work three days a week. For some conditions there will be days when you simply won't turn up. The problem then is the real world test. Is an employer saying, "I don't need to bother with these sorts of people. I can find able-bodied people." Who needs to employ them? That is the real difficulty for some of the conditions. In the present market you don't need to go looking for disabled people.

Q216 Graham Evans: No. The example you used was the 55-year-old manual worker with back problems and so on. You could tell that 55-year-old manual worker to retrain in IT skills and that there were more sedentary positions there. It is that level of thinking. He is 55, but he still has another 10 years. He could get a sedentary position through the elements of retraining and help and support. Perhaps a pilot scheme could be done somewhere in the country where you could look at that. I know there is a cost element. There could be a pilot scheme for those hard-to-reach people with mental illness.

Professor Harrington: There are people who are supposed to do that. They are not the decision makers we have been talking about; they are people inside the Department or hired by them who look at the work—the work providers I think they are called or something like that—and they are supposed to do exactly that. Then there was this other group of people the Government were using to get people back into jobs and who were supposed to be training people up in exactly the way you said. And there have been some success stories of people who have been trained.

Glenda Jackson: Not enough.

Professor Harrington: Not enough, that is true, but it has been and it is capable of being done. But that requires joined-up thinking between the people who have done this WCA, or whatever you want to call it. It is about work capability. That does not answer the problem of how you are going to get this individual into a job in this locality. That is somebody else's job, but if they work together what you are suggesting could theoretically be done in one fell swoop.

Q217 Graham Evans: Do you think that sort of thing should be put into the contract?

Professor Harrington: It would be jolly useful if it was built into it and it worked.

Q218 Glenda Jackson: On the contract thing, I am no defender of Atos and I thought you were quite harsh about Atos in saying that they were the biggest game in town, but they were awarded a contract by Government and they won that contract—certainly it came out of the evidence that they presented to this Committee a long time ago—because they put in seemingly the lowest bid. Yet in evidence which they gave to us, they were categorical that they would train and that they would ensure that their staff were sympathetic, particularly to people with mental health problems. That clearly did not happen first time around, so surely those should be the requirements that are put in front of the Government when they consider to whom they are going to award this next contract.

Professor Harrington: Absolutely.

Graham Evans: So the lessons learned from the previous Labour Government, who actually awarded the contract to Atos in 2008—

Glenda Jackson: No, sorry, it was a Conservative Government who—

Q219 Graham Evans: Final question. Have you any evidence that Atos assessors were put under pressure to reach targets?

Professor Harrington: They say not, and wherever I have gone anywhere they say not. This is purely anecdotal, but there was one Atos assessment centre I went to where the bosses walked out and I was left with a couple of the assessors having a cup of coffee at the end of the session, and they told me they were under pressure. That does not prove anything.

Q220 Teresa Pearce: I was going to ask this question later, but it follows on the back of what you said, so I will ask it now. You talked about the sharing of information with Work Programme providers, and you recommended that the information obtained in the Work Capability Assessment was shared with them. However, Dr Litchfield said in his review that that did not happen and should happen with some urgency. Do you know what the barrier to that is?

Professor Harrington: No. Sometimes they work on different floors, and sometimes they don't know what the internal telephone extension is.

Paul Litchfield, who is coming in here next, has done a very good job. He did an excellent job at BT with his work on mental health. One of his strengths is that he is a process man and does not just say, like I do, "I think you ought to change this," and then somebody says "Well, I'm not quite sure how you do it." He has come along and said, "This is how you

do it." He has done it for that work and for the triaging of decision makers. I think in general, he has not disagreed with any of my recommendations, and he agrees that the decision maker is central. He has put forward some concrete ideas about how you can do it better, rather than saying, "Do it better."

Chair: Interestingly enough, in our Work Programme inquiry report, we said it was ridiculous that Work Programme providers did not get the information that the Government had spent a huge amount of money getting from the combination of Atos and the decision maker. That is the reason for the questions that Graham has been asking—that whole bit of the process is missing completely.

Sheila has some questions on decision making.

Q221 Sheila Gilmore: I think we have covered some of them, on the decision maker's role and putting them at the heart of decision making.

We had evidence last week from one of the tribunal judges, and when he was asked why different decisions were reached, one of the things he pointed out was that at the tribunal stage, these things seemed to come back together again. In other words, there is a layperson—the judge in the case—and a medical person, and they are working together. Do you think that should be brought earlier in the system?

Professor Harrington: The judges do not work off the same rules, though—they do not have to work by the rules laid down in the Work Capability Assessment. They are often seeing the claimant six to nine months later, by which time more medical evidence may have accrued, so what the judges look at in the tribunal, with their medical member, is different—or worse. They can look at the thing in the round, which in some ways the decision maker has been stymied in doing.

What I got the Department to agree was that the decision makers would produce a rationalisation statement at the end of their time, saying in a paragraph or two, "I think this individual should be in this particular group, and the reasons are this, this, this and that." That then goes as the Department's view, as part of the appeal. What I was trying to get to was not just having a pile of paper handed on to the judges. The decision maker would say, "This is why I have come to my decision, and if you don't like it or don't agree with it, will you please tell me why?" That is why I wanted feedback from judges right from my first report, and I did not get it, because the judges didn't want to do it.

Q222 Sheila Gilmore: I thought you said in your original report that you were not given the opportunity to discuss that with the judges. Is that correct?

Professor Harrington: Well, I did: I discussed it with the first-tier tribunal president on a number of occasions in my first year and into my second year, and we had a verbal agreement that we would have a form of feedback from the judges. Some individual district judges said to me, "I'll do it now. It won't take long; it's just another couple of minutes at the end of it." They did not do anything. They then refused to deal with me, and wrote me long letters saying that it was outside my remit to deal with the appeal system. My response to that is that the claimant's journey, from the first telephone contact to the end of the appeal process, is my remit. In the end, I went to see Chris Grayling and said, "I'm getting nowhere with the judges. Will you please do something about it?" and he did. They then established

the pilot scheme, which is still not more than a pilot scheme and we are five years down the line.

Chair: We have some questions on appeals.

Q223 Sheila Gilmore: On the additional evidence issue, there has been a court case involving additional medical evidence for people with mental health issues which seems to be stuck somewhere in the system. We get a lot of—I think we had it yesterday—people still feeling, in terms of the additional material they want to bring, that they either do not know what they should be producing or do not feel it is taken into account. Have you got any suggestions for how to improve that part of the system?

Professor Harrington: I have always thought that further medical evidence was a real, big issue. In my third report, I made clear what I thought was the right way to go—rightly or wrongly—and I canvassed opinion right across the board. In fact, I think I spoke to your group about whether we go for mandatory or voluntary requests for this stuff. The upshot of it all was that further medical evidence is very important in a number of areas, but I suppose that for mental, intellectual and cognitive disorders, you really ought to have a system whereby you probably ask for it in all those cases. With other people, I just want the decision maker to stand back from the process and say, "Have I got all the information I want? Do I want more medical evidence?" If they say they do not need more, they need to write down on a piece of paper why they do not need more. In other words, for a lot of cases, they will ask for more. That is really the basis of the judicial review that Mind and Mencap brought against the Department, on the fact of not using that. My view is that, if the Department had done what I said in the third review, they might not have had a judicial review at all, but the Department's response to that was, "Atos can do that." We are back to the circular argument here: they will not and they cannot, so let the decision maker do it.

At what stage do you ask for further medical evidence? Ideally, right at the start. But no one ever produces it right at the start. Even if you ask for it to come in with the ESA50 form, it does not, often because the claimant does not think it is needed or because it would cost them 50 quid to get it from their GP. That is why I used that last example of the decision maker phoning the claimant right at the end of the process and saying, "I have come to the end of it. Is there anything more you want me to look at?" They say, "Yes. What about all this other stuff?" and then you get it.

Q224 Sheila Gilmore: So you think the decision maker—taking us back to the beginning of my questions—should be the one who evaluates, before they make their final decision, whether they have enough material and then request it if they have not?

Professor Harrington: I think they are the backstop. In an ideal world, what a decision maker should be doing is making sure that information has gone through the Atos assessment, or whatever it will be called. Or, that they discuss stuff which they do not understand with the health care professional and say, "I have had this report in. I think I know what it means but what do you think?" Between the two of them, they come to a decision on what they do about it. That is another bit of joined-up thinking between the various sections of this process.

Q225 Anne Marie Morris: You have talked a lot, quite rightly, about communication and the need for the administrative arm to talk to the medical arm. Just a minute ago, we began to move on to communication with the judiciary and the first-tier appeals. Clearly, from what you said, you agree that there needs to be much more sharing of information to ensure that lessons learnt at the first-tier tribunal are passed down the line.

You have talked a bit about the pilot programme, but—putting the pilot to one side—I would be interested in your views on where we are today and what the current situation is. We started out with what I would describe as a minimalistic feedback system, which is just a kind of tick-box one reason. Now we have moved on to something that, in theory, is better because it allows you to give a descriptor. None the less, it is still fairly constraining. My understanding from your views and what you have written is that you don't think that has quite gone far enough. I would like your comments on the move from the one-line tick-box to the greater descriptor and whether you think we have got to a satisfactory point. If not, and I suspect the answer may be not, where do we go from here?

Professor Harrington: I thought that one-liner was pretty minimal. I was prepared to let that go ahead, but I didn't like it. Talking with some of the district judges—who are much more prepared to co-operate than the first-tier president—they said, "I'll do that for you, it won't take me a moment, it's just a couple of paragraphs." That is the same sort of statement that I have got the decision makers to do—saying, "I believe this individual is in this group and these are the reasons why I think it." In a paragraph, they can do that. The judge was perfectly prepared to write a note back saying, "I don't think you're right and these are the reasons why I think you're wrong." That does not mean that I get people into the business of pointing fingers. That is a learning process: "Thank you very much, I see the error of my ways" or whatever.

Judges don't like being judged, that is the real crux of it. Who judges the judges? The assumption is that the judge's decision is right. I am asking why. Perhaps they are wrong and perhaps the decision maker is right. A number of decision makers came to me and said, "You have got it all wrong, you don't understand the case at all." But you cannot say that about judges. I think this is one of the reasons we are having difficulty getting feedback, because feedback means two things: not only telling the decision maker that they don't know what they are talking about, but occasionally the decision maker will make it clear that the judge has got it wrong.

Q226 Anne Marie Morris: That is very helpful. That addresses the issue of the judges and the cultural challenges we have there, but we still have some information now going to DWP. It is not sufficient or adequate, but it is something. What could DWP do better to use that to implement change and improvement?

Professor Harrington: Training. They have got a quality training programme in place for the decision makers, which they didn't before, and there is also audit. There is also the business—which the airline pilots have been doing for years, and the medical profession too, to some extent—of having these confidential, no-fault conferences between each other and saying, "How did you screw up?" and being prepared to talk about it. That is happening inside the Department as well.

This business of feedback is a very positive process of learning. If people all feel that the object of the exercise is to get this thing right—and right first time so that we don't have

an appeal process at all—then you will get to a position where both the decision makers and the judges have some sort of dialogue, maybe a literal dialogue over some cases, and respect each other and what they are trying to do.

The object is not to pull the wool over anybody's eyes or to score points over somebody else. The object is: what are you going to do about this claimant and what is the appropriate benefit or work capability programme for them? Don't mess around and mess so many people up and take so long about it. The longer the process goes on, the more stressed the individual claimant becomes. I didn't realise that a lot of these people feel that going before a judge is going to a court of law where they are going to be found guilty or not guilty. That is hanging over them for six or nine months and it makes them more ill. They don't see it the way I see it, as just a tribunal. No, this is a court of law and a lot of these people see this as a criminal court. They know no other court and so are they going to be found guilty or not guilty of persuading the Government that they should or should not have a benefit? Their health deteriorates during that period of time. If you can get rid of that alone, that would be something.

You have to have an appeal system; I accept that. No system should ever be without an appeal system.

Q227 Anne Marie Morris: That is really helpful. To summarise what I think you are saying, this is about a need to change the culture, which may be how you articulate and shape the appeal process and how you present it. The solution is very much about that and training, as opposedz to fiddling with more information being fed through, whether it is one line, a paragraph or whatever. In a sense, the concept of just more information for DWP is not something that would work so it is an irrelevant thing to really consider.

Professor Harrington: The other thing the judges said to me earlier is that the DWP never turn up to the appeals, although they are perfectly welcome to turn up. In the old days, the adjudicating officer often turned up to appeals. One of the reasons why they don't is the sheer volume of stuff. If the process I am suggesting decreases the number of people who go to appeals, maybe the numbers will become small enough for it to be possible sometimes for the DWP representative to attend and be part of the final process. It is a direct learning experience for the judge and the decision maker because they sit in the same room looking at the same case.

Chair: I would like to say we have exhausted our questions, but we have not—there are still hands up. Unfortunately, we have exhausted our time. Thank you very much for coming along this morning. What you have told us has been very useful. Your knowledge has been useful, and you have reflected on what should be happening and still is not happening. That is what we will take from this morning's evidence. Thank you very much for your time.

Examination of Witness

Witness: **Dr Paul Litchfield OBE**, gave evidence.

Q228 Chair: Dr Litchfield, thank you very much for appearing in front of the Committee for the first time. I don't know whether this will be the first of many appearances, like your predecessor, but your coming along this morning is much appreciated.

One of the things that is often said about the Work Capability Assessment is that it is not really a Work Capability Assessment, but a benefits eligibility test, so there needs to be another test to look at a person's employability and barriers to work. Do you think the WCA should be replaced by two tests that do those very different things, which might result in a better outcome for claimants?

Dr Paul Litchfield: Being of a certain age, I remember the genesis of the current system. One of the things I thought when I was looking from the outside at the development of the Employment and Support Allowance was that having a second assessment would be really helpful. As you say, it would focus on identifying the support people need to get into and remain in work. As I understand it—I came into this a little less than 18 months ago—the second, work-focused assessment was put into abeyance in 2010 for all sort of reasons that seem to have been largely practical. As I understood it at the beginning of my review, there is no intention to resurrect it in the near future. Certainly, most people in the world of work and health saw the original design as a positive thing. Whether the practicalities and the practical difficulties that ensued can be overcome is another issue.

Q229 Chair: Would an assessment such as a WFHRA—a work-focused health-related assessment—or something similar make the WCA that Atos or the private contractor carry out less expensive, and could the assessment be simplified if there were two elements to it?

Dr Paul Litchfield: I am not sure about that. If one has the premise that eligibility for benefits should be based on capability, you need some sort of capability assessment. The practical issue is how you translate that into practical support for people who are deemed to have capability for work or work-related activity. One of the things one finds in trying to support people with health problems who are in work is that if you don't supply that support, which needn't be overly complex, they don't succeed.

Q230 Chair: But isn't there a psychological difference between someone going into an assessment that will decide whether they get the money or not, and someone going into an assessment that is much more discursive about the barriers to work and may be help-focused, rather than punitive assessment-focused?

Dr Paul Litchfield: Absolutely. I don't know if I would use the word "punitive", but certainly in terms of determining eligibility for a benefit, that is quite a different interaction, between the person making the assessment and the individual being assessed, from one where somebody is being assessed to see how one can help them. They are quite different. Whatever one has in terms of an assessment for benefit, I think that is always going to be an issue—how you make sure that people feel that the process they are going through is fair, which is one of the things that I tried to focus on in my review.

Q231 Chair: You recommended that less emphasis should be placed on the points obtained by each claimant in the Work Capability Assessment and that the calculation should

simply be used to assess whether the threshold for benefit has been reached. How would you change the system to have less emphasis on points?

Dr Paul Litchfield: I can see the value in having a points-based system. What one is trying to do, in a system that is conducting a very high number of assessments over multiple sectors, is to take an assessment and ensure that it is applied consistently. Having a points-based system allows you to take expert opinion, which is the way the test was designed, and translate it into something that a non-expert can apply in a consistent way. I get that, and it is important for the mechanics underpinning the assessment.

My worry, when I started looking in detail at the assessment, was that there seemed to be an undue focus on those points. That has two consequences, really. One is that, because there are points, people assume that there is a linear relationship—that 18 points means twice the lack of capability of nine points, for example. That most certainly is not the case. We took quite a lot of time going back to determine how the assessment was developed in the first place. It was very much about whether you did or did not qualify for the benefit. It was trying to determine which side of the threshold people sat. The points are a way of getting there, but we certainly could not find any mathematical relationship between them. People assume there is a relationship because those points are there.

I saw examples of people with the best of intentions arguing about or trying to move somebody from one set of points to another, even though it would make no difference whatsoever in terms of their eligibility for benefits. I think that focus on points is a distraction from the real issue. It can also imply a degree of sophistication that is not there.

Q232 Chair: Would it be better if it was some kind of sliding scale?

Dr Paul Litchfield: I think that if one is going to have a sliding scale, that would confer a considerable number of benefits. To move beyond my terms of reference and think more broadly about the way that one could use that sort of system, if there was a reliable sliding scale, at different points in the economic cycle one could shift the threshold to match the labour market. With the current system, you cannot do that. One might assume—talking to a lot of people, the assumption did exist—that one could do that with the current system. You cannot; it is very much either side of the 15-point threshold. If you had a sliding scale, it would allow you to have a more dynamic system, but to create that one could not start from where we are at the moment. One would have to go right back and create an assessment based on a different set of parameters.

Q233 Chair: So you would have to get rid of the descriptors that they currently have?

Dr Paul Litchfield: I think you would have to create a system that was based on a completely different set of premises. We would be talking there about fundamental research. My estimate, in ballpark terms, would be a minimum of five to seven years to get something like that designed and tested, so it is a long-term project.

Q234 Chair: Other advanced economies have the same problems that we have with assessing people and their fitness for work. So there is nowhere else internationally that does it better than we do, or does it differently?

Dr Paul Litchfield: There are certainly people who do it differently. Whether they do it better is a subjective opinion, which I do not think I am qualified to comment on; but certainly when one looks at other systems, we comment in the report about both the Netherlands and Denmark, where they assess things in a different way that takes into account the impairment to earnings that people have suffered as a way of determining benefit. That is one way of doing it.

I have looked a bit more closely recently at the New Zealand system. Again, that is more similar to ours, but looks at things in different ways. The capability assessment, which they are just in the process of implementing, is at the back end of the process rather than at the front end, as we apply it.

Q235 Chair: Can you clear something up about the points system and at what stage different people know about them? We met with some Atos assessors who have been doing what I think was a pilot for the alternative assessment. They told us that, as assessors, they do not see the points; they just tick the relevant boxes or fill in the box as they are going through the interview, and it is only the decision maker who sees the points that the person has achieved. That was news to us. Is that the case? Is that how it works? Who generates the points?

Dr Paul Litchfield: The points are generated on the basis of the assessment carried out by the health care professional. I am sure that it is entirely accurate to say that the health care professional does not see the points. However, if you have any degree of experience at all, you know which descriptors equate to which points, and it does not take a great deal of mathematical ability to work out what you are saying in terms of a point score. Even if people do not actively think about it, I am sure it is running through their mind when they are doing the assessment. It is quite right that decision makers are the ones who see the points.

Q236 Chair: So it might be that you have an experienced assessor who knows that if they tick that box they will generate three points and an inexperienced assessor who has no idea or cannot remember because they are inexperienced. Would that help to explain the difference and why, on one day, an individual gets no points, but then goes to appeal and gets 15 points? It has always been quite difficult for us to grasp how it could be that wrong when the same person presents not with a variable condition, but with exactly the same disability or ill health, but to a different person.

Dr Paul Litchfield: I suspect that there are several answers to that. One is a different interpretation of the same information that is presented. The second is that, when one is looking at appeal, quite often there is additional information that is taken into account. Certainly in the appeals that I have witnessed, that was a significant factor in coming to a different conclusion from the one that was originally determined by the Department.

Q237 Chair: In response to your recommendation that there should be less emphasis on points, the DWP said that it was going to review how we communicate the point scores to claimants. Do you think that is enough?

Dr Paul Litchfield: I think it is a start. I think it is also the way in which decision makers are trained to look at points and understand that this is not a linear scale. I think that

bit of learning—which, as I say, was new to me—appeared to be new to some other people in the Department whom I spoke to and who had made the assumption that it was much more of a straight-line scale. So I think communicating what the points mean more effectively to decision makers would be a valuable contribution.

Q238 Chair: We have talked about the descriptors. In answer to my question, you said it would take seven years to start from scratch again. Do you think the descriptors are basically wrong at the moment? Do they need a major overhaul?

Dr Paul Litchfield: I haven't looked at the Evidence-based Review in detail yet. It hadn't been published at the time I wrote the report for the fourth review. I have read the review. The way I tend to work is that I like to mull things over, so I want to examine in much more detail what was actually said in the Evidence-based Review. But to come back to your question: are the descriptors wrong? No. Could they be altered? Of course they can, but every time you alter a descriptor you are altering the whole basis of the assessment. If you change one thing, you have to be very careful about the unintended consequences there might be for the whole of the assessment. So there is a policy decision to be made about whether one fixes things as they are at the moment, or with any revisions that have come out of the Evidence-based Review that end up being accepted, or one starts with the design of a totally new system.

Q239 Chair: But the Evidence-based Review will inform your second year.

Dr Paul Litchfield: It will indeed and it is going to be an important part of what we comment on in the fifth-year review.

Q240 Sheila Gilmore: In terms of the whole issue of points, the reason claimants have become so concerned about it is that it determines eligibility for benefits. Inevitably people will think that is really important and therefore query how this is arrived at. In terms of people feeling confident in the system, is it not really important that we get this done better?

Dr Paul Litchfield: I think it is extremely important, in terms of having a system that is perceived as being fair, that people understand the basis on which a decision has been arrived at. What worries me is that people focus on "I should have had nine or 12 points instead of six", when actually it doesn't make a difference to their eligibility for benefits. Understanding the reason why you have or you haven't qualified for a benefit is critical, but having that very strong focus on points, which came over very forcibly to me during the course of the review, can be unhelpful.

Q241 Sheila Gilmore: Where do you think that comes from? I can understand why it comes from claimants, because they focus on that as a way of perhaps improving their position or arguing their case.

Dr Paul Litchfield: I think it comes from there. I think it comes from the way that the Department's processes are constructed. I think it comes from a variety of different areas. Certainly from the Department's point of view, explaining more clearly to everyone involved in making these decisions what the point system actually means, and how the whole assessment process was constructed, would be helpful in their understanding and therefore

their communication to people making a claim about why they have come to the decision that they did.

Q242 Glenda Jackson: Does the decision maker know what is behind that? They know what the descriptors are. So they know what is awarded. When they have that, they are in a position, are they, with the individual sitting across from them, to question it then and there?

Dr Paul Litchfield: Yes they are. Of course, they are not sitting across from the individual, which is one of the other points I comment on in the report. But certainly if they get through on the telephone when they are making the decision assurance call, it is the focus of part of the discussion they have with the person then. So the statement that, if you like, generates the points is something they have available to them so they can talk about that and they can talk about the evidence that has gone into determining whether it is that statement that is most appropriate, or whether it is one of the other statements that is appropriate.

Q243 Glenda Jackson: But these claimants are not unknown, presumably. They have a history of benefit claims.

Dr Paul Litchfield: Not necessarily. It could be a first claim.

Q244 Glenda Jackson: And also it could be somebody who has never worked in that particular Jobcentre before. I understand that. But that seems to me to be the area where, if we are going to reduce the number of appeals, it should happen.

Dr Paul Litchfield: One of the things that I recommended in the review was that there should be a more personal interface between the decision maker and the person making a claim, because it is not someone in the Jobcentre that is doing this work; it is somebody in the Benefits Centre, which is divorced—sometimes geographically by quite a long distance—from the person involved. While there may be telephone contact with that person, there is almost never face-to-face contact. Maybe I am old-fashioned, but I feel that face-to-face contact is a much better way of generating trust.

Q245 Glenda Jackson: Sorry to keep on. I accept the point about new claimants, but, for historic claimants, someone somewhere within Jobcentre Plus or DWP must have a history of that individual's health, be it mental or physical. Surely that should weigh very strongly when it comes to assessing what the computer has said.

Dr Paul Litchfield: One of the issues that the Department is looking at is ensuring that that history is available to decision makers—

Glenda Jackson: Oh, they are.

Dr Paul Litchfield: Because, at the moment, it is not always available to decision makers, so they may or may not have information related to previous assessments, whether that is in relation to Employment and Support Allowance or its predecessor, or indeed the other benefits. One of the points that I make in the review is that a number of other related but slightly different assessments are coming on line and, at the moment, there does not appear to be any process to ensure that information, where appropriate, is shared there. It just

strikes me as common sense that if a decision maker has as much evidence as is available to the Department, that should be there for them to be able to use.

Q246 Dame Angela Watkinson: We have heard accounts from individual claimants of medical evidence from doctors or consultants being either ignored, disregarded or overruled by assessors. Did you find that during your review?

Dr Paul Litchfield: I did not see specific examples of it. I certainly heard examples quoted of it by a number of people. I think one has to differentiate between a medical report which is focused on medical issues and a report which is focused on capability. A lot of people in the health care professions do not necessarily comment on capability when writing reports, so you will often see a medical report that is full of important things about investigations and diagnosis and even prognosis in a medical term, but that does not mention at all that person's ability to do day-to-day tasks, let alone their ability to work. One has to weigh medical evidence on the basis of what it is telling you that is useful and relevant to the decision that you are trying to make.

Q247 Chair: We were in Newcastle yesterday and a welfare rights worker used the example of one her clients whose GP had filled in a DS 1500, which is for terminal diagnosis, which was then discounted by, I think, a decision maker. How can that happen? Or should that happen?

Dr Paul Litchfield: Stuff happens. It sounds very odd to me, certainly something like that which is not about capability for work. This is terminal illness—

Q248 Chair: It is just not believing what the doctor had written.

Dr Paul Litchfield: That surprises me. I certainly did not come across any examples of that sort of thing. I am not saying that it would not happen; I have forgotten the numbers, but, as we are talking about a system with 100,000-plus cases being dealt with every month, mistakes happen. But it does sound odd to me.

Mr Thornton: If you remember, Chair, one of the Atos people who was a doctor said, "The doctor's doing the DS 1500"—

Chair: They filled the wrong form in, but it seemed strange. Actually, as it turned out, this client was in hospital at the time and was seriously ill.

Q249 Teresa Pearce: On that point, you have seen that doing Work Capability Assessments is very process-driven job and we heard that it is very boring. Do you think that the people who do it get some sort of compassion fatigue so that they do disbelieve things? I have had an instance with housing: a letter from the police saying this person was in danger of violence from an ex-partner and needs to be moved, and the housing department said that the police write those letters all the time, because they get compassion fatigue. Did you see any of that with the tedium of the job?

Dr Paul Litchfield: I didn't. We are talking about the health care profession—

Teresa Pearce: Yes.

Dr Paul Litchfield: Who do the face-to-face assessment. I didn't come across that, no. When I have visited Benefit Centres, I very much doubt that the poor performers are put in front of me. I suspect I have the better performers put in front of me. Nevertheless, I did not see that. Indeed, both in terms of health care professionals and decision makers—I comment on it in the review—I was impressed by the degree of diligence and compassion that was shown. I sat in on some assessments, and in all of those I felt that if I had been the person being assessed, the manner of the person carrying out that assessment would have satisfied me. But that is not to say that compassion fatigue does not exist. You are quite right, and one sees it in other contexts. It is a risk. It is something that I, as a health care professional, along with all others, need to be particularly alive to. Just because you see something all the time, it does not mean that it is not very special for the person who is experiencing it.

Q250 Debbie Abrahams: Out of a group of about 120, there were two counts of a DS 1500 being ignored. I appreciate your saying that that has not been your experience. Again, we were impressed with the group of professionals we saw, but it does seem to be very variable and patchy. In your reviews, how are you going to make sure that you pick up on that variation?

Dr Paul Litchfield: There are several elements there. First, this is news to me about ignoring, or interpreting differently. It is something I will pick up on in the year 5 review, because it is something that merits my looking at. In terms of ensuring there is consistent quality, I think it comes down to having the right experience with people carrying out the assessments. That is something I comment on in the review. It comes down to training. Again, I have commented in the review on enhancing training both for health care professionals and decision makers. Then it is making sure that the quality assessment framework, which the Department applies to its own decision making, considers not just the process elements, which I think it is very strong on, but the outcome elements, so that one looks at the decisions that are being made and reviews them, not just at whether all of the steps in the process are being carried out correctly. So I think there is a range. It is, I suppose, trying to implement a quality circle within the process. It does exist, but, like any quality circle, it can be improved.

Chair: Just to be clear, I think there was only one example of a DS 1500 being ignored. The other example was someone whose medical report said that they were a suicide risk and had already attempted suicide. That was ignored and the person went on to commit suicide before they got a determination. I think the family pursued it. Again, that ignoring of the medical evidence caused a huge amount of distress, as you can imagine. It was very powerful.

Q251 Sheila Gilmore: One of the things that causes a lot of stress is the number of repeat assessments. You make one recommendation about one group who perhaps should have a five-year period before being reassessed. Do you think that could be taken further? We repeatedly hear how choked up the system is—there are delays and lots of people—and yet repeat assessments continue to happen a lot of the time. Do you have a view on that even wider than in your recommendation?

Dr Paul Litchfield: In terms of that recommendation, the element that struck me most forcibly was that for people with severe conditions—I picked particularly on people with

severe brain conditions because those were the cases that were reported to me the most often—and particularly with deteriorating conditions, it did not seem terribly logical to me that you would call those people up for review after a relatively short period. Now, I recognise that one never wants to write people off, and I think that is absolutely important, which is why I suggested that as a start, perhaps, one should implement a longer review for that group. Perhaps it is pragmatism on my part in trying to get things done in large organisations over very many years, but I think that if you ask for something that seems eminently reasonable, you are more likely to get it, and you can build from there. If you ask for something that is much more difficult, you might not even get past first base.

Q252 Sheila Gilmore: I see that, but one of the problems we are faced with is that we have had a Minister announcing that because there is a backlog, he is going to suspend reassessments for an unspecified period—it is very unclear—so people still do not know whether they are happening or not. From the evidence yesterday, reassessments still seem to be happening, despite what the Minister has said. The phrase that comes to me is "rod for own back." To some extent, the delays and the huge workload that seems to be going through the system are exacerbated by insisting on such things. The response is often that we do not want to leave people for ever doing nothing, but surely there is some sort of happy medium here.

Dr Paul Litchfield: I am sure there is. Other recommendations that relate to that are: after somebody has been through an appeal—I certainly had brought to my attention cases where literally a few days after the appeal result came through, so did the request for a reassessment—I recommended that there should be at least a period of perhaps six months. One might think of that as a cooling-off period, if you like, but I think we should certainly introduce some sort of gap there.

The other element, in terms of suggestions around potentially redesigning the process, is that I think there is potential for doing more, particularly with review cases, on a papers-only basis. If one shifts the way in which the process is designed, one can achieve that so that those face-to-face assessments—which can be hugely valuable but, I recognise, can also be very distressing for people—are not the automatic default, if you like, but are commissioned on the basis of a conscious decision by a decision maker that that is something that will help to provide information that will make for a better decision. If one did those things, it would provide a rational approach to reducing the caseload.

Q253 Sheila Gilmore: These issues like not calling people back in just after an appeal are not new. You are finding it now, but we have been hearing this for four years and probably longer. Why is this still not being tackled? Is some guidance needed as to what is an appropriate period for recall?

Dr Paul Litchfield: I made the recommendation, and I do not recall that recommendation being made explicitly before, although I do recall it being commented on. By making it a specific recommendation, it elicits a response from Government. We will see the action that results from that, but at least it is the one thing I could do to prompt that activity.

Q254 Mr Thornton: We have gone through a lot of this already, but I would like to know how you think your recommendations for improving perceptions of the WCA fairness have been taken up. Are they being looked at?

Dr Paul Litchfield: I think it is early days. The report was published in December and the Government's response came out a couple of months ago. Most of my recommendations, and certainly those relating to the perception of fairness, seem to have been accepted, albeit in some cases with the caveat that they need to be looked at in more detail. Part of this year's fifth-year review, which I am doing, will be to look at that and to see what progress is being made. I do feel it is fundamental: it is at the heart of the whole report that if people in general in society do not feel that this is fair, it will never be successful, so we really have to work on that. What I have tried to do in the review is to give practical suggestions for how that might be achieved. Many of them are quite little things, but sometimes little things can make a big difference.

Q255 Mr Thornton: I noticed something yesterday when we were in Newcastle that may not be being attended to. I have a great deal of experience and a large part of my professional career involved interviewing people for financial services. One thing that was very evident when I was being trained and when I was training other people was that people do very well at the training stage—they know exactly how they are supposed to react, pass with flying colours and go on to get a job—but very often within a very short period, sometimes days, they are not following the process in the way they were trained and they are not interacting with the person on the other side in the way they were trained.

We have all heard about the building society thing—"Oh, computer says no"—and that is in a commercial environment where someone is paid more if more people take their products. It happens there, where there is a financial incentive to do better. I used to go out and train people and then go back and retrain them. I would tell the supervisors in charge, "Look, you've got to keep going back and checking that they're doing it. They are not doing the process particularly I trained them in—a process that reflects what you want to achieve."

I am just wondering about Atos and the reason why. The people we saw yesterday seemed very competent and said they were getting the right answer out of people, but how many of them are actually doing what they are meant to be doing, and how many are just going, "Okay. Okay. Okay. Sorry, that's it."? I suspect that there are far more than we think. What do you think?

Dr Paul Litchfield: You may well be right. Certainly one of the things I recommend in the review is revalidation of health care professionals. Just because you pass a driving test—as I did in 1971, I think it was—doesn't mean that you are still a good driver however many years on it is, and it is the same with health care professionals. Certainly in the medical profession these days, we revalidate generally every five years. It struck me that having some form of revalidation for health care professionals would be a sensible enhancement. I have not been privy to the detail, but I know that negotiations are going on by the Department in terms of new contracts, and it may well be that the Department would wish to consider putting something in.

Q256 Mr Thornton: It is not just the revalidation; it is actually the continuous, effective training and supervision all the way through, day to day, to ensure that people are keeping up with the right way of doing it. It is quite a tough management system to do that.

Dr Paul Litchfield: I think it is, but there are ways of doing that, whether it is Ofsted-type things, periodic sitting-and-watching assessments, or routine recording which is monitored regularly. There are ways of doing that but, yes, I take your point and I agree entirely.

Q257 Mr Thornton: Moving on from that, one thing that you recommended is suitable and sufficient previous experience of dealing with people with mental health problems so that they can contextualise their findings at assessment, and have the ability to understand mental health difficulties and problems without being overwhelmed by them. Do you think the Government are responding to this recommendation? Should there be different types of assessors with different skills interviewing different people?

Dr Paul Litchfield: The Government's initial response was to ask for some help in determining "suitable and sufficient", and I can understand that. I have to say that when the boot is on the other foot and you are working for an employer when the regulator in a health and safety context says you need to provide suitable and sufficient training and you ask for clarification, you tend to get the response, "Well, that's for you to determine."

We have had some discussion and I am happy to help to give some advice and guidance on what suitable and sufficient looks like, but at the end of the day it has to be for the Department to stipulate that and for the provider then to be held to account for delivering against that. But in general terms, I don't think we are talking about people who have had training as a psychiatrist, for example. I think it is having sufficient general experience of dealing with the broad range of issues. For example, general practitioners see an awful lot of people with mental health problems, but there are other branches of medicine. A pathologist, for example, could in theory be employed on this contract, because they have a primary medical qualification, but I very much doubt they have any current or relevant experience in dealing with mental health problems.

Mr Thornton: They are not looking for that in people they are examining, are they?

Dr Paul Litchfield: Their bedside manner is said not to be terribly good, yes.

Q258 Mr Thornton: If there were a certain number of assessors who had more mental health training than others—so if it was recognised that some cases were difficult, and they could be given an appointment with one of them—do you think that might be helpful?

Dr Paul Litchfield: One of the changes that has been made as a result of Professor Harrington's recommendations is the introduction of mental health champions. That does seem to have been helpful, but mental health champions are a resource that is available to other health care professionals or, indeed, decision makers over the telephone. It is a compromise between the practical difficulties of trying to match individual people making a claim with the skills of the health care professional, and then coping when you find that, actually, what you knew in advance is not what the real issue is and that can often be an issue with mental health, as opposed to the other approach, which I think I favour, which is to make sure that everybody has suitable and sufficient experience in dealing with the common

things that come up and that they then have appropriate training to help them to deal with that. So I think training up the mass of health care professionals is probably—certainly for those common conditions—a better approach than trying to do the rather complicated matching, which would be another approach.

Q259 Mr Thornton: It is just making sure that they can recognise the signals and what someone is talking about there may not be underlying problem at all?

Dr Paul Litchfield: Absolutely, and being able to contextualise it.

Q260 Kwasi Kwarteng: You mentioned Professor Harrington's recommendations, and I wanted to ask you about the idea that information gathered up during the WCA should be shared with the Work Programme providers. I just wanted to know what your thinking is about the urgency that you want the Department to show in implementing these recommendations.

Dr Paul Litchfield: First off, it struck me that it was the only one of Professor Harrington's recommendations where there appeared to have been little or no progress. The other recommendations, in my opinion, had either been fully implemented or at least there was material progress being made in terms of implementing them, but that one had not. When I delved into it a bit, there appeared to be a lot of procedural process, sometimes legally based issues around why it could not be done. I felt therefore a fairly strong recommendation to get on with this was appropriate. It is certainly something that I will be looking at again this year. I have already met with some work providers to try and understand better what would help them to assist people, particularly following this work-related activity group, but again, rather like making sure that decision makers have access to as much information as is already available to the Department, it just seems odd that you are collecting a whole load of information which could be of value and then you are not using it. I am sure there are difficulties, but I feel that perhaps we need a little more oomph in terms of overcoming those.

Q261 Kwasi Kwarteng: Following on from that, were you happy with the Government's response to your recommendations?

Dr Paul Litchfield: Do you mean in general, or on that one specifically?

Kwasi Kwarteng: I seem to have trodden on—

Chair: Carry on Kwasi—

Q262 Kwasi Kwarteng: I was taking a slightly more free-flowing approach to these proceedings. I was thinking about what you were saying about the implementation of Professor Harrington's recommendation about specifically sharing information, and what you thought more generally about the Government's response to your recommendation.

Dr Paul Litchfield: They said they were looking at it and that they would try to do it, but again, it is something I will specifically focus on this year and see where we are getting to.

Q263 Chair: We hear a lot about mental health—even in the assessment by Professor Harrington there was a lot about mental health and, indeed, there was a lot about it yesterday in the evidence we got—but there is also the group with learning disabilities and autism. Some of the people in my constituency who work with that group of claimants are very, very critical of the form of questioning, because questions are often set on the computer but are not phrased in a way that someone with a learning disability or autism can understand. There seems to be no credence given or, when the carer or parent goes along with them to the interview, they are basically told to shut up and are not allowed to speak, even though they are trying to point out that he or she does not understand the question phrased and it will have to be phrased totally differently. There is no sense that there is any proper training for assessors in how to deal with that group of individuals.

Dr Paul Litchfield: I have not looked specifically at the training for that, but it is a good point and I will look at that this year. In terms of companions, it is something I comment on specifically. The rules state that a companion is perfectly entitled to be present if the individual wants that. We certainly came across examples of that not being properly applied, or the perception of the individual and their companion that their evidence was not taken seriously.

All my experience in occupational medicine is that having someone else there can often be extremely helpful, particularly in the case of people with learning difficulties. I have recommended that the Department improves the guidance on that. I think it is absolutely critical for that group that questions are framed in a way that they are likely to understand, that testimony from those who know them best is taken fully into account and—again, something I found in the review—that inferences are not drawn on the basis of oblique questioning. That is when you ask something and then draw an inference on capability based on indirect questioning. First, I think that, particularly with that group, that can lead you into errors. Secondly, I think that if you draw conclusions in that way, it undermines trust—people think you are trying to catch them out. I think all of those things apply, and I hope the Department will pick up on all of them.

Q264 Nigel Mills: Starting on that last point, the use of oblique references is fundamental to how they carry out their assessments. They ask you how long you can watch TV for and how you cook your dinner. They do not ask you, "Can you lift something from here to here?" That would change the whole thing.

Dr Paul Litchfield: I think there is a difference between indirect and oblique. The example I put in the review was a woman who was asked if she had a cat and, on the basis of that, all sorts of conclusions were drawn about her degree of manual dexterity, which came down to whether she could use a tin opener. I do not have a cat, but I am told that cat food does not often come in tins these days and that, if it does, it is a ring pull. Apart from the potential error in that logic flow, I think most people would feel that was oblique questioning, which seems designed to catch people out.

Indirect questioning is fine, because people will often not have recent experience of the things you are interested in in terms of their capability for work, but they will do things in their day-to-day lives which you can make legitimate comparisons with. I think that is fine; it is indirect. It is the oblique element that I did not really like.

Q265 Nigel Mills: Can I take you to the issue of additional evidence, which has obviously raised a lot of, "They ignored all the medical evidence I took with me and just used all the indirect things I had said against me,"? How do you see that working? I suppose my first question is: should the assessor—Atos or its successor—go through all that evidence and weigh it in, should it be for the decision maker to look at the assessment, compare that with the evidence and come to a decision, or is it a bit of both?

Dr Paul Litchfield: Fundamentally, what I would like, and have recommended, is that the Department looks at a redesign of the process. I completely agree with Professor Harrington. The decision maker should be at the heart of the process. The decisions about eligibility for benefit are societal ones. They are lay decisions, not medical decisions. Let us say that one had the decision maker at the front end of the process, looking at the information that had been submitted by the person making a claim—the ESA50. One of the recommendations I made was that we encourage the submission at that stage of additional information that might be helpful and, in particular, non-medical evidence from people such as carers and support workers. That evidence is there up front. The decision maker then decides what additional information is required. That may be medical reports; it may be a face-to-face assessment. Then, having that information available, the decision maker makes the final decision. On the question whether the health care professional, if they are involved in that assessment process in the middle, has access to that additional medical evidence, that may or may not be helpful. What one is looking for there is an objective assessment of what people can and can't do, so it probably is helpful that they have it, but it isn't necessarily always the right thing to do.

Q266 Nigel Mills: I cannot remember whether it was you or your predecessor who commented that it seems a bit strange that you pay a lot of money to get an independent assessment and then systematically ignore it. Is that what you are suggesting?

Dr Paul Litchfield: That was me, and that particularly relates to the rising rate of decision makers overturning the decisions—health care professionals do not make decisions—overturning the results of the assessment made by health care professionals. By the time you reach—we're back to points—the level just below eligibility for benefit—when we looked at the data, the rate of overturn was well over 50%. Paying money to a health care professional to give you an assessment if you are going to overturn that decision in more than 50% of cases does not seem terribly logical. There are two ways of looking at that. One is that there need to be better health assessments and more confidence in health assessments. There is quite a bit in the review about how there appears to have been a breakdown in trust between decision makers and health care professionals, which I think is quite a complex issue; all sorts of reasons may underpin it. But I do think it is something that the Department and whoever the new providers are need to address.

Q267 Sheila Gilmore: Is that partly because decision makers are getting more information? Is that the problem? This is the information that Nigel was talking about in terms of whether it should come in at the beginning. Is the difference there because when the decision maker is looking at it, they are looking at the WCA assessor's report, but also other things that have—

Dr Paul Litchfield: Some of the time, but certainly—of course, of necessity, I sat in with a relatively small number of decision makers, so the sample is not statistically valid, but certainly I saw several examples of where the report by the health care professional simply wasn't felt to be right. It just didn't ring true to the decision maker. That may be a completely valid conclusion, but it does imply a degree of lack of trust between the two groups. When I talked to decision makers and, indeed, health care professionals, it did not seem to me to be a relationship of somebody dealing with a trusted adviser. It was very much "them and us." That was brought home to me quite forcefully in Northern Ireland. The health care professionals had been in-house in the system over there until very recently, and the relationship there between the decision makers and the health care professionals appeared significantly better than what I discovered in Great Britain.

Q268 Nigel Mills: I am tempted to ask you a question that I asked Professor Harrington earlier. Do you actually feel that there will ever be enough confidence in a private contractor doing this work for the system really to work, or does this actually need to be brought back in-house somewhere if people are to feel it is a fair system?

Dr Paul Litchfield: I think that's very difficult. There is no doubt that when you are all of one company, it is easier to engender that sense of team working. On the other hand, the operation of an effective system using outsourced providers can work. I suspect it is the way that you set the system up and then work on and develop the relationships over time. One of the things that I recommended that the Department seriously looks at is the co-location of staff because you can get that divorce of two groups, even within a single organisation. Just the fact that you are paid by the same body does not necessarily mean that you work well together. I think it is probably more important that active consideration is given to the development of relationships between the two, and encouraging things like seminars and various other ways of getting people to work together better.

Q269 Nigel Mills: I have one last question on additional evidence; I think somebody else will ask you about that last point. You were a bit less certain that additional evidence for mental health patients was a good idea. Can you just talk us through why that is perhaps not quite as necessary as it is for other cases?

Dr Paul Litchfield: It might be my poor use of English, but what I was trying to say was that I didn't feel that getting medical evidence in mental health cases in every case was the right thing to do. That doesn't mean that additional medical evidence is not of value—it can be in mental health cases as well as in physical health cases. However, there was a suggestion made—this very strong advice—by some of the groups that we spoke to that, exceptionally, in every single mental health case additional medical evidence should be got up front. The rationale I tried to apply in the review was that getting that evidence may not be the best way to progress, that there were lots of sources of non-medical evidence that could be of more value, and that in many mental health cases, the person you would obviously go to—the general practitioner—may not actually have a good knowledge of that individual. So just saying a black and white, "Yes, you must always get additional medical evidence," I did not think was the right thing to do. That doesn't mean that you shouldn't get medical evidence. I think you should get additional medical evidence, but it should be based on a rational decision of what is going to help you to come to a conclusion in that case. I think it

should be a conscious decision to get medical evidence rather than an automatic, "We will always get this."

Sheila Gilmore: Do you see—

Chair: Hold on, Sheila. We're up against time and Debbie is coming in.

Q270 Debbie Abrahams: My quick question is whether the change in the relationship—*[Interruption]*—between decision makers and the reports from Atos assessors related to more reports from Atos assessors coming through and awarding people a higher number of points. Does that reflect the quality and improvement programme that they went through last year?

Dr Paul Litchfield: I'm sorry; it was probably the bell, but I missed the beginning.

Debbie Abrahams: There was a quality improvement programme, as I understand it, for assessors. As a result, more reports have awarded a higher number of points. Is that when there was a breakdown—or when you noticed a breakdown—in relationships and more people having their reports overturned?

Dr Paul Litchfield: I suspect not; of course, I can only comment on the point in time when I looked at things, which was 2013, but when one looks at the data in terms of rates of overturn, it's been a climbing trend over a five-year period. So it's not something that appears to have happened overnight; it appears to have been a gradual drift, and that would fit with what one knows from other situations where providers of advice become more distanced from the people who are commissioning it.

Q271 Sheila Gilmore: One issue that has come up recently—I don't know if you have been looking at this in your next review—is the reconsideration, which was made mandatory. People are reporting quite lengthy delays in dealing with that, which seems to be a workload issue perhaps, but it causes stress and upset. It also causes financial loss to people because of the rules. In your view, should that be reported on separately? At the moment, if a decision is overturned at the reconsideration, it is counted in the same sort of category as the first decisions, unlike appeals. Is this an area that you would want to look at?

Dr Paul Litchfield: I think it would be an interesting thing to look at. We were not able to do it last year. It is something I will see if we can do this year. Certainly, by including the reconsiderations, of course, as you say, the workload increases very significantly, and that can compound some of the difficulties in terms of delays. The other thing is this is a different client group, so people who perhaps have been on benefit for very many years who are coming for an assessment—

Q272 Sheila Gilmore: No, I was talking about the reconsideration stage of the decision-making process.

Dr Paul Litchfield: Mandatory reconsideration—I beg your pardon. Yes, that came in in October, so really too soon for me to be able to comment on in the year-four review. I am certainly looking at that in year five. I have one session with people carrying our mandatory reconsiderations. It is something that I will be looking to comment on in year five. I am sorry I misunderstood you.

Sheila Gilmore: That's fine.

Chair: That's okay.

Q273 Anne Marie Morris: Briefly—I suspect, almost finally—on the feedback through the summary reasons, which is an improvement on the one-liner, between the judiciary and DWP, how can DWP make better use of that feedback to improve its processes?

Dr Paul Litchfield: I think it's important, and it is a very welcome development. In terms of feedback, I think it's part of the quality improvement process that I was talking about, so I think the decision maker whose case has been reviewed by the Tribunals Service should know what the outcome has been about, and not just when their decision has been overturned, but also when it has been supported, because you need to get both sides to have a balanced view.

The other element, which I have recommended in the report, is that that should be extended and the health care professional who did the original assessment should also see that flow of information. So if the conclusions that they have arrived at have been overturned or supported, they should have a feel for that, too. It may not be practical to do that on a case-by-case basis; it may be something that you communicate in terms of numerical feedback—so 25% of your cases were overturned by decision makers and whatever per cent were overturned by the Tribunals Service—but I think that feedback loop, with qualitative information to supplement any quantitative information in a balanced way, is an important part of getting everybody to improve their performance within the system. So I think it is a very welcome development. I think it is the one that the Department needs to look at how it is going to apply and get the best learning from, but also not just to stop with decision makers and to extend into the health care professionals, who are an important part of the system, too.

Q274 Chair: You've asked the Department to carry out an impact assessment on the feasibility of changing the process system so that it's the DWP that sends out the ESA50 rather than Atos, and it decides on whether there will be a face-to-face assessment. Why did you recommend this, and what is the Government's response to that?

Dr Paul Litchfield: The Government's response is that they are examining it, so we will see in the course of this year what progress has been made on that and what their—certainly initial—views are. The reasons I recommended it are twofold. The first one is I think it's important that the decision maker is at the front end of the process, because that does reinforce the injunction that they are in control, so they are the ones who decide how best to get the information.

My background over the past 30-odd years has been very practical in terms of delivering and procuring services. It also strikes me that it helps to simplify the whole process. One of the problems I think that we have in the current system is that it has become over-complex. Stripping out some of that complexity would help in speeding things up. If you are not going for as many face-to-face assessments, you are speeding things up.

Q275 Chair: That was my next question. Do you think that will reduce the number of face-to-face assessments?

Dr Paul Litchfield: Yes.

Chair: Most definitely?

Dr Paul Litchfield: My opinion is that it will reduce the number of face-to-face assessments. I am sure this doesn't happen, but you can see a potential conflict of interests if the organisation carrying out assessments is determining whether it should be a face-to-face assessment or papers-only. I am sure it wouldn't happen, but you could see a situation arising where, if you have professional resource sitting around doing nothing, you push more to face-to-face assessments and if you are under pressure to meet targets, you go for more papers-only. I am sure that does not happen, but it is a risk.

Q276 Chair: The Department wasn't very keen on your idea of co-locating the health care professionals and the decision makers. Why do you think that is important? You have probably touched on that already.

Dr Paul Litchfield: I think it's important for several reasons. One reason is that I think it encourages joint working between the health care professional and the decision maker. They get to see how each other think—if you can see how people think. They get to see how each other work and get an understanding of how each other think. I think it would make for better decision making. It is much more akin to what happens in the tribunals, where you have a lay member and a medical member. I feel that one element of why there is significant disparity between the decisions arrived at by those two systems is that the Tribunals Service sees the individual and has the opportunity for the medical member and the judicial member to talk about the case. If it is practical, it would be helpful for the Department if we could introduce that for the core ESA assessment and WCA.

The other element is that it brings the decision maker and the person making a claim face to face. Feeling that you have had your day in court is an important part of feeling that something is fair. For those three reasons, I think it would be an advantage. I can understand all the practical difficulties that it involves but I think it is worth looking at.

Q277 Chair: This is my last question before we lose our quorum—obviously the bells have started ringing. On the paper-based assessments, I have a number of constituents—again we picked up on this yesterday—who are not getting face-to-face assessment and are being put into the WRAG. Of course, they only realise that has happened to them if they are on contributory ESA and, after a year, it has run out.

When the WCA was first envisaged, everybody in the WRAG, regardless of whether they were contributory or income-based, would keep the benefit so it didn't really matter whether they were in the WRAG or the Support Group in terms of the money they got, although it did matter to the conditionality that was on them. That has changed as a result of the 2012 Act, which makes it time-limited. Have you seen any evidence of that or thought about its implications for individuals? They haven't appealed that they should have gone into the Support Group because they didn't know, because of the way the letters worked, that they had been put in the WRAG until the money stops.

Dr Paul Litchfield: No. It's not something I have looked at, at all.

Q278 Chair: Is it something that you might look at in your next year's review?

Dr Paul Litchfield: I will think about how that fits within the terms of reference. I am always alive to not straying—too far, anyway—beyond the terms of reference.

Q279 Chair: I had a suspicion that if anybody was on upper rate DLA, that might mean that they got paper-based assessment and went into the WRAG—I couldn't quite understand why it was the WRAG, rather than the Support Group—but there was somebody yesterday who that had happened to and they were not on upper rate. They were only on the mid-rate DLA, so I was wondering what was distinguishing about the group that has gone through the paper-based assessment. I didn't know whether or not it was pressure—backlogs building up—and this was a way of dealing with it.

Dr Paul Litchfield: It's something I clearly need to understand better, so I will certainly look at it.

Q280 Debbie Abrahams: May I ask a final question? I have just been contacted by somebody who is commenting on the number of people dying every week as a result of being found fit for work after an assessment. Would you like to comment on that?

Dr Paul Litchfield: I don't have any information on that. I haven't seen numbers on that. Clearly, every case is a tragedy.

Chair: Thanks very much for coming this morning. We really appreciate it. We still have questions we haven't asked, and the same happened in the first session as the time has beaten us, I'm afraid. Everything that you have said is very helpful for us. Good luck with next year's review. You have listed a whole load of things that you are going to be looking at, and we will watch with interest.