HOUSE OF COMMONS

Work and Pensions Committee

Oral evidence: Employment and Support Allowance and Work Capability Assessments, HC 302

Monday 9 June 2014

Ordered by the House of Commons to be published 9 June 2014

Watch the meeting

Members present: Dame Anne Begg (Chair); Graham Evans; Kwasi Kwarteng; Teresa Pearce; Mr Michael Thornton; Dame Angela Watkinson

Questions 281- 406

Witnesses: **Lisa Coleman**, Senior Vice President, Health Market, Atos; **Dr Angela Graham**, Clinical Director, Atos Healthcare; **Helen Hall**, Head of Communications and Customer Relations, Atos Healthcare gave evidence.

Q281 Chair: Can I thank you very much for coming along this afternoon? We had originally planned to have you a couple of weeks ago, but we prorogued Parliament early and so we have had to reschedule. Maybe you do not know that, but that was the intention. We have the Minister coming on Wednesday for our last evidence session in this inquiry, so you are the second last. Can you introduce yourselves for the record, please?

Lisa Coleman: My name is Lisa Coleman. I am senior vice president for Atos Healthcare.

Dr Graham: I am Dr Angela Graham. I am the clinical director for the WCA contract for Atos Healthcare.

Helen Hall: I am Helen Hall. I am head of communications and customer relations.

Q282 Chair: Thank you very much for coming along. Can you begin by telling us where you stand with regard to the contract? I understand that either you or the Government are withdrawing from the contract. Maybe you can explain which of those is correct, and what is happening in the meantime with regard to delivering the WCA.

Lisa Coleman: For quite a number of months we have talked with the Department about what the best way is to move forward on this contract. I do not think it has escaped anybody's notice it has been a challenging contract to deliver for a while now. We are

finding it increasingly difficult to distinguish between Atos as a supplier and what is happening in terms of policy. Through those negotiations and discussions we have agreed mutually with the Department—we both came to this conclusion—that the right thing to do would be for Atos to exit the contract at the right time, recognising that the Department need to get a new supplier in place. The Department are currently out procuring that new supplier. As I understand it, they will be looking for a single national supplier. Our target is to exit the contract from February 2015. Our original contract was due to expire in August 2015. In the meantime, our focus is on making sure that we continue to deliver our commitments. We are acutely aware that we have a number of people—about 700,000 at the moment—who are going through that process, and we are conscious that we need to make sure we continue to deliver that service while the Department are finding a new supplier, and that we support them in that process.

Q283 Chair: Are you delivering the service to the same volumes as you were before, or has something had to go?

Lisa Coleman: It is slightly different. At the moment, we are delivering the new claims volumes coming through, and we are delivering re-referrals on those people where maybe there is a change of circumstances. The Department decide what referrals to send to us. We are currently getting about 88,000 to 90,000 referrals a month, but that is a combination of new claims for ESA and all the other benefits that Atos are responsible for delivering. We have about 88,000 on ESA, if you look at the April data, and we have another 8,000 or 9,000 of re-referrals coming through, but the Department decide what they want to send through to us.

Q284 Chair: What word are you using? Is it "referrals"?

Lisa Coleman: "Re-referrals". That is where somebody has already gone through the process and the Department decide it is now time to review that case. They send that referral across to us. We refer to them as re-referrals, in effect.

Q285 Chair: My understanding is that when people are up for reassessment that is not happening at the moment, so is a re-referral different from a reassessment?

Lisa Coleman: Yes. You have new referrals, where somebody is new to claiming the benefit, and you have IB reassessment, where somebody has been on Incapacity Benefit and they are due to be reassessed under the policy. They are no longer being sent to us. I think we have dealt with the number we expected.

Q286 Chair: None of them at all?

Lisa Coleman: We are not getting IB reassessment cases through right now.[1]

Q287 Chair: What is happening to them? Are they just staying on IB?

Lisa Coleman: Somebody who was on IB will remain on IB until that case is reviewed. If somebody is already on Employment and Support Allowance, in effect when that case

[1] *Correction from Witness*: Atos is currently receiving approximately 5,000 IB reassessment referrals a month from DWP. See also oral evidence taken from DWP on 11 June 2014, Q458 (Jason Feeney).

comes up for review, if there is a change of circumstances, as I understand it, the Department are sending some of those cases through to us. For example, that could be somebody whose condition has deteriorated. Is that right, Angela?

Dr Graham: Yes.

Lisa Coleman: Those cases will be referred to us through the natural process.

Q288 Chair: So the migration from IB to ESA has effectively stopped. That was meant to be completed by August next year. Is that right?

Dr Graham: Just for clarification, there is a cohort of people, both ESA re-referrals and Incapacity Benefit reassessments, who are already in our space, as it were, so we are still carrying out assessments for those people, but we are not getting any new referrals.

Q289 Chair: Do you know how many people are still on IB and have not started that process, and so now will not be migrated to ESA?

Lisa Coleman: I do not have access to that data; that will be with the Department.

Q290 Chair: But IB was not meant to exist after April of this year. Is that right?

Lisa Coleman: Yes, as I understand it, the expectation was that they would have processed all of the people on Incapacity Benefit by that point. I believe they have processed the number they expected, but there are more still to be done.

Q291 Chair: Have the people on Incapacity Benefit who know that this is coming been told it is not coming?

Lisa Coleman: We have not communicated with them because we do not have access to who they are. I do not know whether or not the DWP have communicated with them.

Q292 Chair: So that is a question for the Minister.

Lisa Coleman: I would suggest so, yes.

Q293 Chair: In terms of the people who have started the process and are in the system, what are the numbers presently going through that process?

Lisa Coleman: Looking at those people who are on Employment and Support Allowance, or the WCA process, and those that are on IB reassessment who we have already had referred to us, currently we have about 788,000 live referrals with us. That does not mean that is the number of people who are waiting for an assessment. That is everyone in the process from the point when somebody has referred a case to us to where we will have sent them a questionnaire and we are waiting for that questionnaire to come back, and we will have scheduled an appointment already. We schedule three weeks in advance. We are clearing around 120,000 a month back to the Department currently, and we will continue to work on that head of work.

Q294 Chair: Anecdotally, we are hearing a lot about very long delays. Is the reason for that just the volume and you are not managing to cope with it at the moment?

Lisa Coleman: A number of factors contribute to the delays. Historically, a number of changes were brought in, all of which came in in quite rapid succession. There was the WCA review; there was IB reassessment; and then we had the Professor Harrington changes. It is well known that, following the introduction of the personalised summary statement, Atos had problems processing that change, and the volume of work we were seeing going through added a significant amount of time to the assessment process.

In addition, we were seeing an increasing number of referrals coming across to us. We get a couple of forecasts a year. Those volumes were higher than were forecast with quite significant regional variations. That led to an initial backlog of claimants. We worked really hard with the Department to try to reduce those through various interventions we ran, including continuing recruitment. We then had the quite well-publicised quality issues, which meant we had to make more changes. That has led overall to a much longer assessment. We need to do a lot more work around the level of justification, which is the written part of the assessment, and that is now leading to backlogs.

Q295 Chair: You said there was a mutual agreement between yourselves and the Department to end the contract, but there must have been reasons from your point of view that made you want to end it. What were they?

Lisa Coleman: It was a number of factors. We have battled for a long time to try to explain to people the part that Atos play within the end-to-end assessment process. We have done a lot of work educating people and explaining the difference between what Atos, the decision-makers and the tribunals do. We have found it increasingly hard to distinguish where the policy sits; I think you yourself said we had become the lightning rod. On the back of that, there are also an increasing number of issues with our practitioners, who are trying to deliver the service asked of them in increasingly pressurised conditions; even though we are doing 50% fewer assessments, we have seen a 30% increase in the number of issues that we have had. We have had security incidents involving our practitioners. We got to the point where we felt that Atos continuing to deliver the Work Capability Assessment was not a position we could continue with for the people who need to be able to deliver that service in a safe way and in the most effective way, and for the claimants going through the process, where it is clear there is a level of distrust about Atos and the WCA. We felt we were not going to retender for the bid in 2015. We have made that decision. The Department were clear that at that point they wanted to go to three providers—it is now one—and we just looked for the right way to exit as soon as possible, quite frankly.

Q296 Chair: You say it was not clear what was policy and what was practice. Presumably, the policy and practice will be the same in any new contract; it just will not have the Atos name attached to it. Do you think a new supplier coming in will be able to rise above the criticism you as a company have had and start from scratch, or are there things inherent in the whole design of the process that mean they will be open to the same criticism you were?

Lisa Coleman: I am not going to comment on the policy. What I will say is that, unless something is done about educating people about the operational reality of the policy and what it potentially means for individuals going through it, it is difficult to see that just

changing the supplier will change things. There are a number of other things that could be done differently, and it would be a real shame if, in moving to a new supplier, the opportunity was not taken to do things in a different way.

Chair: We will probably come to questions that might allow you to explain where you think the system is going wrong as it is and how it might be improved.

Helen Hall: If I can just add, a new supplier will not be able to do it in isolation either. We have worked extremely hard over the last couple of years on claimant experience and trying to improve people's understanding of the part of the process that we carry out. If you imagine someone being asked to come in for an assessment with Atos Healthcare at the moment, they read the media stories, listen to the public rhetoric and understand what people have said about us. They might come into that assessment feeling that the assessor they are going to see will treat them with contempt, cannot be trusted and is not trained. They might have to come into an assessment centre and walk past protestors; they might sit opposite someone in the waiting room wearing an "Atos Kills" t-shirt, and then perhaps the nurse comes out. Quite often, people are coming in for an assessment and they are saying to people at the end of it, "By the way, you have just been recorded on my iPhone and I am going to expose you on the internet". If you put all of those together and imagine how both parties are feeling, that environment is something that has to change. Personally, I do not think the private provider by themselves can achieve that level of change without support from other parties.

Q297 Chair: When the new provider comes in do they get LiMA, or does that go with you?

Lisa Coleman: That is going to continue. The expectation is that we will work to ensure a smooth transition to the new provider. I understand they will be looking to use similar premises and a number of the same people.

Q298 Chair: Our other questions will tease out some of that stuff. At the moment, the way the system works is that when the DWP refer to you an ESA claimant you send out the ESA50. You take the process through from the issuing of the ESA50, getting it back in and then doing the assessment. Dr Litchfield has suggested that perhaps that should be better done in-house with the DWP or Jobcentre Plus. What is your view on that?

Dr Graham: The process is that we are issuing it on behalf of the Department for Work and Pensions. In terms of the logistics, the system we use is one whereby the Department for Work and Pensions can send the case to us electronically. It is that that triggers the issue of the ESA50. The only people who do not get a questionnaire issued are those who are identified by the Department for Work and Pensions as being terminally ill.

From our point of view, the decision about the issue of the ESA50, or the ESA50A, which obviously goes out to people where there has already been a decision about limited capability for work, is already being made in the DWP space, and effectively all we are doing is issuing the paperwork. It then comes back to us so we can move on to the next stage of the process.

Q299 Chair: It is going to be a paper-based assessment. Would it not speed up the process in those examples, because ESA50 would go back to the decision-maker who at that stage would see whether there was a need to have a face-to-face and pass it on to you, or whoever is your successor, as opposed to you having to chase up all the paperwork and make that assessment and it then going to the decision-maker to make another assessment? Would that not slimline the process?

Dr Graham: It would cut out the process where a healthcare professional had to look at paperwork. I am sure there would be cases where the paperwork on its own would be sufficient for decisions to be made, so for a proportion of the people who come through the process it probably would make the process shorter.

Q300 Chair: In your experience, do you think more use should have been made of paper-based rather than face-to-face assessments?

Dr Graham: In the current process, we do as much as we can to try to avoid unnecessary face-to-face assessments, but there is a limit to how much we can do. For example, with an initial referral the only thing we can do to avoid a face-to-face assessment is to advise Support Group. If Support Group does not apply, a face-to-face assessment is inevitable. There is a cohort where there may be some room for manoeuvre.

Q301 Chair: I certainly have constituents—I know colleagues do as well—who have had paper-based assessments and been put in WRAG. I cannot understand that. What you have just described was what I thought should happen, but in reality that is not happening.

Dr Graham: That is currently the process for initial referrals only. If it is an initial referral, we cannot advise WRAG, but for a re-referral or an Incapacity Benefit reassessment we can advise WRAG.

Q302 Chair: But these are initial; these are IB migrations.

Dr Graham: No. IB migrations do not come through the system as initials; only fresh claims come through as initials.

Q303 Chair: But why could an IB reassessment not be a paper-based assessment? I know we have a question on this later. I have probably nicked somebody else's question. They have been on IB; they fill in their ESA50; they get a letter that they do not understand, which says they have been found capable of limited work, or incapable of limited work. I can never remember the two phrases. They do not understand what it means. The consequence of that is that they are put into WRAG, and they discover that this is a problem only a year down the line because they are on contributory ESA. Their money has come to a stop and at that stage they do not understand why. It is only at that stage they realise they have been in WRAG. Who is making those decisions?

Dr Graham: There are a number of things in that question. The determination about WRAG is based on the evidence presented. Bear in mind that whenever we are looking at Incapacity Benefit reassessment, we may well have a significant amount of evidence that has come from the Incapacity Benefit claim, so we may well have had the opportunity to assess that person on more than one occasion. That evidence will be available to us to consider. If somebody has a long-standing condition, we have that body of evidence. On

top of that, we look to obtain fresh evidence. The questionnaire goes out to the person going through the process and they tell us what they perceive their disability to be. Effectively, they have the opportunity to say, "From my perspective, I fulfil the criteria for the Support Group in this area", or, "In this area I have a problem, but it is not as severe as Support Group". Obviously, it is not as overt as that.

Q304 Chair: But the claimant does not know what the criteria are.

Dr Graham: But the questions are clear in the ESA50. For example, if the person indicates that they can mobilise more than 50 metres, effectively that makes it difficult to understand how they could fulfil the criteria for the Support Group in that area. That is not to say we do not understand that sometimes people disadvantage themselves by understating their disability, but, for example, if the previous assessment had indicated they had a more severe restriction of mobility than appears evident from the ESA50, and that the treatment they are on and the level of secondary care in which they are involved, etc, all suggest they are more severely disabled, at that point we would go to their GP, or other healthcare professional, to say, "Is this person more disabled than they think they are or are presenting?" We would try to triangulate the information. For example, if somebody has a problem with loss of consciousness and that is their only disability, there is no Support Group where that person can fulfil the criteria. Even if they score 15 points on the back of consciousness, there is no Support Group for 15 points in consciousness. If we have evidence that somebody does fulfil the 15-point threshold in that area but they have no other condition, we would be able to advise WRAG in that situation, for example.

Lisa Coleman: This is a key point for us. It is very difficult for anybody completing these forms to understand what the policy might mean. One of the things we often find is that when somebody assumes Atos has done an assessment incorrectly against the policy, what has happened has been right. It is very difficult to understand that somebody with quite a challenging illness, or difficult condition, does not necessarily go through the process as you would expect, which is why we come back to people understanding what it means in that process. There is always a safeguard. You asked who makes the decision. It is the decision-maker in the Department who makes that decision. One of the areas we look for is a lot more transparency around the whole end-to-end process, including what these descriptors mean and the potential outcome for people with quite difficult conditions.

Q305 Chair: In making a paper-based decision, do you take into account what other benefits they are on? If they are on higher rate care DLA, is that one of the things that might make you think it should be based on paper rather than going through a face-to-face assessment?

Dr Graham: Yes. If somebody was on higher rate DLA, it would be one of the pieces of evidence we would consider, but we could not consider that as the only piece of evidence.

Lisa Coleman: If that is made available to us.

Q306 Chair: I can understand why that would determine whether somebody went into the Support Group. I still cannot understand how a paper-based assessment can determine that someone goes into WRAG, which will obviously have attached to it a prognosis of when they are going to be fit for work within the next six months or year.

Dr Graham: It is one of the areas where there is a misconception. It is not about saying when they are going to be fit for work but when we should review this person again. There will be situations where our advice will be, "This person is in Support Group. They have been unwell for many years. It is extremely unlikely that they are going to improve, and therefore our advice would be they are unlikely to change in the longer term." With a more fluctuating condition, for example a condition par excellence would be chronic fatigue or fibromyalgia, where you would expect fluctuation in the ability to function, in that circumstance we might well not find them fit for work in 12 or 18 months' time but review their case to see whether or not they have changed. Even in a case where, for example, clearly the medical condition is not going to change, the situation arises from time to time where somebody has lost a limb, and we would advise in that circumstance. If somebody loses a limb today, they are severely disabled by that, but a young person, given adequate rehabilitation and an appropriate prosthesis with the right aids and adaptations, could reasonably be expected to adapt to their disability. Even though their condition is not going to change, their level of function may well change. Therefore, it is appropriate in those circumstances for those cases to come back for us to review their disabilities.

Helen Hall: One of the disability representative groups last year referred to the perception that, if you are in the Work-related Activity Group, there is only one way out and that is to be moved to being fit for work. That is just not the case. You might end up moving into the Support Group when you are reassessed.

To go back to the point you raised about people receiving a communication and not understanding what it means for them, I have worked closely with the DWP on communications since the beginning of ESA. We have both done an awful lot of work to try to demystify this, but even the terminology is confusing for people. In the beginning, I had in mind how, if I had a member of my family going through this, they would feel. Would they understand it? I still think it is confusing for people, and there is a lot of misconception causing people anxiety. I think there is more work for us to do around communications.

Q307 Chair: That is certainly the case. Can I just clarify that new ESA claimants can be put into the Support Group only on a paper-based assessment?

Dr Graham: There is a very small group—

Chair: On consciousness.

Dr Graham: No. If the issue is consciousness, we have to bring them in for an assessment. Some people fit into a category that we call "treat as limited capability for work"; that is, somebody who is pregnant and within four weeks of delivery, or somebody who is going through residential rehabilitation for a drug or alcohol problem, is deemed to be a hospital in-patient and therefore is deemed to have limited capability for work. They are not deemed to be in the Support Group; they are deemed to have limited capability for work. There is that small group, and people on dialysis, for example, fit into that category too.

Q308 Chair: But, if it is an IB reassessment it is perfectly possible for a number of them to be a paper-based assessment and end up in WRAG.

Dr Graham: Yes.

Q309 Chair: In the Support Group, how often is the reassessment?

Dr Graham: It depends on the condition. For example, if you are in the Support Group because you have a significant anxiety depression and you are deemed to be at risk of self-harm, in that circumstance we might reasonably anticipate that, with appropriate treatment, you might improve, and we might want to have another look at you in perhaps 12 or 18 months' time. If the Support Group has been advised that you have a chronic psychotic illness, such as schizophrenia, and you have already been unwell with that for 10 or 15 years, the prospect of your getting better, even in terms of your ability to function, is very slim. In that circumstance, we would be advising that there be no change. Within the DWP process there is a loop whereby, even if we advise no change in that case, they will send it back in three years' time for reassessment.

Q310 Teresa Pearce: Lisa, could I take you back to something you said earlier? We talked about people who were historically on IB, all of whom were meant to be reassessed by now and have not been. You said you had reassessed the number you were told to reassess; you were told there was a number of historic IB people and you had done all of those.

Lisa Coleman: No. I said that I think the Department had stated they had processed the number they expected to deal with. We still have some on our books. I do not know the total number; that would be a question for the Department.

Q311 Teresa Pearce: To get this clear, you said there were people historically on IB who were already in the system, so you will continue to do those.

Lisa Coleman: Yes.

Q312 Teresa Pearce: Will that be the complete number, or will there be others?

Lisa Coleman: I do not know the numbers, but I believe the Department still have some people who need to be reassessed who have not been referred to us. I do not know what they intend to do with them, or when they intend to switch them back on, whether it be with us or through a new supplier. The ones we have had referred to us we will continue to process.

Q313 Teresa Pearce: You will complete the task.

Lisa Coleman: We will complete the task we started.

Q314 Teresa Pearce: Why was it that, when you were given the IB reassessments to do, the number you were given was not the right one? Surely, the Department must have known how many people historically were on IB.

Lisa Coleman: I genuinely could not answer. I know they had a number in mind. I think it was 1.5 million.

Q315 Teresa Pearce: They had a number in mind.

Lisa Coleman: I do not know where they are against that number. That would really have to be a question for the Department. I do not see their data.

Teresa Pearce: That will be a question for the Department.

Lisa Coleman: I am sure it will.

Q316 Teresa Pearce: Claimant experience has been that there have been a number of reports of significant delays in being invited to a face-to-face assessment. We have heard this morning that there is a backlog. Why is there a backlog? Is it for the reasons you expressed: the Professor Harrington changes and other changes? Is that why there is a backlog?

Lisa Coleman: There are a number of factors. I referred to a number earlier. There were a number of key early changes, before we started Incapacity Benefit reassessment, that led to us finding that the assessment was longer than we expected. We have been trying to deal with those. We have also seen an increase in intake over the years. We get new forecasts from the Department. We found that at national level they were lower than had been found in reality, so the operational numbers coming through were higher. In particular, we found that the volumes in London and the home counties could, in some months, range up to 130% of what we were expecting, so the regional variations have caused us a real problem. We tried to move practitioners around.

Q317 Teresa Pearce: When Atos bid for the contract it said it could do it. What changed? When you bid for the contract and it was all laid out—the process and the numbers—was that wrong?

Lisa Coleman: No. A number of factors changed. Most of them were around the changes that came afterwards. We have been running this since 1998; not many people know we have been doing it for as long as we have. In 2005 the contract went out to retender. At that point ESA was not even discussed. We were looking at continuing with Incapacity Benefit reassessment. In 2008 Employment and Support Allowance came on board. I do not think anybody had heard of Atos until about 2010 when Incapacity Benefit reassessment started. At the point in time, when we bid for the contract, we did not know those changes were coming along.

Q318 Teresa Pearce: But, surely, when those changes did come along it was a variation to the contract.

Lisa Coleman: Exactly.

Q319 Teresa Pearce: Did you renegotiate the contract?

Lisa Coleman: We did.

Q320 Teresa Pearce: I do not want to be rude, but did you massively underestimate the volume you would have to deal with?

Lisa Coleman: No. At that point we gave the Department a view of what we expected the assessment to look like, including what we needed to recruit. We then saw some further changes. It was those changes that have caused us major problems, particularly the personalised summary statements. That probably added 30% to the assessment duration.

Q321 Teresa Pearce: We have heard in previous sessions how much that aspect has added, but when you were asked to do that were you not able to charge the Department more? It is my understanding that Atos was paid more for implementing those changes.

Lisa Coleman: There are two things about implementing the changes: there was the activity to train and retrain people to do it the same way, but the Department were also very clear that they wanted the Professor Harrington change to be time-neutral. We flagged that we thought the assessments would take longer, but the Department wanted that to be implemented in a time-neutral way. We worked with the Department to see what we could do to introduce that, but flagged a number of risks. We thought the operational reality of that change would add time to the assessment. We also said that ideally we would like to pilot it.

Teresa Pearce: You asked for that.

Lisa Coleman: Yes, we asked to pilot that. The Department wanted to move that forward on a national basis. I do not know what discussions went on within the Department at that point. Under our contract we are obliged to implement changes. There is a clause whereby in effect if we have a dispute we still have to move forward with the legislative changes regardless. We implemented that change and immediately saw that the assessment duration was about 30% longer. Through a series of initiatives with the Department about changing justification and retraining our practitioners again, we were able to bring down that assessment duration, but that took time and in that period we created a backlog of assessments.

Helen Hall: If the volumes are higher or the assessment is taking longer, quite often there is just an assumption that we can go out and recruit extra doctors, nurses and physiotherapists very quickly to fill that gap. Of course, there has to be an environment in which people are willing and want to join the company because they see it as a valuable career and their professional credibility is intact. It is a difficult environment in which to recruit. Despite that, you have to bring people in, train them up, support them and take other people off their productive activities to provide that additional support. We cannot easily flex that resource.

To go back to the point Lisa made earlier about where those additional forecast volumes are, we saw in 2013 that half of the over-forecast was in the London area alone, which is a difficult area in which to recruit. All of that compounded the situation, and the ability to flex quickly to adapt to the changing volumes is just not there.

Lisa Coleman: The period from recruitment through to having a practitioner fully productive, with all the auditing and mentoring, is now about six months.

Dr Graham: It is longer than that if you take into consideration the lead-in time for recruitment. Once they start with us it takes about six months for them to be up and running and working with, if you like, a background level of support.

Q322 Teresa Pearce: What sort of retention levels do you have?

Lisa Coleman: Currently, attrition is one of our major challenges. We see a voluntary attrition rate of about 27% of all the practitioners we recruit. They leave for a variety of reasons: often the stress of the job; the environmental challenges particularly are becoming more prevalent. We lose about 27%, often within the first six months.

Q323 Teresa Pearce: Given that you have a contract that you bid for at a price and now you are being asked to do different and newer things, with change and change and change, and people are leaving—employing somebody new comes with an investment—that must mean you cannot make money out of this contract. Is that why you have quit?

Lisa Coleman: No, it is not. We are a business and have commitments to our shareholders. We have had lots of various and complex commercial discussions with the Department where we and they have had issues. I cannot say it was not a contributing factor, but we have a long relationship with Government. We deliver in lots of other areas. Our board at times has said, "Should we continue this contract?" We have always worked with the Department to see how we could best implement those changes. We got to the point where there were a number of factors. The ability to run this contract in a viable way for us was one of those, but it was not the overriding one.

Q324 Teresa Pearce: From all that you have said already this afternoon, it seems that a new provider is not the answer because it will have exactly the same challenges as you. A new provider is just a rebrand.

Lisa Coleman: It would be massively over-simplistic to say that a new provider is going to fix all of the issues. It is very difficult to separate the private provider from what the policy is, or the people who are delivering the service from the understanding. Other things would definitely need to happen.

Q325 Teresa Pearce: A new provider with the same system will have the same problems.

Lisa Coleman: Possibly, yes, and it depends on what the Department decide to do with the new contract.

Helen Hall: To go back to your point about recruitment, a new provider will not simply be able to throw money at it and encourage people to want to come in and carry out disability assessments unless that environment is fixed. These are professional, trained people; they care about the job they do. They are doing a very good job and applying the legislation the Government have laid out. Despite that, they are being vilified for it. Any new person coming in will have a look on the internet to find out what the new organisation is like and might find all sorts of threats against people. As to the level of intimidation of and negative coverage about professional people, I am not sure that issue will be resolved by a provider just throwing money at it. The environment has to be taken very seriously, because you want professional people to carry on doing this kind of work.

Q326 Teresa Pearce: I want to talk quickly about two more areas. One of the things that got a lot of people hot under the collar was the fact that you had assessment centres that

were inaccessible to disabled people. When you think about it, it just seems unbelievable. In November 2012 the Minister told us there were six assessment centres responsible for 73% of all the incidents of inaccessibility. Is that all resolved now?

Helen Hall: The Department are responsible for the estates strategy. They asked us at the end of 2011 to provide them with some costed options for those six centres. We provided those options in 2012. We have managed to resolve two of them and those have been agreed, and there are ground-floor rooms available in two out of the six. In the other four, we are waiting for the Department to give us a decision.

Q327 Teresa Pearce: Where is the sticking point on that? Is it you or the DWP?

Helen Hall: As I say, the Department are responsible for the estates strategy, so they have to approve any decision made on that.

Q328 Teresa Pearce: We had DWP Ministers in front of us who said they found it inconceivable that you would have inaccessible properties. You are saying that it is the Department's responsibility.

Helen Hall: Most of the properties are DWP-owned and we lease a small number of them. You raise a good point about the sticking point here. A lot of this came about because the accommodation used was from the original contract in pre-ESA days, so the issue is to do with the type of people who would have difficulty evacuating the buildings, not their accessibility—for example, the ability to evacuate first-floor rooms if the lifts fail. Those people were not coming in when this original accommodation was set, so that is part of the issue.

To be fair, it is not straightforward, because you might be in a building where it is not easy to get a new ground-floor room. It is not just about having a single room; you need an area where people can wait before the assessment; there has to be somewhere where there can be a receptionist. The DWP have considered the solutions. In two of them there is a possible solution with a ground-floor room; in two of the sites it will probably mean—

Q329 Teresa Pearce: Currently, there are four sites that are not fully—

Helen Hall: There are four sites out of those six where we are awaiting the decision. I agree; we all find it frustrating. From a claimant's perspective, I can understand it is frustrating. We try very hard to make sure that people are not disadvantaged by it. As you probably know already, it is made very clear on the appointment letter for any of those sites that if people would need help to evacuate they need to let us know. We can offer an alternative assessment centre; at times we can offer a home visit, or perhaps a taxi if the nearest available centre is not close by. We also try to do an extra level of scrutiny at the paper-based stage of the assessment, so that we can proactively try to identify people who might fall into one of those categories. We do all we can to try to make sure the situation is easier, but it is probably one of those areas where the whole estates strategy might be something that the DWP want to consider.

Q330 Teresa Pearce: One of the other things that makes the claimant experience quite difficult is the practice of overbooking. In 2011 we recommended that you review the

overbooking policy so people were not turned away. If you overbook and everyone does turn up, people will get turned away. Currently, how often are claimants turned away as a result of overbooking?

Helen Hall: We did review the policy on overbooking. We got some external and internal analytical people to come in to have a look at the right profile. The did-not-attend rate varies across the whole country. We had a look at this to see if there was a model to try to better predict when people were likely to attend, and then we can encourage people to attend their assessments, and obviously overbooking figures in that.

We are now able to adjust our booking rate at individual assessment centre-level, so we have that degree of granularity. We look at the attendance pattern for the previous three weeks. If it fluctuates, that is fine because we take that into account. We look at the attendance for the previous three weeks and then book three weeks in advance, so we are able to overbook at the right level for that individual assessment centre.

Q331 Teresa Pearce: Do you have any figures for how many people currently are turned away because of overbooking?

Helen Hall: It is not down to overbooking necessarily, because overbooking is about getting the right number of people in for that particular—

Q332 Teresa Pearce: If somebody comes along for their assessment and you cannot see them, that is not their fault.

Helen Hall: Absolutely, and that might be for a different reason. Overbooking is about understanding that in one site on a Friday, for example, in the last few weeks they might have seen a higher level of non-attendance and so it will adjust accordingly. That will range depending on the site. As to people who are turned away, that could be as a result of overbooking, although we try to pool morning and afternoon sessions. Clearly, in a smaller centre with one or two practitioners, the impact of overbooking might be more severely felt, whereas in the larger centres you can offset that because you have different practitioners able to deal with that.

Q333 Teresa Pearce: For what other reasons would people be turned away, other than that you being too full to see them?

Helen Hall: They might be turned away if we have short-term absence, for example if a doctor, nurse or physiotherapist who is due to work in the centre that day is off sick.

Q334 Teresa Pearce: Would you not try to contact the person and tell them?

Helen Hall: Yes, wherever possible we do.

Q335 Teresa Pearce: Would it be possible to let us have the figures for people turned away now, as compared with before you reviewed the policy? Would that show a reduction?

Helen Hall: The policy is ongoing; that is trying to address people's attendance patterns. The number of people sent home might be a product of that. It might also be a product of absence, so we need to address that by looking at stress support and our sickness levels. It

is also impacted by the assessment duration. Recently, with the quality issue we are now doing fewer assessments during the day. We then had to build that into the policy. Up until that point, between 1.5% and 2.5% of people were being sent home unseen. It is currently running at about 4.3%, and that was really up until the quality issue in 2013. Now that we have got the predictability of the assessment duration in hand and are working hard on the other two areas we are able to reduce some of the variability, so it is now coming down.

Lisa Coleman: In June 2013 it was 6.7%, and we have now reduced that to 4.3%. We will look to continue to reduce that further now we have stability over the length of assessment durations.

Q336 Teresa Pearce: I understand it is very difficult. However, for each one of those people it is a problem.

Helen Hall: Absolutely, and we always aim to reduce it.

Q337 Teresa Pearce: You very eloquently referred to the traumatic nature of these encounters sometimes, not just for your staff but the people coming in. They have to make the effort to get there and then have to come back.

Helen Hall: You are absolutely right. We have done a lot of work on attendance patterns. I have to say that I do not think we have ever found the magic formula, and the Department might want to look at whether there is a bigger issue here that can be resolved. One thing we have tried to do, which I think has helped a lot in terms of attendance, is that when we came before the Committee previously the contact centre was making a lot of outbound calls in the belief that, if we got to speak to people, they were much more likely to attend the assessment. We have now switched that around and the contact centre is functioning much more as an inbound contact point. We now send out appointments and people are invited to contact us if they need to change that appointment. That means we have also freed up capacity in the contact centre for people to be able to call with any queries. Roughly half the calls are to do with people wanting to change the time of appointments and half are questions. Because we are now able to answer those and provide that good level of service, we did a quick piece of analysis on 400 of those cases. Where people had called in and we had been able to resolve their issue, the attendance rate went up dramatically. We think that by having that inbound contact point and improving customer service we are helping people to be able to resolve issues that might prevent them coming in for their assessment.

Q338 Mr Thornton: On the attendance record, normally how long is it between when you give people a date and when they attend? How long is the gap?

Helen Hall: It is two to three weeks. The statutory minimum is a week, but we tend to work on two to three weeks, although if there is a short-term appointment we might offer it to people but then there is no obligation for them to take that.

Q339 Mr Thornton: My wife works in a clinic in the health service. They found that if they made the appointment several weeks before and the patient did not get a reminder

the attendance rate was poor. If they got a reminder, the attendance rate was good. Some people's lives are chaotic; they do not have diaries, calendars and stuff. Were you doing reminders just before to remind them? Did that help attendance?

Helen Hall: The Department piloted that in 2012 and the impact on attendance was inconclusive. It did not seem to have a big impact. Having said that, people's use of mobile phones changes all the time, so I would suggest it is probably a good thing to look at again. It could be that a lot more people now have mobiles and would use that.

Q340 Mr Thornton: Text reminders are quite effective because they stay on the phone, don't they, and can be referred to if you want to?

Helen Hall: Yes.

Q341 Mr Thornton: I want to look at descriptors, which was something we had a discussion about in Newcastle as well. People complain that sometimes they do not get the chance to tell the truth about themselves. One of the complaints I get as an MP is, "But they did not let me tell them what was wrong with me; they just ticked boxes and so did not know what was actually wrong with me." That is probably the most common complain I get about the interview. Do you think these descriptors in the WCA could be improved to get a more accurate assessment?

Dr Graham: There are two separate questions in that. Perhaps I may come back to the question about the descriptors. As to tick-boxes, practitioners do have to, if you like, tick a box in terms of the descriptor they are advising to the decision-maker. That is the very last part of the process. Before that, their job is to gather evidence about the medical condition, the treatment that is being undertaken, who they see and how they function in their everyday life. A really important tool for us is the typical-day tool, so in the questionnaire in the ESA50 the person has indicated how they perceive their disability to affect them in terms of the descriptors, effectively. We then have to gather evidence around that to be able to formulate an opinion as to whether or not their own perception of their disability is realistic, an overstatement or an understatement. It is a fallacy to describe it as a tick-box. People perceive the use of LiMA as a tool that pushes the practitioner to a tick-box, but even Professor Harrington indicated that when he looked at it critically it did not do that. LiMA allows us to make sure that, for example, if somebody has a number of different conditions, all of them have been appropriately considered. The system will remind the practitioner, if you like, that they need to think about the back problem, the deafness and the mental health problem. From that point of view, it will prompt the practitioner, but it is the practitioner who is driving the direction of the evidence-gathering and it is absolutely not a tick-box process.

Q342 Mr Thornton: What you say is interesting. I spent many years in the financial service industry where a fact-find is an essential tool. There were two main types of people who used the fact-find: those who interrogated the person they were talking to, asked very closed questions and wrote down the answers; and the much rarer ones, even though this was about them making a living and a decent amount of money, who would ask very open questions and have a long conversation with somebody, for instance whether they have any children, and say, "Oh, you have two. Are they at university?" They get around that. The other ones would say, "How many children do you have? What ages are they?" It was those

types of questions that ended up with insufficient information to judge properly someone's needs.

When we talked to the assessors in Newcastle they seemed to be on the better side, but when I was talking to people in my office for so many of them, when I asked about the conversation, it was the other one: the interrogation. Many people say it was done unsympathetically. They felt that the person talking to them was not interested in them as a person whatsoever. I understand; it is a boring job, or whatever. They did not feel happy about the answers given and the time given to answer them, and did not feel they were able to tell the assessor exactly what was wrong with them. Instead, they feel it is a short conversation; they do not get the truth out; they are told to answer the question, and when they try to expand they are told, "You have answered that, and now we will go to the next one." It is not a conversation; it is an interrogation. The number of people who describe the conversation—it should be a conversation—as an interview is frightening. I think that a lot of the problems arise not from what you want them to do and what they do when a supervisor is there assessing them but what they actually do when they have been doing the job for a while and are getting bored, a bit fed up and demotivated.

Helen Hall: Can I take that and then pass it to Angela, who I am sure will have a view on whether or not the job is boring? I understand that by necessity a lot of anecdotal stories go around with genuine worries about people's opinion. That is quite simply not borne out by the data we see, which is independent data. We have a customer satisfaction survey that looks not just at the experience with the doctor, nurse or physiotherapist, but the whole way through the process and how people feel they have interacted with the contact centre or the receptionist on the day. That is consistently about 90%, so we do not see that issue borne out by the claimant satisfaction survey, nor do we see it borne out in complaints. Less than 1% of our assessments result in a complaint, and less than 0.5% of the assessments we carry out result in a complaint about the healthcare professional's manner.

Over and above that, one of the things I did look at before I came to this Committee was the anecdotal feedback we get as a private provider from people who write to us describing our healthcare professionals—I can read out a long list—as "kind", "caring", "sensitive", "listening" and "treating people with respect", all things that are described as things that are not Atos Healthcare traits. I would strongly deny that. The independent information we see is exactly the opposite.

Q343 Mr Thornton: So the people who are coming to see me are just moaners and complainers.

Helen Hall: That is not to say that anyone is a moaner or complainer. Everyone's feedback is absolutely valid.

Mr Thornton: They might be.

Helen Hall: I do not think that is the case. Where we see poor feedback we will always act on that. I am saying there is independent information to suggest that is not the big picture. Part of the issue about creating this environment of distrust is that people only ever hear that kind of feedback.

Dr Graham: We do get this feedback. I am responsible for the training, consistency and governance of the practitioners who carry out this work. I do not see uncaring or unsympathetic people. These are healthcare professionals who, by and large, have come from the NHS. They are highly trained, caring professionals. They do not come to us and change overnight. We have a very stringent recruitment process, and from notification of interest to appointment there is significant attrition. We look at people's communication skills at interview; we look at the sort of work they have done before they come to us. I have seen a comment made about a pathologist, for example, being unsuitable to do this sort of work. If somebody had worked only in pathology we would not take them. We look at the package, if you like, before we even appoint somebody, and in the training process we focus on communication skills, empathy and rapport. We use actors and video. If somebody cannot demonstrate they are competent in that area, they will not pass the training.

Q344 Mr Thornton: I find that very interesting, because it is exactly the sort of thing that happened in my financial services and bank training. People passed a rigorous assessment. The companies involved were not going to take on people who cost them money if they did not think they would be successful and did not follow the training package they used. I used to train people. I worked with a company that went in to look at retraining opportunities. The number of people who, three to five months after they had had their initial training, were no longer using the majority of the training tools they had been taught was enormous.

I have no doubt at all that the people you are talking about are caring and sympathetic. I suspect that as time goes on the effectiveness of their training wears off. That is not unique to your company or any other company. As an ex-trainer, the difficulty is that if you are not there watching every single interview you cannot know what is going on. I am not saying they are unsympathetic, but that your information-gathering systems are perhaps not as useful as you think they are. They are being caring and sympathetic, but the information-gathering system they are using is more an interview and less a conversation. Whenever a conversation degenerates into an interview you lose enormous amounts of volunteered information. You can see it effectively between two different types I was talking about. Some people write notes on bits of paper and some fill in the form correctly but are not looking at all the extra bits of information. That is my experience from many years of interactions between individuals.

Lisa Coleman: You say that is your suspicion. We have worked on the data we gather from an independent provider who talks directly to and gathers information from those claimants who have gone through that process. That allows us to take that information and look at how we can use it in terms of those complaints that are unprompted. We have also put in place an MP hotline, which I know a number of members of this Committee have used, to feed back to us. We take that really seriously. We look at the evidence that comes through as complaints; we look at the evidence from the independent survey; and we look at the evidence you give us, and then we investigate. If we find a situation where somebody may not be performing to the right level, we take action. We deal with the facts, not the suspicions.

Q345 Chair: The two versions are not really contradictory, inasmuch as the volumes you are getting through mean that even a small percentage of people complaining is a large number. I think we have 150 individual testimonials of people writing to this Committee with concerns about how they were treated. They do not write to us to tell us how great it was, nor will they come to MPs' surgeries to say what a wonderful organisation Atos is. I am sure that is a disappointment for you, but we get the complaints. Possibly it is only a small number of complaints as you say, but for those individuals who, by their very nature, are the most vulnerable these have been horrendous experiences. They feel they have been stuck in some kind of Kafkaesque world that they cannot get out of and cannot understand, and they cannot see the rationale for being asked to pick up a pound coin or a pencil. They might be able to do that but then cannot use the pencil for any purposeful reason.

Helen Hall: Dr Graham will probably want to pick up on the second point. I fully take your point that if you just give people training at the beginning of their role and do not reinforce that you might expect people not to keep up their soft skills, and I am a passionate advocate of soft skills. As a non-clinical person, you have to appreciate that, even with the kindest and most sensitive healthcare professional, it is a daunting process to go through. We do make sure that in at least two modules a year soft skills and interviewing skills are brought to the fore. I have personally been involved in one of our training products where we work with one of the disability representative groups. It was amazingly helpful. Not only were they looking at the healthcare professionals' skills but also trying to bring that insight into the claimant's mindset when they come into the assessment centre. I think that it is good, on a regular basis, to keep that in mind.

Dr Graham: Perhaps I may comment on two areas. We have already said that the proportion of cases where we get complaints is very small indeed, but we do take them very seriously. We investigate every single one. Where we have any concerns at all we will act appropriately. If we have concerns about an individual's manner, we will put appropriate support in place up to and including retraining. Ultimately, if we cannot resolve that issue we will stop using that person.

On your point about not being able to understand questioning, for example the descriptors, that comes back to people's understanding of the process. I am not minimising the difficulty of people who are going through the assessment process experience. It is a difficult process and requires the person to talk about difficult subjects and tell us what their problems are in areas where they might not want to tell their nearest and dearest what their problems are. Often they will tell us things that they have not told their GPs. For example, when somebody tells us that they have a continence problem, it may be very difficult for them to tell us, but in order for us to do the job we are required to do, we have to probe around the nature of the continence problem. If we do not, we cannot give advice to the decision-maker, so it is inherently a difficult process for people to go through. All I can do is assure you again that the practitioners for whom I am responsible are doing the best job they can in a very difficult circumstance.

Q346 Chair: Do you think it is the reputation and fear people have before they come for the WCA that is feeding some of this? They are already in a heightened state of anxiety because of the publicity and everything else, and therefore they are never relaxed and it is impossible for them to feel that this is a benign process for them.

Dr Graham: Absolutely. Time and again, we see people who come in and are on their guard and are anxious. They do not want to be there. They expect us to be the big bad wolf, which is not our job and is not what we want to be. We want to do the best job we can. It is our job to be as objective as we can, but to do it in the most effective and caring way we can.

Lisa Coleman: Helen referred to letters—I have seen them myself—from people who have kindly written to us to say, "I read it in the media. I looked at social media. This was not what I was expecting. Even though I did not want to go through the process, you made it as pleasurable as could happen." We do get to see the other side, but we take seriously every single complaint we get.

Q347 Dame Angela Watkinson: I want to ask a question about the descriptors. Would you say that an experienced assessor would know how many points are attributed to any particular descriptor?

Dr Graham: We try to encourage people not to think about the scores of the descriptors, especially when they are new and are just getting up to speed, because it is not their job to try to identify who is over and under the threshold. Inevitably, when you are an experienced practitioner you know what scores are attracted by which descriptors, so once they are up and running, and confident and competent, they do know which descriptors attract which scores.

Q348 Graham Evans: On the point about the "big bad wolf" that Angela just mentioned there, I have question for Lisa and Helen. Dr Litchfield recommended that perhaps DWP decision-makers should be in the same locality as the healthcare professionals in terms of getting the decision-making process right. When he mentioned that in his evidence, I also mentioned another dimension to that. You are sitting in a community, one way or another; you are sitting in my constituency. You look at the job market in the vicinity of the community you are dealing with, so you bring in that other dimension—yes, you have an assessment to do as a clinical professional, but you also have benefits there. If you are found clinically unable to work, you hotfoot straight into benefits, and it is done and dusted.

However, if there is an opportunity for work, looking at a community and area there are nuances. They are not all the same. Some communities have more job opportunities than others, but it is a question of getting potential employers into the mix and saying, "Yes, you do have a condition". However, we and you know that there are opportunities for people with that condition with the right training, health and support to avoid the analogy that you use. Has that been thought of? Do you agree with Dr Litchfield about bringing that into the decision-making process?

Lisa Coleman: You might ask Angela about this because we have talked about it a lot.

Q349 Graham Evans: Angela is the healthcare professional; you are the director.

Lisa Coleman: I am quite happy to answer it; it is just that we have a clinical view as well. From our perspective, we know that by working closely with the decision-makers and sharing information there is a lot of value in that. We also know that, when we look at changes, we have to think about them in terms of the operational reality. For example, we

operate out of 140 sites. No claimant is expected to travel more than 90 minutes within their constituency. We have talked about the challenges around the estate. You have to balance that and what works versus the operational ability to deliver that, but the closer the working with decision-makers the more we would value that. As to co-location and whether it would work, of course it could only add value.

As to concentrating more on the work-focused side of it, historically when Employment and Support Allowance was first introduced there was something called the Work-focused Health-related Assessment. Our practitioners found that very useful and enjoyable work. It moved the conversation into a different space. At that time, there was also a lot of crossover with the Work-focused Interview—it is a great service for acronyms—or the WFI that is done by Jobcentre Plus. It is important to make sure that the amount of work is done in the right place, but also that you separate out the assessment and then move the conversation into a different space from somebody describing their condition and how it affects them in their daily life to looking at one of the barriers to employment, which can often be different from their particular health conditions. That was why I wanted to bring in Angela because it is a slightly different conversation. In terms of that recommendation, if it could be operationally doable we would say that co-location could only add value.

Q350 Graham Evans: So you agree with co-location.

Lisa Coleman: Yes. The operational reality is somewhat different. Building that against the policy of the practitioner and having to have decision-makers at 140 sites, any joint working is always very valuable.

Dr Graham: The learning opportunities are immense.

Lisa Coleman: They are huge.

Q351 Chair: Do you think the Government were wrong first to suspend and then get rid of the WFHRA?

Lisa Coleman: I certainly do not think they were wrong to suspend it. There was an awful lot of change all at once in terms of what we were going through at that point in time. They needed to use the capacity where it was most required at that point. There is a huge amount of value in terms of the conversation about moving people back towards work, but there was a lot of crossover. It was quite early to do enough to evaluate it, but there is a lot of crossover between what was done in the Work-focused Interview and what was done in the Work-focused Health-related Assessment. That needed to be evaluated more fully.

Dr Graham: There is a point that needs to be made about the concept of the practitioner considering the availability of work in the workplace, which is that the Work Capability Assessment is absolutely not about considering the availability of work or what barriers there are.

Q352 Chair: We have been critical of it for that reason in the past.

Dr Graham: But for the practitioner to be vilified because it is transparent that this person could not work in a workplace does not take cognisance of the fact that what the

practitioner is doing is giving advice about the level of function in the areas of activity as defined in the legislation.

Helen Hall: To make one point on the Work-focused Health-related Assessment, some of the feedback I remember at the time from some of the disability representative groups was just to be slightly careful about the length of time a person is sitting. They were done back-to-back initially, so someone could be sitting for quite a long period of time, doing the first assessment and then having the WFHRA afterwards. That can be quite tiring from a claimant's perspective, so if it is brought together you have to be conscious of that.

Chair: But in terms of getting a rounded view of the individual, the WCA cannot do that because it is just a functional test; the Work-focused Interview cannot do that because it is just a work-focused interview. There is a key part missing that looks at how people will function in the real-world situation of work. That seems to have gone out of the system, which clearly has made it more difficult for the work programme providers as well, because they are getting people without any of that proper assessment. Mike, I think I interrupted you.

Mr Thornton: I think we have more or less covered it.

Q353 Dame Angela Watkinson: I think we have covered most of these as well. It is probably fair to say that at our meeting in Newcastle the claimants and service users had not come to tell us how satisfied they were with the service. They were people who had a grievance of one sort or another, so we did hear accounts of how the Work Capability Assessment had been impersonal and too computer-led. Some people said that the assessor did not look up and looked at the screen throughout the interview. Do you think the semi-structured interview piloted in the Evidence-based Review (EBR) of the Work Capability Assessment is an improvement, or can you think of any other ways in which the interview stage could be improved?

Dr Graham: I think a number of areas would bear fruit, as it were. We have worked quite hard, following a previous review, on improving typing skills, so that practitioners were able to focus less on the keyboard and more on the person going through the assessment. We also did some work on our soft-skills training around remembering to make sure that the person understood that you were not just filling in a form.

The semi-structured interview from the EBR pilot was perceived as being separate but, if you look at what we do in the context of the WCA with the LiMA tool, that tool provides that sort of structure around the skeleton, if you like. For example, in terms of trying to establish somebody's difficulties around mobilising, it will prompt the practitioner to ask questions that will highlight difficulties or demonstrate abilities around the area of mobilising, so there is an element of structure within the LiMA tool. The practitioners involved in the pilot found that the structure of the questions created a framework which allowed them to use it, taking into consideration that they were doing a clerical report, but they also felt that it was mirrored by the existing LiMA tool.

Q354 Dame Angela Watkinson: Would you say it is an easier and more accurate way of recording what claimants are saying?

Dr Graham: The semi-structured interview or the EBR?

Dame Angela Watkinson: The EBR.

Dr Graham: I think that the actual process by which both tools lead the right behaviours is very similar, in all honesty. There were more difficulties in the EBR pilot, partly because of the real complexity of the descriptors that were there, which made it very difficult to drive down and nail the—

Q355 Dame Angela Watkinson: In the LiMA system there is a facility for free text that would give the opportunity to highlight the differences between individual claimants, which may not be standard to the form. Is that used very much? Do you think that is an advantage?

Dr Graham: It is used a lot, and we encourage its use. We monitor the level of use of it. We have the capacity to look at how much free text practitioners are using. If we have practitioners who are not using a lot of free text, it will raise a flag for us and we will effectively go back and look at the quality of their work and see if what they are doing is what we need them to be doing. Often the answer will be, "We need you to place less reliance on the pre-populated LiMA phrases". It is important to have that free text because, even filling in the questionnaire, it is not always easy to fit what you want to say into a pre-populated phrase.

Q356 Dame Angela Watkinson: It is a way of extracting the individual information that you need.

Dr Graham: Absolutely. We monitor its use and, where we think it is not being used enough, we would use that as an area where we need to check and, if necessary, support.

Q357 Dame Angela Watkinson: There is an issue about the inaccuracy of reports and how that might be addressed where the claimant disputes what has been recorded and what took place during an interview and will have a different version from the one produced. Do you think it would help if claimants were able to see the report at the time it is being produced?

Dr Graham: We would have no difficulty with that. I know it is another one of Dr Litchfield's suggestions that we reorient the space so the practitioner and the—

Q358 Dame Angela Watkinson: Is there an opportunity for adjustments to be made?

Dr Graham: It is what happens in PIP, so there is a precedent. We also have to take into consideration health and safety issues for our staff. In the environment we are working in, where people come into the examination centres with knives and threaten to throw acid in the face of the receptionists and so on, our rooms are set up with alarms and panic buttons. We would have to take that into consideration in the context of whether or not a practitioner is in a safe place.

Helen Hall: It comes back fundamentally to addressing the environment in which these assessments are carried out. At the moment that is one of distrust, and everyone needs to look at how we can resolve that.

Dame Angela Watkinson: It is a bit like MPs' surgeries.

Q359 Chair: You have mentioned that a few times. Where does the responsibility lie for improving or changing that environment?

Helen Hall: I think it has to be with all of us. We have worked very hard in the last few years to try to help claimants understand what to expect from the part of the process we carry out. We have done a lot of work on our website. We now have videos on YouTube; we regularly write blogs so that, if people are searching for information about Atos Healthcare and any part of the assessment process, they will find that.

Q360 Chair: But it has got worse.

Helen Hall: It has got worse, and that is because I do not think the issue is with understanding the process. The issue lies with the fact that everywhere someone looks there will be a case highlighted and, if it is in the media, by necessity it tends to be a short case or debate-raiser. The assumption always is that Atos Healthcare have wrongly found someone fit for work. The expectation is that it is the private provider that is getting this wrong, rather than that this is a tough policy and people have an expectation of what the outcome might be; for me, that is driving an awful lot of the issues.

Q361 Graham Evans: I am an employer. When I used to employ people I used to look behind the superficial thing at whether they could work. As an MP, people come to my surgeries saying they want to work and they look for work. They have conditions, especially mental conditions. I am thinking, "They are not fit for work", but I am just a lay person. I know that some of the recommendations have included the introduction of specialists. Mental health conditions are particularly hard because they can fluctuate. How important do you think that sort of specialist expertise, such as in mental health, is in the accuracy of the assessment?

Dr Graham: A number of things need to be said about that. The first thing is that the practitioners that we use to carry out these assessments are highly qualified practitioners. We do not take people fresh out of college; they have worked. We look specifically for breadth of experience within whatever experience they have had within the NHS. We are dealing with people who are already highly trained and highly qualified.

On top of that, we train them to carry out disability assessment. If you look at the spectrum of people that we see, very few have a single problem; most people that we see have multiple problems. Especially for Incapacity Benefit reassessment cases, the average is something in the order of 5.6 conditions. If you want to assess that person holistically, you have to assess it from a different perspective. We are not looking at their condition in terms of what treatment they need and how they can be stabilised, or any of that. We do not have a therapeutic relationship with them. We are looking at them objectively in terms of their ability to function in their day-to-day life. I do not think you need mental health specialists to be able to do that.

Lisa Coleman: However, we know it is really important to have support for any practitioner going through the assessment process. If at any point during that process they come across a condition, or there is something they are concerned about—even if they are concerned about the person going through the condition—they have the ability to go to a

support mechanism. One of Professor Harrington's recommendations that we introduced was to do with mental function champions. We have about 60.

Dr Graham: We had 60 but we have lost some, and we are about to retrain some more. Of the ones we do have, since January we have had 4,500 calls to mental function champions, so it is a service that is being used, and it is found particularly valuable by people who are new to the process.

Q362 Graham Evans: Since January has that helped to improve the accuracy of the assessments?

Dr Graham: There are a number of things there, too. Since January the evidence that I have is that the quality of the assessments we are producing is to the required standard. We have already said there was a well-publicised drop in quality early last year. We have worked very hard to put that right, and we have put a lot of training in place around that. Currently, we feel that we have the quality of the assessments where it needs to be.

Q363 Graham Evans: The introduction has been helpful and has had an impact.

Dr Graham: It has been helpful; people have found it useful. As I have said, particularly when people are new to the process they have found it very helpful and supportive to have somebody more experienced in that area with whom they can have a useful dialogue.

Helen Hall: Can I pick up on a communication point there? You referred to seeing people and a decision being made on their benefit. From a layman's point of view, you think this cannot be the right decision for them. That is something we see very often. That causes a huge issue for us, because Atos Healthcare's doctors, nurses, physiotherapists and DWP decision-makers in most of those cases are applying the legislation correctly, but from an individual's perspective that might be an outcome that people find shocking. That is not to say the healthcare professional and the DWP decision-maker have done their job wrongly, but that the outcome is either not well understood or is unpalatable to people. We tend to see the assessment provider, healthcare professional or decision-maker being blamed for that when the policy is being applied correctly.

Q364 Chair: To go back to the contract, what are—perhaps it should be "what were"—the key service standards that you are expected to meet under the contract?

Lisa Coleman: We are measured in three key areas. The first is the throughput—the time it takes to process somebody from the point when we receive an assessment to the point when we clear that assessment back to the Department. We are measured on the quality of the assessments, and we are also measured on a number of customer service standards, a few of which have been mentioned today, such as how many people we send home and how long people are waiting.

Q365 Chair: I think the general impression is that there are no penalties associated with the contract. Are there? Have you had to pay any penalties?

Lisa Coleman: There are penalties. We have paid penalties where we have not delivered against the expectations of the contract. Where we think that might be related to something that has changed in the contract we will negotiate hard, as do the Department.

We have had many a robust conversation around things, but where penalties are due we pay them. There are penalties within the contract against the revenue we earn.

Q366 Chair: Can you give me an example of some of the penalties you have had to pay?

Lisa Coleman: We have paid them on processing time and quality.

Q367 Chair: How much are these penalties?

Lisa Coleman: There are different percentages depending on which benefit it is. I would be happy to give you a note. I do not want to go into what we have paid because I am legally bound by a recent heads of terms that we signed with the Department. I cannot talk about what we paid, but we have definitely paid penalties.

Q368 Chair: In terms of the ending of the contract, is that coming at some cost to yourselves?

Lisa Coleman: We made a financial settlement, as the Minister stated.

Q369 Chair: In July 2013 the DWP identified a reduction in the quality of reports that you were producing, which was regarded as contractually unacceptable, and they announced that they had instructed you to enact a quality improvement plan. What were the contractual obligations relating to the quality of those reports that you were subject to?

Lisa Coleman: The criteria are that we can deliver no more than 5% of our reports at C grade. As to the way our reports are measured in terms of quality, we have A and B grade reports. It does not mean there is anything wrong with the report, but it may be a point of learning that we can use to feed back to practitioners. Professor Harrington said that was a really good way of gathering that learning. We then have C grade reports which mean they are not fit for purpose and we need to do more work. We identified a problem not with the assessment process but with the written part of the report—the justification side. As soon as that was identified we put together a series of measures, which included taking all of our practitioners right back to basics and reapproving them through one-to-one training with every single one of them. We put every single one of them back through the approval training and went to one-to-one mentoring.

Q370 Chair: With all the things you have had to put in place and the things that you have faced penalties on, you said you could not tell us today because you were prevented from doing that. Will all of this information be available to the new providers who might be bidding for the contract?

Lisa Coleman: I do not know what the Department are providing.

Q371 Chair: Because otherwise they do not know what they are getting themselves involved in.

Lisa Coleman: We are doing due diligence with the new providers. As part of the transition to the new provider, there is the ability to do due diligence; there is a series of documents and data and analysis that will be provided to them in a data room; and the

Department will provide a series of information as well. I do not know on what basis that will be done, because we are not bidding. I do not have visibility of what is being procured. We are just working with the Department in respect of how we exit in a smooth way, so that, for the people going through the process, it is quite seamless.

Q372 Chair: If you knew then what you know now, would you have bid for the contract in the first place?

Lisa Coleman: That is a hard one. Quite honestly, if I knew then what I know now, probably not.

Q373 Chair: To pick up the questions Teresa asked about the fact that the contract cannot make you money, or does not appear to, has it made you a loss?

Lisa Coleman: Again, I am commercially bound not to talk about my commercials, unfortunately.

Chair: You can give us an idea.

Lisa Coleman: If we knew what we know right now, I have shareholders and stakeholders who would not let me bid for a contract that would give rise to both the reputational and profitability issues we are facing with this contract now. It is not a position that I would want to sit in front of my board and ask them to sign up to.

Dr Graham: It is fair to say that the contract that we are working to deliver now is a different one.

Lisa Coleman: It is very different from the one we signed up for in 2005.

Dr Graham: It does not bear much relation to the one we started out with.

Chair: The one you signed in 2005.

Lisa Coleman: Yes.

Chair: That was before ESA came in.

Lisa Coleman: Yes. If we were being asked to bid for the contract that we bid for in 2005, we would absolutely still bid for it on that basis. Knowing what we know now and the changes that have been introduced and the impacts of those changes, both on Atos and the people going through the process, hand on heart I am not saying I would.

Q374 Dame Angela Watkinson: Are you now in a position to assess what would be an achievable level of productivity in the new contract, in the light of the experiences from the old one?

Lisa Coleman: We are absolutely clear that right now, with the assessment as it stands against the legislation as currently laid down, we are working to what we think is the right level of productivity. We are doing about 5.6 assessments a day. That is based on what we now know is the quality standard and level of justification—all of the things we have talked about today. What the future productivity requirements would be depend on what

changes in terms of policy and delivery model, but right now, if nothing changes, we think that is the right amount to be aiming for.

Chair: I am going to bring in Mike because he has some totally different figures.

Q375 Mr Thornton: You are doing fewer than six a day at the moment, so one day you do six or seven, another day five and so on.

Lisa Coleman: Yes.

Q376 Mr Thornton: An Atos employee told us that he was told that for Atos to be profitable you had to do eight a day. Do you recognise that figure?

Lisa Coleman: I recognise the doctor you are talking about; I have spoken to the gentleman myself. You always need operational planning assumptions because in any business you need to work out the capacity you have and the people you need. We have always had operational planning assumptions. If I go right back to the Incapacity Benefit days when I first started on this contract pre-2005, we did about 10 assessments a day based on that set of requirements. There was a period when we were doing seven, eight, sometimes nine, assessments a day. It depends on the people coming through the door. Angela has already spoken to you about the people coming through with more multiple conditions. The average number of conditions is now higher. In the past we might have spoken about eight a day, but now the right productivity, based on what we know the assessment requirement to be, is around the six mark. The amount of time people need is very separate from the commercials that underpin this contract.

Dr Graham: It is also really important to say that eight a day as was—5.5 or six a day now—is a planning assumption. For example, Glasgow is a 25-room centre. If we have 10 practitioners working in Glasgow, we will make planning assumptions around that. We do take into consideration the fact that there is a learning curve for practitioners. Somebody who starts tomorrow will not be able to do six a day, but we will plan the sessions on the back of the fact that there will be some coming and going between practitioners. Some will be able to see more and some will be able to see less. Each case takes as long as it takes. If you have a very complex case with multiple conditions and somebody who is distressed, or is having difficulty communicating with you, that assessment may take a lot longer, whereas if you see somebody who perhaps, if we had had the right information in front of us, we would not have called in at all and who is, for example, breathless by the time they walk from the waiting room to the examination room, that assessment may not take long, because all we need to gather is enough evidence to support the advice that that person is severely disabled by their breathlessness and, therefore, is likely to be within the Support Group. That assessment may take a very short period of time, and that is right and proper. If that person is severely disabled, or somebody has a severe mental health problem and is really struggling with the assessment, and we can make that a shorter assessment for that person and have the right amount of information for the decision-maker, that is the right thing to do, too.

Q377 Mr Thornton: How many hours do your HCPs work? What are their weekly contractual hours?

Dr Graham: 37.5.

Q378 Mr Thornton: If they do six a day over five days, that is 30 in a work week of 37.5, which means basically they are doing them like that and do not have time to sit and gather their thoughts and go back into the next interview refreshed. I would find it extraordinarily difficult to do that many interviews a day. At the end of the day, I would probably be ready to shoot myself, so I cannot see how you can do that and maintain it through the whole day or week. Maybe on Monday morning you are fine, but I would have thought that by Wednesday afternoon you are really flagging if you are going at that pace.

Dr Graham: There are a few things to say there. A significant number of our practitioners do not work five days. We recognise that doing assessments and nothing but assessments is not an easy option. Therefore, we have sought to develop a clear framework that allows people to progress from a situation where they are doing nothing but assessments, day in, day out, to doing other parts of the work, for example file work. We are currently rolling out a clear framework that hopefully will mean that when somebody has been with us for 12 months, unless there is a very good reason why not, they will go on and be trained to do file work. Then we have other people who have enhanced roles, such as mentors, trainers, and auditors, so we are looking to provide people with work they can do that does not necessarily involve face-to-face assessments, but that is what you do to start off with. You come in and learn that skill. Once you have got that skill and are competent with that skill, we look to develop you into other areas.

Q379 Chair: Can I just clarify about your payment? Are you paid for every WCA that is carried out, or every referral that the DWP make to you with regard to a WCA?

Lisa Coleman: We are paid for the reports we complete. It is a combination. There are some things that are fixed as part of our cost base: IT and various other things. There are others that are variable, and there is a complex financial model that underpins that and wraps in different elements.

Q380 Chair: One complaint was about a number of short-term claimants. They had been on ESA for four weeks. They have long stopped ESA and they were getting appointments for WCA. They were insisting that they come along to WCAs weeks after the payment had stopped.

Lisa Coleman: We do not know. If we have done a report on somebody, or we have a referral, we are working on the assumption that that is a live referral. We cannot stop processing that referral until the Department withdraw the case.

Dr Graham: We have no visibility.

Lisa Coleman: We have no visibility at all. In the example you have just described the individual would need to contact the Department, who would then tell us. They would withdraw the case from us. Unless we have been told, we will continue to process.

Chair: That explains that.

Q381 Teresa Pearce: We have been told that when assessors put more people into the Support Group or the WRAG than the DWP expect in their forecast their reports could then be subject to 100% audit. Is that correct?

Lisa Coleman: No. We hear a lot that Atos have got targets for taking people off benefit. That is simply untrue. What we do is look at what people refer to as norms. We will look at how practitioners process cases. For example, if somebody is putting everybody in Support Group or nobody in Support Group, we will look at that and say, "Is that correct?" It might be that that individual practitioner has just had a run of people who should have been in Support Group. Equally, if we see people who are not putting them in we will say, "There should be some more training".

Q382 Teresa Pearce: You do not have a target.
Lisa Coleman: We have no targets whatsoever.

Dr Graham: We use it as an opportunity. One of the things we have to do is make sure that, if you come in and see practitioner A on Monday morning with the same information that you see practitioner B on Friday evening, you ought to come out with the same result. It is not one-size-fits-all. To take the examination centre at Truro, we will know what most practitioners in Truro are doing in terms of finding people in the Support Group. If we have somebody who is way outside that norm, we will use that as an opportunity to focus on what that person is doing. It may be that, when we do look at what they are doing, we will see some cases where they have put them in the Support Group and some where they have not.

Q383 Teresa Pearce: You are saying that you expect a range of results, and if something is outside that range you will look at that person's work.
Dr Graham: Yes.

Lisa Coleman: But if there is nothing wrong nothing happens.

Q384 Teresa Pearce: Is there not a possibility that if someone knows that, if that day everyone seen that day is unfit for work they will think, "If I put everyone through as unfit to work someone is going to crawl all over my files and look at things"? In your experience, when you examine some of the work have you ever found somebody has tried to fit a norm rather than give each person an individual assessment?
Dr Graham: We try very hard to make sure people understand what it is we are doing. People will know that, if they have a high Support Group rate this month, the chances are that we will look at some of the reports they have done. Equally, we will have given them feedback about it. If we have identified absolutely no quality issues with the cases we have looked at, we will have given them that feedback, so they should be reassured that in that particular circumstance there is not an issue.

Q385 Teresa Pearce: But no one likes to be reviewed. Do you not see the point I am making? Will people not try to fit the norm rather than look at each individual case and ignore the norm?
Dr Graham: The reality is that everybody is looked at all the time. We are probably among the most audited cohort of practitioners ever in the universe. We do an enormous amount of audit. It is not driven by the need to manage people into norms. We use norms as a tool to inform people as to where to look, but we give an enormous amount of

feedback around that. We have structured the support in such a way that the more experienced practitioners—we call them clinical performance leads, or CPLs—will have their own team of six or eight practitioners to whom they will be giving feedback and with whom they will be having conversations and providing support, day in and day out.

Q386 Teresa Pearce: You have got lots of different ways of monitoring it and you are looking at it all the time, but if you have people who give results outside the norm and you look at them in depth, how often is that found to be a failing, or is it that that is just the proper result? Do you quite frequently find that they have done it wrong, or have been underzealous or overzealous?

Dr Graham: It varies from case to case. It is important to explain that there is not one norm for the country; there is not even one norm for the Wembley area.

Q387 Teresa Pearce: But quite often the people coming to see you are more complex and have more complex issues.

Dr Graham: Yes.

Teresa Pearce: It is difficult to know how there could be a norm.

Dr Graham: For example, in central London the background rate of severe mental health problems is much higher than anywhere else in the country. Therefore, there is an expectation that the number of people with mental health problems who go into Support Group in central London would be higher than perhaps in Truro. It does not always work out that way, but as a general principle we do not predict that the rate in Truro will be X% and the rate in Glasgow will be Y%. We look at all the people who are working. We do not look at it over a week or a month but on an ongoing, rolling basis. If we have 20 practitioners working in the same examination centre over the course of a three or six-month period and most of them are finding a Support Group rate of, for the sake of argument, 25% and one is at zero, we have to look at the person who is at zero.

Q388 Teresa Pearce: It is normal internal audit risk, is it not?

Dr Graham: Yes.

Q389 Teresa Pearce: Given we hear that at first tier tribunal 40% of claimants are successful in overturning the decision, who should bear responsibility for that? Atos would say they are not the decision-makers, but who or what is responsible for 40% of decisions being overturned?

Lisa Coleman: One of the challenges we have is the constant statistic around appeals, and often it is quoted that 40% of the Atos assessments are upheld at appeal. When you look at the number of people to whom that equates, it is not 40%.

Teresa Pearce: I am sorry.

Lisa Coleman: It is often said that 40% of the Atos assessments are appealed and upheld.

Teresa Pearce: 40% of decisions.

Lisa Coleman: It is also often reported as 40% of the Atos assessments. It is 40% of the decisions that are fit for work are then appealed against, which is not the same as 40% of all the referrals.

Teresa Pearce: You are saying that there are 100% of people; of them, a percentage will be found fit for work.

Lisa Coleman: Yes.

Teresa Pearce: And of those, it is 40%.

Lisa Coleman: Yes.

Dr Graham: 30% of the fit for work will appeal, and 40% of them will be upheld.

Teresa Pearce: I will work that out later.

Lisa Coleman: There are lots and lots of statistics and all are quoted in different ways. You asked me about the position going forward. We would look for 100% feedback from the appeals. We still do not get that. The only statistic we have ever had is the one quoted by Robert Devereux directly from the appeals, which is that in less than 3% of the appeals that were fed back it was the Atos report that was found to be the main contributing factor to why it was upheld.

Q390 Teresa Pearce: What you are telling me is that you are involved in a process where it changes all the time; you are trying to do what you are trying to do. 40% of a group of people get their decision overturned, and you have asked for feedback.

Lisa Coleman: We do not get that feedback.

Teresa Pearce: That would help you in your process.

Lisa Coleman: It would help us in the process.

Q391 Teresa Pearce: Why has that been refused?

Lisa Coleman: I cannot comment on the conversations that have gone on within the Department. It was definitely one of Professor Harrington's recommendations in the first year.

Teresa Pearce: Graham referred to working together, because we are all dealing with the same person.

Lisa Coleman: We would look for 100% transparency along that end-to-end process, particularly at the appeals end. We have talked a lot about how we value feedback. If there was one piece of feedback that would be on my wish list, it would be to understand what actually happened at every point. Was it additional evidence? If so, what was the additional evidence? How could we capture that earlier in the process? If there was ever a wish list, that would be No. 1 on mine.

Mr Thornton: What you are saying is that basically you have no idea; you are not told why it has been overturned.

Q392 Teresa Pearce: I was going to ask you why they are overturned, but you do not know because no one has told you.

Lisa Coleman: We do not know.

Dr Graham: There is a process whereby the tribunal can send back a report for us to look at, but it happens once in a blue moon. It is in double figures per year.

Lisa Coleman: It is frustrating. We are constantly accused of the assessments being overturned at appeal, but we do not have any evidence or statistics to see what actions we could take, and whether something has happened there that was linked to what we were doing earlier in the process. We understand that there is additional evidence. We are not even clear as to against what it is being assessed. We would really value that; that would be very high on our wish list.

Q393 Graham Evans: It is wrong to compare manufacturing with people, but in manufacturing you have a product outcome. If it is not good quality you have a feedback loop, and that feedback loop goes back to quality control and you adjust the mechanism to make sure the quality is right.

Lisa Coleman: One of the challenges that we fed back to the Department—this did change over a period of time—was that we were seeing people who were looping back to us, and we were really concerned. Often the first time the practitioner found out about it was when the person was sitting in front of them. They would then be called back for a referral and we did not know they had been through an appeal. They were referred to as the revolving-door cases. We asked the Department for a policy position on that to say, "Is this really what we want to happen?" I think there have been some changes around that that have been really valuable, but that was one of the things we were seeing and we did feed back to the Department.

Q394 Chair: That was because the reassessment started from the day of the original decision, not the appeal, so somebody just got a determination and three months later they were back.

Lisa Coleman: And we would not know. Often, because the only person somebody sees in the whole assessment process face-to-face is the Atos assessor or receptionist, there was an assumption that Atos were calling them straight back for an assessment, whereas they were being referred back to us and we did not know they had been through the appeal process.

Q395 Mr Thornton: There seems to be a lack of communication. Some of the statistics coming out from that press release you would disagree with. What about that one that says thousands of people are dying left, right and centre after being assessed as fit for work? Is there any accuracy in that whatsoever?

Helen Hall: I would like to raise two points. First, that is an inaccurate statistic often quoted. It comes from a freedom of information request; the DWP published statistics on 2011. The statistics they published referred to people in receipt of benefit. As I understand it—perhaps you can clarify it with the DWP—I do not think they capture the statistics for people who have been found fit for work.

Chair: So they were people in receipt of any benefit.

Helen Hall: Of ESA. The majority of people were in receipt of Support Group rate of benefit at that point. The statistic is usually misquoted. The Department have also put a lot of effort into trying to make sure people do understand that statistic. The reason it makes me furious to see that time and time again, going back to the environment that our doctors, nurses and physiotherapists are working in, is that you can imagine people coming for an assessment believing that the healthcare professional they are seeing is responsible for killing people. That is absolutely abhorrent. I cannot imagine how someone must feel turning up for an assessment like that. The reality of that is that a few weeks ago one of our assessment centres received a letter from people quoting this statistic and saying, "You are responsible for deaths, and now it is payback time. By the way, we know the addresses of the people who work there." The fact somebody has read that and is so shocked by the statistic that they feel they need to threaten our staff is absolutely unacceptable. I imagine everyone finds that unacceptable. My question is: what can you do to stop that?

Q396 Mr Thornton: Would you like to clarify exactly what that statistic was that has been misquoted, so it is on the record here?

Helen Hall: It is a DWP statistic. I will allow the DWP to clarify that. What I will say categorically is that it does not refer to people who have been killed by Atos Healthcare. That is an abhorrent thing to say.

Q397 Mr Thornton: These are not people who have been refused benefit by Atos Healthcare who then die later.

Helen Hall: Again, Atos Healthcare do not refuse people benefit, to be slightly pedantic.

Q398 Chair: I think that the accusation is that a number of people—I cannot remember the number—have been found fit for work by Atos and then have died within a timescale. If you are saying that the statistic that the DWP published was for ESA presumably they were not found fully fit for work, as they would have been on JSA.

Helen Hall: Exactly, so they were in receipt of Employment and Support Allowance.

Q399 Chair: So this was a number of people across the whole cohort who were in receipt of ESA.

Helen Hall: They were either in receipt or had made a claim, so a small proportion of that number were in the process of making a claim or waiting.

Lisa Coleman: To be absolutely clear, because I did write this one down because—

Mr Thornton: For the sake of clarity, make it absolutely English clear.

Lisa Coleman: It was published by the Department under the Freedom of Information Act in 2011. 10,600 people had died while in receipt of ESA, either under the Support Group or WRAG. Therefore, they were in receipt of ESA so they had been through an assessment, and were on the benefit.

Q400 Chair: On the point about referring things back, the individual decision-makers can send reports back to the healthcare professional to be redone if they are not of appropriate quality. How often does that happen?

Dr Graham: The proportion of cases that come back to us as rework is less than 1%. They can also refer them back if, for example, they get some fresh evidence or want clarification on a particular issue. They can send them back for advice, so probably a comparable amount come back at that stage. Sometimes they will not send them back but will pick up the phone and discuss it with our customer service desk and explore whatever the issue is they want clarified in that way, but the number that actually come back for rework is less than 1%.

Q401 Graham Evans: The Government are thinking of giving this contract to more than one provider. Do you think that is a positive development for the quality of the assessments but also for value for money for the public purse?

Lisa Coleman: If you look at the Personal Independence Payment (PIP), that is exactly the way it has gone. There are two providers, one of which is Atos in that equation. It offers different ways of delivering services, and different providers will have their different ways. There are now a number of requirements for healthcare practitioners in different ways. We see increasing volumes around WCA; we have seen the challenges about making sure we have enough healthcare practitioners; we see the challenges in the NHS; we have the Personal Independence Payment; we have state occupational health; and we have mental health champions in police stations. It is really important that there is a holistic view as to where you best get the skills and resource to deliver all of this requirement, and how you can use that valuable time with the individuals to gather information that can be used maybe for more than one purpose. It drives different delivery models and it brings innovation, but it needs to be considered in the light of the much wider requirements now for assessment services.

Q402 Graham Evans: You also mentioned to Teresa that if there was one thing you could change it would be feedback. Dr Graham, is there one thing you would look back on and improve and do differently?

Dr Graham: Currently, the biggest issue for me is the difficulty of working within what has become a very toxic environment. My biggest wish is around the communication of the process. As I have said, we perceive that a lot of the toxicity is about a misapprehension that somebody has lost benefit to which they are entitled because of the practitioner, whereas in reality most often we find, when we look at the facts of the case, that the practitioner has done exactly what is expected of them. The reality is there has been a lack of understanding of exactly what the benefit assessment was likely to require. For me, it is a communication issue.

Helen Hall: I would probably echo that. Either people need a better understanding of the reality of this policy or it is too unpalatable for them. Just pointing the finger at the assessment provider will not change any of that. There has to be a better understanding. For me, it is about driving trust in that environment. Without that understanding, I do not think we will get trust back into this environment, and that impacts on people going

through that process and causes unnecessary anxiety at the moment, and for the staff delivering it at times it is equally unpleasant.

Q403 Chair: You said you had been involved in doing assessments to put people into a category, whether it is out of work or fit for work, since 2005, and previous to that it was invalidity benefit and then Incapacity Benefit. The assessments have always been done, but none of them created the toxic atmosphere you have just described. What is it about this particular benefit, or is it this particular process or this particular policy, that is different from what went on before and has made it—the word "toxic" comes back to my mind—so much more of a problem for you as a company in administering it, and for the Government in delivering the policy? Is it the policy? Is it the way it has been administered, the lack of communication, or is it a combination of a number of things?

Dr Graham: I have been doing this for a very long time. I have been doing this since it was invalidity benefit. I started doing it in 1985, so that is how old I am.

Helen Hall: When it was managed by the Department.

Dr Graham: When it was managed by the Department. For the first 10 years that I did it, it was managed by the Department.

Mr Thornton: You started when you were 17, then.

Dr Graham: That is right; I was a child bride. Seeing the changes from invalidity benefit to Incapacity Benefit to ESA, there has been a step change every time, but the level of information-gathering, detail and so on that we now apply is much in excess of anything that we used to do way back, even when we started doing Incapacity Benefit. When ESA was introduced at first for new claims it was a different environment. I think people had a different expectation, but when people who had been on Incapacity Benefit for many years were brought up to the plate, as it were, to be considered against a different set of parameters, I do not think they really grasped the implications of that. That was where things began to go wrong in terms of people's perceptions about the assessment.

Q404 Chair: I was trying not to talk about PIP and DLA because they are very separate and people keep getting them confused, but is there not a lesson from what you have just said—that it was the reassessment of existing claimants under a completely different set of criteria? Is that not what is going to happen with DLA claimants under the new PIP criteria? Are the Government potentially setting themselves up to fail again for the same reasons? You have a group of people who think they are entitled; that is why they get the benefit, and as a result they will feel very aggrieved when they do not match up to the new criteria as they clearly did under the old ones?

Lisa Coleman: There are absolute similarities to be drawn.

Chair: You have the contract.

Lisa Coleman: We have the contract. At the moment, in Atos we are dealing only with new claims on PIP. However, in the future we will see people who have already got an expectation of benefit. That is where you meet a number of challenges, if you learn the lessons from Incapacity Benefit reassessment. These are people who have an expectation

of benefit already. When you bring them in you have the challenge of that expectation being set against where the policy now sits, compared with where it sat previously; that is different. That will come with similarities, and it is incredibly important that those lessons are learned.

Q405 Chair: And you have long backlogs with just the new claimants for PIP, so it is looking a bit worrying, is it not?

Lisa Coleman: It is a very different benefit. As an organisation we have learnt some lessons as well. We are not processing the natural reassessment claimants yet. We are clear that that assessment process needs to settle and move forward. We are very clear on what we need to do before we take the next step and bring people through. One of the things Professor Harrington talked about was not starting the reassessment process until you have settled down and stabilised the assessment. Having learnt the lessons and been through the pain, personally I would endorse that.

Q406 Chair: The very fact people are on DLA means that they are at the more severe end of the disability spectrum than the people who are on ESA.

Lisa Coleman: They have a clear expectation of benefit, yes.

Chair: I think we have exhausted our questions. I suspect we have exhausted you as well. Thank you very much for coming along this afternoon. We really appreciate it, and we appreciate your candour.