

Public Accounts Committee

Oral evidence: Contracted out health and disability assessments, HC 727

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Members present: Meg Hillier (Chair), Deidre Brock, Kevin Foster, Nigel Mills, Stephen Phillips, John Pugh, Karin Smyth and Mrs Anne-Marie Trevelyan

Sir Amyas Morse, Comptroller and Auditor General, National Audit Office, Adrian Jenner, Director of Parliamentary Relations, NAO, Max Tse, Director, NAO, and Marius Gallaher, Alternate Treasury Officer of Accounts, HM Treasury, were in attendance.

Witnesses: Tom Pollard, Policy and Campaigns Manager, MIND, Rachael Badger, Head of Policy for Families, Welfare and Work, Citizens Advice, and Phil Reynolds, Co-Chair, Disability Benefits Consortium, gave evidence

Q1 Chair: Welcome. We are here to look at the National Audit Office's "Contracted-out health and disability assessments" Report. We have two panels, the first of which I will introduce in a moment. Our second panel will be the contractors who are delivering the assessments, and the DWP—I will introduce them when they arrive.

For anyone following on Twitter, we have a hashtag: #HADassessments. I thank everyone who has contributed. A number of organisations and individuals have passed us evidence about their experiences of the assessments. Very much at the heart of the work of this Committee is the personal experience of the service user at the end of the line. It is important, obviously, that the taxpayer's money is spent well, but part of that is that the Department delivers an effective service to the people on the receiving end.

In our first panel, I am delighted to welcome Tom Pollard of Mind; Rachael Badger of Citizens Advice; and Phil Reynolds from the Disability Benefits Consortium. You are here representing a much wider group of interests out there, the people who are going through the assessments. We have seen some major changes in recent times, with Atos giving up on the contract and Maximus taking over that particular part of the work. Will you start off by

giving us a minute or two of your assessment of your particular experiences and, in your case, Tom Pollard, some of the challenges around people with mental health problems, because we know that that has been a running issue with these assessments? Is it getting to the right place on that now?

Tom Pollard: Since the work capability assessment was introduced, people with mental health problems have got in touch with Mind about the issue a lot—it is one of the issues that we get the most unsolicited contact about. Particularly in the early days there were some really terrible stories of people who were under section being declared fit for work and almost absurd scenarios. I would say that on the whole those cases are much less common, but now the experience is of people finding those assessments stressful—the whole process, not just the face-to-face assessment itself—and finding that assessors do not seem to have a good grasp of mental health or of how to communicate and work with someone with a mental health problem. People find that the process does not seem to take account of the impact of their condition on their day-to-day life and their ability to work, seeming to be much more focused on their function, rather than on their employability or ability to hold down a job. People feel that they are treated with suspicion throughout the whole process, rather than it being supportive and moving them towards a place where they can get the right support. On the whole they feel that the process is there to trip them up, and it causes them a huge amount of anxiety. The problem is that if the long-term objective is to help people move into work, having the start of that process being something that people find so difficult sets a tone that makes it really difficult to get back from.

Rachael Badger: We have seen about 30,000 inquiries about medical assessments at Citizens Advice in the last year. Of all the things that we help people with, from housing to debt or consumer issues, ESA and PIP are the two biggest areas of advice that we give.

Our main concern is really poor claimant experience during a process that is inevitably difficult and stressful and one in which people are asked personal questions. We have seen a slight fall in the number of inquiries related to the face-to-face work capability assessment that arise in relation to face-to-face PIP assessments. The sorts of problems that we have seen, to give you a brief summary, are delays in getting appointments, which have got less bad, but continue for some individuals; unreasonable journey times to assessment centres, particularly if people have to use public transport; PIP assessments sometimes being double-booked, which has increased recently; more generally, a perceived lack of empathy among assessors, which we hear a lot about from local Citizens Advice, and sometimes not enough knowledge of particular, fluctuating or specific health conditions; and, finally, something around accuracy of the reports in terms of reflecting the abilities and circumstances of the individual.

Phil Reynolds: From our perspective, I think we are seeing fewer examples of long delays, particularly with regard to the personal independence payment, but we are concerned that speed is coming at the expense of quality. We note that around 60% of appeal decisions are successful for both ESA and PIP, so we have real concerns that quality is being affected by speed.

As Tom and Rachael have said, the quality of assessments continues to be very mixed. Assessors have a very mixed understanding of many long-term conditions. We continue to hear examples of people with very severe degenerative conditions being asked how long they are likely to have the conditions. Very fundamental understandings of conditions are being missed. We continue to hear examples of medical evidence and supporting evidence not being recognised or claimants not believing that it is being taken into account. Obviously if quality is an issue and the assessment outcome is not correct, that leads to further delays, because people then have to undergo mandatory reconsideration and appeals, and that can significantly extend the amount of time that they are without that support, which can have knock-on impacts on other state services—health and social care, for example. There is still a lot that needs to be done.

Q2 Nigel Mills: Thank you for those observations. May I ask the first question? Do you sense that some providers are better than others? With PIP, we have three regions and two contractors. Does your data suggest that there is a real variation among their performance?

Phil Reynolds: The data that the Disability Benefits Consortium has does not allow us to identify one assessment provider as better than another. The issues that I mentioned just now around inconsistent quality of assessments and supporting evidence not being taken into account are issues that affect both PIP assessment providers. The issues and problems that people are having are fairly consistent.

Q3 Nigel Mills: Rachael, does your data regionalise?

Rachael Badger: No. We have tried quite hard to look for any kind of regional differences, but we cannot pick that out relating to how specific providers are operating. We have seen slightly more people in the north-west, north-east and south-west in comparison to London on ESA, but the pattern is quite similar with PIP, which means that you cannot really draw any conclusions from it. It might relate more to the supply of advice. More generally, I would say that the NAO Report shows that there are differences in provider performance. This is clearly a really difficult operation to run, and no one has got it right yet. There is probably more opportunity for learning and improving by looking at what is going on in different organisations. Perhaps the next step is to think about that a bit more in the design of the contracts.

Q4 Nigel Mills: Do you perceive that where this process goes wrong is down to the assessments? Or is it down to the decision maker not properly using the other information that they have or ought to have?

Tom Pollard: It depends how you define it going wrong. In a sense, a lot of the issues that we hear are just about people having a poor experience, and their main point of contact is going to be the assessment itself, so that is clearly a problem. Where people are

getting an outcome that they do not feel is appropriate, it will be a mixture of things. We have seen real issues with a lack of effort to collect extra evidence. For people with mental health problems in particular, the process whereby you are expected to self-report how your condition impacts on your ability to work—or your day-to-day life in the case of PIP—is really difficult. Some people will literally lack the capacity to do that. They might lack insight into how the condition impacts on them. For other people, it is just difficult to go to a stranger and talk about their mental health, which is a personal and intangible thing. We know that people struggle with that process.

We want to see much more use of evidence from people such as their psychologist or psychiatrist—people who know them and understand how their condition changes over time. On the whole, it is left to the individual to seek that evidence, particularly for ESA. We know that in a lot of cases evidence is not sought. They are just relying on the assessment and the form that is submitted by the person. If you look at some ESA50 forms submitted by people, they are really sparse and people often struggle to fill them in. They are not a rich source of information. There is a lack of focus on getting a wider source of information.

Q5 Chair: I want to follow up on your point about other evidence. Perhaps you could each give a response, but if somebody has already said it, you don't need to repeat it. I understand that GPs are paid and are required to provide evidence on behalf of a claimant, but other professionals are not. Has that created any particular issues? Phil Reynolds, you are nodding your head; do you want to start?

Phil Reynolds: That is right. The Disability Benefits Consortium runs an annual survey of welfare rights advisers, as well as of claimants themselves. Based on the survey data that we have so far, 98% of welfare rights advisers have told us that providing that supporting evidence is either difficult or very difficult. As Tom said, it is great that GPs are reimbursed for providing that evidence, but for people with long-term conditions, it will often be the secondary care specialist, the nurse specialist or carer—people they are more likely to have regular contact with. Those are the people who need to be incentivised or supported to provide that evidence.

Q6 Chair: Do you find that they are not providing it because they are not incentivised?

Phil Reynolds: I think it is that they often do not understand the importance of providing it. If it was part of a contractual obligation, like it is with GPs, that might make it easier to provide.

Q7 Chair: Do you have anything to add to that? If you agree, just nod.

Rachael Badger: Yes, our research has found the same things about situations where clients had to pay for the evidence and still struggled to get it.

Chair: They have to pay for it.

Rachael Badger: Yes.

Q8 Chair: What sort of amounts are people having to pay?

Rachael Badger: I can come back to you on that.

Chair: That would be very helpful.

Rachael Badger: It is a significant amount in some cases. There is also an issue with how providers and the Department are working together and where the evidence fits into that process. It can often be that the evidence is provided, but it doesn't quite get to the right place in time to support the assessment, so that is also a concern.

Q9 Karin Smyth: MPs are very parochial, so I want to revisit the regional issue. I know you said that you did not collect much evidence, but I have some very disabled constituents in Bristol who travel down to Wells and Weston-super-Mare. I appreciate that most people will not know that journey, but it is difficult, particularly if you are disabled. Do you have any more evidence about how far people are having to travel and whether they can get access?

Rachael Badger: I have a bit on that. We see quite frequent examples of people having to travel 20 miles by public transport, which I would imagine is quite tough in Somerset. There are even examples of people travelling 60 or 70 miles, which sounds an awful lot. Even when there is an assessment centre in their town, people are sometimes having to travel, presumably because of capacity constraints. To give a specific example, we had a client with Asperger's syndrome and epilepsy who had to arrange childcare and travel more than 20 miles by bus for a PIP assessment. That is incredibly stressful. Assessments are often not at the best time of day to make such journeys possible. If it is early in the morning, that's quite hard. This client waited for over an hour and was then sent away because he was double-booked. There are some examples of really poor claimant experience, and it's a very stressful process.

Q10 Karin Smyth: Do you have any views about home assessments or the ability to conduct them for such people?

Phil Reynolds: In the context of PIP, people should be offered home or even paper-based assessments if they are too unwell to be seen or if there is sufficient evidence. We hear anecdotally that people are not being offered home assessments in a large proportion of cases.

To speak to the point you mentioned earlier, we continue to hear examples of people who are being turned down for home assessments and are then asked to travel a long distance. Someone responded to one of our surveys and said, “I’d just had surgery and was housebound when I received the appointment letter. The assessment venue was 50 miles away, which was impossible to get to by public means. I called and explained my circumstances and asked for a home assessment, which was then denied.” Those two issues do overlap. People are being asked to travel long distances because they are unable to get home assessments.

Karin Smyth: I would certainly back that up from casework experience.

Q11 John Pugh: I want to follow up on the point you made, Rachael, about where reports from the secondary care sector fit in consultants and the like. Most people with long-term chronic or acute conditions are more intimately connected with their consultant than their GP. I have had cases in my own patch where reports have been submitted in due time and procured, but they have been ignored by the provider on the grounds that they are seen as not relevant at that stage. You get into a debate as to whether the nurse’s view on the patient’s condition as it presented itself that day overrides the view of the specialist who may have been looking after the patient for a year or so. Is it always clear where these consultants’ and others’ reports fit in?

Rachael Badger: We see similar problems. The point of the assessment is to consider what an individual can safely regularly and reliably do, not what they can do on one day as a snapshot. You have to give more weight to the view of someone who has known that person much more closely over a longer period of time.

Q12 John Pugh: But are the guidelines on these reports mandatory, or are they discretionary depending upon the individual assessor or provider?

Rachael Badger: I think there are pretty clear guidelines.

Tom Pollard: There are certain instances with ESA where a provider is required to go and seek evidence—for example, if someone has clearly expressed suicidal thoughts or self-harm.

Q13 John Pugh: Seek evidence?

Tom Pollard: Yes, but on the whole it is down to the claimant. Another issue with evidence, particularly when it is collected by the claimant themselves, is that if they get a report from their psychiatrist, say, which just gives a description of their condition and a brief outline of how it impacts on them, that is not going to speak to the criteria used in the assessment. So when the person then carries out the assessment and collects what they see

as specific information on that criteria, that will override what they see as a more general description from a psychiatrist.

What you need to do to get good evidence—a good benefits adviser will tell you this—is ask the specialist or whoever it is for evidence that really speaks to the criteria used in the assessment, so that it says, “This person can’t walk this far,” or, “This person can’t do this alone.” Unless that information is specifically about the descriptors used, it is often going to be overridden.

Q14 John Pugh: So it is open to the claimants to present what evidence they deem relevant, but there is discretion for the assessor to deem whether they need to take account of that evidence.

Tom Pollard: Any evidence that is submitted should be considered, but there is a question about how much time they have to do that. They get a pack of evidence about a person and will briefly read it before an assessment. There is a question about how much that evidence is really considered.

John Pugh: How much weight they put upon it. Okay.

Q15 Nigel Mills: I think all three of you mentioned in your opening statements that the claimant experience of these assessments was not a positive one. I have a couple of questions on that. Clearly, Atos had a pretty bad reputation both here and around the country. Do you sense the claimant fear is reducing a little now that someone else is carrying out the assessments?

Phil Reynolds: Generally, in terms of public confidence in the notion of benefit assessments and disability benefit assessments, there is a certain stigma attached to them. People approach all of these assessments—ESA or PIP—from a perspective of fear and, to a certain extent, suspicion because of the stories they have heard.

As to whether the new assessment provider has improved the process or perceptions of it, it is too early to say. Certainly, the data we have seen—the escalating successful appeal rates and the fact that there continues to be a backlog in delays—suggests that there is not a significantly different experience being had. In the context of my work with Parkinson’s UK, we are hearing examples of people facing waits of a year for their work capability assessment because there are not enough specialist medical advisers to assess them. So it is difficult to say that attitudes are improving as a result.

Tom Pollard: The stress that people experience in that process is much bigger than the provider. The provider plays a large part in that, but the process has been set up as one that, rather than looking for what support these people have and providing those support needs, is largely seen as a process for weeding out people who might be cheating the

system. That is often how it is presented. People do not go into it thinking of it as something positively there to help them.

Part of the problem is that not just the assessment itself but the whole system is set up with an assumption that once someone has been assessed, the group they get put into is all about what that person can then be mandated to do under the threat of sanction. The whole system is quite pressured, stressful and coercive; it is not set up in a supportive way. The whole system beyond the assessment makes people nervous and anxious. The assessment itself can be a really bad part of that process, but it goes much wider than that. It is about the way people are treated throughout the whole benefits system.

Q16 Nigel Mills: So you do not sense any improvement?

Tom Pollard: In some ways it has got a lot worse. Under the last Welfare Reform Act the things that people could be required to do as a condition of being in the work-related activity group was massively extended. At Mind, our perception is that there is a lack of imagination in terms of how we support people to move off these benefits. The reaction tends to be that there is one lever to pull, which is increasing conditionality and sanctions. That lever gets pulled time and again without any real evidence that it is effective or working for this group of people. Yet, we continue to see that as the direction of travel. It gets cranked up time and again, and it is not an effective way to support that group of people.

Q17 Stephen Phillips: What alternative levers would Mind use, Mr Pollard?

Tom Pollard: To offer genuinely personalised and effective support for that group. People with mental health problems have a really high want-to-work rate. People do not want to be on this benefit. They know that being in work is better for their health. The problem is that they are being put in a position where they feel under threat, under pressure and under suspicion. Back-to-work schemes that help people and genuinely get good results are based on mutual trust and understanding, and are delivered by people who understand mental health. They are not based around a system that says, "You have to do this. If you don't do it, you will lose your benefit." It just represents a fundamental misunderstanding of the motivations of disabled people and particularly those with mental health problems.

Q18 Kevin Foster: I was interested to hear the comments so far. Under the 2005 contract with Atos, the Department was paying £115 per assessment. It is now paying £190 per assessment under the new contract. Have you seen any corresponding improvement in quality of outcomes for that increased money from the taxpayer?

Phil Reynolds: No. As I said, the Disability Benefits Consortium run our new monitoring surveys. When we asked ESA claimants the extent to which they felt assessors

understood their condition, 60% disagreed or strongly disagreed. That proportion has remained relatively consistent over previous years. In the data that we have seen, we haven't—

Kevin Foster: It is pretty much as it was.

Q19 Karin Smyth: The last comment from Mr Pollard to Mr Phillips' question was interesting. Would you be able to share any examples with us of schemes that you think do work well, and that are positive and supportive in different parts of the country?

Tom Pollard: We can send through evidence of that. There is a model called the IPS—the individual placement and support model—which is much more integrated with health. It really takes someone's health into account and it is delivered by people who understand mental health. Although it has higher unit costs than something like the Work programme, it has much better success rates.

Q20 Karin Smyth: In terms of the return—

Tom Pollard: In terms of people returning to work. But we have also seen evidence from people who have been through ESA and the Work programme, which shows that it actually has a detrimental impact on their health. They come out of that process feeling more unwell and less able to work because of the pressure they are put under and because of the lack of understanding they get. On the whole, they are treated like a JSA claimant. They get sent to fairly generic back-to-work support.

Q21 Karin Smyth: Examples of positives would be a helpful alternative.

Tom Pollard: We can send that through to you.

Chair: Although it is not a focus of today to look at some of these things, including the Work programme, this Committee does look at those issues.

Tom Pollard: What is fundamental to understand in the WCA and in these assessments is the purpose of the assessment and what it leads to. If, at the moment, it is largely just a test of benefit eligibility, that is part of the reason that it does not really work. It does not look at people's support needs. In terms of delivering value for money, ultimately it needs to sit within a system that works.

Chair: The whole premise of the policy that the Committee is here to discuss is that it helps people to get into work. If it is not delivering that, that is important. Obviously you will be glad to hear that DWP officials are behind you to hear what you are saying.

Q22 Stephen Phillips: Ms Badger, at the beginning of your evidence you said that in the past year Citizens Advice has been contacted by about 300,000 clients.

Rachael Badger: It is 30,000 on medical assessments specifically, but it is more like 300,000 relating to ESA and PIP as a whole.

Q23 Stephen Phillips: On the medical assessments side, how do those figures compare with the past few years? Are fewer people now making inquiries in that specific area or is it about the same?

Rachael Badger: On the work capability assessment for ESA, it has fallen slightly. It peaked in 2013, but the numbers of inquiries about PIP face-to-face assessments were 6,000 in the last year, and that is rising. I would expect it to rise as we see migrations from DLA to PIP.

Q24 Chair: My final opportunity for you is to say that you are in the same room as the officials responsible for ensuring that these contracts work—indeed, the contractors. What one or two things do you think would make this better for clients, bearing in mind we are also looking at the cost to the taxpayer of the whole process as well? Phil Reynolds first.

Phil Reynolds: In terms of recommendations and things to think about—obviously there is a system of service credits in place—perhaps an assessment provider should be accountable for successful appeal decisions where it can be proven that the quality of the assessment was an issue and that fault can clearly be determined. Another suggestion could be to compel assessors to examine evidence and make sure that when people undergo assessments, a full picture has been taken and that they have really paid attention to the supporting evidence, because as we have said, it often makes that critical difference between a correct decision and a wrong one.

Rachael Badger: I would say three quick things: first, to explore scope for using evidence in support of the claim for one benefit in terms of the assessment for another; secondly, to work with the advice sector more closely. We have heard a lot about welfare advisers and their views, and there has been input here to increase the efficiency of the process. DWP were doing a lot digitally to help people with ESA and PIP claims. There is loads of potential for us to work more closely with providers and DWP. Thirdly, to think about using complaints data better to drive service improvement.

Chair: There is certainly a lot of that in the Report.

Tom Pollard: I think much greater focus and expertise around mental health. Around half the caseload are claiming primarily for that reason, and yet there is very little expertise around mental health within the pool of assessors. Using extra evidence from elsewhere is vital to get a more rounded picture of the person. But I think there is something more in general about the culture, which is to approach it as something that is there to understand

people's support needs. On the whole, people still report to us that they feel like the process's approach has a focus on trying to make sure that people are not slipping through the net and over-egging the impact of their condition. We know that people, on the whole, because they struggle to report the impact of their condition, are much more likely to under-report that impact than over-report it—so, much more empathy, as Rachael was saying, and a much more sympathetic attitude towards people.

Chair: Thank you very much indeed for your clear and concise evidence. Your crisp answers have set a good example to our next witnesses. You are welcome to stay for the rest of the hearing. The transcript of this and the next session will be out in the next couple of days, uncorrected, and our report will be out at some point after the February recess. We have a lot of reports still waiting to be published, so it will be a little while, but thank you very much indeed.

Tom Pollard, you promised to send information to us, so that would be very helpful. If you could do that in the next week or so, that would help our deliberations.

Examination of Witnesses

Witnesses: Robert Devereux, Permanent Secretary, DWP, Nicole Kett, Director for Health Services, DWP, David Haley, Client Executive, Personal Independence Payment, Atos, Chris Stroud, Divisional Managing Director, Capita, and Leslie Wolfe, General Manager, MAXIMUS UK, gave evidence.

Q25 Chair: Welcome to our second panel. We have in front of us Nicole Kett from the Department for Work and Pensions; we welcome back Sir Robert Devereux, permanent secretary at the Department for Work and Pensions; Leslie Wolfe from MAXIMUS UK; David Haley from Atos UK; and Chris Stroud, divisional managing director of Capita. So we have the three contractors that provide the service and the civil servants responsible for it.

Looking at the NAO Report, we would acknowledge that one of the biggest risks was avoided and the handover when Atos withdrew from the contract went smoothly. Sir Robert—or maybe Nicole Kett—you must have been lying awake at night worrying that it would all fall over, but we recognise that that change in contract and the change in contractor happened, and the service continued. We also acknowledge that PIP assessments are now down to four weeks from a very high peak—the Minister was in the House every week at one point on this—so that is a welcome improvement, and terminally ill assessments are now turned around within five days on average. Those are clearly important improvements.

We would say—we want to probe you on this—that ESA assessments are still quite long at 23 weeks. That is an average, but that is a long time for someone waiting for an assessment, and there are still longer-term risks about the sustainability of the contract, which we want to probe in today's session. It is still difficult to assess—there is a quite a lot in this which Mr Mills will come in on—how individual contractors are assessed. There are

quite different approaches on that. We are really most interested in how we are going to ensure, looking into the future, given the volume that is expected to go through—you heard about the issue of quality and volume. We are concerned about that too, because every wrong decision has a huge impact on an individual and is a cost to the taxpayer.

Before we go into the main hearing, I want to put on record my apology. In recent media coverage of this issue, I misinterpreted a figure in the NAO Report, in the “key facts” section, on the percentage of accurate assessments. I said then that 13% of assessments were graded as low quality. In fact, what I should have said is that only 13% of report targets were being met. I refer to the NAO Report, page 16, which has it in writing, and page 21, where there is a graph explaining that in detail if anyone wants to clarify it.

What I would like today—I say this particularly to you, Sir Robert—is not a fencing match. I say that to the contractors as well. This is a complex and important area of work. We want to have an honest and straightforward discussion of it. There have been huge problems in the past. All of us have a raft of cases in our constituencies, and we have a lot of testimony coming from people about their experience of this.

What we also really heard from the first panel, but see locally as well, is that people are now very fearful of this process. At the very least, it should run well. Appointments should happen when they are supposed to, they should happen swiftly and the decisions should be accurate, but there is other room for improvement too. We hope to tease out what the issues have been, where there is room for improvement and how it will be delivered. It has got better, but there is still a long way to go.

I will kick off by asking about Atos. David Haley could you explain why you left the contract and decided to go in 2014?

David Haley: At that time, a decision was taken that clearly the contract was not working for the people who were going through the process, it clearly was not working for the Department and it was not working for Atos, so we entered into joint negotiations to exit the contract early.

Q26 Chair: I understand that you made a payment to exit the contract early, because you broke your contract. Can you tell us how much you paid the Department to exit?

David Haley: That is commercially sensitive information. The NAO is aware of the payments and the structure of the exit termination clause.

Q27 Chair: But you did make a payment to leave, just to be clear?

David Haley: Right.

Q28 Chair: How many health professionals—you had some problems appointing health professionals, so I want to ask you about it, and then I will come to Leslie Wolfe. What were the issues around recruiting health professionals when you exited the contract? We understand that there were some issues there with getting the right people in and the numbers of people in. Is that right? I am talking to David Haley first about Atos, and then I will come to Leslie Wolfe of MAXIMUS.

David Haley: As part of the transition plan that was mutually agreed and put in place, there was an expectation to transfer across 700 full-time equivalent health professionals. We transferred across 748 full-time equivalent health professionals at the time of the exit.

Q29 Chair: At that point, were you at capacity for the number of health professionals? Did you have any vacancies because of the problems you had had?

David Haley: The number of health professionals at that time was complicit with the transition plan that we had in place that we had to—

Q30 Chair: But were you short of the total number of health professionals you needed at the time that you exited the contract?

David Haley: No.

Q31 Chair: So you had a quota of 748 places to fill, and you had 748 people in those posts?

David Haley: The quota was to provide 700 across the—

Q32 Chair: No, you are talking about a different thing, to be clear, Mr Haley. I am asking what your complement should have been when you were running the contract; you are talking about the agreement for the transfer. I am talking about when you were running the contract. How many of the health professional places that you were supposed to fill had you filled? Was 748 your total complement, or were there any vacancies?

David Haley: At the time of transition, no. We constantly ran the need to replenish health professionals who were leaving and bring them on board. In terms of being able to meet the volume agreed with the Department, we had the requisite number of health professionals.

Q33 Chair: What kind of numbers were you running at below the total number you needed in the last year or so of your contract? This has come up in evidence and we need to

probe the fact that it has been sometimes been difficult to recruit. I want to come to MAXIMUS too, but could you answer that question, please?

David Haley: Attrition was always in excess of 25%, so we were always having to ensure that we had the number of health professionals in place. We were constantly in the marketplace looking for those health professionals. The transition plan agreed the volumes that had to be in place and that had to be delivered following the issues with backlogs, so the number of health professionals that we had was the number required to deliver that volume target.

Q34 Chair: So you were always running to catch up when you were delivering it.

David Haley: *indicated assent.*

Q35 Chair: Ms Wolfe, you have taken over this contract. How has it been for you? You have obviously taken on some people, but have you had a similar attrition rate and challenge with holding on to health professionals to do the assessments?

Leslie Wolfe: Yes. As you know, we took over on 1 March, and the Report reflects our performance—

Chair: We are talking about 1 March 2015, to be clear.

Leslie Wolfe: Initially, we did have difficulty attracting, retaining and graduating healthcare professionals at the rate we had anticipated, so we started to fall behind the volumes. We set out, of course, to meet all our contractual targets. We fully expected to meet volume and quality, and we had further ambitions to reduce wait times and improve the customer experience. Initially, we did have difficulty with retaining and graduating healthcare professionals, but since then we have taken a number of initiatives to improve on that. We have improved our retention and graduation rates from the 30% or so reflected in the NAO Report.

Q36 Chair: So you had a 30% retention rate, to be clear.

Leslie Wolfe: Yes, sorry. Initially, we attracted the right number, but they weren't staying. We were not doing a good enough job at screening people and making sure that they really understood the role. We didn't initially have access to the seasoned, most experienced healthcare professionals when we first started to recruit, because they were just transferring in or had not yet transferred in, so we needed to change the way we were screening and what kind of competencies we were looking for. We were also not really telling well enough the story of what the job entails for healthcare professionals, so we developed a video that we passed to our recruitment partners. We also increased the number of recruitment partners so that we could cast a broader net. We then began to start

to attract much more suitable people who really understood the work and were keen to do work of that nature. Also, our more experienced staff began interviewing and also helped us with coaching and mentoring.

The number of initiatives we needed to undertake to keep them so that they would not leave before they were graduated and so that they would be successful through graduation meant that we revised our training process and programme. We reduced the size of our training classes and added in one-on-one coaches and mentors. That is the kind of thing we did to keep the healthcare professionals and get them to a successful productivity level.

Q37 Chair: How many have you recruited in addition to the ones who came over from the Atos contract?

Leslie Wolfe: We have actually been keeping the people who transferred over with a fairly moderate—

Q38 Chair: How many have you recruited in addition to them?

Leslie Wolfe: In addition, 1,241 people have accepted offers with us and are still there. Of those, 364 are now accredited.

Q39 Chair: So you recruited that number, but only 364 are able to carry out assessments.

Leslie Wolfe: No, we have more than 1,200 in the team.

Q40 Chair: That's including the Atos ones.

Leslie Wolfe: Including those who transferred over, so we've doubled our workforce of healthcare professionals. Most of them are now becoming productive and accredited. We are now being quite productive: we have actually just achieved our best month ever in terms of volume through-put.

Q41 Chair: We will come back to the volume in a moment, because obviously that is one of the crucial success criteria for the whole programme.

I want to ask the contractors about how you approached the pricing of these contracts. I want to go to all three of you, because I know you do different contracts. Can you talk us through your approach? There has been a big jump in the cost of doing the assessments—from £115 to around £190, on average—so Capita, to give you a chance to

speaking, could you explain how you approached it for your area of the work? Then we can go along to David Haley and Leslie Wolfe.

Chris Stroud: We worked with the original assumptions that the Department gave us, and we have a completely open-book arrangement with the Department across our account in how we charge. We are currently in negotiations with the Department, so although I am happy to provide the information, because we are in a commercial negotiation I would need the agreement of Sir Robert to provide it to you outside this forum, in writing.

Q42 Chair: In writing would be fine, but how did you approach the costings?

Chris Stroud: In the original contract there were assumptions about how long it would take to do an assessment and how many assessments we would need to do. We worked through a complex algorithm, if you like, to work out how much we thought we could do each assessment for.

Q43 Chair: Did you get that costing right?

Chris Stroud: No, we did not.

Q44 Chair: What have you done since?

Chris Stroud: Since then, we have worked through all the assumptions again. We have looked over the experience of the past two years and, working with the Department, we have come up with a different set of assumptions that more reflect the time and effort involved in conducting good and balanced assessments.

Q45 Chair: Are you still doing home visits?

Chris Stroud: Yes, we are doing home visits. Since the start of the contract, we have done probably 64% home visits versus 36% to clinics. That changes month to month, but it is pretty much still as we were.

Q46 Chair: David Haley, what about Atos? I suspect that one of the reasons you left your contract may be because you had under-priced the assessments. Do you want to explain how you went about pricing them?

David Haley: The process around pricing for the PIP contract was that we secured two lots. It was not just the front-office health professionals who were required to deliver the face-to-face assessments. There was a huge back-office operation that needed to be in place for the admin and paper-based review teams. You have the MI teams scheduling and

booking. You have the auditors and the mentors. There is clearly a lot of infrastructure required to run a contract of this size, as was said earlier, given how complex it is. It is a volumetric pricing contract under which we are paid for every assessment that we undertake, whether face-to-face or by paper-based review, but there are huge infrastructure requirements behind that to ensure that the service can run.

Q47 Chair: We will come back to that in a minute, because your contract was a lot cheaper than what MAXIMUS is now costing, which is about £190 per assessment. Leslie Wolfe, do you want to explain a bit more about how you got to that figure and what you are doing differently from what Atos did?

Leslie Wolfe: Certainly. First, it is difficult to compare our contract with Atos's contract for WCA. They are very different. In our contract, for example, we are required to do about 75% face-to-face assessments. In a face-to-face assessment, it takes approximately 75 minutes on average for a healthcare professional to see someone and then write up the report, meaning that we will need many more healthcare professionals to hit the 1 million target that was set for us. That meant we needed to hire a lot of healthcare professionals.

It was an assumption-based contract in many respects. We had a lot of experience from other operations and other programmes, so we set a number of assumptions around how we would attract and recruit enough people, train them and mentor them and when they would graduate and become productive. It is quite a complex modelling process in which you anticipate when you are going to be able to get people from zero to two, to four, to six assessments a day. That was the structure we built it on.

As I mentioned, the NAO Report only covers us at five months in, which is right at the height of our staffing and recruitment, so all our experienced members are actually coaching and mentoring and doing one-on-ones with people. They are not actually producing the assessments. It was initially taking us longer to graduate people, so the experienced workforce was being drawn down. Initially, on a per assessment basis, it is going to look like it is much more costly because we are not yet pushing the volume through. We are still in that ramp-up phase. Unfortunately, that is taking longer than we had hoped. The other expenses are just around salaries.

What we thought would be the greatest risk for us in the contract was attracting healthcare professionals. We did a market survey of staff and in order to attract doctors and nurses and physios into this type of work we wanted to ensure that we were attracting them at market rates. We did boost salaries, particularly for doctors and a little bit for nurses, to ensure that it was attractive. The salaries are higher, but what you are mostly seeing in the first five months is just that. Unfortunately, we had a lot more people than you would expect for the volume that we were producing. Over time, what you will see is much more value for money on a per assessment basis.

Q48 Chair: As you heard from the previous panel, money isn't everything, but we are here to watch the taxpayers' pound and money is very much at the heart of what we do. We are all taxpayers, I guess.

David Haley, what we are hearing from MAXIMUS is that if they are having to pay professionals more to keep them and to get the right calibre in, it sounds like Atos did it a bit on the cheap. Did you fall down on that aspect of your contract?

David Haley: As I said earlier, the contract was not working. It was outdated. It was not working for the people coming through the process, for DWP or for Atos. That is why it was agreed to terminate early.

Q49 Chair: We have heard some clear testimony that there were real concerns about the quality of many of the assessments. A lot of the evidence we heard not only from the first panel, but from elsewhere related to your time running the contract.

Do you acknowledge that there were problems with the quality of the assessments and with the qualifications of some of the medical assessors doing the work for you?

David Haley: There was certainly an identified quality issue in 2013. We worked collaboratively with the Department on the issue that was identified. A lot of work went into that at the time to understand exactly what changed and what the issues were. A lot of work was done to rectify that quality issue at the time. We heard earlier about the stress levels of the people coming into this, and clearly, it was a very stressful time for people going through that assessment. The quality issue that was identified exacerbated that, so we worked very closely with the Department to rectify it.

Q50 Chair: So you acknowledge that there was a quality issue in your contract that caused stress to the service users—the individuals going through the assessment.

David Haley: I think previous Reports found that there was an identified quality issue.

Chair: We like to call a spade a spade in this Committee, and we are grateful when people acknowledge problems. You acknowledge that, and that is perhaps a small comfort for some of the people who have been through it. I am going to hand over to Nigel Mills, and then I will come back again.

Q51 Nigel Mills: Ms Wolfe, under your contract, where does the risk sit if costs start to escalate? Does it sit with you or does it get passed back to the Department?

Leslie Wolfe: Risk associated with not meeting targets?

Q52 Nigel Mills: No, with costs escalating. If you have to pay higher salary bills than you were expecting, does that get passed back to the Department, or do you incur it?

Leslie Wolfe: The way that the contract is structured, we have a budget that is based on bottom-up costs. Beyond that, there is a loss-gain share if we go over the budget.

Q53 Nigel Mills: What's the share?

Leslie Wolfe: For year one it was 20:80, and for year two it was 50:50.

Q54 Nigel Mills: Which way was the 20:80?

Leslie Wolfe: We would share 20% in year one, and we would share the gain if we were under budget. We would receive a 20% share of the savings if we were under budget, and the Department would bear 80% of that cost. It was determined that year one would be the most risky year, because it would be the year of growth and scaling. After that, the contract is structured so it is 50:50.

Q55 Nigel Mills: What was your experience of that in reality, rather than in your forecasts? Were you glad that you had a risk share?

Leslie Wolfe: The risk for us was on service credits. The biggest risk for us was not meeting our volume and quality targets. That is where the incentives are built. All of our tension is on making sure we meet our volume and quality targets, as well as meeting timeliness on smaller benefits. That is where the real risk lies for us, and rightly so. We had to repay for the service credits where we didn't meet our volume and quality targets.

Q56 Nigel Mills: Quite rightly. So you aren't seeing a need to go back to the Department to say, "The cost estimates we used are so way off that our 50:50 risk share is going to make this unviable for us"?

Leslie Wolfe: No, we haven't done that.

Q57 Nigel Mills: And you're not planning to do that.

Leslie Wolfe: No. It's not a cost issue for us; it's a performance issue. We needed to get the right number of people to a productive level. We're now producing the volumes, and we feel very confident about year two. Month after month, we've continued to improve on our volume throughput and quality.

Q58 Nigel Mills: Do you perhaps feel that you made some mistakes when you bid for this contract in assessing how fast you could ramp it up? Do you think the Department led you down a blind alley and tricked you into agreeing to some things that were never really possible?

Leslie Wolfe: It was definitely an assumption-based contract. Obviously, as a supplier, we are going to ask for allowable assumptions in the negotiation in case we get it wrong. Some things you get in a negotiation, and some things you don't. We are also a provider, and there is an expectation on the Government side that we should know our business. We owned the assumption at the end of the day, and we signed the contract. In hindsight, do I wish I had an allowable assumption for that one? Yes, but the good news is that we've now remedied our processes, training and throughput. We're at a place now where we're keeping 82% of our new healthcare professionals. That's where we hoped to start, so we made it; we just didn't make it in time.

Q59 Nigel Mills: The NAO Report tells us some of your rival bidders withdrew because they knew they could not meet the million assessments in the first year. I sense you will not make that million target in this first year. Do you feel that the contract should not have been let, requiring that unrealistic target?

Leslie Wolfe: We knew this was going to be a risky contract. We felt the risk was in the recruitment, but we always knew this was an ambitious programme. We always knew when we started off that it would take 12 to 18 months to turn this around and transform the service, improve wait times, clear the backlog and improve customer service. It is unfortunate that we are not going to make our volume targets, most of all for our own reputation and for our service and the aspirations we had.

Q60 Nigel Mills: Can I ask a similar question to Mr Stroud? You hinted that you had been trying to reset or renegotiate your contract or something. Do you feel you entered into a contract that was not sustainable by your fault, or do you think you were led astray a bit by what the Department specified?

Chris Stroud: No, I think we have a similar experience to Ms Wolfe in that we listened to the assumptions of the Department and we worked out our own assumptions. We entered into a contract with the Department, we recognise that we have a duty of care to deliver against that contract and we have been doing that since.

Q61 Nigel Mills: Do you feel with hindsight that some of those assumptions were never realistic in the first place?

Chris Stroud: When we entered into the contract, the idea of an allowable allowance, or an allowable assumption, was not in place at the time. Given where we were

at the time, we entered into the contract in good faith and we have delivered against that contract in good faith ever since.

Q62 Nigel Mills: Okay. Volumes being hit is not something that we see very much of in these contracts and we have had a series of them. We had the original ESA where we were nowhere near the volumes, we had the PIP stuff where we were incredibly nowhere near the volumes, certainly at the start, and now we have a new ESA contract and we are nowhere near the volumes in the first year. When you guys bid, don't you think these volume targets are unrealistic and that you should try to tender on a more sensible set of assumptions?

Chair: I will bring in the contractors and then Sir Robert Devereux. Leslie Wolfe, do you want to go first?

Leslie Wolfe: From a volume point of view, under our contract we are save harmless if the volumes are not there, so there is protection if there is not sufficient volume. It is a challenge not having the volume exactly where you want it and where your staff are, but there is some protection for us if it is beyond our control.

David Haley: Assumptions need to be made at the beginning of any benefit—particularly PIP, which was a brand-new benefit. Some assumptions were made and our reaction to that was to build in some tolerance around those expected assumptions. I think it has been proven that some of those key assumptions were then found to be not sustainable at the beginning of the contract. It is difficult with any new benefit where you have to work with your experience but also try to understand exactly what can be delivered at a time when the workload can be 100% new benefits and new claims, which is always very difficult to forecast.

Q63 Nigel Mills: When you bid for the PIP contract, you had had several years of the ESA contract, so perhaps your organisation, unlike Capita and MAXIMUS, in the UK at least, knew how difficult these assessments were and how difficult it was to recruit people to do what I accept were slightly different assessments but not that different. Perhaps you should be a little more regretful that you made a horrible over-assessment of what volume you could generate.

David Haley: I think, as I say, using that experience as you have pointed to is invaluable to help you understand that some of these assumptions will end up not being reality. But once a new benefit and a new contract is let—this is why a tolerance was put in place at the time. It is important to balance the quality of the assessment and the volumes required to meet targets, which is always a very complex balance. I think that working with the assumptions was basic practice; that is what you have to do. And I think we used our experience at least to apply some level of tolerance to those assumptions and to a brand-new benefit, which we clearly found, once we went into it, was going to cause some challenges around those assumptions.

Q64 Chair: Quite some challenges, I think, to your reputation. Sir Robert Devereux, could you come in on this?

Sir Robert Devereux: You started with some general-ish remarks about how things have improved, which is kind. However, coming back to the point you just made, I think there are two different things going on in these contracts. So, when Mr Mills says that we aren't delivering the volumes, let's just parse that a bit.

In the PIP contract, the last time I was here, we clearly were not delivering the volumes, which is why we had backlogs. The Report makes perfectly clear that the contractors have now got on top of that and we are now delivering in reasonable time, and we are not sitting on backlogs. So I think I could reasonably say that the volumes in the PIP contract are working.

Q65 Nigel Mills: So, the expected volume you had for this year in the contract you are actually hitting, or you are hitting a completely new expected volume that you reset at some point?

Sir Robert Devereux: No. The position is as the contractors are describing—this was a new benefit. I remember coming and explaining last time that the thing that we were assuming, just as you did just in a moment in an aside, was that these are broadly similar assessments, so the process should take about the same time. In practice, it turned out that the PIP assessment was taking longer. In the very early period, nobody really knew whether that was a learning curve problem and eventually as a professional you would speed up, or whether it was systemic. When it became apparent that it was taking longer, it took a while for the contractors then to recruit more people to make sure they got on top of it, but as things stand today we are doing enough volume on PIP fast enough to make sure that we are not sitting on backlogs of any kind.

The story, I think, on the WCA is a different one. What I think that you have just heard Leslie say is that the assumptions that she made that lay behind the, "Yes, we can do a million", are assumptions that she is now meeting but she did not meet them in the first few months. So, again, I think I would argue that in just the same way that you have acknowledged that performance is improving, each of these contracts is on an upward trend.

Q66 Chair: Just to clarify, Leslie Wolfe, you seemed to indicate that by the end of year two, you would be on target with the volume and on the quality of the assessments that you're doing. You have made that commitment in public. Have I misunderstood you, or do you just want to repeat that? You said that you are getting to the point of reaching all your targets by the end of year two. Did I interpret that correctly?

Leslie Wolfe: We will not, unfortunately, make our volume target for our first contract year. We can't make up for—

Q67 Chair: Not the first year—year two.

Leslie Wolfe: For the second year, yes, I feel very confident for the second year, because—I mean, just in January we just cleared over 75,000 and that puts us in good stead for our year two volume. Now, we've got a mature workforce and we don't have to have that big map—

Q68 Chair: We return to these things as a Committee, so we may have to call you back to hold you to that. I hope that your prediction is right, because our constituents want it to be right, too.

Q69 Nigel Mills: I just want to get back to this theme of, "Are we setting realistic contracts?", Sir Robert. I suppose the question is this: some bidders withdrew from the ESA contract, or at least one bidder withdrew from it, because they knew they couldn't hit that million volume, so are you concerned that maybe you're setting assumptions in these contracts that are too demanding or just not achievable, and therefore you're not getting quite the range of bids that perhaps you had all wanted?

Sir Robert Devereux: I am not sure about that line of argument. I mean, it would be very easy for me to set very easy targets and I'd be awash with bidders, and by now I'd be sitting in front of you being told that I was paying too much for no output. The reality is that I need to be getting of the order of a million, which is why we asked the contractor to do it. I ended up with two bidders above the line to choose from. If some left, fine, but actually I had a healthy competition and I've got a healthy price for it—

Q70 Chair: You had two who remained in. How many originally expressed an interest? What's the market like in this area?

Sir Robert Devereux: I can't remember quite how many we—

Q71 Chair: Ballpark? Or perhaps Nicole Kett could either write to us or find out from somewhere—

Q72 Sir Robert Devereux: It won't be a huge number, but the NAO has focused on the people that left—

Max Tse: There is a figure in the Report—on page 40, figure 13—which has some detail on the number of bidders who were invited to negotiate, and so on.

Sir Robert Devereux: Anyway, the point of my story is that if I thought I had strong-armed a reluctant contractor to sign, you would wonder what sort of contractor it would be if they were prepared to be strong-armed, but I actually got two of them in the room, and I am in a position to believe that. And it seems to me that since you want me to get value for money, and you want me to be on top of volumes and backlogs, then I should indeed press to get what the taxpayer and the Government need, and not settle for something lower just because it's easier.

Q73 Nigel Mills: The reason I asked is that in a previous Report on this topic, one recommendation was that the Department should quite strongly challenge assumptions that contractors use in their bids to make sure those bids are actually achievable. Perhaps one example is when a MAXIMUS bid assumed a very low level of staff departure or a high level of staff retention that was presumably higher than Atos managed to achieve and turned out to be much higher than MAXIMUS managed to achieve.

Sir Robert Devereux: Not quite. The way you are invited to read the NAO Report leads you to that conclusion. What you just heard Leslie say is that they are now retaining more people than was the assumption that NAO has questioned. So they didn't do, to start with, which is why, as Leslie has said, initially volumes were awry, but at the moment they are recruiting and retaining at a higher rate than the assumption that is being questioned. So when we had a conversation in the bidding process, we were testing why they believed they would be better at this than the previous contractor. They gave us some reasons. We went with that.

Q74 Nigel Mills: Can I ask you quickly, Mr Stroud, what is your retention rate like now?

Chris Stroud: Now, our attrition rate is approximately 4% a month. So our retention is a reverse of that number. We are recruiting and retaining people rather above where we have been in the past.

Just to give you a bit of background, quarter one is our highest ramp-up period for managed reassessments. In quarter one 2015, we have achieved over 110% of our recruitment target and our attrition is tracking in single figures.

Q75 Nigel Mills: Four per cent. a month sounds like you lose 50% or 48% in a year.

Chris Stroud: In the past that would be the case. What we are seeing now is a much more improved performance against that. So, in January for example, we lost three people from our workforce.

Q76 Nigel Mills: That suggests that MAXIMUS is somehow a much more attractive place to work.

Leslie Wolfe: May I explain that? When I was referring to the 82% retention, that was for the first 90 days. It is the first 90 days when we all face the greatest challenge because people are just coming into the work and getting trained and certified. It is very difficult for people as adults to go through training again and then discover the nature of the work. That is when you are most likely to lose people. After the first 90 days, you lose just under 2% a month. So of our most mature people who have been with us, we lose about 2% a month which isn't that different. Healthcare professionals have their choices in the market and we would expect some turnover

Q77 Chair: We heard from our previous panel and we have had quite a lot of evidence from the National Deaf Children's Society, Sense, Mind in Greenwich and other places about the specialist assessments: people with very specialist situations, particularly mental health problems. In the generic training, are you properly taking account of complex mental health problems? Certainly in my case load, the biggest challenge is people with serious mental health problems who have a really rough time through this process.

Perhaps we will start with Capita, then go to MAXIMUS and back to Nigel Mills.

Chris Stroud: Within the training programme we do focus on mental health issues and in our recruitment, in our teams, we have senior mental health clinicians working with us, both in a dedicated fashion and in providing support to the other assessors we have working for us.

Leslie Wolfe: We do not have generic training for all our disciplines so for doctors, nurses, physios and occupational therapists, there is slightly different training for all those disciplines because each one has different levels of training on musculoskeletal, mental health and various other health issues. It is tailored to the discipline. Beyond that, we have taken a number of initiatives to continue to improve training in and awareness of mental health issues.

It is a very sensitive area and why we have put so much focus on customer service as well. Towards improving the whole training, we have created our customer relationship group. There is a 25-member group made up of a number of national charity representatives. They have participated in the review of our training materials and various other things, including communications. Part of improving the process and the journey for people with mental health issues is trying to make sure they return some of their paperwork. The ESA50—the self-assessment that one of the charities mentioned earlier—is a barrier for some people. It is quite daunting. It is a huge form and quite difficult so we created a helpline to help people to complete that ESA50. We have made it available as part of our improvements. We also created videos and put them on our website so that people

can see what an assessment is going to be like. We try to encourage people to bring companions, because that in itself can help to relieve some of the associated anxiety.

Q78 Chair: One of the things we know, and we know it in our own constituencies as well, is that the third sector often supports people through advice, and through specialist support in the case of organisations such as Mind. Have you considered any partnerships with those sorts of organisations? It would make it better quality and speed it up if someone comes with the right bit of paper and the right evidence filled in properly, rather than coming and finding that your assessor does not have the information they need to do the work.

Leslie Wolfe: We have not partnered, per se, in terms of what we are each saying and how we are helping customers when they call in. Sometimes they are calling for different reasons. They may want to appeal or to complain. Some of the other charities are actually helping people to complain, so they have their own goals and other services that they provide, but because many are members of our customer relationship group, they have weighed in on some of the scripts, on how we interact and on training. In that way, we have invited criticism and feedback.

Q79 Chair: There may be something to explore here, but I will just ask Capita, and then I will go back to Nigel Mills to maybe pursue this. Do you use any third sector partners to help people get over that threshold of filling out the paperwork, which is very daunting for a lot of people?

Chris Stroud: We do not partner with anyone at the moment. What we do is work with groups across the country and across our area. Through the expert collaboration forum, for example, we take feedback from them and they help us with our assessments and our training, similar to Ms Wolfe, but we don't partner directly.

Q80 John Pugh: Can I just butt in on the staffing? Two per cent. a month is still losing about a quarter of your staff over a year. This stuff has never been gotten right since the Elizabethan poor law. Is it fair to say that, for any medic, it is a bit of a shock working in a new environment? Previously, people were pleased to see them when they showed up as a nurse or a doctor, but this is the one context where, as a nurse or a doctor, people are not necessarily overjoyed to make their acquaintance. This question is as much for Sir Robert as anybody else, but do you not have to build it into the system that there will be higher than usual wastage and rotation of staff?

Sir Robert Devereux: I think you have touched on a very important point.

John Pugh: Oh good.

Sir Robert Devereux: The NAO very kindly added, although I did have to ask them, that in the next three years we are going to spend £92 billion of taxpayers' money on these collective benefits. Part of that process, which the Government have decided policy-wise, and you can understand why, is to say, "Look, I want this £92 billion to go to the right people." So, yes, I am going to put in place a process that involves people with healthcare professionals. You are right that it is a different sort of healthcare professional work from what they would find if they were in a GP's surgery or hospital. None the less, we are in a happy position where, just to take MAXIMUS, we have 40% more healthcare professionals currently working in that sector doing tests than previously, so the contractors are doing something. You are absolutely right that this is a difficult area because, with your other hat on, you are asking to make sure that funds go to the right people, and when it comes to issues of sickness and disability, even getting the rates right—leaving aside whether they were previously getting nothing at all, there are two rates for both of the PIP things, so I need to get the right one. If you are sitting in front of a healthcare professional, you would like the high rate. Healthcare professionals are trying to do difficult work. You have heard how we are seeking to train them to get that right as often as possible.

Q81 John Pugh: Making different sorts of judgments from what they would ordinarily have been familiar with.

Sir Robert Devereux: Not different sorts of judgments.

Q82 John Pugh: Not just medical judgments but how the medical judgments equate to the benefit.

Sir Robert Devereux: Maybe the thing to think about is for whom they are working. If I go to my GP's surgery and I am ill, I want the doctor to make me better, and that is the nature of the relationship. In this particular case, the healthcare professional is seeking to do a functional assessment on behalf of the Government to see whether or not the conditions of the benefit, as laid down by Parliament, have been met, and that is a different sort of one-on-one relationship.

Chair: And that's just one relationship.

Q83 Nigel Mills: We have been building up to this question a little bit. You are right that you have some £90 billion-worth of benefits here. Presumably you still regard these assessments as a very important part of the welfare system.

Sir Robert Devereux: I do.

Q84 Nigel Mills: I presume that what you want is a sustainable market of people wanting to carry out these assessments and to bid for them as and when tenders come out.

What are you doing to try to ensure that there are enough healthcare professionals out there who are willing to work in this sector?

Sir Robert Devereux: Before we got anywhere near the personal independence payments introduction, let alone the subsequent work with MAXIMUS, we went and did a very detailed study with some external help on the nature of the healthcare market, what sort of hours people want to work and whether people would like to do some of this on the side of other things they are doing. The conclusion that came back was that there is plenty of potential for people to want to do this work.

The thing I am feeling more positive about, based on the Chair's remarks at the start, is that you can now see each of these contracts getting to a place where backlogs are coming down, the speed of processing is going up and people are getting on top of this. That, in itself, will be a positive reinforcement in terms of saying, "This is work you can do. It is important work. The Government does need it done."

My view at the minute is that I have contractors performing not entirely in all parts of the country as I would want, but none the less in the right direction. That probably means I am feeling relatively positive about my chance of finding more than one person to compete for the next one. I found two, as I told you, for MAXIMUS.

Q85 Nigel Mills: Lots of these contracts are coming up for renewal or extension.

Sir Robert Devereux: I only have three altogether.

Q86 Nigel Mills: You were talking about trying to regionalise the contracts. That would give you a few more to find, wouldn't it?

Sir Robert Devereux: Yes.

Q87 Nigel Mills: So you are optimistic that you are going to have the right range of bidders to give you the choices, risk transfers and quality you are after?

Sir Robert Devereux: I am feeling better about that now than when I came in front of the Committee two years ago, when we were at the height of backlogs and we were still in a position with Atos that you have come to a conclusion on. On metrics, the questions you should be asking are, "Are we doing enough tests? Are they prompt enough and good-quality enough?" Actually, those things are drifting in the right direction, which will help the market response.

Q88 Nigel Mills: It is tempting to ask Mr Haley and Mr Stroud if they are going to fancy re-bidding for any of these contracts. Is there any comment you would like to make on that? Do you think these are good things for your organisations?

David Haley: Our focus is 100% on delivery of the PIP contract that we own. That is our complete focus. In terms of what will happen in the future, it is impossible to talk about it.

Q89 Nigel Mills: Do you think your reputation is recovering from the ESA situation?

David Haley: We are focusing on improving the quality, which is an ongoing need. As Mr Devereux says, the volumes are—we do not want to go back into backlogs. We want to make sure we are delivering successfully across our contracts, and that is our 100% focus.

Q90 Karin Smyth: Sir Robert, you talked about regionalisation, which I am interested in. You said it was going well everywhere. This Report does not cover, for example, Northern Ireland, although some of the assessments obviously do. Can you give us an idea of the differences across Scotland, Northern Ireland and England and maybe in between them, or is it going well everywhere?

Sir Robert Devereux: I do not think I said it was going well everywhere. What I said right at the start was that the overall numbers—you can see it in the figures in the Report—show that backlogs are coming down. In the PIP case, we do not have backlogs and are processing it promptly. In the ESA case, we are now reducing backlogs and processing faster. Because Leslie is taking on more staff, she is able to do even more. That is the aggregate position.

In any one area, the contractors do or do not have problems. It has always been more difficult to recruit people and retain them in London, for example. One of the things that the NAO Report has credited us with is that we are much closer to what is going on. Nicole is spending her entire life making sure she knows exactly where there are recruitment issues and why, and being on the contractor's case to make sure they fix it. Please do not take my comments about the aggregate performance as implying every part of the country.

Karin Smyth: Can you share some of those differences with us across those regions?

Q91 Chair: Are there any areas you are worried about, particularly?

Sir Robert Devereux: Maybe Nicole can tell you about some of these, but we are looking at this in each of the different areas. We know how much work is going into each of the centres. We know what their backlog is. We know what their time for processing is, so we are working through each one to make sure we get a consistent performance.

Q92 John Pugh: Are you looking at necessarily the right metrics? Previous witnesses pointed to the fact that the number of appeals was going up and the number of successful appeals was going up. You presumably look at charts like figure 5a, which shows the number of assessments rejected is relatively small. Presumably, Mr Devereux, you look at a score card and you compare the assessments rejected against appeals founded and successfully pursued. Do you?

Sir Robert Devereux: There were several different things in there. The process that we are running at the moment, which has changed in the past several years, is to encourage people who think that they did not get the right decision the first time around to come straight back to the Department to tell us why. This is the process that we call mandatory reassessment.

John Pugh: Yes.

Sir Robert Devereux: The consequence of introducing mandatory reassessments is that the number of appeals to tribunals has fallen very, very sharply. Just to be clear what language we are using, people are coming back to us—the Department—as part of mandatory reassessment, but the numbers of people then seeking to actually appeal is very much smaller. In doing that process, we are responding to the consistent effort the Government have made on PIP and WCA, through the independent reviews by Professor Harrington, Dr Litchfield and Paul Gray, and saying, “What is the best way to do this?” One of the best ways is to ask people to come back and tell us if they think they have not had a proper hearing, and to ask them to tell us what other information is available. We consistently do that, and people are coming back and we are processing their mandatory reassessments.

Q93 John Pugh: To follow on from Karin’s point about regional variations, is it the case that when you get a large number of assessments of not fit for purpose in a particular region, you will also see a large number of appeals or people applying for mandatory reassessment or whatever in that same region?

Sir Robert Devereux: So—

Q94 John Pugh: I am inquiring about the management of the contract and how you manage suppliers on a regional basis.

Sir Robert Devereux: The different contracts are processed in different ways. There is a finite number of centres out of which Leslie is operating. We have the data for each of those centres and we look at them, one by one, to see what we know about how many people they have, how many are trained, and what the grade C reports and the appeal rates are. Maybe, Nicole, you want to say how we spend our time with the contractors to understand all that.

Nicole Kett: We do. It does not make sense to look at the overall national picture. In the discussions that we have with MAXIMUS on a weekly basis, we ask for the breakdowns of where the regions are and what is happening in each of them. Then we can see very clearly what the problems might be and we focus on the ones where there is obviously more work than there should be.

In addition, I have people who are based in the regions, and work closely on the shop floor with the contractors and with our own operations people to help smooth things through where necessary. There are people on the ground who can see what is happening and then we have a regular discussion every week, asking, "What is happening in this region? Why is that? What are you doing to correct it? What are the problems here?" The contract, in the case of MAXIMUS, includes regional floor targets. That is an incentive for MAXIMUS to ensure that they address areas that we knew were difficult. London and the South East was one of those areas, and Central was another. I think there was a third, but it escapes me for the moment. But that is the discussion we have because we do not want to satisfy ourselves that nationally this all looks great, thanks. We don't. We go and have a deep dive into the detail.

Q95 Nigel Mills: I think we have probably moved on to the quality questions. Perhaps we can start on the PIP assessment quality. Mr Haley and Mr Stroud, figure 5 in the NAO Report suggests that quite a high percentage of reports are not meeting the contractual thresholds. For Atos regions 1 and 3, the target was 4% falling to 3% and it seems to hover at about 13% and 14%. You are not meeting the thresholds for three times as many reports as you should do, Mr Haley. Is that right?

David Haley: I think the Report quite clearly shows that the progress we are seeing around the quality service level continues to improve. At the point of this Report, it reflects the closing position of 9% and 8% in each of the lots. That progress continues to improve as it has done into this year.

Q96 Nigel Mills: So where are you now?

David Haley: Sorry?

Q97 Nigel Mills: What's your percentage now?

David Haley: It's heading in the right direction. It is a couple of points lower than that, as we stand, across the lots.

Q98 Nigel Mills: So what is it?

David Haley: Based on our internal MI, we are sat at around 7%.

Q99 Nigel Mills: Just twice the target you are meant to achieve.

David Haley: I think it is important to understand that this is an important target because it ensures that we are very focused on the quality of the reports. As we know, the quality of the reports is critical to outcomes and so on. A colleague mentioned the return rate where a decision is impossible unless there is some rework. The C-grade quality, where a report is deemed to have had some issues, continues to be under focus. We will always ensure that we are staying within that as well.

One of the interesting things in the Report is the need to grow the amount of health professionals that you need while staying focused on quality. It is complex to grow the huge number of new health professionals coming into this while also ensuring that the quality is not only under control, but stays as the central focus. That is a very complex area. When you are, as we currently are, growing the number of health professionals, you must always keep the quality discussion in balance. Ms Wolfe was talking about taking front-line experienced health professionals to help them with mentoring, training, auditing and the 100% audit required for when new health professionals are coming into that. There is a lot of focus on the quality at all times, because the assessment—

Q100 Nigel Mills: I kind of get this, but we are well over three years into the contract. I thought that you might have been a little apologetic that you were still missing the target by double, even now.

David Haley: I think any failure on the quality target is unacceptable, and we would not be happy with that. We are always going to be focused—

Q101 Chair: You are talking as though it is theoretical. Are you happy with that? You said that you “would not be happy”, but are you happy?

David Haley: No, of course I am not happy with the target, and that is why we will always stay very focused on ensuring that we hit and exceed the service level targets that are in place.

Q102 Nigel Mills: Mr Stroud, we have just had Atos apologise for still being double the target. The last month that the NAO assessed, you were a rather whopping 12 times the threshold that you were meant to get to. Is that something that you have sorted out in the meantime?

Chris Stroud: First, let me apologise and acknowledge that our quality has not been acceptable, and there is no shying away from that. On the two figures in the Report, 5 and 5a, one talks about whether the reports are fit for purpose for the Department to make a decision and, as your colleague remarked, we are performing at well over 99% on that.

Against figure 5, it is evident that we need to improve. We have a quality improvement plan in place. We have had that since the NAO fieldwork was done this month. Our position this month is unaudited, but we reached 20%, so we have a downward glide path. It is still not good enough, but we are working very hard.

May I just explain figure 5? It is a provider self-audit of quality, and what we look for there is how well a report is written and presented. When we look at that report, we look for such things as spelling mistakes, grammar and overuse of abbreviations or acronyms. We also look at whether the select choices that have been made have been right or poor, and we also look at the narrative within that. We self-audit very hard. It is a robust audit, and I am confident that we will improve. We are improving and, moreover, our marking will stand up to—

Q103 Chair: Mr Stroud, we know that there are a lot of issues around self-audit, but I will leave that to Nigel Mills. On spelling mistakes, it is right that you should watch for them, but it is a bit shocking that you have highly trained professionals who cannot write a report without littering it with so many spelling mistakes that you have to pick it up in audit. Do you not think that that is a bit of a failure from the beginning?

Chris Stroud: We mark robustly. It is an open and transparent audit. If there are mistakes in there, we mark accordingly.

Chair: It just smacks a bit of sloppiness.

Sir Amyas Morse: My questions range across the providers a little bit. Ms Wolfe, when you listen to these gentlemen describing, you clearly reckon you know how to raise the quality much more quickly than them by being more intense in your approach. Do you think they really are not managing it in the same way that you are? Is that right? I am trying to understand, because they have been in these contracts for quite a while, and they are still not making their quality targets. We are having short-term explanations about growth in numbers still being put forward. What is the difference between them and your company in what you expect to achieve on quality? How come it is so different?

Leslie Wolfe: I think we still have some quality issues ourselves. We are still not where we need to be, either, so I am not happy with that. I will not be satisfied until we meet our quality score as well. There was a change in methodology when we took over on 1 March, but that is not an excuse. We agreed to a 5% target and we need to get there. Again, the NAO Report is reporting our performance for the first five months. The good news is that we have continued to trend towards that target. As of December we are at 7.4 for our C grades, and I am determined to get us under 5. We have done a number of things to get us there, including changing the training, as I mentioned. There is much more mentoring and coaching. We have changed the structure a little so that there is a bit more one-on-one time.

There used to be a real focus on 100% audits—too much 100% audit—and an over-reliance on that, which meant that people were not getting quick feedback, and it is the quick feedback that changes behaviour and makes people more aware of where their errors are. So, some of those initiatives that have taken place are bearing fruit now and we are seeing the right trend line. That is the good news, but unfortunately we are still not there, either.

Q104 Chair: You seem to be doing it quicker than the other two, as Amyas has highlighted.

Sir Amyas Morse: I am not trying to put you in an awkward position, but we need to learn from this. I think you described some things that sound pretty good. I am just trying to understand whether, as you listen to what Miss Wolfe is saying, you are thinking, “We are doing all that as well and still not making our quality target”, or are you thinking, “That sounds like a good idea; we should be doing it”?

Chris Stroud: We are doing very similar things to Miss Wolfe. Our quality is improving; it is not what it was. Initiatives we have put in place—training, audit, and increasing the number of senior clinical coaches in the field—are bearing fruit.

Sir Amyas Morse: The same for you?

David Haley: I completely agree. This is a learning practice as we move forward. We are always looking to improve the structure of how we manage and improve the quality, particularly with senior clinical leads and the auditing, training, developing and mentoring. This is complex and it is a lot to be able to manage. Time, of course, is important, but making sure that we are heading in the right direction and learning, and continuing to bring that learning back into continued improved practice, is clearly something we need to always be on top of.

Sir Amyas Morse: It is very easy to say this. I am sorry to persist with this, but I will try one more time. You guys are not making your quality targets. You have been at this longer than Miss Wolfe. Is it actually achievable to get to these quality targets? I know you are trying hard and you are improving, but it is not incredibly rapid improvement. Let us be honest. Is it achievable to get to these targets, or is that something about which you will just keep on saying in future, “We are really keen to do it”?

Chris Stroud: We want to achieve that target of 3%. We are working very hard to do it. We have agreed an improvement plan with the Department, which brings us to that target during this year.

Sir Amyas Morse: But you believe it is achievable. That is not the same as wanting to achieve it.

Chris Stroud: I believe the target is achievable.

Sir Amyas Morse: Same for you?

David Haley: We believe we will meet the expected target.

Leslie Wolfe: Yes, sir.

Q105 Nigel Mills: Mr Stroud, I think you just told us your performance is still at 20% failing this internal audit that you do. I guess I can cope with a few apostrophes being missing and a few spelling mistakes, but you have suggested that some of these assessments fail because the commentary is not adequate for certain parts of the assessment. Do you have a breakdown of what proportion fail for spelling mistakes and what proportion fail for substantive issues?

Chris Stroud: I do not have that information with me at this moment in time.

Q106 Nigel Mills: Do you have a feeling for it? Is it mainly spelling mistakes or more qualitative ones?

Chris Stroud: I do not have the data. I think it is across the board. Some of the improvements we have done in the improvement plan are around support tools for the assessors. We have built an algorithm, so if an assessor picks a criterion that says that the claimant can wash unaided, and then picks another criterion later that says the claimant needs help to dress below the body, the tools we have now built will automatically flag that to the assessor and stop that happening. So we have taken the learning from the mistakes that have occurred in the past and we are building that into the support tools that we have going forward, and that is showing benefits in what we are doing.

Q107 Chair: It is the DWP that sets the contract, so we should hear from you, Sir Robert.

Sir Robert Devereux: We do know something about what is going on in grade C reports, and it is not primarily spelling mistakes—I'm not going to go to this trouble just to get the spelling right. Two different things are going on. First, perhaps I should say that assessing somebody's disability is actually quite complicated. It is not straightforward and black and white. The claimant will have filled in the form and said what they think. They will probably have supplied some data from the NHS, their GP, perhaps a surgeon or a psychiatrist or whoever it might be, and there may have been a face-to-face assessment with a healthcare professional. The thing that we are most interested in is whether all that information has been thought about and, in so far as it might appear to be superficially inconsistent, whether we can make sure that we have reached the right judgment. We are paying to make sure that we have all the information and have thought about it, and that we then put the weight on the right thing.

A grade C report is when, prima facie when you come to do the audit, you can see that those things don't all necessarily stack up. We are saying to the contractors, "Look, I have given you a set of functional tests that I am trying to do. I do appreciate that people's conditions are many and complex and varied. Please can you think about all this evidence and tell us which way you think the scores go?" That is the process that is going on. As you can tell from the data, at the minute, two of the suppliers have gone from somewhere in the 10% to 12% down to 7% on the way down to 3% and 5%. It is the case that we have more issues at the moment with Capita, with a high number, but that is the nature of the issue. It is to do with the mutual consistency of all the data, on which we can then make a safe decision.

Q108 Nigel Mills: Okay, I get that. I guess we would all be quite concerned if reports are internally inconsistent on what look like indicators where you would expect that if you cannot do one thing, you probably cannot do the other.

Sir Robert Devereux: Let me make one other observation. These are assessing the quality of the reports as they come to the Department. We haven't touched on the fact that in practice the final decision is made by my staff, who are paid to be decision makers. They spend their life weighing evidence, so although they are not healthcare professionals themselves, they can spot that if fact A seems inconsistent with fact B, they had better ring up the assessor and do something about it. What actually goes on in practice is that there is a lot of contact backwards and forwards, because the decision makers are saying, "I don't get this."

Q109 Nigel Mills: Okay, so there is a lot of contact. I am intrigued by figure 5a in the Report, which suggests that the target threshold on ESA and PIP was 1% for assessments returned to the provider as not fit for purpose.

Sir Robert Devereux: That is a different thing. The story I have told you is that the thing we are seeking to measure in figure 5 is, "Is this report well thought through? Have you looked at the data and paid attention to it?" I have also explained how, if the decision makers perceive that a report doesn't meet the standard, they will go back and ask. In some cases—a very low number of cases—the report is of such poor quality that no amount of ringing up is going to make it better and it needs to be sent back to be reworked. That is the very small percentage that you are seeing in figure 5a, but it is not the same. I don't want you to be misled into thinking that we are sending back only 1% and the other 8% or 9% are just going through as is, because there is a lot of to-ing and fro-ing between the decision makers who, at the end of the day, make the decisions. They don't just take the reports.

Q110 Nigel Mills: But that to-ing and fro-ing is not measured in any kind of assessment, is it? You have to understand that we are a little concerned that one figure tells us that Capita thought that 36% of their reports did not meet contractual standards—we

understand that some of that is not spelling and grammar, it is fundamental inconsistencies and errors in the report—yet for that same month you were sending back around one in every 130 of those reports as not being satisfactory. It looks like there is quite a gap there, doesn't it?

Sir Robert Devereux: Yes, but what I am trying to describe is that sending things all the way back to be completely reworked from scratch injects time into the process. Remember, these are just sampled cases, so most of them are not in the audit process, they are just coming through. My staff are reading a report and they say, "It looks as if they said something about walking over here that doesn't seem to match what the surgeon said over there. Will you please tell me whether you asked this question and resolved it?" If the healthcare professional says, "Actually, I did ask that question and I just didn't write it down," we're fine. If they say, "No, I didn't notice. I will think about whether I want to change it," then that's fine. I am drawing a distinction between the actual processing and the amount of thought my staff are putting into it and the 5a metrics, which are actually about where my staff say, "I am not sure what I can do with this. I am just going to send it back and have it reworked." I can see why they appear to be the same, but they are quite different things.

Q111 Nigel Mills: If I were a claimant who had just been turned down for PIP, I would be a little annoyed that your person had to review the medical assessment and check: "By the way, did you find out whether this person can walk the required distance or not? It doesn't appear to be in the assessment." That strikes me as being so fundamental—

Sir Robert Devereux: No, you've started putting words in my mouth. If, for example, the claimant says, "I can't walk more than 20 metres," and then elsewhere in the description of their day they say, "Every day I walk to my sister's," it would be perfectly respectable to ask, "Actually, how far away is your sister's?" to corroborate that. If it is not obvious that the healthcare professional has asked that question, there is a question that said, "They said these two things. Did you actually test it?"

Q112 Chair: It does affect the fundamental quality of the assessments, because this is something that is common sense.

Sir Robert Devereux: I quite agree. As far as we are concerned, the performance on figure 5, the actual quality, is an important thing. I want it to be the percentage which they all committed to do, and I do not want anyone to be distracted by 5a to think that somehow, I am broadly happy. I am not.

Chair: Good. You say you are not broadly happy; we will leave it there. Acknowledging that there is still work to be done is very important in this respect.

Q113 Nigel Mills: I am still trying to get my head around that. So when Capita or Atos do an audit of a sample, they find in Capita's case that one in five is not meeting the standard, commonly for quite fundamental reasons. When your decision maker reads every report, including the 80% or whatever percentage has not been audited, you only feel the need to send back one in every 130? I am thinking that probably 20% of all the ones that have not been audited will be well below standard.

Sir Robert Devereux: Yes. That is what I am trying to tell you is not happening. There is a difference between physically sending it back and saying, "Please do this all over again," and picking up the phone and saying, "Look, there's only one inconsistency, and it's this. Did you ask?" If the doctor says, "Actually, yes, I did ask, and this is the answer," tick, fine. We are trying to make sure it is a consistent story. In many cases, the assessment files will do it. It is a failure of the writing of the report. That is important, because I would rather not have to make the wretched phone call in the first place.

Q114 Chair: Can you be sure someone would remember? This is an obvious question. If a report goes back because there is a query, would the assessor remember if they have done six to eight assessments in a day?

Sir Robert Devereux: But these are coming back quite quickly. Let me make another observation, because then you may understand why I feel this is a reasonable thing. Given the variation in quality, you might have thought, if the risk was the one that you identified, that the rate at which people succeed in securing PIP at each rate of benefit would be different depending on quality. It is not, actually, so it does look for all the world as if the system operates between writing the report and my staff having to go back when they do not think it is right—too often, which is worth acknowledging—but the system is none the less getting to a sound decision.

So that is the thesis I am putting in front of you. I have explained a mechanism; I have also now adduced an actual fact, which is that the success rates are broadly comparable despite quality. I want you to be clear that I do not think it is acceptable not to meet these standards; it would make life a lot faster and better if they were met. They have all agreed to do it, and I look forward to seeing it shortly.

Chair: We all do.

Q115 Nigel Mills: I suppose the question that we have in terms of contract management is this. There is a measure in figure 5a about the absolute ones that are sent back. I can understand that some have issues that need clarifying and correcting but are not a complete rejection, but in terms of how you provide service credits to the providers, I am assuming you need a measure to say, "This report is not acceptable; it requires us to go back and clarify things," and that that triggers some other target that is being missed. It appears that your targets are too far apart for this.

Sir Robert Devereux: There are service credits for failing on figure 5. If people are getting 20% grade C reports, they are going to be hit with service credits. If people get 7%, they are going to be hit with service credits.

Q116 Nigel Mills: So you are happy that the targets and measures you have in these contracts are in the right place, and that they are capturing the whole range, from spelling errors down to fundamentally unacceptable, and there is nothing else you would like in between?

Sir Robert Devereux: As I said earlier, spelling errors can be a bit of a distraction. I would rather they were not in there, but that is not what we are doing this for. The question which the Department is trying to think through at the moment is that we are trying to do an audit of this which basically says, "Does it all hang together?" It is not quite the same as "Has this report led to the right conclusion?" There is an interesting question whether you can tie together the two parts of the story that I have told so that you can go back and re-audit something and say, "I am now checking whether this is right. Did the right answer come out of it?" We said in the report that we are looking at how that might work, but for the moment I am comfortable that these are the right targets.

We are looking to see whether there is a possibility to make it—

Q117 Nigel Mills: May I drift on to service credits and figure 9? I accept that the periods do not necessarily entirely overlap, but it just seems that Capita are performing a multiple of several times worse on those assessments than Atos and yet it appears that you accrued six times as many service credits for Atos as you did for Capita. I accept that the payments are more similar, but it just looks like a slightly strange situation.

Sir Robert Devereux: You are looking at monetary amounts and the contracts are of different sizes.

Nigel Mills: Yes, the Atos contract is twice the size of the Capita one. It is not six times, is it?

Chair: Who is not clear about who here? Repeat it, Nigel.

Q118 Nigel Mills: Just looking at the raw data between Capita and Atos, I accept that Atos has perhaps twice the area to cover, but it looks like they have had service credits accrue at six times the rate of Capita despite their performance looking slightly less bad.

Sir Robert Devereux: All the conversation that we have just had was about one area, which is one service credit. There are more like a dozen of them. The NAO has not reproduced performance against all the other things that we take into account.

Nicole Kett: Exactly. There will also be service credits around delayed cases, backlogs, etc. I think it is quite difficult to draw a conclusion like that. Atos has 75% of the volume of PIP, but the figures will not necessarily be like for like.

Sir Robert Devereux: To put it another way, the regime for service credits is the same in both.

Nicole Kett: Yes.

Sir Robert Devereux: And if you are further away from the target, as is the case with Capita, you will be paying service credits as a consequence.

Chair: We have about 15 minutes, Nigel, and there are others to come in.

Q119 Nigel Mills: I suppose it just looks a bit strange that Atos accrued service credits of £35 million, but only paid 17% of what they accrued, whereas Capita paid 70%.

Sir Robert Devereux: Can I take you to footnote 4? At my age, you have to put your glasses on to read it, but it states that £25 million of Atos's payments was suspended, so if you were to do what it says in footnote 4, you would find that, leaving aside that £25 million suspension, they had £10 million of service credits accrued and they paid £6 million, which is broadly the same percentage as the rest.

The £25 million that was suspended works like this: we were in the middle, as you know from when I was before you last, of a world in which we were finding there was a persistent sense that it took longer to do these assessments than we had expected. That required Atos to acquire more people and more property in which to put those people, all of which costs money. In practice, we said, "You go and get them. This is going to cost you £25 million, and we will not penalise you with a service credit, because this is a necessary adjustment of the contract as the facts have changed. It takes longer to do and you need more people." I could just as easily have taken the service credit and then paid the £25 million and this table would have looked better. In practice, however, we said, "Let's cut out the middle man and crack on and fix the problem," which they have done.

Chair: Yes, and that has been audited.

Q120 Nigel Mills: I presume that Capita just somehow never accrued it in the first place and never had to be forgiven. Is that because you just suspended measuring the targets for them or something?

Sir Robert Devereux: No. I know, because it is in the figures here, that their performance warranted a service credit of £25 million, but part of the reason why their performance required that was the length of time these tests were taking on a brand-new benefit was longer than we had all anticipated. We were recognising—it is a sensible

arrangement—that they needed more people and more property and that would cost money, so we made an adjustment to the contract to reflect the reality that we found.

Q121 Nigel Mills: This table, on the face of it, suggests that Capita did not have to make the same adjustment and did not have the same issue.

Sir Robert Devereux: Oh, sorry, Capita.

Nigel Mills: It seems that Atos accrued £25 million-worth of service credits that you thought it fair enough not to charge, but Capita never seemed to accrue the same level of service credits, suggesting that they did not have the same issue.

Sir Robert Devereux: So they all set out with a different delivery model. We touched earlier on the extent to which they do home visits. You do not need more buildings if you do mainly home visits. The remedy for an organisation with a different delivery model will be different.

Q122 Nigel Mills: I am a bit confused now. So Atos accrued six times the service credit for three times the volume even though Capita have a different delivery model, but somehow you did not charge them the service credit in the first place for missing all the volume and quality targets.

Sir Robert Devereux: Since this is a relatively complicated story and I know you are running out of time, how about if I offered you a nice constructive note?

Chair: That would be very helpful. Brief, clear, crisp and in plain English of words of one syllable—maybe that is a bit of a challenge—

Sir Robert Devereux: That's not fair!

Q123 Chair: It is the DWP, so perhaps that is not the case. Sorry, I see too many letters—a simple letter would be very helpful.

I want to touch on a couple of other points that have arisen. From the Department's point of view, we have heard some real concerns that the contracts, even several years in in some cases, are still not going very well. What have you learnt, Nicole Kett and Sir Robert Devereux, about setting up the contract and managing it? You have changed the contract and the contractor, so what would you do differently if you had to do this again? Sir Robert touched on the complication, but some of this is not rocket science. Someone with a mental health problem cannot be assessed by a generalist; they need someone who knows about their particular problem. What are the two or three things that you would say you will take away from this?

Sir Robert Devereux: The couple of things I would take away, which to be fair are what I think we have done, are first to recognise that you do need to have enough people to do this who are properly trained, so there is no point having some sort of underpriced contract that is not properly remunerating it. Part of the reason we are paying more now is because the price the contractors need to pay to get people to do this work is at a higher level than it used to be. So one thing is make sure you—

Q124 Chair: Than it used to be, or than it should have been in the first place?

Sir Robert Devereux: A bit of both, actually, because I do think people's perceptions of all this work has changed, but in any case the answer is: make sure you have got the right people. The second thing I have learnt for sure is that you do need to be very close to what is going on to manage it. You cannot just sit back and say "Fine, we got that, and the Report has been complimentary about that."

Q125 Chair: That is Nicole Kett's role that you are watching every contract.

Nicole Kett: Yes.

Q126 Chair: But isn't that fairly recent?

Sir Robert Devereux: It is basically the currency of the Report you have got here, so you should thank her for the hard work, really.

Q127 Chair: But it was not the same when we had you in on this issue two or three years ago.

Sir Robert Devereux: No, it was not. We have made a conscious choice based on our experience both with the original Atos contract and with the first six to eight months of the PIP contract to do contract management differently. As you have been asking the Government to do, we have done and here is proof positive.

Chair: Absolutely—we wanted that.

Sir Robert Devereux: The right people is one thing. The contract management is the second thing. And in that, basically paying attention to the service credit regime does mean that people are properly incentivised to do the right work. I think we have got that straight in the contract that we most recently let, because we are further forward. So the one with Leslie, I think we know how that works and she has had to make a stock market announcement about the extent to which her profits are not where she thought they would be. That seems to me to be three lessons I would pick out.

Q128 Chair: I think we would all say that private profits come secondary to the quality of service to the individual. That brings me on to an issue around quality and the types of people you have doing this. You heard from our first panel and we have had a lot of evidence from other people about applicants being very concerned about appeals and their perception of the service—perception is reality for those going through it. Do you think that your definition of quality matches those of the disability groups that we heard from earlier?

Leslie Wolfe: I do think that quality should be measured in various ways and not just the quality of the reports, which are still incredibly important. These reports support a decision that impacts people's lives, so the reports are critically important. But there are other measures of quality that are equally important and that is why we focus so much on the customer aspect as well. We pay close attention to our customer satisfaction surveys and we have expanded our survey to get more information, more feedback and quicker feedback and we will take that on board and continue to improve.

The other that is really important is wait times. What came out in the evidence prior to us was the long wait times people are facing and the increased anxiety that is causing them as they wait for a decision. We are quite proud that we have broken the backlog—

Q129 Chair: Okay. But you recognise that it is still a problem—

Leslie Wolfe: It was a problem. We inherited 550,000 when we took over on 1 March. The audit Report notes it was down to 280,000 at the time of the—

Q130 Chair: That is in the Report. That's fine. We've got that.

Leslie Wolfe: As of 1 December, we were down to 110,000. Hopefully, that is reflected in the testimonies.

Q131 Chair: To be clear to anyone who has read the Report, the field work was done in October, so that figure is news. We tend to work on what is in the Report.

David Haley: Quality always remains a focus. Although there is a metric that is reported in this Report, more importantly we work with disability representative groups on things such as the condition insight reports. We are always trying to work with organisations such as Mind and others to understand exactly how such conditions can affect individuals and how they present themselves. It is critically important to understand that it is a complex area and a complex policy, and everyone is unique. The stress of going through an assessment is very high, so it is important that the quality remains—

Q132 Chair: “Everyone is unique” is a very simple statement, but it is the nub of the problem. Atos’ original approach didn’t treat people in that way; there was too much automation.

Chris Stroud: Quality is absolutely critical, and we are focused on that. Moreover, from working with and getting feedback from the different interest groups, we are changing what we are doing. The primary focus for us is to deliver a respectful, empathetic and dignified assessment.

Q133 Chair: You’ve said all that. We’ll hold you to it. My colleague Madeleine Moon, the MP for Bridgend, who is heavily involved with the Motor Neurone Disease Association and Parkinson’s UK, attended a meeting with you, Mr Haley. She has written to you since, but as you are here I will ask you this question. Her letter says, “It would be helpful to have clarification as to the qualification of the health professionals employed by Atos.” I will ask the other two as well, as you are here. “In the meeting, David”—that is David Haley—“said that Atos ‘do not employ doctors’, which surprised us. If that is the case, who are the health professionals that Atos employ, and what experience is necessary to become an Atos health professional?” We’ve heard a lot about your training. Leslie Wolfe, you talked about that at great length. This is to Mr Haley first, and then we will take Capita and MAXIMUS. Do you employ any doctors? And what about all these specialist health conditions? Can you really train people up to deal with them in a generic way?

David Haley: We do not employ doctors to work on the PIP contract; we employ nurses, nurse practitioners, occupational therapists and a range of health professionals, all of whom have a minimum of two years’ qualification in their field. I talked about the condition insight reports. The job of the assessor is to understand how the individual presents and their functional capability. An understanding of the impact of that is important. We have supplementary support, such as—

Q134 Chair: May I interrupt you there for a minute? If someone has a serious mental health problem, and a nurse practitioner, however good they are, recognises that it is a bit more complex, are you saying that there is no doctor or specialist that they can be referred to within Atos?

David Haley: We have mental health functional champions—

Q135 Chair: What is a mental health functional champion?

David Haley: It is somebody who is available to a nurse practitioner who is about to do an assessment with somebody who has a severe mental illness.

Q136 Chair: What is the qualification of a mental health functional champion?

David Haley: I don't have that information. I am happy to send you full details of all the qualifications.

Q137 Chair: It is an extraordinary title. I don't think I've ever heard the words "mental health functional champion" before. It just seems a funny phrase. Can you tell us who they are? None of them are doctors?

David Haley: No.

Q138 Chair: Okay. What about Capita?

Chris Stroud: Again, we don't have doctors carrying out PIP. We have two chief medical officers who are dedicated to the contract. 75% of our healthcare professionals are—

Q139 Chair: Are the chief medical officers doctors?

Chris Stroud: They are doctors, yes. 75% of our healthcare professionals are nurses. Within that nursing population, we have mental health nurses who work specifically in that area. They also act as support for other healthcare professionals who are not mental health professionals.

Q140 Chair: Can they refer upwards if they think there is something they can't deal with?

Chris Stroud: Yes. As part of our quality improvement process, we have a dedicated line so they can ring into the hub and get help during the assessment.

Q141 Chair: Leslie Wolfe, and then I am going to bring in the Comptroller and Auditor General.

Leslie Wolfe: We have 186 doctors today within our total workforce, which is 1,251. We also have similar mental health functional champions. Those people have either worked in psych wards, have had mental health specialisation as part of their training, or we have supplemented their training to give them a specialist role. They are exactly as my colleague mentioned.

Q142 Chair: You say you have got doctors—

Leslie Wolfe: Yes, we have 186 today and we are continuously trying to recruit more—

Q143 Chair: So if I came to see you for an assessment for my employment support allowance with a complex mental health problem, and the nurse practitioner couldn't properly assess me, you could get me referred to—or you could get support for that individual from—a qualified doctor in the area?

Leslie Wolfe: The likely outcome would be that if the case could not be completed because it was overly complex, they might be able—just as my colleague described—to phone a mental health functional champion and bring them into the conference. That person can help to ask the right questions and make sure that we're probing in the right areas, or they can contact a doctor or someone with more specialisation in that area.

Q144 Chair: There is a real concern about these complex fluctuating conditions, as you will pick up.

Sir Amyas Morse: We agree on that. I was just thinking about a description of the interaction of the Department. These are multi-factoral assessments and you want to make sure that all the factors have been brought together, but the likelihood is that in the case of Capita and Atos at least they are being brought together by somebody with a nurse background. Are you satisfied that by training people with those backgrounds, they can assess complex, multi-factoral medical conditions across a—?

Sir Robert Devereux: Let me—

Sir Amyas Morse: I am sorry, but it's a fair question.

Sir Robert Devereux: It's a perfectly fair question, but I don't want you to think that in setting up these two functional tests, which is what the WCA and the PIP test are, the Department and its doctors—and I mean doctors, if we're going to argue the toss about it—have gone through what is necessary to make sure you can safely make those functional tests by way of healthcare professionals. The general sense of the Committee, which is, "Unless you're a doctor, it really isn't going to happen", is not the view of the medical professionals who are in charge of this test definition—

Sir Amyas Morse: When I asked the question, I didn't say that. I was simply asking a clarifying question, and I am perfectly entitled to ask it, thank you. I am sure people have thought about these things, but none the less what you are telling us is that as you assess people's complex medical conditions, it will be down to somebody who has medical training up to a point, and then has specific training by yourselves? That is how it is resourced, isn't it?

Chris Stroud: Yes. Our assessors are healthcare professionals. They are trained; they are experienced. And they will complete the functional assessment as described by Mr Devereux.

Chair: Okay. Karin Smyth wanted to come in.

Q145 Karin Smyth: I just want to raise this regional issue, which we talked about a couple of times but we haven't really picked up anything concrete. I really want to be assured, and I do not think we get this from the Report. My Bristol, South constituents would have a different experience were they in Wales, Northern Ireland, Scotland, or possibly even in another region.

I think you said that you look at the different parts of the UK, as well as perhaps different regions, to understand that. What we can't get from these figures—the NAO may help me out here—is any sense of what's going well where, or lessons learnt. Northern Ireland is very small—I realise it is not part of the NAO's Report—but it has very small numbers compared with the rest of England, or indeed the south-west.

You probably cannot cover it in the few minutes here, but I wonder if there is a way that we can perhaps get a better sense of that.

Sir Robert Devereux: Let us see what I can do within the framework of the published statistics. As a general rule, whether it is this particular piece of the benefit system or the entire gamut of it, we spend an awful lot of time making sure we understand how office X's performance differs from office Y doing exactly the same work, and learning from that how to make them both better.

Q146 Chair: Absolutely. We just want transparency.

Sir Robert Devereux: It is one of the reasons why the Department's performance has risen so strongly—because of doing that—and we apply the same technique, which is what Nicole is doing, to make sure that, centre by centre, we know precisely—

Q147 Chair: So, Sir Robert, in response to Karin Smyth's question, will you be able to provide—you are saying there is all this published data, which is fine—some breakdown of the performance, so we can tell, and colleagues can tell their constituents—

Sir Robert Devereux: I am happy to go away and see what I can provide, subject only to the question that it has to pass the statistician's test of whether it is fit for purpose—

Q148 Chair: Well, the statistician's test, the confidentiality and all the rest of it—

Sir Robert Devereux: No, not of confidentiality; it is whether it is good enough statistics.

Q149 Karin Smyth: If we can have broad country and broad regions, that's fine.

Sir Robert Devereux: Let me see what I can find.

Q150 Chair: I am sure the NAO will happily work with you on—

Max Tse: There are some published statistics on PIP by region—waiting times and so on—

Q151 Chair: Colleagues across the House have raised concerns with us about performance. It is a very big issue for us. Our surgeries are full of people who have gone through the system or tried to go through the system. If we can know whether our own local area is doing well, we can hold the contractors and the DWP to account. I am sure you would welcome that, to improve performance.

Q152 Deidre Brock: My question is about the use of NHS healthcare professionals. I wonder if the providers could indicate the rough percentage of their assessors that have come from the NHS to your organisation.

Leslie Wolfe: Do you mean the experience that they undergo?

Q153 Deidre Brock: No—have they come straight from the NHS to your organisation?

Leslie Wolfe: About 30% of our new entrants have come from the NHS.

Q154 Deidre Brock: And were older entrants from the NHS as well?

Leslie Wolfe: The vast majority of people who come to us have come from other parts of private healthcare.

David Haley: A similar percentage. Indeed, one of our models for delivering the assessments is through supply chain partners. Two of our supply chain partners are NHS trusts.

Chris Stroud: The same. About 30% of our staff would come from the NHS. The rest would come from other providers.

Q155 Deidre Brock: I have had it raised with me by disability campaigners and NHS healthcare professionals who are still in the NHS who have been very concerned about the effect this will have on the NHS service. What would you say to that?

Leslie Wolfe: If I can help to assure you about this, we are pretty well through the steep recruiting curve we were under. We have a much lower recruitment rate that we need to go through to meet our year 2 numbers and targets. We will be mostly, in the near term, backfilling people who leave the service. I don't think our small numbers, going forward, will negatively impact the NHS service.

David Haley: Again, it is important to understand where the health professionals come from. In terms of the volume that we are looking to grow and succeed at, I would agree; I think we are very similar. We are very mindful that we need to work with the NHS to make sure there is a continuation of service for the health professionals themselves in terms of their continuous professional development.

Q156 Deidre Brock: How do you go about doing that?

David Haley: We do ongoing, regular training every month. We do deep-dive into particular modules of areas of expertise, to make sure that their registration and certification can continue, because they will probably return to the NHS at some stage.

Chris Stroud: We have a similar scheme to that of Atos in retraining ourselves and making sure our health professionals are ready. If they wish to exercise their choice and go back to the NHS, they can.

Q157 Deidre Brock: I see. You take on extra staff to cope with the big backlog that you have. Your ultimate intention is that once that backlog is gone and you are back to more of an even keel, they go back to the NHS. Is that right? I thought you were trying to say that, ultimately, the staff would be returning.

Sir Robert Devereux: As individuals, they may choose to return to the NHS in due course and then they will have a career structure.

Q158 Deidre Brock: I just wondered, Sir Robert, whether you have discussed that with your counterpart in the Department of Health and the impact of it.

Sir Robert Devereux: The short answer is no, but the grand total of people we are employing to these contracts is a tiny fraction of the 1 million people in the NHS, so I very much doubt that it is changing the price.

Q159 Chair: Before I ask Stephen Phillips to come in, I believe that you are on the record saying that MAXIMUS needed to recruit 1,000 new healthcare professionals. In earlier questioning, you said to me that you inherited 750-something and you now have 1,200-something people. Maybe I am wrong and you didn't say that you wanted to recruit 1,000 more. What is your final total that you need to get to by the end of year 2?

Leslie Wolfe: Right now, we are at about 1,200 or 1,250. That is about the number we need—about 1,200 full-time—to clear the year 2 contract target.

Q160 Chair: So it is just now attrition that you are backfilling—

Sir Robert Devereux: It is not another 1,200.

Chair: Right. I just wanted to be clear and make sure I had those figures right.

Q161 Stephen Phillips: That figure of 1,000 was widely reported at the time, including in the print media. Where did it come from?

Leslie Wolfe: I think—I certainly hope—what I said was that I needed to recruit hundreds to reach the number.

Q162 Stephen Phillips: *The Guardian* reported a direct quote from you that said it was over 1,000.

Leslie Wolfe: At the end of the day it would be over 1,000, yes.

Q163 Stephen Phillips: Sir Robert, which corporate entity is the contract with MAXIMUS with?

Sir Robert Devereux: It is with CHDA, which is a wholly-owned subsidiary of MAXIMUS.

Q164 Stephen Phillips: Ms Wolfe, is that the company that employs you as its chief executive?

Leslie Wolfe: No, my payroll is currently with MAXIMUS, Inc.

Q165 Stephen Phillips: In Virginia?

Leslie Wolfe: In Virginia.

Q166 Stephen Phillips: The company that is delivering the contract, what is it called?

Leslie Wolfe: CHDA.

Q167 Stephen Phillips: Is that company registered in England and Wales? You said it is a wholly owned subsidiary.

Leslie Wolfe: Yes, we are wholly registered in the UK.

Q168 Stephen Phillips: Where is that company going to be paying its tax on the profits under this contract?

Leslie Wolfe: In the UK.

Q169 Stephen Phillips: Mr Haley, obviously you have a contract in relation to PIP as well. Where is Atos paying its corporation tax?

David Haley: Everything we book we bill in the United Kingdom.

Q170 Stephen Phillips: And Capita?

Chris Stroud: The United Kingdom, Sir.

Q171 Stephen Phillips: Coming back to you, Ms Wolfe, this is a £595 million contract. Obviously the profit margin is commercially sensitive but one assumes, in accordance with Government contracts, it is somewhere between 10% and 20%. I think Atos, across all contracts, is 14%. Will you be paying corporation tax on about £60 million in the United Kingdom under this contract?

Leslie Wolfe: If we realise profits of that nature, we will be paying the appropriate tax. For fiscal 2015 we actually recorded a loss on this contract. That is public.

Q172 Stephen Phillips: I know you are Canadian and are employed by a Virginia company, but where are you paying your personal taxation? Where are you domiciled for tax purposes?

Leslie Wolfe: I am considered a US resident. I have a visa in the UK, so I pay UK taxes, but there is a reciprocal tax agreement. That is how it is managed, and we use an accounting firm to make sure it's all proper.

Q173 Stephen Phillips: That's fine, but you are domiciled for tax purposes in the United States. Is that right?

Leslie Wolfe: Currently, correct.

Stephen Phillips: Thank you very much.

Q174 Chair: I want to finish the hearing. Thank you for coming along. It is really important that these contracts work. We have seen quite a contrast between a new contractor and former contractors, where there are still problems. We are seeing MAXIMUS seemingly ramping up in terms of its low error rate compared with the others. Overall, the costs increasing for assessment is obviously a worry for the taxpayer, but we do recognise that there is a balance there with quality. If more money is going in just because costs are going up and we are not seeing quality, that is a big concern. The costs going up over 65% with continuing problems of performance is a worry, and I am sure that still worries Sir Robert as he watches this contract going forward.

The handling of assumptions has clearly been an issue between both contractors and the Department, particularly from what Ms Wolfe was saying, as someone new coming in. There were detailed discussions about the contract, and assumptions were made that did not match the reality on the ground. Sir Robert, you talked about what you had learned from the contracts, and I think you acknowledged that there were lessons learned from the early days to now on that. I think that that has come out in the hearing, and I think that planning for the future is something. Maybe, if we are being positive, we will see things stabilise. We wait to see. We have had a lot of promises today, on which we will hold you to account, but there is planning for the future. This is a costly exercise that has a big impact on people's lives, so getting it right is important foremost, but then making sure that it is actually delivering is vital.

Sir Robert, you are looking puzzled.

Sir Robert Devereux: I am looking puzzled only because that sounds very much like a summing up, but we haven't discussed several of those things. If you don't mind, can I go back and re-read this in the transcript? If I think there are things in there on which we might usefully give you some further evidence—

Q175 Chair: We know that the cost of assessments—we have discussed the costs—have gone up.

Sir Robert Devereux: Yes, but you have not asked by how much the number of assessments has gone up. You haven't asked about the extent to which the counterfactual—

Q176 Chair: But we have some of that information in the Report.

Sir Robert Devereux: Okay—I am just making an observation that there are things that you are saying—

Chair: We don't read out the entire Report in the session. I won't get drawn into the figures at this late stage, but I have summaries and the full report of the figures. We know that the average cost per assessment has gone up. We discussed that, and we discussed partly why that is. We talked about the issue of quality and about having the right qualified professionals and making sure they stay. Those are all things that are an important part of delivering contracts. Nevertheless, we are watching taxpayers' money, as well as service for the user.

Sir Robert Devereux: So am I.

Chair: Absolutely—we should be on the same page on that issue. It is important that we know that, when that extra money is going in, it is actually delivering quality. That is the point I was trying to make. Sorry if I wasn't clear, but hopefully we would both agree on that point.

We have had some really clear pledges from the three contractors in particular, and we will be coming back to it. The NAO will look at it regularly, and I know that our sister Committee, the departmental Select Committee, will be looking at this at some point. We will be holding you to those statements, which you've made in public. If you come back and you haven't achieved them, we will be sorely disappointed but, more importantly, our constituents and people up and down the country will have been poorly served. You are in receipt of taxpayers' money to deliver this contract, so we therefore consider you to be public servants and expect you to continue to promise to deliver, and actually deliver in that vein.

Thank you very much indeed.