

Work and Pensions Committee

Oral evidence: PIP and ESA assessments, HC 355

Wednesday 6 December 2017

Ordered by the House of Commons to be published on 6 December 2017.

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Members present: Frank Field (Chair); Heidi Allen; Andrew Bowie; Jack Brereton; Alex Burghart; Neil Coyle; Emma Dent Coad; Ruth George; Chris Green; Steve McCabe; Chris Green.

Questions 107 - 259

Witnesses

I: Simon Freeman, Managing Director, Capita Personal Independence Payments, Dr Ian Gargan, Chief Medical Officer, Capita Personal Independence Payments, David Haley, Chief Executive, Atos Independent Assessment Services, and Dr Barrie McKillop, Clinical Director, Atos Independent Assessment Services.

II: Dr Paul Williams, Programme Director, Centre for Health and Disability Assessments (CHDA) MAXIMUS, and Leslie Wolfe, General Manager, Global Health, Centre for Health and Disability Assessments (CHDA) MAXIMUS.

Written evidence from witnesses:

[Captia](#)

[Atos/IAS](#)

[MAXIMUS](#)

Examination of witnesses

I: Simon Freeman, Managing Director, Capita Personal Independence Payments, Dr Ian Gargan, Chief Medical Officer, Capita Personal Independence Payments, David Haley, Chief Executive, Atos Independent Assessment Services, and Dr Barrie McKillop, Clinical Director, Atos Independent Assessment Services.

Q107 **Chair:** Welcome. Might you begin by identifying yourselves for the sake of the record and say what you do? We will go down the list, and then Chris is going to open.

Dr Gargan: Thank you, and good morning to the Committee. My name is Dr Ian Gargan. I am the chief medical officer for Personal Independence Payments for Capita, and my professional background is a practitioner psychologist and orthopaedic surgeon.

Simon Freeman: Good morning, everybody. My name is Simon Freeman, and I am the managing director for Capita's PIP contract.

Dr McKillop: Good morning, everyone. I am Dr Barrie McKillop, the clinical director for Independent Assessment Services.

David Haley: Good morning. I am David Haley. I am the chief executive of Independent Assessment Services from ATOS.

Q108 **Chris Stephens:** Good morning, everyone. We have had some evidence from claimants who have advised us that they were not advised prior to an appointment that they could bring someone with them on their behalf. Can I ask you, first—both companies—do you notify an individual prior to their interview that they could have the right to be accompanied and whether that person could also advocate on their behalf? Maybe start with yourself, David.

David Haley: We make it very clear in all of the publications that we actually advise that a claimant coming in for an assessment can bring an advocate, a family member or somebody who knows them well.

Q109 **Chris Stephens:** Is that in a letter that they would receive that that would be the case?

David Haley: Yes, and when we are actually in communication with them prior to their actual appointment we make it as clear as possible in the publication that they are able to bring an advocate or a family member.

Q110 **Chris Stephens:** Okay. Can I ask Capita—

Simon Freeman: When we provide letters out to claimants to welcome them into the process we also identify that they can bring a companion or somebody to support them during the process. We also publish it on our website.



HOUSE OF COMMONS

Q111 **Chris Stephens:** Can the person that can come in with them, then, a family member, for example, speak on behalf of the person?

Dr McKillop: Yes, we welcome not only companions, advocates, family members, into the assessment but we also welcome their views for the assessment. The assessment is of the individual themselves, but the extra value that the views of someone who knows them well can add to that process is something we actively encourage.

Q112 **Chris Stephens:** Ian, is that the same—

Dr Gargan: We absolutely encourage the claimant to bring an advocate, a friend, a family member or a carer with them, whoever they appoint, and garner information from that person as well as the claimant themselves. To Mr Gray's second review, it is really important that all voices and anyone who cares for the claimant as well as themselves be heard.

Q113 **Neil Coyle:** Just a quick follow-up: you both suggested you are really encouraging of individuals to bring someone with them; what percentage of claimants do actually bring someone with them to an assessment?

Dr McKillop: I am sorry, I do not have the actual figures for that.

Dr Gargan: My apologies; I do not have the specific figures either. In any of the assessments that I have sat in, all of the claimants have brought in advocates and supporters during it. I take it from that that throughout the majority most people would bring someone into the assessment with them.

Q114 **Chris Stephens:** Could you both maybe provide a standard letter that goes out to a claimant so that we can confirm that the right to be accompanied has been offered? It was of great concern to many members of the Committee where claimants are advising the Committee that they were not aware that they could bring someone with them. If you could both provide a standard letter that you have sent out to a claimant, I think that would be helpful. Do you think also that the Committee members when they come into the surgery might ask for the full set of papers so we can compare?

Chris Stephens: Yes, I think that would be helpful.

Q115 **Emma Dent Coad:** Given, as we know, that face-to-face assessments can be very stressful, do you think making better use of medical evidence supplied by the claimants would allow you to reduce that number of face-to-face assessments? Obviously, it would have to be good-quality medical reports. Could I have maybe Simon and then David and the doctors after you?

Simon Freeman: Yes, we recognise that this can be a very stressful process for people, and we do everything we can to try to reduce that. We make a decision when the case is passed to us by the Department as to whether we garner more medical evidence, in many cases we do, and



HOUSE OF COMMONS

we then make the decision as to whether we can do that via a paper-based assessment where we do not need to see the person face to face or whether we visit the person in their home or in the clinic.

David Haley: Clearly, our target is to make sure that we get somebody in for an assessment as quickly as possible, and if further evidence is able to provide that via a PIP case review that is obviously a lot quicker than that would be our preferred method, but clearly further evidence is absolutely key to the part of the process that we are involved in, particularly face to face.

Dr Gargan: Every claim is carefully considered, and the uniqueness and complexity of their case is considered. We encourage the disability assessors with the background that they have as a medical professional to seek medical evidence or indeed further evidence from other carers and other sources and so actively encourage that and use it for the purposes of the report.

Dr McKillop: In reference to further medical evidence and also in reference to Paul Gray's recognition in his second independent review, in PIP we look not only at further medical evidence at the first part of the process but also at further evidence in the broadest sense, not just information from perhaps a GP, a consultant or a specialist nurse but also wider information, perhaps a care report, information from a social worker, from someone else who knows that individual well. I think the key aspect for me is that PIP, while it is for people with medical problems, is a functional assessment. It is looking at how that person's medical problems affect them on a day-to-day basis. Although further medical evidence is a useful piece of information, because it lets us understand the severity and complexity of that person's clinical condition, it is a part of the jigsaw looking at how that person is affected in their daily lives, which may be very different for different people even with the same condition.

Q116 **Emma Dent Coad:** What percentages of people are seen face to face or assessments done by paper exchange of documents? Do we have an idea of what percentages and how that works?

Dr McKillop: In our areas of the country around between 10% and 15% of cases that are referred to us are undertaken as a paper-based review without the individual coming for a face-to-face assessment. The balance will be undertaken having that face-to-face assessment to allow us to get the fullest level of information possible to the decision-maker to make their decision.

Simon Freeman: For Capita about 15% of our total caseload is done via paper-based review. Those people who we do not see via paper-based we will either visit in their home or request them to come to one of our clinics.

Q117 **Steve McCabe:** This is an issue that comes up all the time—I am



HOUSE OF COMMONS

thinking particularly about ESA—about how many of the assessments move on to face-to-face and how many end up being conducted at people's homes. What is the relative financial impact of making these decisions? Do your organisations get more money if it is done on paper or if it goes to a face-to-face interview? Do you lose money if it has to go to a home interview, because the costs are higher? I am just curious to know how that could impact on any decision-making process.

Simon Freeman: I would like to be very clear the decision as to whether we go by paper-based review or whether we see somebody face to face in their home is a clinical decision and that that criterion is set out in the PIP assessment guide, which the Department publish. It is not in any way a financial decision.

Q118 **Steve McCabe:** But I am asking: could there be any financial impact? I am not saying that you do not make a clinical decision; I am just wondering what the relative financial impact is.

Simon Freeman: There is a difference in the cost of seeing somebody face to face, as you can imagine, versus doing it on paper, but that has not a bearing on whether we go down one route or the other.

Q119 **Steve McCabe:** That would be the same for all of you?

David Haley: Yes, we have a cost for a paper-based review and a cost for a face-to-face assessment.

Q120 **Chair:** When you say a clinical review, is that a doctor that would make that decision? "Clinical" is a rather big-group term, isn't it?

Dr Gargan: This is not a medical assessment, as said before. The purpose is not to make a diagnosis or to suggest prognosis or intervention. Per the PIP policy we have a number of clinical staff that are nurses, occupational therapists, physiotherapists or paramedics—and also doctors may join the PIP assessment team, of course—and they must have a minimum of two years' registration. On average, the tenure of a health professional in Capita would be 12 years. The skills that they have garnered from extensive experience, whether it be in a hospital or private-based medicine, allows them to have the insight about what evidence may be required, if they should look for further evidence or maybe what other area to look at, from a community psychiatric nurse or from a carer at home etc. That is the extent of the clinical decision.

The other clinical aspect of their experience would be their empathy and history-taking skills, and that helps facilitate the standards of excellence in their assessment.

Q121 **Chair:** But who makes the clinical decision? Who makes the decision, "This paper is going for a clinical decision to decide whether we go to their home or whether we do it by paper"? Who makes that decision?

Dr Gargan: One of the named professionals that I have mentioned already will make that decision, whether the person should be seen or it



HOUSE OF COMMONS

should be a paper-based record. If there is sufficient evidence on the claimant questionnaire or if there is already further evidence that has been supplied, they will make the decision on the back of that; if insufficient, then whether they go to clinic or home. They will also look at other factors to see maybe if they should be specifically seen—

Q122 **Chair:** No, I wanted to know how qualified the clinical person was to make the decision. For example, one claimant sticks out in the mind for me. He did not get benefit because he had a dog and he walked the dog. He could neither walk nor had a dog. Who would judge whether, “We should see this person”, or, “We will do it by paper and just assume you have a dog and you walk the dog”?

Dr Gargan: While I cannot speak for the actual benefit and the decision about that, because we are there to create an objective assessment and make an ultimate decision about the benefit, it is the clinician who makes the decision to the committee. That clinician that I have already mentioned will make the decision on whether it is going to be a paper-based review or they will be seen in the home or in the clinic.

Q123 **Chair:** Here is your group of people who are making decisions, the paper comes up, and you, the clinician, decide then whether you draw on one of our medical skills to decide whether in fact that is a paper-based or a face-to-face interview, going to their home or their coming in, and that it would be a clinician that actually knew about what was on the form? You would not just, say, shovel them out where, “You are all clinicians; just make decisions”; it would be, “I am deeply depressed”, say, and it would go to somebody who had some real expertise in this area, not a physiotherapist who knew about whether you could walk or not?

Dr Gargan: The disability assessors have a minimum of two years’ experience and tenure—

Chair: No, it is not that.

Dr Gargan: But they will go through a standard disability—

Chair: We may come on to the standards later. There are a number of us who want to come in on this; we are really at the heart of it, I think. When there is a clinical decision made it could be made by a clinician that knows nothing about the condition that our constituent has written on the form. I do not understand at the moment who decides to which clinician the papers go for this key decision: is it paper, or is it personal? There must be somebody of your quality, is there not, deciding, and do they decide it is a specific clinician relevant to why the claimant is applying for benefit?

Dr Gargan: I believe all the disability assessors are of excellent quality. They will have had the standard training. It is not a specialist that will make that decision. They are all specialists in disability assessments to the standard training that has been agreed with the Department and what we have developed ourselves. They do have leadership and



HOUSE OF COMMONS

direction from specialists like clinical coaches and particular champions for certain conditions, but, to your point, it will not be a specific specialist who will make that decision.

Q124 **Chair:** If we take me and my constituent, “I am deeply depressed”, he cannot walk, it may be the same clinician that would decide this can be done by paper or it has to be done more personally?

Dr Gargan: Correct, and I understand the concern of the Committee. The comprehensive five-week assessment, as well as a continual quality, learning and support mechanism, colloquially known as audit, ensures that the people have the adequate training and our disability assessors have that training to be able to make that very important decision for each unique case on each claimant.

Q125 **Andrew Bowie:** Why don’t you assign assessors to claimants with expertise in their conditions? What is preventing you doing that?

Dr Gargan: It is not that there is any prevention from doing it. It is the fact that this is a functional assessment relative to a medical challenge in the person’s life. It is not a medical assessment per se. This standard training to be able to disability-assess, we feel, is excellent so that each claimant’s needs can be addressed and those disability assessors can clearly make that decision on whether the person should be seen or should we have sufficient evidence to be able to write the paper-based review. That is our opinion, and we stand by the excellence of our disability assessors in that background.

Simon Freeman: I think it is probably also worth adding that many claimants do not present with one condition. You could send it to the team that deal with that, but people do not present with one condition, and so even if you were to send it to somebody with a specialism then you would be not looking correctly at the other conditions they may present with. That is why, as Ian has described, we have very random training.

Q126 **Andrew Bowie:** You can understand why people do not have much confidence in the system if they are being assessed by somebody who has no expertise in that field at all.

Dr McKillop: I think one of the most relevant things, as Simon just mentioned, is that the majority of people who come to see us for an assessment or who are referred to us by the Department do have multiple medical conditions that can affect the physical health, their, mental health, sensory and cognitive function, and because, as Ian has mentioned, we undertake what is called a functional assessment it is really challenging to look at, for example, an individual who has a diagnosis of depression, arthritis and multiple sclerosis and to recognise that although that individual may see specialists to have these individual conditions diagnosed and treated the role of the PIP assessment is to look at the impact of all these conditions together on that individual’s daily function. PIP, as the Committee recognises, looks at 12 areas of an



HOUSE OF COMMONS

individual's daily function, and of course someone with multiple conditions may have some of their activities impacted more by one condition than by others. For example, their depression may impact on their ability to leave the house because of their mental state, but it may be their arthritis that is more disabling in terms of their physical ability to walk. Rather than having a specialist looking at one condition in isolation, our reports and the focus of our assessment is looking at a person's overall function and how their daily life is affected across the board.

Q127 Neil Coyle: The Department tell us that the one of the biggest single reasons for decisions being overturned is the provision of additional medical evidence. What are the barriers to people providing that information upfront; or is it just ignored by your assessors?

Dr Gargan: Certainly not ignored; first of all, it is discerned what evidence may be required, there is a standard general-practitioner record template that we send out to GPs in order for them to complete, and that can constitute further evidence.

Q128 Neil Coyle: How many of those come back before the assessment takes place?

Dr Gargan: On average about 35% of cases would require that there be further GP evidence required. We receive fewer than 10% of those back, of which 3% would actually be relevant to the functional capacity during the assessment. However, to Mr Gray's report on the second mandatory review and to the point about the barrier, further evidence, not further medical evidence, constitutes something very useful for decision-making ultimately by the case manager and the Department, and with that evidence, like, as Barrie has spoken to, a community psychiatric nurse or a carer, I think you are correct: there is a barrier to that where further education would be required and maybe needed by families and carers to know what evidence they could supply to help in the initial decision about paper-based or to go for further assessment.

We are continually working with the Department to understand and to develop ways in which we can encourage that evidence to come in. We talk to stakeholders. I recently met representatives of cystic fibrosis, and they did not understand particularly what their claimants or their members needed to supply in order for us to adequately assess them for PIP; we gave them that information, and that has really helped them in the application process.

Chair: We shall go on to the later stages of the reviews in a moment, but do you want to pursue this point, Neil?

Q129 Neil Coyle: I would just like to hear all of the answers to that same point about that additional medical evidence. If you are asking people to come in and not telling them what they need to explain or bring with them, then that is part of the problem; or is it the timeframe? Why aren't GPs responding to the questionnaire? There are all kinds of issues wrapped up in this, which are not necessarily all your fault, although from seeing



individual constituents I know where they lay—

Simon Freeman: If I may just add to the point. There is a significant element to the process prior to the case being handed to the assessment provider that captures all of the information from the claimant and encourages them to provide any further evidence. That evidence has been scanned and then passed to us. We then may choose to seek further evidence. I think encouraging upfront and being very clear with people what sorts of evidence may be helpful would definitely be a benefit, and certainly we find it very useful to gather as much evidence as we can, because that means we can make the most robust and accurate assessment when we meet the person.

Dr McKillop: It is a very similar position within Independent Assessment Services. At the point where we write a report and send it to the Department for their decision to be made we want that information to be as complete as possible. As Simon has mentioned, individuals who are claiming PIP are notified of what information they can supply along with their claim form may be particularly useful. We have worked with the Department on that over the lifetime of the PIP service, and we have that information on our websites and leaflets as well, because people are welcome to send additional information in or bring it to the assessment at any part of the process.

We do not gather formal information on this, but around half of the cases that are referred to us from the Department already have some additional information, some further evidence, which may be medical or may be additional information from elsewhere, at the point where it is referred, and then, as Ian mentioned, we would either write out or telephone for additional information to anyone that has been mentioned on the claim form to attempt to get that additional information to either allow us to undertake a paper-based review or to help support the face-to-face element of the assessment if that is what proceeds.

Chair: Before Chris comes in, Andrew, can you follow up your questions as well?

Q130 **Andrew Bowie:** How many doctors do you employ in this process as a percentage of the people who—

Dr Gargan: There are two doctors in our organisation: myself and one medical director, who is another leader of technical governance.

Q131 **Andrew Bowie:** Doctors are not involved in the—

Dr Gargan: In the assessment process? Not in our organisation, just because they have not applied to work within the organisation to carry out the assessment; they are absolutely eligible to apply to work in it. Over two thirds of our professionals have a nursing background, and the remainder are from occupational therapy, physiotherapy and paramedicine.



HOUSE OF COMMONS

Q132 **Chair:** How big is your staff? You have two doctors out of how many staff?

Dr Gargan: There are 1,500 staff in total who work with Capita Personal Independence Payment; around 1,000 clinicians.

Q133 **Chair:** Barrie, might you answer Andrew's question?

Dr McKillop: It is a very similar number to ourselves. We have two doctors working with Independent Assessment Services. Seventy-five per cent. of our health professionals are nurses, and the balance is either paramedics, occupational therapists or physiotherapists.

Q134 **Chair:** We have a whole crowd of young doctors who are GPs who probably then wish to start a family, who leave the NHS for a period of time to raise their families, and neither organisation has actually tried to contact them to say, "Would you like to work from home during this work for us?" God knows how many tens of thousands; and they will come back into the NHS when their children are older.

Dr Gargan: I would say to the Committee, to talk about the evidence of the GP formal record, for instance, the template, which needs further improvement, we would have worked actively with the British Medical Association and other doctors and GP colleges so they—

Q135 **Chair:** We are actually concerned with your daily activities. You have two doctors each, a mega-workload, we know there are a lot of doctors out there who would long for some part-time work, and because they have not come to you you have not actually sought them out, to raise your game, have you?

Dr McKillop: Our health professionals are mainly nurses, and, very similar to our colleagues in Capita, our nurses have an average of 14 years' clinical experience before coming to work for us. Health professionals other than doctors have been used in disability assessments for over 10 years now, and we know the skills that they have from their previous clinical backgrounds, which are very often well matched to the PIP functional assessment that we undertake, because they have communication skills and they have the ability to look at an individual's daily life across multiple medical conditions rather than being focused on diagnosis and treatment, which is very much where a doctor's clinical work flows—

Chair: We will come on to how difficult they are in a moment, if we may, these judgments, but does anybody else want to come in on this aspect?

Q136 **Chris Stephens:** It goes back to Andrew's original question and the answers we got from that. Can you tell me, for the Committee and for those watching, what is the difference between a functional assessment and a medical assessment? The claimants who arrive think they are being assessed on their medical needs. Could someone answer the question about what the difference is between a functional assessment and a medical assessment?



HOUSE OF COMMONS

Dr Gargan: There are lots of details to that question, but the specifics would be in a medical assessment I would be assessing to know what particular diagnosis I need to make—I may not have a diagnosis—and also then what interventions need to take place for the person to get better or indeed maybe what medication as well as surgical intervention, in my experience as an orthopaedic surgeon, need to take place. A functional assessment would be to look at the condition and see how it affects the activities of daily life as well as mobility. I as an orthopaedic surgeon may look at a diseased hip and decide that I am going to replace that hip, but then as a PIP assessor that has gone through standard disability assessment training I would be looking to see how that hip pathology affect the activities of daily living, like how far that person can walk, whether they can leave the home, whether they can feed themselves, among all the other extant activities as set out by the PIP assessment.

Q137 Chris Stephens: I am tempted to test that, because obviously claimants—certainly in my case, and I do not think I would be alone—will challenge the issues surrounding when the assessor says, “This person can walk 50 yards unaided”, or all of that. How would you do that in a functional assessment?

Dr Gargan: There is a standard guide to the PIP assessment policy of how those various activities are measured. That is addressed in all the training the disability assessors go through, but also then it is continually reviewed. I understand the question, and an enhanced questioning by the disability assessor may be required above and beyond the prescribed questioning that they had during their training, but our quality, learning and support mechanism then allows that our clinical coaches and clinical champions—who may be from a musculoskeletal background, for instance, but I am talking to hip pathology—would be sitting in on the assessment watching how someone is exercising that standardised assessment process and asking the questions about how far a person can walk.

Q138 Chris Stephens: If you are aware that someone has had MS and depression for two years, who would they be referred to in your organisation to assess that particular person?

Dr Gargan: One of the disability assessors from the standard group. They would not be assigned the specific specialism; they would be given the individual with the background that I have already described, with the standardised disability assessment training.

Q139 Chris Stephens: Do you understand, then, my claimants are frustrated when they come to either of your organisations and feel that neither of your organisations understand their condition? Do you understand how they feel about that?

Dr McKillop: We absolutely recognise that people who are coming to see us with multiple, often complex medical conditions are going through a



HOUSE OF COMMONS

stressful experience. We do try to deliver that part of the assessment that we are responsible for in as compassionate a fashion as possible. While I recognise that it is natural for people to want to be seen by a specialist in their particular medical condition, notwithstanding what we have discussed already, that many people have multiple conditions, perhaps in the example that you gave the difference from my point of view between—

Chris Stephens: It was an example you gave, to be fair.

Dr McKillop: The difference between a medical assessment, which, as Ian says, focuses on diagnosing, treating and following up a particular condition, and a functional assessment is absolutely that everyone who has a medical condition will be affected in their own way. For example, two individuals with schizophrenia, for example, may have a very similar medical picture when you look at the information from their GP. They both have the same diagnosis—schizophrenia—and they may perhaps both receive the same medication at the same dose and the same level of input from a community psychiatric nurse. That is the medical aspect of their condition.

But when you speak to these two individuals when you undertake, for example, face-to-face assessments for PIP and talk about their daily lives you may get two very different pictures as to how these individuals are functioning. One individual may be functioning well. Their medication may be controlling their symptoms well. They may have limited needs day to day for support. The other individual, although on paper their medical condition seems very similar, may be really struggling. They may have ongoing symptoms. They may be in need of a significant amount of support. I think the key is that the medical condition is the beginning of a functional assessment but the value of a face-to-face assessment is that it recognises that everyone with a condition will be individual. Very often people do struggle to express the needs that they have on their claim form, and by having that face-to-face assessment we can actually recognise that some people understate the level of need that they have. They do not express on paper—people try to cope. People with chronic medical conditions try to sometimes present a most positive coping picture than may actually be the case, but by having that face-to-face assessment—

Q140 **Chair:** I think we have got that. I really anxious to quickly go round; there were going to be three themes here, and this is only our first theme. Who wants to this side ask other questions specifically on the assessments? It is not that you do not get brief questions; it is the answers that I am slightly worried about.

Q141 **Andrew Bowie:** I may have misunderstood. You said that there were occasions when experts do sit in on assessors?

Dr Gargan: There are people with particular backgrounds who are very good at teaching. They are called clinical champions, and there are also



HOUSE OF COMMONS

clinical coaches. They are people who offer further support services to our disability assessors, and they develop continual professional-development modules that our disability assessors can get training in and learn more about the specifics or questions they may have about the condition if they feel they still did not get adequate information from their disability assessment training.

Andrew Bowie: So, they are not experts in a particular field of—

Q142 **Chair:** You have two doctors; how many clinical champions, please, do you have?

Dr Gargan: We have clinical coaches at a ratio of one clinical coach to 15 disability assessors.

Q143 **Chair:** You have two doctors, haven't you?

Dr McKillop: Yes, that is right.

Q144 **Chair:** How many clinical champions?

Dr McKillop: In terms of the daily clinical-support management for health professionals, we have a ratio of around one to 12 clinical managers to health professionals. We also have mental-function champions, who are specialists in the field of mental health and/or learning disability, and we have one mental-function champion for around every 20 health professionals in the business.

Q145 **Chair:** We are right about how many hours they spend; we do not have any figures about numbers of people. Are these all full-timers, these champions?

Dr Gargan: Yes.

Dr McKillop: Yes.

Q146 **Steve McCabe:** I was interested in Dr McKillop's point there about the people where you tease out the extra information because they have understated it. It sounds like an untold story of your organisation. Do you collect data on how many examples of where that occurs? If you could send us those figures, that would be great.

Dr McKillop: Every assessment that we undertake is of an individual who has—

Q147 **Steve McCabe:** No, I mean where you have these examples that people had understated and you were able to correct it because of that face-to-face. That is the information that would be really useful, if you could send us the data on how many cases that happens, how many times that occurs. That is part of the untold story of your assessment. You have just given it as evidence; I would like to see it clarified. I think that would be really helpful.

Chair: We will help you by writing to you afterwards what we would like to have. Is that all right?



Q148 Ruth George: I am particularly interested in home visits and the dynamic around that, because many claimants struggle to get to an assessment centre. Do your companies receive an additional rate of payment for performing a home visit?

Simon Freeman: No, we receive the same whether we see somebody in clinic or home.

David Haley: We are the same.

Q149 Ruth George: Does that have any bearing on whether people receive visits or not? I have a particular constituent with a fractured vertebra whose doctor's letter said very clearly he was not able to travel and had a phonecall that said that they simply did not have time to travel out to see him and therefore he had to come into an assessment centre. Is that the sort of decision that is being made?

Simon Freeman: From a Capita perspective, over the contract term probably 60% of our assessments have been done in the home. If you take off the 15% that are done by paper, we do deliver quite a large number of home assessments. If there is a clinical instance, as just referred to, clearly that would require a home visit, and I would expect that to be the case.

Q150 Jack Brereton: On that point about home visits, often, I believe, the GP or the medical practitioner does not understand what information is required to ensure that where there is a need for a home visit one takes place. What are you doing to ensure that a GP or whoever else is seeing somebody in a surgery knows what information you need to ensure a home visit does take place when it is required?

Dr Gargan: That is a very good point the Committee makes and relates to the barriers that we talked about earlier on, in that the general-practitioner template or record at the moment that is completed does address and does give the evidence. Once that is completed, that would give us enough evidence to know whether it should happen in the home or in a clinic.

Dr McKillop: In terms of our home assessment we recognise that the barriers to travelling to an assessment centre can be physical or mental-health-related, sensory; there can be all sorts of issues. We do not require medical confirmation or proof, if you like, that an individual does require a home assessment, and in fact over the course of recent months we have seen the number of home consultations that we undertake steadily increase to reflect the complexity of the case mix that is coming through. If an individual tells us that they are struggling and that they would be unable to travel to an assessment centre, then we would look to arrange a home assessment for them.

Q151 Jack Brereton: What criteria do you use, if you do not use medical evidence, to suggest that someone would require a home visit? How do you identify those who do and do not need a home visit?



HOUSE OF COMMONS

Dr McKillop: We have all the information that has been provided to us, principally the claim form that the individual themselves has written, and if people tell us that they have a serious medical condition, that they struggle to leave the home and that they would require a home assessment or if there is further evidence that we have received to that date or a telephone call that we may make to the GP to follow that up then that would be sufficient to allow us to arrange—

Jack Brereton: There are some differences between the organisations on that.

Chair: But also, Jack, given what you have said, the person who answered Ruth's constituent was wrong: that, "We do not have the resources to come out".

Q152 **Ruth George:** What proportion of ATOS's assessments are done in the home?

Dr McKillop: Currently it is around 18%.

Q153 **Ruth George:** Are claimants informed upfront that they can get a home visit if they require one?

Dr McKillop: Yes, they are. It is on our website. It is in the letter that they receive as well once the case is referred to us.

Q154 **Ruth George:** Is that the same for Capita?

Simon Freeman: Yes, the same for Capita; the upfront guidance is if an individual feels they need a home assessment to make that clear and we will provide a home assessment if—

Q155 **Chair:** The percentage?

Simon Freeman: Over the contract term 60% of our assessments are conducted—

David Haley: It is worth pointing out that the model for us to be able to deliver our assessments is slightly different to the Capita model. Ours is mainly based on assessment centres in terms of the claimant coming in for an assessment, and I think Capita's was mainly around the whole consultation model.

Chair: We noted the word "slightly".

Q156 **Emma Dent Coad:** Some of the issues on the slowness of process in getting through these assessments seem to be based on good, robust documentary evidence and written evidence that comes in. We have talked earlier about if you had really good evidence you could do a paper exercise rather than having to have face-to-face assessments. Ian, you said something about the percentage of doctors who filled in questionnaires, and I am not sure if I understood; it seemed quite low. You mentioned some statistics about the percentage of doctors who filled in questionnaires and whether you had to go back to them. Can you just



HOUSE OF COMMONS

run me through that again? It seemed low, and I may have misheard you.

Dr Gargan: There is a particular criterion for looking through the evidence they have supplied. The statistic I mentioned earlier on about 33% of cases that we see we request further medical evidence: we may request other evidence. When we say “medical”, in this instance it is the GP evidence against that template that I have described already that has been developed with the British Medical Association. Of that 33% we would receive fewer than 10% of those back from the GPs in this instance, and less than 3% of that is actually relevant to functional capacity. To the Committee’s point earlier on about the GP knowing what to fill in, sometimes the formal record or the template is not completed. It is just, even though it is very valued in some instances, the GP letter, but it will not actually be relevant to the functional capacity; it will be more relevant to diagnosis and intervention, which is the natural inclination, as we talked earlier on, for a doctor.

Q157 **Emma Dent Coad:** Clearly, there may be things we can do to help doctors to provide the evidence needed, because with the robust evidence is needed there seems to be an issue.

Dr Gargan: Yes, and those statistics come from a number of trials that we continually engage in with the Department to see what may be better. Then we try that with a sample on what would be more useful and whether it is better for a claimant. One of the trials we are working on is actually developing a better template that may be easier for a busy GP to complete.

Q158 **Emma Dent Coad:** Obviously, it is a very low return rate, isn’t it, and the evidence you are getting is not robust enough to—

Dr Gargan: Absolutely, and maybe the return rate is reflective of the onerousness of the template. Maybe we need to make the template a little bit easier so that the claimant’s doctor feels that they have the adequate time and insight to know what information to give us.

Simon Freeman: If I may just add to Ian’s point, by the time the case has come to us and we have then written out to get further evidence actually some time has passed. Clearly, this can be a daunting process, and we want to try to reduce the time taken for the overall process. I think providing that guidance to claimants upfront, because Paul Gray identified in his review that actually claimants are best placed to have that information already, as to exactly what would be useful so they can put that in with the application form so that comes to us immediately would then prevent the need for us to write out. GPs are extremely busy already. It would prevent the need for us to write to them, because we would have all of that to start with, and I think the Committee really could help us in making clear upfront in this process the sorts of evidence that would be helpful to the rest of the assessment process.

Q159 **Heidi Allen:** I have sat through a couple of PIP assessments, and I do



HOUSE OF COMMONS

not for one minute doubt the professionalism or the compassion of the assessors—they really try hard—but it is quite a robotic process. It really is computer question, your answer is—and they write it down, but that is the model. We have heard the word “model” a lot, and, from Ian particularly, “excellence”. I do not doubt what you try to achieve. My question is slightly devil’s advocate, perhaps, for the chief exec and the clinical director to look each other in the eye. Is there a tension here? I do not think we are right to assume that a doctor is the right person or a wrong person—we are not clinicians—but is it the costing model, the contract model, that means you have this generic programme of excellence and generic assessment in triaging, and would your clinical directors look you in the eyes as MDs and chief execs and say, “If the contract were different, we would prefer to have more specialist triaging”? How would you like the contract to be, and would it be different from how it is now?

Dr McKillop: My view is that the model of assessors at present looking at function rather than diagnosis is a strong one. We do recognise that the people who come to work for us bring all of their clinical experience in different areas and do have the communication skills to look at individuals on an individual basis, look at all their conditions together and do that functional assessment. As Paul Gray recognised, the key is providing support, training—

Q160 **Heidi Allen:** Is it as good as it can be?

Dr McKillop: We recognise that it is a challenging task to ensure that someone on that one-off face-to-face assessment—

Q161 **Heidi Allen:** If cost comes into this, would you prefer to afford more specialists in musculoskeletal, mental health, whatever it may be, for that initial triaging both on paper and when they come to assessments? Would you prefer that? Yes or no?

Dr McKillop: No.

Dr Gargan: Quality is absolutely imperative to delivery of the PIP assessment in our eyes. The operational model comes second to that. Absolutely, any efforts that can be made to improve the quality of the assessment to make it accurate, succinct and objective per the functional assessment and to improve the ability of the disability assessors is the priority.

Q162 **Heidi Allen:** Would having more variety of specialisms assist with that, in the triaging process, from your point of view?

Dr Gargan: I think having more learning and having potentially additional information of what claimants are going through so that we understand how to better question—because it is a challenge of trying to—

Heidi Allen: But you would not have a greater range of specialisms



triaging those particular cases?

Dr Gargan: No. We feel the disability assessment training is excellent as it is. Everything needs to be improved all the time. We need to recognise that. Nothing is perfect. But I feel that the standard template is—

Q163 **Heidi Allen:** But both sides are very happy with the model that you are operating?

David Haley: One of the benefits that we find working with disability representative groups is we work collaboratively on what we call condition insight reports. This is where the specialist knowledge and the appreciation of how different conditions can affect individuals through the eyes of the specialist disability representative groups we find is a very powerful tool to be able to assist all of our health professionals in terms of understanding the specialist conditions, and that is particularly powerful at the triage stage.

It was great to hear you recognise the professionalism and the passion of the interviewers carrying out—

Heidi Allen: They do try.

David Haley: It is important to state that that assessment takes as long as it needs to take. There is no time pressure on the assessment. There are not targets set for how many you have to have and seeing how quick—that assessment is the most critical part of the process, and it will need to take as long as it takes.

Q164 **Chris Green:** Just a brief question, Dr Gargan: before, when we were discussing about the number of doctors that you have, you said the other doctor is a director; so, presumably, not available for frontline services, for attending assessments, largely spending his or her time doing directors' responsibilities?

Dr Gargan: Yes.

Q165 **Chris Green:** So, actually, there are not two doctors available for assessments or to work on assessments, is that correct?

Simon Freeman: Just to be clear, it is a role recognising the seniority. That does not preclude the individual from getting involved with frontline services.

Q166 **Chris Green:** "Does not preclude"; that could give me an idea of—is this a full-time person doing assessments or involved in assessments, or could it actually be a very small fraction of the time?

Dr Gargan: The gentleman, for it is a "he", is a medical director and is responsible for quality assurance; so, looks at all the feedback about improvements we could make on our reports and actually reports that are carried out by assessors and so, while not sitting in a room assessing, but does do that to be calibrated, to ensure that he is up to the sufficient standard at all times, looks at all of the reports that are questioned to see



what learning we can get from that to further improve the disability assessors' skills.

Q167 Alex Burghart: I just want to come back to the example that you gave of two people with schizophrenia manifesting itself in different ways that impact on their functionality in different ways. It would seem to me that the only person who would be able to fully understand both the condition of schizophrenia and the way it may manifest itself differently in two different people and to be able to understand the functional consequences of that as well as the fact that the condition may affect people's ability to answer questions in assessment differently would be a specialist in schizophrenia. Is that the case and would you always use a specialist in a case of somebody who had been referred for schizophrenia; or talk me through how the process would work in order to overcome those difficulties?

Dr McKillop: In the case that you mentioned, an individual with schizophrenia, it is a very similar process to an individual with any of the other medical conditions—physical, mental or sensory—that can present to us for an assessment. We recognise that the individual has a serious mental-health condition, but our assessors are there to look at the impact of that on their daily life. They are not specialists necessarily. Although many of our health professionals do have a mental-health background, they are not necessarily a specialist in that particular condition. What they do recognise, from, as David mentioned, condition insight reports, training, the multiple examples that we provide in continuing professional development to our health professionals, is the impact that schizophrenia, for example, can have on an individual, looking at that safeguarding and ensuring that the individual is not overstating or understating the level of need that they have, and just by having that rich conversation about their daily life and looking to ask the questions that the individual themselves may not have completed in the form. It is looking at the impact on daily life but recognising that that specialist support, training and guidance we give to all our health professionals will equip them to have that conversation with that individual.

Q168 Alex Burghart: This does seem like a very tall task for someone who is not a specialist in a very complex condition such as schizophrenia.

Dr McKillop: Our disability assessors are specialists in disability assessment medicine, and, as I said, many people with schizophrenia as one medical condition may well have multiple other conditions as well that may affect other aspects of their daily life just as much or perhaps even more than that mental-health condition. It is really important that we look at the person as an individual and their own situation rather than that individual label of a diagnosis.

Alex Burghart: I think we will need to move on. I would just ask, Chair, that maybe both Capita and ATOS could provide us with some documents on the training that their assessors go through, because I think there is a lot more—



HOUSE OF COMMONS

Chair: But I think we have got the picture; you need the wisdom of Solomon, don't you, to be able to do this task, it seems to me, anyway.

Q169 **Alex Burghart:** As you may have picked up, one of the things we are interested in is the accuracy of the reports that are written. We have been given multiple examples of reports that contain basic factual inaccuracies, not necessarily talking about medical observations but just things that were wrong about the person's background, about their lifestyle, about things that they could and could not do—

Chair: Like my example of the man and his dog; he could neither walk nor had a dog.

Alex Burghart: Yes—Frank is piping in—the non-existent-dog example. As a constituency MP, I have come across these cases, where people have brought me reports and on a simple reading it is clear that passages in those reports do not relate to the person sitting in front of me. Are either Capita or ATOS familiar with that sort of simple mistake? We have come across it here.

Simon Freeman: The example you have given I have not seen. We train our assessors very carefully to make comprehensive notes during the assessment—

Alex Burghart: Sorry, because we are running short of time, I just want to cut straight through—have you come across cases where basic factual errors have been committed in reports?

Simon Freeman: We have had cases that have come back through our complaints process where people have questioned the content. I have not looked at the specifics as to whether it would be as extreme as in the example you have said, but we have cases come back that do question the content sometimes.

Q170 **Chair:** We have nearly 3,000 submissions. We have never had submissions like it for this inquiry. In your reply to Alex, may we have a breakdown of the reports you get back from our constituents about errors on their forms?

Dr Gargan: We could absolutely help with that.

Q171 **Alex Burghart:** Given that you do not know the answer to that question, how do you review for accuracy within the reports that are made?

Dr Gargan: We have a quality and learning support colloquially known as an audit mechanism. There are a number of stages of audit. There is the audit for affirmation and performance of the disability assessment when they come out of training—they must get to a certain standard before they are allowed to have individual assessments—but there is a mentor taken independently by the Department to look at samples of reports to see that they are meeting the correct standard.

Q172 **Alex Burghart:** When somebody says, "I do not have a dog", or, "Part of this report is not me", how does that feed back into your audit process?



HOUSE OF COMMONS

Dr Gargan: First of all, Simon will explain the mechanism of how that can come back to be looked at again, examined and reviewed by clinical governance or otherwise, but during the audit of the reports the report will be scrutinised against the assessment to make sure that there are no errors and that there is consistency.

Q173 **Alex Burghart:** When it is shown that assessors have made basic errors—not subjective errors; basic factual errors—what are the consequences for those assessors?

Dr Gargan: First of all, the quality, learning and support mechanism is for feedback for the disability assessor. It is not just an audit against a template; it is for the claimant's benefit. We want the disability assessor to not make the same mistake again. They will have a full audit then subsequently until they reach a standard that is sufficient.

Q174 **Alex Burghart:** You will then audit all of their cases past that point?

Dr Gargan: Correct.

Q175 **Alex Burghart:** For what proportion of your assessors have you had to do that? Have you had to put them on a full auditing?

Simon Freeman: A full auditing can be for a range of reasons, not just for the situation you talk about. It varies. When people join the organisation we also put them on full auditing until they have completed the training programme. It would be hard to specify those that are on full auditing for specific case examples versus those people who have just joined the organisation.

Q176 **Alex Burghart:** One would hope that your organisation would have some record of the number of assessors who have made mistakes. In lots of jobs people make mistakes, and when they make mistakes they are maybe given a warning or suspended. You must have HR details for these cases.

Dr Gargan: That figure is absolutely available.

Q177 **Chair:** A snapshot, today, of how many people are actually being watched in both organisations?

Dr Gargan: Yes.

Q178 **Neil Coyle:** It is not just the curious incident of the dog in the assessment centre; this is about multiple cases where it is said that they drove to the assessment centre when they do not have a car or driving licence. Would perhaps a fine for inaccurate inclusion of information or omission of important information that was raised in assessment help improve the quality and accuracy of the assessments?

Dr McKillop: Our health professionals are registered, and as such they are bound by their professional registering bodies, such as the Nursing & Midwifery Council, the Health Council or the HCPC for non-nurses to record clinical notes that include the work that we do accurately and



HOUSE OF COMMONS

correctly. One of the key things is that registered health professionals have that duty.

Q179 **Chair:** How many have lost their status as a result of the errors that Neil has just spoken of?

Dr McKillop: If there are complaints made about a health professional, for example the examples that you have given where information has been allegedly wrongly represented or incorrectly represented, we will always follow that up.

Chair: I want the numbers that actually get penalties. How many lose their status by their professional body because their work is just so hopeless?

Dr McKillop: I can come back to the Committee with any numbers.

Chair: Could both of you do that for us, please?

Dr Gargan: We have a close relationship with the governing bodies. They have to be registered with those bodies in order to be a disability assessor. If those governing bodies have a complaint and they wish to carry out an investigation on the individual disability assessor, they are immediately suspended from active duty with us while that investigation is pending. But we may not know—that person may not come back to work but we may not be given feedback from the organisation, because it may be private and confidential, on whether that person is fit to practise nursing again, or physiotherapy or—

Chair: But what we would like from Neil's point is how many are actually referred to their professional bodies and how many come back to you because, we assume, they are found not guilty if the professional bodies do not tell you terrible things.

Dr Gargan: We would be happy to provide the Committee with those figures.

Q180 **Neil Coyle:** Do you refer to those professional bodies, or do you deal with this as an internal complaints process?

Dr Gargan: There is an internal complaints process, and there is their professional body's process.

Neil Coyle: Do you refer to those professional bodies?

Dr Gargan: Yes.

Neil Coyle: Can we have that number as well?

Q181 **Heidi Allen:** Again, just continuing on the theme about the quality of assessments that are done—perhaps if we start with Capita and then move to ATOS—an assessment that is done from the DWP's contract management point of view is acceptable or not, and bear in mind that within the term "acceptable" I think there are four categories of levels of error that still make a report acceptable, including information errors with



HOUSE OF COMMONS

it that need fixing; so, “unacceptable” is really pretty damning.

Capita, this year alone from a target of 3%, which the DWP sets, already this year you are creeping up to 7% of your assessment forms being unacceptable, and there have been times in the contract period when it has been 60%. Explain that, and what on earth are you doing to put it right? From a claimant’s point of view, it is either acceptable or unacceptable, and it is their life at the end of the day.

Simon Freeman: The recorded 60% was absolutely unacceptable, and we took very targeted action over the last 18 months.

Q182 **Heidi Allen:** Which was—

Simon Freeman: We have improved our recruitment processes such that we bring in the right candidates and we set the right expectations for the role; we have significantly enhanced our training capability—we have five weeks of classroom plus another five weeks of onsite or working with claimants and specialists in the field—and we have enhanced our quality, learning and support function, which is the audit capability that Ian referred to earlier. That has shown significant improvements in quality over the last 18 months and for the early period of this year we have been within 1% or 2% of the Department’s target. The Committee is absolutely right to raise the last two months, which have increased. That is not acceptable to us, and we have taken—

Q183 **Heidi Allen:** What is going wrong again? Surely you should have learnt the lessons from the first time.

Simon Freeman: We absolutely do understand the levers that bring quality down. As I say, we have evidenced that with the improvements that we saw. We have some very specific things that we are taking action against at the moment, and we are confident that the performance will come back to the levels that we have seen previously.

Q184 **Heidi Allen:** What is it specifically that has wobbled again?

Dr Gargan: The quality, learning and support—you are right to name the categories. There are four categories: acceptable, acceptable with feedback, acceptable with amendments and unacceptable. A number of reasons may make a report unacceptable. At the moment from our quality, learning and support mechanism we can see where the trends are that make a report unacceptable, and there are a number of reasons that are presenting, one of which would be enhanced questioning. Rather than the prescriptive questioning that I talked about that is received during the training, we need to encourage a cascade of the training to 1,000 people that they may enhance their questioning to gather more information to improve the quality of the report.

Q185 **Heidi Allen:** This is improving the trying-hard-but-robotic questioning, which is what I saw when I sat through a PIP assessment?



HOUSE OF COMMONS

Dr Gargan: The process is prescribed so that it is factual, accurate and objective, but, to your point, you are absolutely correct—sometimes we need to go and enhance that questioning, further improve it or maybe garner more information where we are seeing that that is lacking somewhat and has made some of these reports unacceptable—and we are cascading that training at the moment to bring it back to this—

Q186 **Heidi Allen:** What do the DWP do if you do not improve? Are there financial penalties, whether you would lose your contract—

Simon Freeman: There is a financial penalty when we do not meet the 3% target, and that is agreed with the Department. Clearly, this is about the claimant experience and making sure that we get these reports right. We recognise this has a profound impact on people's lives and that this is a very individual experience. We are not driven by the finances, but the Department do have finances as a result of—

Q187 **Heidi Allen:** Is it immediate? Is that month reviewed with the DWP?

Simon Freeman: Yes.

Q188 **Chair:** Is there a period when you have ever met the target?

Simon Freeman: I think the Committee has had the data from the Department.

Chair: I just want it on the record.

Simon Freeman: Our best performance has been 3.5%.

Q189 **Chair:** So, you have never met the target?

Simon Freeman: No, we have not.

Q190 **Heidi Allen:** A similar question to ATOS; your statistics are slightly better, but, again, we are seeing it creep it up from 3% to about 6%. I think the last three months rolling have really lifted, which tells me we have some pretty stinky figures coming through recent months. At times in the contract you have had 30% of your assessments unacceptable; again, the same questions to you.

David Haley: We have been very clear that the beginning of the contract was completely unacceptable. Quality is our absolute prime target and prime focus, and I am not happy at all until 100% of the cases are deemed to be acceptable and pass those criteria. Our focus remains 100% on getting to that target.

Q191 **Heidi Allen:** Again, what have you identified in your deep assessment of the situation that has gone wrong?

Chair: But, also, could you tell us today are you meeting the target? We have presented a picture. We have been fascinated in the first two questions. We took a long time over them so we could understand from your point of view what was going on. So we fully understand, have you been presenting this information to us when you are meeting the DWP's



HOUSE OF COMMONS

target? Are you meeting it today?

Dr McKillop: At present, as David said, we are continually striving to meet and to exceed the target.

Chair: So, you have not; the answer is no?

Dr McKillop: We are not meeting the 3% at present.

Q192 **Chair:** How near are you?

Dr McKillop: We are currently around 5% or 6% in the two different lots. Very similar to our colleagues in Capita, our focus has been on the areas that are causing our reports to become unacceptable, which is mainly around the individual descriptors—

Q193 **Chair:** Have you ever met the target?

Dr McKillop: We have not met the target on a rolling three-month period, no.

Q194 **Chair:** Will you give us details of the turnover of your staff by grade? Heidi, are you happy with that? Well, you are not happy with it, but are you—

Heidi Allen: Of the four categories of unacceptable, I am probably at the top of those right now. What specifically, in the same way as Capita responded, were the things that you found? Again, was it questions not being probing enough or—

Dr McKillop: Certainly, that is an element; other main areas looking at reports that are initially audited as unacceptable are around the advice given on the individual descriptors with the 12 PIP activities not being consistent with the evidence contained within the assessment report or that that has not been explained and justified clearly to the decision-maker. A really important point is that when a report is deemed and audited to be acceptable or unacceptable that process takes place before that report is used to make a decision on that individual's claim.

Chair: Thank God for that.

Dr McKillop: If a report is deemed as unacceptable, that report will come back to us, we will amend that report and make it meet the "acceptable" criteria before it is used for decision-making by the Department. It is really vital to ensure that unacceptable reports do not affect the outcome.

Q195 **Heidi Allen:** Which is good to hear. If I am the claimant, does that mean I am waiting longer to get my answer?

Dr McKillop: We get these cases turned around within two days at our own cost.

Q196 **Heidi Allen:** It is still within the decision—okay.

Dr McKillop: Yes.



HOUSE OF COMMONS

Q197 **Chair:** How many Secretaries of State brought you in and just wept or doubted or screamed—I do not know what they would do—with your figures? He is running a benefit, he is responsible to Parliament for this, and neither of the two arms that he is employing have ever met his target for any length of time. Some of you have never met it. How many times have you met the Secretary of State for him to bawl you out for this performance? Could you tell me?

David Haley: I have never met the Secretary of State, but I have met a couple of the Ministers.

Q198 **Chair:** You have not met the Secretary of State; he has not had you in? All right. Simon, have you been up before the Secretary of State?

Simon Freeman: I have not met the Secretary of State, but we do interact with the Department very regularly to discuss these figures.

Chair: One would hope that; very, very good. Thank you.

Q199 **Chris Green:** Accuracy and trust are key to any customer relationship, and certainly the Government approach is the delivery of these assessments is an open market for people to apply and then deliver these assessments, but customers come to you; they cannot choose to go to one assessment centre or another. How important is the audio recording of assessments for maintaining standards? Actually, I think we need to be in the situation of raising standards. How important are those audio recordings? We will go to ATOS first.

David Haley: We would welcome the use of audio recording in all of the assessments.

Q200 **Chris Green:** Can you make that decision?

David Haley: The criteria set by the Department for the delivery of the contract will set the criteria for how a current assessment is undertaken. That does not include audio recording. There are occasions where that—

Chris Green: It does not necessarily include it, but you could make that choice to include it?

David Haley: If the claimant makes the request to have the assessment provided with audio recording, then we would look to meet with that requirement, which is in line with the criteria. That is not standard. Obviously, we would welcome that moving forward.

Q201 **Chris Green:** What assessment have you made of the awareness level of people coming in for assessment that they could have the option of an audio recording?

David Haley: We offer anybody the opportunity to request—

Chris Green: But what is the awareness?

David Haley: Probably not as high as it should be.



HOUSE OF COMMONS

Chris Green: Have you made any kind of assessment at all? Do people really know that they could have an audio recording?

David Haley: I believe it is made aware to the claimant that they can request an audio recording.

Simon Freeman: We have actually conducted a trial with the Department, and we have conducted audio recording. This is not the claimant needing to instigate it; this was we and the Department doing it. That was referenced, I think, in Paul Gray's review, and, probably similar to our ATOS colleagues, we would welcome audio recording. Anything that increases transparency and claimant trust in the process we would wholeheartedly endorse.

Q202 **Chris Green:** Paul Gray recommended audio recording in all assessments. Because you are not choosing to do this rollout yourself, do you need direction from the Ministers to deliver this or to change the contract?

David Haley: The criteria need to change to reflect the fact that a standard offering within every assessment is the opportunity to be able to provide audio recording. Currently, it is a very complex system in terms of the provision of that report following the assessment etc. We would welcome the opportunity to provide a much simpler audio-recording facility in each assessment.

Q203 **Chris Green:** How many recording devices do you have per centre at the moment?

David Haley: I do not have that information to hand. I can provide the facility that we are able to provide and how many times it has been requested, if that would help.

Q204 **Chris Green:** Would you be confident in saying that there is at least one recording device per centre?

David Haley: No.

Simon Freeman: I think it is probably worth referring back to the policy. The policy says that the individual can record if they choose; it does not require the provision of the audio-recording device. When we did the trial we provided those audio-recording devices. It was actually at our Birmingham clinic.

Q205 **Chris Green:** If there is less than one recording device per centre and if someone says, "I want a recording of this assessment", you may say, "We cannot record it. You are going to have to come back another day"? Is that fair comment?

Dr McKillop: The current criterion is that if a claimant wishes to have their assessment recorded they provide the equipment for that to take place.

Q206 **Chris Green:** The client has to?



HOUSE OF COMMONS

Dr McKillop: That is the current criterion.

Q207 **Chair:** We were told claimants cannot provide their own equipment.

Chris Green: My understanding is that you as an organisation would want a copy and the client would want a copy as well so then you have the same copy, so you have the same evidence, so if there is a challenge from them you can meet that challenge because you have the same evidence, but you are saying only they can bring recording equipment.

Chair: We have been told that they cannot record it with their own equipment, and I think that is general for lots of our constituents. I am sure the Secretary of State is watching all of our sessions; so, let me get a clear message going for him. You would like as standard practice recording equipment to be used on all of these key interviews unless the claimant requires you do not do it, is that right; that they opt out?

Dr McKillop: We would welcome the opportunity for a simple process whereby a claimant could have their assessment recorded if that is what they wished.

Q208 **Chris Green:** I would suspect that in any organisation where you do not have equipment freely available and as standard or routinely used there would be an institutional bias against using that equipment. If you have to get recording equipment from a different centre to provide a recording and you have all of the logistics that go into that, that is actually going to institutionally make you want to be biased against providing that equipment, because it is a great deal of hassle. Is that fair comment?

David Haley: No.

Q209 **Chris Green:** Not having the equipment in a centre, you would think, is not going to create a barrier against people in that centre encouraging and supporting people to have that equipment in the assessment?

Dr Gargan: The disability assessors do not actually encourage one or the other. They just carry out the objective assessment. The trial, actually, was a comprehensive trial. The data was interesting and is with the Department at the moment, they are going on the back of the Paul Gray report and the back of that data, we are awaiting their recommendations, and then whatever they recommend is what we will implement, but there is not meant to be any barrier to a claimant's experience.

Q210 **Chris Green:** There should not be, no. The final question: since we do want to improve accuracy and we do want clients to be able to challenge—because we have had instances where people have been in for a seven-minute meeting; what kind of assessment can you have there? If someone is coming away from what may be a high-pressure, distressing environment not feeling as though they have had the opportunity to fully explain and describe their position and then on appeal they get a radically different outcome in terms of points, that is a problem within the system. In terms of accuracy and trust, if more people became aware that is a good idea to have recording in an assessment and if tomorrow everyone



HOUSE OF COMMONS

started demanding that, what ability would you have to meet that expectation? How much would the assessments actually go down?

Dr Gargan: I think the data from our trial—

Chris Green: No, not the trial but—

Dr Gargan: But that is indicative of what would happen to the general population, and it would not go down.

Q211 **Chris Green:** If people started coming tomorrow asking for their right, if more people knew their right and if everyone wanted this assessment to be audio-recorded from tomorrow, what ability would you have to meet their rights?

Simon Freeman: I think this is a discussion to have with the Department. I do not know the policy at this specific—

Q212 **Chris Green:** As I understand it, it is the client's right to have an audio recording.

Simon Freeman: It is.

Q213 **Chris Green:** So, it is your responsibility, it is your duty, to meet their right.

Simon Freeman: I do not believe it is our organisation's responsibility to provide the equipment. If the Department chooses that this is the way forward, then absolutely we would encourage it. We have said on record that we would encourage anything that increases transparency. It would be a change to the contract, and that is something we would need to discuss with the Department.

Q214 **Chris Green:** So you are in the same position of a client brings their recording equipment as well?

Simon Freeman: I think that is set out in the policy, but I would need to check the policy.

David Haley: I think that would be the same sort of thing—I think we should just make it very clear in terms of the terms and conditions that currently surround the use of audio recording. I think we have all been very clear about the fact that we would welcome a very simple method of being able to allow the claimant and the assessor to have the actual assessment recorded.

Chair: Yes, that is a good recommendation.

Q215 **Steve McCabe:** I just wanted to ask a final quick point on this. I am not sure there has been total clarity about what happens at the moment, but I think the answers have been very helpful. Where someone does ask for it to be recorded and you are able to facilitate that, is it accurate that you have to then have an assessor who has had experience of taking part in a recorded session before; it cannot just be the existing assessor? The point I am making is if I turn up and I say I want it recorded it is not



HOUSE OF COMMONS

quite as simple as that just then happens. At the moment you have to know in advance and get the equipment, and you have to find an assessor who has had previous experience. Is that accurate, from your knowledge, of what happens?

Simon Freeman: When we did the trial we trained our assessors in advance to say that, "This is the process", "This is how"—

Q216 **Steve McCabe:** All of them, or—

Simon Freeman: Those people who were involved in the trial. We trained all of them—

Q217 **Steve McCabe:** Your organisation has a percentage of people who could take part in a recorded assessment?

Simon Freeman: Yes.

Dr McKillop: There is no specific training within Independent Assessment Services prior to a claimant requesting a recorded assessment.

Q218 **Steve McCabe:** Do you have people who have more experience of taking part in—

Dr McKillop: Any of our assessors can take a place in a recorded assessment. There is no specific training or guidance that they need ahead of time. If the claimant wants a recorded assessment and we have the equipment brought to that assessment, then any of our health professionals can undertake that.

Chair: Thank you all very much for what I found a distressing session. Should you meet the Government's target while we are writing up our report, might you tell us so we can record it in the report? Thank you very much for coming.

Examination of witnesses

Dr Paul Williams, Programme Director, Centre for Health and Disability Assessments (CHDA) MAXIMUS, and Leslie Wolfe, General Manager, Global Health, Centre for Health and Disability Assessments (CHDA) MAXIMUS.

Q219 **Chair:** Paul, welcome; might you introduce yourself, and then we will go down to Leslie. Could you say who you are?

Dr Williams: Good morning, Chair. I am Dr Paul Williams. I have been a medical doctor for 30 years, first of all in hospital practice and then general practice. About 15 years ago I retrained to become a consultant occupational physician, and I am currently chair and president of The Society of Occupational Medicine. I started working for MAXIMUS three years ago almost now, at the time when we first won this contract. I was initially chief medical officer with responsibility over clinical standards, and then about the middle of 2016 I took over responsibility more



HOUSE OF COMMONS

generally for the programme. I still stay very close to the clinical part of the programme, but I have a wider reasonability.

Q220 **Chair:** You are the boss doctor, then?

Dr Williams: Correct.

Q221 **Chair:** Leslie?

Leslie Wolfe: Good morning. I am Leslie Wolfe. I am a general manager with MAXIMUS. I have had a leadership role in the UK since 2013 over our businesses here. I led the bid for the contract for the service, I ran the service for the first year and a half or so, and I have maintained leadership responsibility over our UK businesses since then. I have been with MAXIMUS about 11 years, and prior to joining MAXIMUS I had about 20 years' private-sector and public-sector experience in Canada, mostly British Columbia.

Q222 **Chair:** Very good. Paul, how many doctors are part of your team?

Dr Williams: The actual number of doctors is something like 260, but not all of those people work full-time. If you were to convert that to full-time-equivalent, I would have to check the exact number. It varies week to week.

Chair: It is hugely different, isn't it, from the teams we have just spoken to, who had four between them; and you have how many full-time-equivalent?

Dr Williams: I would have to check the full-time-equivalent number. It will be 220 or 230. It is about 260 actual people.

Q223 **Ruth George:** For starters I just wanted to ask how many of your assessments are conducted solely based on the application form and medical evidence you receive, what proportion are done face to face and of those how many are home visits, please.

Dr Williams: We will undertake of the order of a million WCAs over the course of this year and probably slightly over. About three quarters of those will be face to face; just slightly over a quarter will be determined on paper alone. The number of home visits is relatively low. That is about between 8,000 and 9,000 in a year. It is worth, I think, Committee members understanding that the nature of our assessment and the benefit that we are assessing for is slightly different to what you have been hearing about this morning. Our first port of call, if you like, is when the ESA50 is received, and any further medical evidence would be to see if we could advise the Department on that case at that stage. Part of our training for our assessors is if it would appear that a home visit is appropriate actually if somebody is sufficiently disabled that they cannot travel from their home it may well be that we could get evidence to say that they are also sufficiently disabled that we could advise on their fitness to work at that point too.



HOUSE OF COMMONS

Q224 **Ruth George:** The case that I actually mentioned in the earlier session was actually a case from CHDA of a constituent who had a fractured vertebra and a doctor's letter saying that he could not travel because he could not sit for more than five minutes and was denied a home visit. Is that the sort of evidence that is not being looked at?

Dr Williams: Not at all, no; if that was one of our cases—and I am not familiar with the details of that specific example—I would be really quite cross if we had medical evidence that confirmed the home visit and that was denied. We would certainly take that very seriously.

Q225 **Ruth George:** It was meant to take place today. I had to intervene on Monday to prevent it; but only in that case.

Q226 **Chair:** When you say you would be very angry or whatever phrase you used—

Dr Williams: Yes, I would be very personally disappointed.

Chair: —what would you do about it?

Dr Williams: Like any investigation, it is important to establish the facts first of all. If that was a complaint or an enquiry received by us, then the first thing we would do would be to go back to check what information we had. We would look at the ESA, we would look at any medical advice that we received, and we would form a judgment on whether or not the allegation was correct first of all. I am not doubting this specific case for a moment; I am just talking about the general approach if we were to have a complaint of this sort.

Some of the time there has perhaps been a misunderstanding we are able to clarify, but if there has actually been a failing on the part of the practitioner then we would certainly discuss that with the practitioner, and the action taken would depend on the circumstances. Sometimes people make a genuine mistake. People try their best. They are highly trained professionals. They have high professional standards. An isolated error we would treat differently to a problem with attitude or a systemic failing. We would have to follow a proper HR process and make a judgment.

Q227 **Chair:** How many staff have you actually sacked because of their inability to make good decisions?

Dr Williams: The number that we would actually dismiss at the end of a full investigation process would be very low, because the vast—

Q228 **Chair:** You would want to change their behaviour and attitude.

Dr Williams: Exactly. We employ nurses, doctors, physiotherapists and some occupational therapists. Before they come to us they have to be fully qualified in their profession, then they have to have had two years' postgraduate experience before they come to us, before they are able to become an assessor we give them initial introductory training in the principles of functional assessment, and it actually takes about three



months before somebody is able to conduct an assessment solo, so to speak, because first of all we have them sat in on a one-to-one observation and then even as they start assessing solo we observe their practice by auditing every case. It typically takes about 60 cases, which is two to three months, before they are qualified to do that.

Before they then go on to undertake a file-work case review, to provoke the question, they have to undertake further training when we judge that they are sufficiently confident and competent in the face-to-face assessment. They then go back and retrain, if you like, for a period of time specifically in interpreting the medical data and the information that the customer has supplied on the ESA50, and we then specifically audit all of their cases to make sure that they are applying those criteria correctly.

Hopefully that paints a picture that we are working with people who do have high professional standards, and generally speaking if something is brought to our attention where they have made an error the overwhelming majority of doctors, nurses, physios and OTs want to put that right themselves. It is very unusual for us to reach a point where somebody is either unwilling to modify their professional practice, they are unwilling to take on feedback or they are resistant to our training and observation. It would be extremely rare to have to actually dismiss somebody.

Q229 Chair: What is disturbing is that we are not a large Committee but here is an example of one case where Ruth intervened with what would have been—well, I do not know how you would actually describe what would happen to this constituent. It may be just it is a rogue one, but if I was appearing before a Committee and an MP told me that by chance she had taken up this case and she had to intervene and stop what was going to happen today unfairly I would be pretty shocked. How many complaints like that do you get? We have lots of things to do. We do not go round the constituency hoovering up people. We are reactive rather than proactive. We do not go looking for work. How many, Leslie, do you have like that?

Leslie Wolfe: We take complaints very seriously. We have a team that seeks—and we do not wait for complaints either. We send out customer surveys, we solicit input, and we actually invite complaints right at our centres in case people want to share something with us during the experience or after the experience. When we get a complaint, we are always upset about that and personally very upset about that, we do investigate them and follow up, and if it is a process change that needs to take place or an improved management structure we take action on that.

We have had complaints that have actually improved our processes as a result because we have taken that feedback and made sure that it did not happen again. I want to assure you that unfortunately people make mistakes from time to time and we try to prevent that as much as possible but when they do occur we take them very seriously.



HOUSE OF COMMONS

Q230 Chair: Do you take a sample of the people that you have a stewardship for, claimants, and do you then home-visit a sample number of those just to get feedback? Lots of our constituents are on their own, incredibly vulnerable and would not even probably fill in forms if they felt that some mighty injustice had actually happened to them, but they may tell a sympathetic person who came to their home.

Leslie Wolfe: I think that is a good suggestion. I do not think we currently revisit customers to see what their experience was like. We would welcome improvements like that, and we have made a number of improvements to ensure quality and the customer experience is as positive as it can be. We are very sensitive to how anxious the experience is.

Before we bid on this we actually invited some focus groups to understand what worked, what does not work and why the experience is so difficult for customers, and then we invited a number of members from charities and stakeholder groups to form a customer representative group for us so we could try to understand better the format and the way we communicate with people and approach people that are coming into our centres, or not coming into our centres, and so as a result of the formation of this group we have been able to improve training materials, communication materials and get more information and continue to improve the service and the experience. But ideas like that are welcome. They are probably always more ways we can get information and try to make sure that the service continues to improve.

Chair: I want to move on, but we would love to hear progress on that idea.

Q231 Ruth George: On another issue, back at the end of September the Secretary of State made a ruling that various classes of people with severe and disabling conditions would not have to qualify for reassessment. There are a number of people who are already on benefit with conditions such as motor neurone disease who will not need reassessing but are currently having to go through that process in order to be put onto the no-reassessment group and having to waste valuable time—often they do not actually have much left—filling out the enormous forms that they have to. What process is CHDA going to go through for those groups? Is there a way that they can not fill in those forms?

Dr Williams: It is probably just worth highlighting the division, if you like, of responsibilities whilst we work together with the Department. There are parts of the process that are Department parts of the process, and there are parts of the process that are ours. The referral to us is entirely controlled within the Department for Work and Pensions. When we receive a referral from the end of September, when the new policy was introduced, it will require that we do apply that policy. In the majority of those individuals I would anticipate that it is likely that a recommendation or advice would given as to paper assessment, because it is likely there will be medical evidence available to support that case



HOUSE OF COMMONS

But what we do not control is the referrals to us initially. I completely understand the question, and I agree that anything we could do to reduce inconvenience or anxiety to those individuals would be really helpful, but that is probably a question that would be best posed to the Department, who know how their referral process works.

Q232 Ruth George: These are people who are already on benefit and are being asked to be reassessed for it in spite of having a qualifying condition for no reassessment?

Dr Williams: Yes. I completely understand the nature of the question, but that re-referral process sits within the Department.

Q233 Chair: We should address that to the Department out of our recommendations?

Dr Williams: Correct.

Q234 Chair: But if you have a disease that will kill you quite quickly they should actually give you permission on the basis of that to actually reaffirm that they are on it for life, so to speak, their benefit?

Leslie Wolfe: They just will not send the referral to us; so, then we will not send out the ESA50.

Chair: That is even better, Leslie. Thank you.

Dr Williams: That would be ideal.

Q235 Jack Brereton: Thank you, first, for the visit that I made to the assessment centre in Stoke-on-Trent, which was particularly useful. I wanted to ask particularly about a bit more on home visits, because while I was there I think you suggested that in terms of getting the GP records and ensuring that GPs are putting forward the right information you said, I think, that many times GPs will put that the claimant requested a home visit, and actually that is not giving medical evidence, because it is just saying what the claimant has said. What are you doing to ensure that that changes and that GPs are actually where there is an actual need putting forward accurate information to ensure that a home visit takes place?

Dr Williams: Both on the specific points around home visits and more generally around quality and timeliness of medical information, you have heard in the previous session as well just how important that is to us, and we recognise some of the challenges around that when we first began. One of the things we did early on was we undertook some research with GPs to try to understand from a qualitative point of view what some of their barriers were to returning the evidence to us, and then using that information we created some materials for GPs to try to explain to them the kind of information we were looking for and precisely just some of those pitfalls, if you like, in the type of information.



HOUSE OF COMMONS

Then we have trained some of our volunteer nurses and doctors in each area to be local GP ambassadors. I myself have tended to go to national events, but some of them tend to go to local GP events to disseminate these materials and to try to raise awareness of the type of information that we are looking for.

Leslie Wolfe: But in cases where it appears that they would benefit from a home visit we have often followed up and—

Dr Williams: Thank you. That is a really good point. We make roughly a million requests for further GP evidence in a year, but I have already mentioned that we are doing a million assessments, and we do not ask for it in every case. A lot of those requests are actually follow-ups for repeat information where we do not get the information in a timely fashion or where the information is not clear. Often when I am in visiting centres, like we did on that particular occasion, I will hear members of our team on the telephone trying to see if we can clarify that situation. It is something we take really seriously, and we are trying to reach out to GPs and help them to understand the kind of things that would help their patients, because it helps us to make accurate decisions about their patients, but any suggestion as to how we can raise awareness of that further are gratefully received.

Q236 **Chair:** What is the response rate from GPs? We have heard how appalling it was from the previous session.

Dr Williams: The response rate depends on the timeline, Chair. Within the contract and within the medical-service guidance we ask GPs to return the evidence to us within five working days. We achieve about a 30% success rate in that case. We typically at that point either wait a bit longer or make a telephone call, we make a repeat request, and we try to use a certain amount of clinical judgment around just how valuable that is going to be, because we have tried to tread a line between not delaying the assessment unnecessarily, because we realise that someone is waiting anxiously to know what is going on but on the other hand we have to be realistic about how long we can wait.

Altogether we will end up calling somebody for an assessment when we have failed to get medical evidence about 8% of the time. There may be a whole variety of reasons for that. Not all of our customers are in regular contact with healthcare, for a variety of reasons. They may have a health condition that does not really require healthcare contact. They may be quite mobile and not have an obvious connection with a prescribed healthcare professional. There are reasons why some of those 8% are not returned.

Q237 **Jack Brereton:** You have talked about the fact that a number of your assessors have different medical skills, and obviously the people who are presenting as claimants will have differing conditions. What is stopping you ensuring that appropriate assessors with the right skills are assigned to people with those similar conditions?



Dr Williams: I think first of all we like to think that they do have the right skills, because the skillset that we are looking for is somewhat different. We are looking for a broad understanding of how somebody's day-to-day functioning is going to be affected. No two people are the same, clearly; everybody is individual, and even for a particular diagnosis many people will be affected very differently from person to person and according to how successful the treatment may be and how they have progressed. Our customers will typically have been seven and 10 different medical conditions when they apply to us.

I guess first of all there is a practicality element about being able to find enough if we were to go down a specialised model. That would be a big challenge in itself. But I would also make a case just more generally, really. This is not unique to disability assessment medicine. I think even in hospitals and general healthcare there is a strong case for the specialist generalist. Sometimes when people are very specialised they do not necessarily see the connection with other conditions that that person may have. I do think there is a strong case for what I would term a specialist generalist who really understands how all of these things may impact upon each other.

Leslie Wolfe: One of the things that the customer representative group has helped us with is continuing to improve our training—we have a bit of modularised training for different backgrounds in terms of the medical professionals we have to augment certain areas where certain fields have more expertise than others when they come out of their medical school and training—but also we have continued to develop the mental-health awareness training and other areas. Maybe you could add to the Committee's awareness.

Dr Williams: Sure. After our initial training, which I discussed earlier on, we have a regular programme of continuing medical education, which is actually far more substantial than most professional bodies would require, and that is informed by feedback that we get, if we have feedback from complaints, for example, we have feedback from customer groups or perhaps there is an emerging medical condition or a new form of treatment. It can be in response to a whole variety of changes. We produce that training material, we engage with recognised experts in the field—so, if it is around mental health, we may get the training reviewed by somebody from the Royal College of Psychiatrists, for example—and we try to get a customer's perspective on that from representatives of our customer representative group who also comment on it and make sure that that is acceptable from the point of view of their constituents.

We have access to a range of mental-health champions. I think you heard about one of the other providers uses a similar system, of practitioners with additional training and experience in mental health, but then we added to that by creating champions for fluctuating conditions as one of the first ones, because we took feedback from customers that there were concerns about how we assess people whose conditions fluctuate,



HOUSE OF COMMONS

gastrointestinal disorders, cardiovascular disorders, respiratory diseases, and a specialist champion for rare diseases, because nobody can know everything about every rare disease, and so they provide additional information on request. We have really tried to improve that range of knowledge and expertise within the business.

Q238 Chair: Does that show up in the rest of the process of tribunal decisions and so on?

Dr Williams: Perhaps Leslie will speak to tribunal decisions, but, if I talk about the process ahead of time, you mentioned about visiting customers for a follow-up; we do not visit people, but we do telephone them. We have an independent customer survey company who contacts 1,000 of our customers a quarter to seek their feedback, and month on month we have improved our customer satisfaction score. We are currently at 94%, which is something that is showing a really positive and continuing trend. I think it does feed back into part of the process. I will let Leslie speak about tribunals.

Q239 Neil Coyle: 1,000 a quarter, 4,000 a year, 94%—it sounds ridiculously positive given the feedback we get. How is that sample selected?

Dr Williams: it is selected randomly from the research company that we use. The process for it is something that we agree with the Department so that it is open and transparent. It is a random sample generated—if they are not able to make contact with somebody, they may move on to select another case—and it is all handled completely outwith our control, if you like, or jurisdiction.

Q240 Neil Coyle: But you are paying for that service. If my accountant came to me and said they had a 94% approval rate for any particular bit of the service, I would be suspicious of that figure as well, and I think there is a tendency for some of the market research companies to give you the figures you want to hear rather than actually getting to it. What percentage of customers, if you want to call them that, do not engage with the research?

Dr Williams: I do not know, actually. I could find out for you and let you know.

Leslie Wolfe: The other side of the coin, though, is that our complaint rate is quite low. I think it is 0.6%.

Dr Williams: Leslie mentioned earlier we try to actively encourage feedback. We have the complaint forms available readily in all of our assessment centres and the details available on our website. We get six complaints per 1,000 assessments, of which it splits roughly half and half. About three out of 1,000 will be related to the actual assessment itself, and three will be to do with appointment delays, travel arrangements or something—

Q241 Chair: How many of your cases are overturned by higher authorities?



HOUSE OF COMMONS

Leslie Wolfe: Can I maybe start by just explaining our role in that whole journey through to tribunal? Our responsibility is to conduct a fair, dignified, accurate assessment or advice on behalf of the Department, and then the Department makes the decision. I apologise, this is probably obvious to you, but they make the decision, then our customer obviously has the right to question that decision—that is right, and that should be the case—and then they undergo a mandatory reconsideration by another decision-maker, and then if they are still not satisfied they have the right to appeal. But that process once we have sent the advice we are independent of. We are not part of that process.

Q242 **Chair:** But it is unlikely that the Department is going to make any changes, isn't it? They have given you the job to make these decisions.

Leslie Wolfe: We do get the detail of why a decision was overturned. There could be a variety of reasons why a decision was overturned.

Q243 **Chair:** How many, Leslie, at the mandatory reconsideration are overturned, and how many are tribunals? Of the decisions you make, what percentage by a higher authority are overturned?

Leslie Wolfe: I do not have that information. The advice that we sent over—we do not make the decision. They may make a decision that is different to our advice based on other information they have.

Q244 **Chair:** Do they tell you that and why they make a different decision?

Leslie Wolfe: No. There could be a variety of reasons, though, because customers may actually send more evidence than we had present at the time of the assessment, or their condition may have worsened even since the time of the assessment.

Q245 **Chair:** But do you think it would be rather good feedback just what proportion of your decisions are overturned? Wouldn't that be quite useful?

Leslie Wolfe: We work very closely with the Department, and when they see trends or areas of—

Chair: But perhaps not closely enough on this issue.

Leslie Wolfe: We get it in terms of feedback around areas they may be concerned—we are measured and held to other measures across the contract, and that is how we communicate.

Chair: Let us bring in Heidi on that, then.

Q246 **Heidi Allen:** You will have heard in the first session that I am the one with all the unhelpful revealing statistics; so, sorry about that. One thing we have not been able to—it was easier for the PIP assessments, these varying degrees of “acceptable” and “unacceptable”. With ESA assessments it is A- or B-grade, but we have not been able to find out the criteria for which is which. Can you shed some light on that, as a starter for 10?



Leslie Wolfe: Can I just maybe start; and Paul has the detail in terms of the A, B and C, because it can be confusing. The unacceptable rate for us is when advice that we send a decision-maker just cannot make a decision on based on our advice. Those are considered unacceptable in our contract, and we have always met the target for that. That is that 99.5% of our reports need to be sufficiently robust that they can make decisions on. I want to clarify that, that there is an unacceptable rating for us and we have met that target.

We have met the majority of our quality targets since we took over the contract. We are falling short of one of the quality targets—that is the C grade that you mentioned—and it is unacceptable. It is a very high threshold. It is a rating that is based on the technical aspects of the assessment report itself. I am not happy with that, and we need to do better.

Q247 **Heidi Allen:** Could you, though, for our benefit just outline A, B and C and what the criteria are? We have not been able to find that out ourselves.

Dr Williams: Probably the most complete way of doing that would be to make that information available to the Committee afterwards. I can try to briefly verbalise it now, but —

Q248 **Chair:** All right, we will have it afterwards. But, Leslie, on these more difficult criteria, has your company ever met them?

Leslie Wolfe: I am disappointed to say no, we have not.

Q249 **Heidi Allen:** The target is 95%, I think, isn't it, to meet either A or B, and you are around about 92%?

Leslie Wolfe: We are short by about 2.3% right now of where we should be.

Q250 **Heidi Allen:** What have you found out have been the reasons, and what are you doing to rectify that and improve that?

Dr Williams: In terms of the reasons there are a variety of headline causes, if you like. Part of our C-grade criteria is that we can be given a C grade if we are using technical medical information or acronyms. Sometimes the report is actually accurate and reasonable but it does not meet the high quality standards because we are trying to write for a lay audience.

Q251 **Heidi Allen:** You do not have an appointment C; you have a reporting C, don't you?

Dr Williams: No, that is the one that we—our target is A plus B to be 95%. By achieving 92.7%, where we are, effectively it is the C grades that we are accumulating, if you like, and one of the reasons for not hitting the A plus B—I appreciate this is a little confusing; probably easier to read the data, but—



HOUSE OF COMMONS

Q252 **Heidi Allen:** Can I just check, are you saying, then, that is not that you are not getting enough As and Bs, it is that you are getting too many Cs, and that is what is dragging you down overall?

Dr Williams: Effectively, there are two ways of saying the same thing.

Q253 **Chair:** C is what, outright failure, is it?

Heidi Allen: C is they cannot use the report to make a decision.

Dr Williams: Well, a C is the report is unacceptable, and there are a number of reasons for that. One of the reasons a report is deemed unacceptable in this way is because there can be technical language or abbreviations. The report may still be well evidence-based and still lead to—

Q254 **Heidi Allen:** But the DWP assessor cannot interpret technical medical language or whatever?

Dr Williams: Potentially, and then other examples will be where an auditor feels there is perhaps a little more working-out, let us say, if I can put it like that—we may have perhaps three examples that indicate somebody's mobility, but actually the auditor feels that a bit more evidence, perhaps four or five examples, may be appropriate. The fairly commonly consistent issues will be around articulating those examples, essentially so a third party who has never met the individual can really get a good picture.

Q255 **Heidi Allen:** Is that the bulk of the reason why you are not hitting the target?

Dr Williams: It is spread over a wide range of descriptors, but they are broadly in line with the types of conditions that people present to us. As a clinician myself in talking to clinicians about this, the issue is the clinician has the person in the room and we are trying to paint a picture for somebody else who is not going to meet that individual. There is a tendency to think perhaps other people know things because we were there and we saw it but we perhaps have not written down quite enough. A lot of our training around this is just around trying to improve people's report-writing skills. They have perhaps asked the questions and done an appropriate assessment, but they have not conveyed it—

Q256 **Heidi Allen:** I do not doubt that you are trying to fix this, but if you have never hit that target and you have identified so clearly it is about the clarity of the report how is it still not fixed? When are you going to hit that 95% target?

Leslie Wolfe: We have taken a number of initiatives to continue to improve, we have been improving year over year, and we continue to get closer to that target, which is wonderful and as it should be. We have a new management structure that includes clinical supervision. One of the questions asked previously was whether those quality supervisors, clinical supervisors, conduct assessments as well, and the answer is yes. They



HOUSE OF COMMONS

continue to stay current with procedures as well, which is really important in the service. There is monitoring, there are checklists, there is oversight, and quite often, which is surprising, some people rarely are audited with a C-grade report, and when they are they are very disappointed about that. It is a professional grade of shame for people. They do not want to get those Cs. We are constantly trying to stay vigilant; and maybe you can cite more examples, Paul.

Q257 **Chair:** But actually the truth is if any of us were Secretary of State we would have to report to the House that none of the companies we have been talking to today meet the target. It is as simple as that, isn't it?

Leslie Wolfe: It is not acceptable. We do pay service credits for that, as you can imagine, and it is quite right that we do. It is a point of pride for Maximus to deliver quality service on behalf of the Government, and so it is not where it needs to be.

Q258 **Heidi Allen:** Do you think you will get there?

Leslie Wolfe: We are going to continue to strive to get there. We are going in the right direction, we are 2.3% away, and we feel optimistic.

Q259 **Heidi Allen:** From February, though, it has been dropping again, just looking at this year.

Dr Williams: I would probably follow the progress more closely. There is a fluctuation over periods of time for certain—year on year we have overall made improvement, but then within-year there is some variation from one month to another.

Leslie Wolfe: Interestingly, the A grades as a percentage are above target. That is positive news and reflects some of the training and supervision, I think, that has been put in place.

Chair: Thank you very, very much for coming today. We will follow up with you the other data we would like, as we will with the other witnesses. Thank you very, very much.