



House of Commons

Committee of Public Accounts

Department for Work and Pensions: Contract management of medical services

Twenty-third Report of Session 2012–13



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*Report, together with formal minutes, oral and
written evidence*

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Committee of Public Accounts

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The committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the internet via www.parliament.uk.

Publications

The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the internet at www.parliament.uk/pac. A list of Reports of the Committee in the present Parliament is at the back of this volume. Additional written evidence may be published on the internet only.

Committee staff

The current staff of the Committee is Adrian Jenner (Clerk), Sonia Draper (Senior Committee Assistant), Ian Blair and James McQuade (Committee Assistants) and Alex Paterson (Media Officer).

Contacts

All correspondence should be addressed to the Clerk, Committee of Public Accounts, House of Commons, 7 Millbank, London SW1P 3JA. The telephone number for general enquiries is 020 7219 5708; the Committee's email address is pubaccom@parliament.uk

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Summary

The Department for Work and Pensions (the Department) relies on medical assessments to help its decision makers reach an appropriate decision on a claimant's entitlement to a range of benefits. Work Capability Assessments are used to assess new applications for Employment and Support Allowance and to reassess existing recipients of Incapacity Benefit. This is damaging public confidence and generating much criticism of ATOS, but most of the problems lie firmly within the DWP. The Department has outsourced this work since 1998 and in 2011-12 paid its contractor, Atos Healthcare, £112.4 million to carry out 738,000 assessments. From April 2013, a new medical assessment will be introduced for the Personal Independence Payment.

The Work Capability Assessment process is designed to support a fair and objective decision by the Department about whether a claimant is fit for work, but in far too many cases the Department is getting these decisions wrong at considerable cost to both the taxpayer and the claimant. The Department's decisions were overturned in 38% of appeals, casting doubt on the accuracy of its decision-making.

Poor decision-making causes claimants considerable distress, and the position appears to be getting worse, with Citizens Advice reporting an 83% increase in the number of people asking for support on appeals in the last year alone. We found the Department to be unduly complacent about the number of decisions upheld by the tribunal and believe that the Department should ensure that its processes are delivering accurate decision-making and minimising distress to claimants.

The Work Capability Assessment process has a disproportionate impact on the most vulnerable claimants. The standardised "tick-box" approach fails to adequately account for rare, variable or mental health conditions and this can lead to greater inaccuracies in decision-making for these particular claimant groups. We welcome the efforts made to improve the process and encourage the Department to continue to review the operation of the work capability assessment for vulnerable groups

The Department does not know the full cost of the overall decision-making process. Its processes have financial effects across government, for example, in the National Health Service, and high levels of appeals increase the Department's own administrative costs yet it has not assessed the overall cost to the taxpayer. Without this information the Department will be unable to assess the value for money of its decision-making processes.

The Department is currently dependent on one supplier to undertake all medical assessments. In the 14 years since the service was outsourced, the Department has never awarded the contract to a new supplier; it has only ever changed hands due to a company takeover. The inability of the Department to develop a competitive market for medical assessment providers has left it vulnerable, with limited leverage to remedy poor performance.

The Department is not using all the mechanisms it has at its disposal to manage the contract for medical assessments effectively. We saw no evidence that the Department was applying sufficient rigour or challenge to ATOS given the vulnerability of many of its

clients, the size of the contracts and its role as a near monopoly supplier. We are concerned that the profitability of the contract may be disproportionate to the limited risks which the contractor bears.

The Department's evidence was not always consistent with the views expressed by our other witnesses. We heard different interpretations of statistics such as the proportion of successful appeals, the accuracy of decision-making and on whether overall contract performance is improving. As a result the Committee was unable to arrive at a clear conclusion about whether the overall performance is improving and we recommend that the National Audit Office should provide a further report focussing on up-to-date performance data.

On the basis of a Report by the Comptroller and Auditor General,¹ we took evidence from Citizens Advice, Disability Rights UK and the Department for Work and Pensions on the contract management of medical services.

Conclusions and recommendations

- 1. The decision-making process for new Employment Support Allowance applications and Incapacity Benefit reassessments all too often leads to the wrong decisions and is failing far too many people.** Claimants have successfully challenged these decisions in 38% of appeals. In one third of these cases, the appeals have been upheld simply because the Tribunal disagrees with the original decision rather than because new evidence is provided on the day. This raises serious questions about the quality of the overall decision-making process. The Department represented appeals as an inherent part of the process but it does not have the information to judge whether the current rate of appeals indicates serious weaknesses in the decision-making process which could be rectified. We welcome the recent actions by the Department to obtain feedback from HM Courts and Tribunals Service. The Department must collect the detailed information needed to understand why there are so many appeals and why so many of them are successful, so that the contractor can improve its performance and DWP can change its assessment process if necessary.
- 2. The Work Capability Assessment may unduly penalise people with specific health problems.** The one size fits all approach is not appropriate for particular groups, for example, people with mental health, rare or variable conditions. The process is too inflexible and makes it extremely difficult for individuals with particular conditions to demonstrate the impact of their conditions on their ability to work. Too often the process is so stressful for applicants that it can impact on their health. The Department should assess whether the Work Capability Assessment process is unfair to these claimant groups by looking at whether its initial decision is less accurate in these cases and, if so, make changes to its processes where appropriate. We welcome the initial efforts made to improve the process and encourage the Department to continue to review the operation of the work capability assessment for vulnerable groups.
- 3. The Department does not know the full cost to the taxpayer of the overall decision-making process for Work Capability Assessments.** Whilst some costs are known, such as the £26.3 million paid to HM Courts and Tribunals Service for its work on appeals, there is little information on the cost and impact on the National Health Service or on some of the internal interactions within the Department. Without a full understanding of these costs, the Department cannot come to an evidence-based conclusion on the value for money of its current decision-making process. The Department should establish the full costs of the process so that it can benchmark with relevant organisations on the cost effectiveness of its approach.
- 4. The Department has failed to develop a competitive market for medical services.** The market for medical service providers is under-developed and Atos Healthcare is currently the sole supplier for all the Department's medical assessments. It has also been awarded two of the three current contracts for the Personal Independence Payment. The Department is too relaxed about the risk to value for money resulting from a dependence on a monopoly supplier, and on the limitations this has on the

Department's capacity to remedy poor performance. The Department should assess the risks associated with the use of a monopoly supplier and actively pursue opportunities to develop a competitive market through the deployment of its framework contract.

5. **The Department lacks sufficient rigour in managing the contract with Atos Healthcare.** It has adopted a light-touch approach to managing this contract and placed too much reliance upon information provided by the contractor. The Department seems reluctant to challenge Atos Healthcare. It has failed to withhold payment for poor performance and rarely checked that it is being correctly charged for work. The lack of challenging targets for medical quality allows the contractor to conduct thousands of poorly administered tests each year without sanction. The Department needs to reduce its dependence on the contractor's information and processes by adopting a more active and interventionist approach to contract management. This should include obtaining more of its own assurance on information provided by Atos Healthcare, active enforcement of the sanctions available to it through the service credit regime and the setting of more challenging targets on the quality of medical assessments.
6. **The Department cannot explain how the contractor's profits reflect the limited risk that it bears.** Moreover, in a new contract for the Personal Independence Payment, Atos Healthcare is sub-contracting to the National Health Service for part of its work, suggesting it is transferring risk back to the public sector. The Department should explain how the profitability of the contract reflects the actual transfer of risk for both the Work Capability Assessment and the Personal Independence Payment medical assessment contracts.
7. **The Department must improve its internal processes to improve the quality of decision-making and contract management.** The size of the Department and its impact on individuals and on the public purse requires us to have the utmost confidence in the capability of the Department to deliver. Robust systems are a crucial part of this. We are concerned that the Department is unduly complacent regarding the quality of the decision-making process, particularly given the hardship which can be caused to individuals when the decision is wrong.

1 The Department's decision-making process

1. The Department for Work and Pensions (the Department) relies on medical assessments to help its decision-makers reach an appropriate decision on a claimant's entitlement to a range of benefits. The principal medical assessments are the Work Capability Assessments, which are used to assess applications for Employment and Support Allowance and to reassess existing claims for Incapacity Benefit.² The Department's contractor for medical services, Atos Healthcare, completed 738,000 face-to-face medical assessments in 2011-12 and charged the Department £112.4 million. Such assessments include the re-assessment of 1.5 million claimants on Incapacity Benefit between 2011 and 2014, the assessment of new claimants of Employment and Support Allowance (as of February 2012 total caseload was 991,000), and an expected 440,000 new claims for Personal Independence Payment³ each year from April 2013. The Department delivered medical services in-house until August 1998. After that date, service provision was outsourced to a company that now forms part of Atos Healthcare. Atos Healthcare won a seven year contract in 2005 which was extended for three years until 2015, and there is a further option to extend for another two years to 2017.⁴

2. Work Capability Assessments are an opportunity to hear the personal testimony of claimants and to review the completed questionnaire and any supporting evidence before making a recommendation to the Department's decision makers on the claimant's fitness for work. The role of the decision maker is to check that the Department has considered all relevant evidence and that the recommendations reflect that evidence.⁵

3. The design of an adequate process to ensure accurate decision-making is a key factor in minimising the costs to the taxpayer and the burden on claimants, but the volume and proportion of successful appeals is too high, which suggests processes are not working effectively. We found that 38% of appeals against the Department's decisions were upheld.⁶ Whilst the information is incomplete, the Department told us that the most current data suggests that one third of successful appeals are primarily due to the tribunal reaching a different conclusion on the same evidence.⁷ In some cases there is a marked difference between the view taken by the tribunal on the ability of the claimant to work compared to that originally taken by the Department's decision makers. Citizens Advice told us that around 60% of appellants they see who, on the original assessment, scored zero points (which supposedly indicates that they are fully fit to work) but on appeal were designated in a group classified as being the least able to work.⁸

2 C&AG Report, para 1

3 Personal Independence Payment replaces Disability Living Allowance in April 2013

4 C&AG's Report, paras 2 & 1.1 to 1.3

5 C&AG Report para 3.6; Qq 90, 106, 177

6 C&AG Report para 7; Qq 72, 104, 193-196

7 Q 72-74, 216

8 Q 4

4. Over the past decade the Department does not appear to have made a great deal of progress in improving the accuracy of its decisions. We reminded the Department of a National Audit Office report in 2003 which included information on appeals and accuracy of the Department's decision-making for eligibility of certain benefits. This noted that Tribunals upheld approximately a quarter of appeals (24% of Disability Living Allowance and Attendance Allowance appeals and 27% for Incapacity Benefit) because it simply disagreed with the decisions made by the Department based on exactly the same evidence.⁹

5. There is also some evidence that the volume of appeals is increasing dramatically. Citizens Advice told us that the number of people approaching it asking for support in relation to appeals went up by 83% in the months between July and September 2012 compared to the same quarter in 2011.¹⁰ The Department told us that they thought both the numbers of appeals and proportion of successful appeals was currently too high. It considered that one reason for the high level of appeal success may be due to the fact that appeals happened many months after the original decision had been made.¹¹ Citizens Advice told us that they considered the medical assessment was very process driven and did not consider the impact and outcomes for those people who underwent the test. Disability Rights UK agreed that claimants felt the assessment was done very quickly with a tick-box approach taken.¹²

6. There is a risk that a standardised, simplistic form-filling approach risks missing vital evidence from the claimant and those who know the claimant and understand their situation.¹³ This is particularly the case with claimants suffering from mental health problems or from rare or fluctuating conditions such as dystonia or aphasia. Disability Rights UK told us that they knew of examples where the medical assessors were unaware of particular conditions and their impact on claimants.¹⁴ We also heard that claimants can find the process humiliating, cumbersome and often have false impressions of the assessment procedure.¹⁵

7. We welcome the Department's recognition that it needs to improve its understanding of variable conditions and to improve guidance for relevant health care professionals.¹⁶ We were also told that Atos Healthcare now has 60 mental health champions who have particular mental health knowledge, which is also a positive step. Nevertheless, the Department has little information on impacts and burdens on claimants and does not know, for example, the proportion of successful appeals that are from people with mental health conditions.¹⁷

9 Qq 210, 216; National Audit Office, *Getting it right, putting it right— Improving decision-making and appeals in social security benefits*, Session 2002-03, HC 1142

10 Q 6

11 Qq 72, 106

12 Qq 3, 13

13 Q 13

14 Q 18

15 Q 96

16 Q 144

17 Q 219

8. The Department has started to obtain some high level feedback from HM Courts and Tribunals Service to improve its understanding of why so many appeals are successful but it lacks sufficient information to evaluate whether the current rate of appeals is indicative of serious weaknesses in the decision-making process. Without this information the Department cannot provide clear feedback to its decision-makers and contractor on how to improve the accuracy of its decisions.¹⁸

9. The decision-making process also places a burden on the taxpayer in relation to additional costs incurred by government. The Department paid £26.3 million to HM Courts and Tribunals Service in 2011-12,¹⁹ but it has insufficient information on the additional internal costs that it incurs for Work Capability Assessments or wider decision-making.²⁰ Nor does it know the full cost and impact of its decisions on the public sector, for example, on the National Health Service or local government.²¹

18 Q 72

19 Q 180

20 Q 184

21 Q 176

2 Contract management

10. The Department has contracted with a sole supplier for healthcare professionals since it first outsourced medical service provision in August 1998.²² Although the Department now has ten potential suppliers on a medical services framework contract,²³ it awarded contracts to just two of those suppliers for the Personal Independence Payment contract, and two of the three of these contracts awarded to date have been allocated to Atos Healthcare. The Department has had 14 years to develop a competitive market for healthcare providers but continues to depend on a near monopoly supplier.²⁴

11. Despite the risks associated in working with a monopoly provider, the Department has been reluctant to intervene to more actively manage the contract. It has adopted a light-touch approach and placed too much reliance upon information provided by the contractor. The absence of proper validation can create a risk that the Department incurs inappropriate expenditure. In response to our questions the Department revealed that in a typical month it only checked 0.1% of the individual cases that it was invoiced for (139 out of 128,000). The Department has a provider assurance team model for its contracted employment programmes but has yet to introduce an equivalent control for the medical assessment contract.²⁵

12. The contract with Atos Healthcare specifies that the Department will apply service credits where the contractor has failed to meet the specified service level. Service credits are designed to identify the cost to the Department of Atos Healthcare's non-performance against a particular target and to recompense the Department where appropriate. The system allows for Atos Healthcare to supply 'mitigation' where it considers factors outside of its control have adversely affected performance.²⁶ However, the Department has applied only 10% of service credits due since the start of the contract in 2005. Moreover it suspended the whole service credit regime between September 2009 and March 2010 and between June 2011 and December 2011,²⁷ and has put in place an interim service regime since March 2012.²⁸ The Department told us that the introduction of Employment and Support Allowance was the primary reason for poor performance rather than the actions of Atos Healthcare²⁹ but has still appeared reluctant to rigorously apply service credits to remedy poor performance or to penalise the contractor for inaccurate medical assessments.³⁰

13. Medical auditors from Atos Healthcare conduct sample audits of medical assessments and provide an A-C grading. A grading of 'C' is classified as "failing to meet professional

22 C&AG Report para 1.2

23 Q 31

24 Q 30

25 Qq 51-58; Ev 31

26 Q 146

27 Q 152

28 C&AG Report para 3.21

29 Q 146

30 Qq 4, 146

standards". The Department has set a target that no more than 5% of all face to face medical assessments audited by Atos Healthcare should fail professional standards but it was unable to provide a rationale or professional evidence to support the reasonableness of the target when we raised concerns about it. This target does not seem particularly challenging given that in the past year the contractor has, on occasion, performed at a level of 3.5%, so we welcome the Department's commitment to set more stretching targets in the future.³¹

14. We also expressed concern that the Department appears over-dependent on ATOS for self-regulation. The Department only validates a very small proportion of the medical assessments invoiced by ATOS and the scope and scale of the work it does to check the medical quality of the assessments is unclear.³²

15. The Department agrees a service level for how quickly Atos Healthcare processes medical assessments. We found that a significant proportion of cases have been with the contractor for more than 56 days at March 2012 (25% compared with a target of 3%). We also found significant regional variations in performance ranging from 1% or 2% of cases in the north to 28% in London and the Home Counties and 40% in the south east.³³

16. Managing backlogs has been a longstanding issue for the Department. Backlogs in completing medical assessments have resulted from the Department introducing changes to the process and from staff shortages within the contractor.³⁴ This led the Department to suspend the service credit regime from March 2012.³⁵ We understand that the Department is in active discussions with Atos Healthcare and is providing incentivised payments to the contractor to reduce the backlogs.³⁶

17. Accurate forecasting of referral volumes is also critical to reducing backlogs. The contract includes estimates of demand for medical services on which assumptions around fixed overhead costs are based. Where total actual referral volumes are more than 20% over or under these volumes for three consecutive months or more, either party can renegotiate the contract.³⁷ The Department provides detailed operational estimates each year but these have not been particularly accurate. For example in 2008-09, actual referrals for all service lines were 68% of contract forecasts.³⁸ More recently the Department appears to have improved its overall forecasting with a variance of around 3% between April and September, although there are wide regional variations of up to 30% in any one month.³⁹

18. The Department has an open-book accounting arrangement with Atos Healthcare but it would not publicly provide details of contract profitability on the grounds of commercial

31 Q 142

32 Qq 58, 125-131; and Ev 31

33 C&AG Report para 3.14; Qq 165-168, 173

34 Qq 112, 149, 227

35 Q 154

36 Q 169

37 Q 115

38 Q 118

39 Q 115

sensitivity although it has agreed to brief the Committee privately on this subject.⁴⁰ Consequently, it is not clear how far the Department has successfully passed risk to the contractor, or how the contractor's profits reflect the risk that it actually bears. For example, the recent award of a contract to Atos Healthcare for the Personal Independence Payment includes an arrangement whereby Atos Healthcare sub-contracts with NHS Lanarkshire which effectively passes the risk back to the public sector, but at a profit to the contractor.⁴¹

19. The witnesses who spoke for people who have undergone these medical assessments (Citizens Advice and Disability Rights UK) and the Department had different interpretations on the data and performance issues relating to the decision-making process. Both Citizens Advice and Disability Rights UK were critical of the Work Capability Assessment process and its impact on claimants. Citizens Advice, in particular, reported alarming increases in the number of people consulting them about appealing against the Department's decisions.⁴² The Department, however, emphasised recent improvements in performance and the better information it is collecting on why appeals succeed on so many occasions.⁴³

40 Q 35; Ev 31

41 Qq 65, 69

42 Qq 6-8, 12, 13

43 Qq 72, 115, 169

Formal Minutes

Wednesday 23 January 2013

Members present:

Margaret Hodge, in the Chair

Stephen Barclay
Jackie Doyle-Price
Mr Stewart Jackson
Fiona Mactaggart

Mr Austin Mitchell
Nick Smith
Ian Swales
Justin Tomlinson

Draft Report (*Department for Work and Pensions: Contract management of medical services*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 19 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Twenty-third Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for printing with the Report (in addition to that ordered to be reported for publishing on 14 January 2013).

[Adjourned till Monday 28 January at 3.00 pm]

Witnesses

Monday 19 November 2012

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Neil Coyle, Policy Director, Disability Rights UK and **Gillian Guy**, Chief Executive, Citizens Advice Bureau

Ev 1

Robert Devereux, Permanent Secretary and **Dr Bill Gunnyeon CBE**, Chief Medical Adviser and Director of Health, Department for Work and Pensions

Ev 6

List of printed written evidence

1 Department for Work and Pensions

Ev 31

List of Reports from the Committee during the current Parliament

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2012–13

First Report	The Government Procurement Card	HC 1915
Second Report	Mobile Technology in Policing	HC 1863
Third Report	Efficiency and reform in government corporate functions through shared service centres	HC 463
Fourth Report	The completion and sale of High Speed 1	HC 464
Fifth Report	The Regional Growth Fund	HC 104
Sixth Report	HM Revenue & Customs: Renewed Alcohol Strategy	HC 504
Seventh Report	Immigration: The Points Based System – Student Routes	HC 101
Eighth Report	Managing early departures in central government	HC 503
Ninth Report	Preparations for the London 2012 Olympic and Paralympic Games	HC 526
Tenth Report	Implementing the transparency agenda	HC 102
Eleventh Report	Improving the efficiency of central government office property	HC 288
Twelfth Report	Off-payroll arrangements in the public sector	HC 532
Thirteenth Report	Financial viability of the social housing sector: introducing the Affordable Homes Programme	HC 388
Fourteenth Report	Assurance for major projects	HC 384
Fifteenth Report	Preventing fraud in contracted employment programmes	HC 103
Sixteenth Report	Department of Health: Securing the future financial sustainability of the NHS	HC 389
Seventeenth Report	Department of Health: The management of adult diabetes services in the NHS	HC 289
Eighteenth Report	HM Treasury: The creation and sale of Northern Rock plc	HC 552
Nineteenth Report	HM Revenue & Customs: Annual Report and Accounts 2011-12	HC 716
Twentieth Report	Department for Energy and Climate Change: Offshore electricity transmission – a new model for infrastructure	HC 621
Twenty-first Report	The Ministry of Justice's language service contract	HC 620
Twenty-second Report	British Broadcasting Corporation: Off-payroll contracting and severance package for the Director General	HC 774

Oral evidence

Taken before the Committee of Public Accounts

on Monday 19 November 2012

Members present:

Margaret Hodge (Chair)

Mr Richard Bacon
Guto Bebb
Jackie Doyle-Price
Meg Hillier

Mr Stewart Jackson
Fiona Mactaggart
Austin Mitchell
Justin Tomlinson

Amyas Morse, Comptroller and Auditor General, National Audit Office, **Gabrielle Cohen**, Assistant Auditor General, NAO, **Neil Sayers**, Director, NAO, and **Marius Gallaher**, Alternate Treasury Officer of Accounts, HM Treasury, were in attendance.

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

Contract Management of Medical Services (HC 627)

Examination of Witnesses

Witnesses: **Neil Coyle**, Policy Director, Disability Rights UK, and **Gillian Guy**, Chief Executive, Citizens Advice Bureau, gave evidence.

Q1 Chair: May I welcome both Neil Coyle and Gillian Guy? Gillian Guy, I think you had better declare one of your hats before we start.

Gillian Guy: Yes, I declare, for the record, that I am a non-executive member of the NAO board.

Q2 Chair: Thank you. You have just joined?

Gillian Guy: Yes, indeed.

Q3 Chair: Thank you both for agreeing to come. The start is usually quite a short part of our afternoon's proceedings, when we try to hear from people who are at the coal face about what you believe are the key issues we should address. That is what you are here to do. There has been a lot of controversy over this contract and the assessment. Shall we start with you, Gillian? It would be helpful to hear. Is there anything that you think works well? If there is, let us know that. And tell us where you think the problems are and let us know where our questioning of the DWP should be going later.

Gillian Guy: The first thing to say in terms of potentially going well is that we agree with the principles behind ESA: to encourage and assist people who are able to work to get into work, and to give financial support to those who cannot. We also do not have a philosophical objection to employing companies to undertake assessments. That said, we then start into what we think is not going so well. Fundamentally, that is around accuracy, particularly. The evidence that came into our report, "Right first time", lays out some of that. It is also about not having access to medical reports and medical evidence, but taking it on face-to-face, very often when it is not appropriate or necessary. It is also about the contract itself being process-driven, rather than looking at the results of what is happening to those people as a result.

Q4 Chair: Could you explain that a little bit more to us?

Gillian Guy: We are not clear, and would like to be clear—maybe this is a question for later on today—what the key performance indicators are for the contractor in this contract, but we believe there are some perverse incentives about going to face-to-face assessments where, potentially, medical evidence could give that assessment and, possibly, with better evidence over a longer period. We also think there might be perverse incentives around people with variable conditions and how that is dealt with on a face-to-face basis. We have also identified that, although there are some penalties within the contract, few of them are exacted on the contractor for poor performance. We believe that, in terms of inaccuracy, there should be an additional penalty. When cases go to appeal and are successful, based on inaccurate reports and assessments, there should be a penalty there, to give an incentive to the contractor for accuracy. Our evidence is based on the high level of appeal successes, which is almost 40% of those going to appeal. About 60% of those go from no points at all in the assessment to being awarded ESA. That is quite a leap: that is not a fine distinction.

Q5 Chair: Is it different from the previous assessment?

Gillian Guy: In terms of how it used to operate? Yes, we—

Q6 Chair: Is a greater number going to appeal and is there a greater success rate?

Gillian Guy: There is a greater success rate and a greater span of that success, as I said. From nought to success is quite a significant leap. We have also seen a huge increase in the numbers of people coming to us—greater than through incapacity benefit—for

advice, on appeals but also on the initial assessment. Most alarming, because steps have been taken to try to increase the efficiency of the system, our statistics show that in the last quarter, July to September 2012, the number of people coming to us with ESA problems went up to 112,000—that is up 68% on the same quarter last year—and the number of people on appeals went up 83% on the same quarter last year. So our concern is that no matter what is said to have been improved, what is coming through our doors—I am talking about the problems coming to us—is actually increasing. In 2011–12, we saw 300,000 people with ESA problems, and between the start of ESA and 2012, we have seen 650,000 people, but we do not see any let-up; indeed, we see that increasing. There are many other things that both of us could probably go into in terms of the detail behind the process, but the key issues for us are about accuracy, not taking the medical evidence, being driven by the wrong end results—that being through process—and not being penalised for poor performance.

Q7 Chair: Thank you very much. Neil, you are appearing here on behalf of the disability organisations. It was very difficult to select who should come, but thank you for coming.

Neil Coyle: Thank you for the invitation. Gillian has covered many of the same bases as we would as a disability rights organisation. Very quickly, I agree that when ESA was being introduced, lots of disability organisations were saying, “This should be brilliant. It should see better support go to disabled people to deliver work outcomes. It should really change how disabled people are viewed”—the focus on capability rather than inability, if you like. But the delivery has been abysmal. We are inundated—Gillian has given the Citizens Advice figures; we have something like 170,000 or 180,000 people using just our online materials. The impact on disabled people, their families, local disabled people’s organisations, the tribunals service—

Q8 Chair: Just to make a comparison, the figure is 170,000 to 180,000 since the ESA. Under the old IB—

Neil Coyle: This is just this year. We would not have seen anywhere near that level for incapacity benefit under the Disability Alliance as was; Disability Rights UK was only formed this year. There is the level of concern coming from our member organisations as well. We have routine sessions with the Department for Work and Pensions. We have had local organisations come in to talk about the impact. That includes even the most tragic of circumstances, where people are believed to have taken their own lives as a result of being found fully fit for work and losing resources or other support—the knock-on effect. There is frustration. Poor risk or issue escalation was highlighted in the National Audit Office report. Citizens Advice and disability organisations have been saying from the word go that there are significant problems with the descriptors, the communications, the process and the medical information, as Gillian has highlighted.

That is having this massively detrimental effect on disabled people and on advice organisations, but also on public finances. We are looking at about £80 million-worth of avoidable public expenditure. To put that in perspective, it could fund more than 10,000 disabled people into work through Access to Work and make a contribution to the economy. At a time when disabled people are facing cuts to social care and cuts to other benefits, the dismissal of this as a significant area of public policy concern has been incredibly damaging. I should add a final thank you to the Committee and to the National Audit Office for highlighting what is a massive failure in public policy that, if it was replicated anywhere else, would probably have seen heads roll.

Chair: It is replicated elsewhere, I can tell you.

Q9 Mr Jackson: Have you been consistent in that view? What were you saying before this came along? Ms Guy said that from the CAB point of view she does not have a philosophical objection to the involvement of private sector companies or to the scheme per se. Has that always been your position?

Neil Coyle: When ESA was introduced, I was still at the Disability Rights Commission, so it is a slightly different perspective, but as I say, lots of disability organisations and, philosophically, I personally, I suppose, would say yes, we want to see better delivery of employment support so that disabled people actually get into work. But the work capability assessment is only one part of that, obviously. If you want to see the bigger picture, we are not seeing the kind of delivery into work that was estimated when ESA was being established. Of course the economic downturn is a factor in that, but there are significant problems around how the work capability assessment is working that have contributed.

Q10 Mr Jackson: In my constituency, I had over 1,000 people, in 2011, who had been parked on various benefits for over 10 years. Why did organisations like yours, and others, never persuade the previous Government to enter into any kind of final, ongoing programme to tackle that endemic problem, which is bad for them, bad for society and bad for Government?

Neil Coyle: I am not sure—perhaps I did not explain fully. Disability Rights UK, and other disability organisations that I have worked for, definitely support better support going to disabled people, to prevent that parking. Parking people on benefits obviously can have longer term health complications, including depression, for example—the longer you are out of work, the more likely you are to develop depression. We have campaigned for better access to support for getting into work, including things like Access to Work. That is one of the reasons why Disability Rights UK has welcomed the Minister for Disabled People’s statement today on Access to Work and some of the changes there. We would like to see better awareness, but actually we do support disabled people getting better support. We do not believe that the work capability assessment is delivering that because it is routinely failing to identify impairments in health conditions and their impact.

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Q11 Mr Jackson: I know it is a big piece of work, but can I have your general observations on the Harrington review—those of your organisation, and perhaps Ms Guy's as well?

Neil Coyle: We have welcomed Professor Harrington's work in the past. It has been limited in scope, if you want to look at how the WCA actually works in terms of the fuller process of trying to get people into work. We would like to have seen the Harrington recommendations implemented. When we looked at the last two rounds—obviously we know there is more tomorrow—only about a third had been implemented. In particular, there is the need to link up the front communications, if you like—the Department for Work and Pensions explaining to individuals what is going to happen, and the role that advice organisations like both of ours play in that—and, at the back end, the link between the tribunal and the original assessment, and why there is such a significant difference. It is unacceptable to say, “We'll keep burying £50 million, £60 million or £70 million of costs for tribunals” when, with a bit more information sharing, that cost could have been avoided and the assessment could have been done better first time.

Gillian Guy: We have welcomed Harrington, and we would welcome any review that makes this process more effective and more efficient. If the recommendations are not fully implemented, though, it has limited ability to succeed. I think the other thing to say is that, just because there has been a review, and just because there are those recommendations, that does not stop other organisations such as the ones represented here from having some significant evidence from the people who actually go through this process that ought to be taken into account as well. We would like to see us being taken into the DWP with Harrington and saying what should happen in order to make this more effective, and to stop parking, and all those other things that we see happening to our clients.

Mr Jackson: I am sure Mr Devereux will be listening to your words.

Q12 Austin Mitchell: Can you give us your views on the adequacy of the medical examination? We get a negative view, as MPs, but the people who have been coming to me—and I must say that there are a lot more of them—complain that it is not really a medical examination at all, it is a kind of tick-box thing, and that it is very perfunctory. I always advise them to go to appeal, and I notice in your figures that 38% of the appeals sustain the applicant and say, “You are not fit for work.” This indicates to me that the medical examination is not adequate.

Neil Coyle: Clearly, the assessment itself is failing very many disabled people. There are still people coming to us who, on the initial assessment, score zero points but, on appeal, go on to end up in the ESA support group. Clearly, there are big failures. Most recently, we had a local organisation deal with someone with total incontinence—no ability to control bowel or bladder—yet they were found fit for work. That clearly should not have happened. There are definitely problems there. We think that the time slot

available and the qualifications of the assessors are relevant, but also there is clearly a failure to collect the independent medical evidence in advance. The choice of the Department for Work and Pensions to reduce the time frame for that from six weeks to four weeks, unilaterally, without any consultation or any explanation for why that was happening, is likely to have had a detrimental effect on disabled people's ability to get that information in advance.

I am sure you are all fit and healthy and wonderfully active, but if you need to see your GP it can take two weeks just to get an appointment. If you have multiple conditions and need to see a consultant through a GP referral, four weeks is simply not enough. At Disability Rights UK, we support some of our members' views that there needs to be a requirement to get that ESA50 filled in in advance and there needs to be better information sharing from DWP on existing matters. If someone is coming from incapacity benefit, there will be a bank of information from former assessments that could be used to make an educated guess about whether this person needs a face-to-face assessment.

Q13 Austin Mitchell: It is basically a tick-box arrangement, in which you tick on a point. That indicates that it is fairly simplistic and perfunctory.

Neil Coyle: Yes, people definitely tell us that they go through it very quickly; they feel it is tick box. There are lots of people with rare or fluctuating conditions. We have had people with dystonia and aphasia who have asked the assessor if they had heard of their condition and been told no. There are significant issues there.

Gillian Guy: The statistics on the appeals pretty much speak for themselves. This cannot be an accurate and robust system if that number of appeals is being allowed. It is also a question of what gets measured, gets managed. If it is about throughput then it is going to be a very quick process and it is not going to detain itself with looking thoroughly at medical evidence.

The other thing is that medical evidence is not in the moment; it has a history to it. It is really important to go back to medical advisers and those who know the claimant and understand their situation. It is particularly an issue where it is a variable condition. If you hit a good day or bad day for your assessment, that will make a considerable difference. We have cases where people do not recognise themselves in the report, if they do indeed see the report, as is, of course, their right. They do not necessarily understand what is in there.

The other point is that these assessments can be used further down the line. Even if people qualify for ESA they may come to their disability living allowance assessment and find that the report can act to their detriment there, and again they may not recognise themselves. This has quite a profound effect, apart from the emotional effect it has on people, given the amount of delay there is before they even get what is quite a perfunctory assessment.

Q14 Mr Jackson: May I come back on that? Are you saying that the most problematic cases are where there is co-morbidity of physical and mental health? Or are

you perhaps saying—I do not want to put words in your mouth—that in your experience mental health issues are more difficult to spot and, therefore, give rise to higher levels of appeal success?

Gillian Guy: I am not a practitioner so could not fully say that. I would say that it is not just mental health issues that sometimes display themselves or do not depending on the timing of the assessment. If the condition is variable, whether physical or mental, there is a danger that there could be an isolated assessment that is not accurate.

Q15 Mr Jackson: I think the NAO report picked up an intimation of regional differences. In your experience and that of your advisers, would you say that it is the case that there is a regional disparity on these assessments?

Gillian Guy: We pick up differences that happen in regions, but I would not claim that they are regional differences. That is a nicety because there is not sufficient research based on the region. It just happens to be different.

Q16 Chair: When you look at that NAO figure—I can't remember, perhaps someone will point it out to me—the Bristol area appears to perform outrageously badly in terms of doing assessments in time.

Mr Jackson: And Bootle.

Chair: All of them. There is a whole load, down to Manchester doing only half in the time. It is page 22 figure 6. That does not come up in your casework?

Neil Sayers: I should point out, Chair, that is customers sent home unseen regional variances.

Chair: Okay. Sorry.

Gillian Guy: The issue we are talking about, we don't have strong enough evidence.

Q17 Justin Tomlinson: That was going to be my first point; I was going to refer to that chart based on experience. The other particular area is that the report implies that one area they do well on is dealing with complaints within 20 days. I would appreciate your experience of that. Is it that they are doing so in a comprehensive, satisfactory manner or is it somewhat superficial, just to meet that deadline?

Neil Coyle: I did ask for a bit of information from the Department for Work and Pensions—admittedly only last week—about how the Department is monitoring that. It would be good to go into a bit more detail and, hopefully, you will get more from the permanent secretary, but I did not get anything in advance. It would be helpful if advice and disability organisations were built into complaint monitoring, because, again, if you do not identify a problem and acknowledge that it is a problem, it is very difficult to address it and make the financial savings that I am sure everyone sitting round the table would like to see.

Q18 Justin Tomlinson: One further point is that you mentioned dystonia, and there are a number of other illnesses that are not particularly common, so it is not perhaps unexpected that an assessor or any medical person would not necessarily pick them up the first time. Are you finding from your experience of dealing with people who have not been picked up that this is

relatively common, and that therefore they have no choice but to go through the appeals process, because the knowledge was not there and there isn't the ability to pause the system?

Neil Coyle: It is, I think, partly about the individual assessors. You would not just get regional variations; even within one assessment centre, you could have two people with relatively similar conditions go in and get a very different assessment. It is based on the qualifications of the assessor. From the contact we have, member organisations as well as individual disabled people would say, "Yes, there is a lack of awareness of particular conditions and the impact of those conditions, particularly over the long term." Gillian has already made the point about fluctuating conditions, so, ME and MS are also relevant.

In terms of recommendations and where the Department for Work and Pensions might like to go, Australia has a slightly different system, in that it looks at reliably and safely performing tasks on a sustainable basis, which is a better link to work as well. The next independent review—it will not be Professor Harrington, but whoever undertakes that—could look at more international models and better identification of conditions. One final point is that had ESA50s been better used—the form that is supposed to be filled in with the independent medical evidence in advance—there would have been no excuse for the assessor not having awareness of a particular condition.

Q19 Justin Tomlinson: At this stage, if you come to me and I am an assessor who does not fully understand things, can I pause the process or do I have to make an educated guess?

Neil Coyle: You would make a recommendation to the DWP based on what you have seen in that time slot and ask the individual to provide more information to the Department.

Q20 Justin Tomlinson: So if I had had advanced knowledge, I could have then sought the information.

Neil Coyle: Yes. You may not even need to see the individual. Bear it in mind that Atos, certainly from the NAO report, still does not seem to be meeting the target of, I think, 15,000 a week. It was only 14,000 or something last year. People are being seen avoidably, as they may not need a face-to-face assessment. There is also a growing group of people who are contacting us saying that, despite being in the support group, they are being called in every six months for a new assessment. If Atos are not meeting the 15,000, why are people going through this revolving-door assessment, despite the fact that their needs and the impact of an impairment or health condition are unlikely to have changed?

Q21 Jackie Doyle-Price: I am trying to get my head around whether the holes are in the process being followed or in the execution. I heard what Gillian said earlier, but certainly, people who come through my doors with issues tell me stories about how the report that they get does not bear any examination compared with the experience they went through, and that effectively, there is a lot of form-filling. According to

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the report, in paragraph 3.9, less than 5% of assessments fail professional standards. What is your observation on that and how does it feel to you? Is it operational or to do with execution, or is it a flaw in the process?

Gillian Guy: The first point to make is that less than 5% conceals a very large number, so it is 5% of what that is important. That is not a good place to be in terms of “satisfactory” or “unsatisfactory”, which I think is the term used, and also, that does not particularly measure the quality. The other thing to say is that it is probably a mixture. I suspect that there are bits in the contract that could be tightened up. Indeed, with PIP, some of these lessons appear to have been taken forward, including the necessity for the assessors to have taken the medical evidence. So it feels as if there is an evolving learning going on here. I do not see why it could not be applied retrospectively. So in the contract we have spoken about where the incentives are, what the key indicators are, what is driving the performance and where the decision making is taken, which is an important point. When we looked at decision makers, we seemed to see that they are getting less empowered as we go through the process, rather than more, so the initial assessment becomes more critical. If it is being rubber-stamped, if I may use that term, then obviously it is critical to get it right in the first place. When we talk about accuracy, then that has got to be the people sitting there doing the assessment. If there are reasons for them not having the time to be accurate, which is something that we might want to delve into, then that is another issue with the contract.

Overall I think it is a mixture of the design of the service and its execution. I have to say that generally it does not matter to the claimants whether it is the contract or the execution, what matters is the impact on those people. If the DWP, as in this case, happens to be the person pulling the strings, then the responsibility to get it right has to lie there.

Q22 Jackie Doyle-Price: Indeed, and what Ministers have focused on is improving the process. Do you think that that is the most important tool, or is it really scrutiny of delivery that will deal with those claimants who are having very negative outcomes?

Gillian Guy: I think it is both, but I don’t know of any contract manager anywhere who doesn’t require both stipulations in the contract of what they need and then monitoring, to ensure that it is being performed. You don’t have one without the other.

Neil Coyle: Very briefly, 5% clearly masks the bigger problem that is around communications. There are many people who do appeal who do not have a case—they do not overturn the initial recommendation—so there is a communications issue there on the part of the Department for Work and Pensions about what has changed, which is the change from parking people on a particular benefit into something that is meant to be more supportive and meant to focus on capabilities. If there was only a 5% problem, we probably would not have seen the British Medical Association and the GMC stepping in and raising concerns about this particular process and the need for professionalism within the assessment. If things were improving, we

would not see, year on year, rising demand for both our organisations, the backlog in appeals rising and more people being recruited to hold those appeals. The Department for Work and Pensions estimates some half a million appeals this year, rising further.

Q23 Chair: I will bring Guto in but, to follow up on that, you both have big case loads of people coming to you on this. Do you have a feel for what proportion of people are too frightened to take a case to the appeal process?

Neil Coyle: Obviously, we tend to hear from people who feel that the process has gone wrong already, so perhaps there is an imbalance in some of the coverage, but there is a nervousness among many of our members—in particular, front-line advisers—around the requirement for reconsideration before appeal. That is probably causing more concern, because there is a belief, particularly because of the nature of some of the conditions of the disabled people affected, that people will assume that they are being told that they cannot appeal, rather than being told, “It might be better if you go for the reconsideration.” And of course, members are suggesting that reconsideration is not the best option for disabled people, because you do not get paid the same benefit rate.

Chair: Okay, I was going to go to Guto and then call this bit to an end, but go on Gillian.

Gillian Guy: I was just going to add that the number that might be more alarming is that of the people who do not come to us, because once they enter through the door for some advice they have a predisposition to complain and we would encourage them.

Q24 Guto Bebb: My first question is to the Citizens Advice Bureau. You mentioned at the outset a 68% increase in people coming to you and an 83% increase in appeals. Can you give us some background to or context for the numbers going through the system? Clearly, if there are more going through the system, you would expect more to be coming to CAB at some point.

Gillian Guy: What we do know is that, when we compare it with incapacity benefit, the numbers of people are not changing significantly. It is about 10 times the number we are seeing dropping off through incapacity benefit, coming through ESA. So it is not proportionate.

Q25 Guto Bebb: Not proportionate. In effect, there is clearly something wrong with the system, in your view.

I would like to make a second point. We have talked a lot about the appeal system, and when I have asked Ministers about this issue, they have argued quite strongly that the appeal system is part of the process. If a 38% appeals success rate is clearly indicating a problem, what sort of level of appeals would you expect to be acceptable? If there is a system, there will be appeals, because in any system you have to have an appeal process. What would be seen as acceptable to yourselves?

Gillian Guy: I am reluctant to be drawn on a figure that would be acceptable. I think the issue for us is, what are the grounds of the appeal that make them

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successful? If they are going from no points in an assessment to being successful, that hints at a large problem. If they are marginal shifts—and people will always have the right and might want to appeal marginal shifts—that is a different point, and that is the critical point for us in understanding that there is something fundamentally at issue before they get to that appeal stage.

Q26 Chair: That is quite a good question. The CAB deals with all sorts of tribunals. Is there a greater success rate here? Are there other areas of social security, or whatever, where you feel that the original system works better and therefore fewer people are successful in appeal? Just look at it comparatively to the other work that you do at the CAB.

Gillian Guy: In order to give you accurate figures, I would have to go away and produce those for you.

Q27 Chair: Just give us a feel.

Gillian Guy: I am giving you a gut feel, really, before I get you that evidence. This feels like a high percentage. If it was around 10% or 15%, with the caveat that it depends on the grounds for that, that would feel more comfortable.

Neil Coyle: I don't think it is reasonable to conclude that the appeals should be seen as part of this, given that people feel penalised and let down before they even get to the appeal. It is that initial recommendation that causes significant concern for families. And, of course, there is an additional cost. The payment to the Ministry of Justice for the appeals process should be taken into account as part of this. In terms of where we would like to see a baseline, again, I would have to go away and get the statistics to compare with other benefits. But where we see such consistent failure, appeal rates and consistently overturned decisions, that should be more of a concern. To make a quick analogy, the level of failure is one in seven of the initial recommendations being overturned at appeal. The G4S Olympic fiasco was based on the failure to deliver 17% of a one-off contract. Well, this contract is failing beyond that, year on year, and yet we do not see the same swift action to tackle that waste of public money.

Q28 Guto Bebb: Okay.

Just one final question to Mr Coyle. In my constituency surgeries, I come across a lot of people

who claim that they have been refused a home visit. Obviously, they have been asked to attend face to face after asking for a home visit. Do you have any figures in relation to people who feel that they have been let down by the system, because they have been refused a home visit?

Neil Coyle: No, we do not. It is good news that the Government are looking, for PIP assessments, at more home visits. That is welcome. It has been a problem for some. I would not have a figure off hand; I can try and get into those figures. But that is alongside broader concerns here about the Department for Work and Pensions' obligations under the Equality Act to make reasonable adjustments to this public function. That should be passed on to Atos and should include things like communicating with disabled people in a way that is accessible, be it Braille for a blind person, or whatever it might be—easy read for someone with a learning difficulty. The same for home visits. Home visits should be based on someone who cannot reasonably be expected to use public transport, for example. We have heard about cases like this. I believe that there is some scope for legally challenging how this is being delivered, but it is unclear right now whether the DWP has passed on all those obligations and requirements to make adjustments to Atos.

Q29 Fiona Mactaggart: Specifically on passing on the responsibilities of the Government under the disability discrimination legislation when public functions are being carried out by a private company, are you telling us that private companies carrying out public functions do not automatically bring with them the responsibilities to comply with disability discrimination and other equalities legislation?

Neil Coyle: They should, but it is about where—it is not in this report and it is not something that has had enough of a focus. It will probably take a test case to identify who is ultimately responsible, based on it being failure to have a home visit, and failure to provide an accessible letter up front to explain the process, or a reasonable adjustment at the point of the assessment.

Chair: Okay. Thank you so much. That has been really helpful. We will now attempt to take some of those issues up with our permanent secretary.

Examination of Witnesses

Witnesses: **Robert Devereux**, Permanent Secretary, Department for Work and Pensions, and **Dr Bill Gunnyeon CBE**, Chief Medical Adviser and Director for Health and Wellbeing, DWP, gave evidence.

Q30 Chair: Welcome. This is a much better room, I think, than Committee Room whatever it is that we normally sit in. Thank you for coming this afternoon. You asked us not to see Atos for various reasons and we respected that decision, but I also have to say to you than if, at the end of today, we feel that we need more information and a better response, we will be calling them on another occasion.

Good. Well, I am going to start off the questioning. Reading all this, it looks to me like you have a complete monopoly provider of these services. How, in that context, can you possibly assure us that you are getting either value for money or effectiveness? How do you assure yourselves, actually, and then us?

Robert Devereux: Okay. So we do have a monopoly supplier here. Remember, as was pointed out, the

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NAO Report was done quite a while ago. It has only come into the public domain post some of the FOI work, so quite a lot of the story has moved on since then. Perhaps I can just leap on to what we have been doing subsequently.

Q31 Chair: You could answer the question.

Robert Devereux: I am going to work back to it. We have a monopoly supplier. That was the case under the previous Administration, and it is the case under the current Administration.

Chair: It is not a political issue. This is purely asking—

Robert Devereux: It has taken us a long time, but we have now done it for the personal independence payment. We have grown a market where I now have 10 suppliers on a framework contract in order to help me provide medical services contracts in the future. We have used two of those suppliers for the PIP contract. So the big story is that we have changed this. You asked me how I am getting value out of my current supplier—the same way I do out of anybody who gives me a monopoly supply. I have a monopoly supplier for my estates, I have a monopoly supplier for my data centres. Not in everything in life do you end up with multiple suppliers simultaneously. In terms of how we are getting value, I am trying to manage that contract to make sure I know exactly what their performance is. The critical thing, which we are going to come back to time and again this afternoon, I am sure, is that we are seeking at all times to look at the quality of what is going on, even though in practice that is causing us some quite big issues to do with the volumes that we can clear.

Q32 Chair: We all too often hear about promises and the future. We are here to look at the implementation of this contract. I see they have been given a new contract: the new PIP contract. Although you may well be thinking about more people in the market over time, you have not only had a monopoly supplier since 2005, you have extended their contract until 2017.

Robert Devereux: 2015.

Q33 Chair: 2015—a 10-year contract. You have just awarded a new contract to them for a considerable amount of money. It gives me no great confidence.

Robert Devereux: You have just elided several things simultaneously there, haven't you? Fairly quickly after this contract was let in 2005, the Government of the day decided they wanted to introduce the employment and support allowance, and so we had to make a change to the contract to introduce that. Subsequently, Ministers wanted to introduce reassessment of all IB cases. It was that, more than anything else, that caused us to want to extend the contract. For policy reasons, the Government concluded it wanted to do more assessing of incapacity benefits.

Chair: I understand all that. Our real concern is—

Robert Devereux: But these are reasons why the contract was then extended. It is not just for lack of imagination.

Q34 Chair: But we've got a monopoly supplier getting a heck of a lot of public money. For example, let me just ask you, do you know what their profit margin is?

Robert Devereux: I do.

Q35 Chair: You do. Will you share it with us?

Robert Devereux: It is an open book contract.

Q36 Chair: Go on then, what is it?

Robert Devereux: You understand that information about profits is something I guard reasonably carefully.

Q37 Chair: Where there is a monopoly supplier, it seems to me that it is a matter of public interest to understand the gross profit margin.

Robert Devereux: Yes. If the Committee, for its own purposes and in confidence, wants to know the answer then in confidence I will supply it. You will understand that regarding the information itself, I do not really want to give away my position in respect of other bidders for other contracts in a public forum. My contract perfectly properly provides for me to inform Parliament, consequent upon my personal accountability to you, about what is going on, but not necessarily in an open session.

Q38 Chair: Okay. I don't know what the Committee's view is, but we do want that information.

Robert Devereux: Then I will supply it on the basis that you understand why I would want to keep it confidential and not to make it a public domain item. Otherwise it will not be a sensible thing to do in value-for-money terms.

Q39 Chair: It just seems to me that you have a monopoly supplier making money out of a public contract. There isn't even a case of commercial confidentiality because—

Robert Devereux: There is, because other contracts will be let. When those contracts are let, do I want other people to know what profit margin I am prepared to wear or not? The whole point of competition is to get people to bid to me, blind to what their competitors are doing, and blind to the knowledge of what they might be making on their profit margin.

Q40 Fiona Mactaggart: But surely the best form of competition is when everybody knows what margins everybody else is making and therefore you can get the best deal?

Robert Devereux: That is not the way the economy works, is it? Do you tell your builders—

Q41 Fiona Mactaggart: It is the customer against the cartel.

Robert Devereux: Sorry, but who is the customer here? The customer here is the taxpayer. All I am asserting is that in commercial negotiations with companies, it would be wise not to put every bit of information into the public domain if you want me to run that competition wisely.

Q42 Austin Mitchell: But surely, too high a profit indicates that the conditions set by you for the performance of that contract are too lax.

Robert Devereux: Too high—

Austin Mitchell: You appear before us quite often as the defender of these private enterprise organisations, put in to run state functions, which are inadequately supervised. The contract is inadequate and you defend it until we press you, as on the Work programme. You then tighten up the performance. So a high rate of profit indicates that you are not tightening it up enough.

Robert Devereux: I am not aware that I have disclosed a higher rate of profit, so we are arguing on a false premise here. You have asked me the rate of profit. I have told you that I know it and that I am prepared to supply it confidentially.

Q43 Chair: From the reports I have seen in the press, one is that they made £42 million in 2010 and that they paid Keith Wilman, who runs the contract on your behalf, £800,000 and he got a 22% pay rise in 2009. So that is what is in the public domain.

Robert Devereux: Since the public domain figure for the contract costs is in the order of £100 million, are you asserting a 40% profit margin? I can guarantee you without any commercial disclosure that it is not that.

Q44 Chair: When I looked it was about 20%. That is what I figured out from the various bits. But they did pay their guy for running this business in the UK £800,000 and he did get a 22% pay rise in 2009. This is all out of public money, and we are always concerned about issues like that.

Robert Devereux: I am not aware that there are limits set on what somebody should or should not earn in the delivery of commercial companies.

Q45 Chair: Interestingly enough, there has been quite a lot in the press about the BBC director general and what he was paid and gets paid off. There is a concern. Where private companies make money out of public contracts—I say this so often—there is a completely legitimate concern, particularly on the part of this Committee, to protect the taxpayer's interests. That includes what the return to the individual is.

Robert Devereux: So I have a contract which makes it open books, so I know what the profit margin is.

Q46 Chair: But you don't know what Mr Wilman gets paid. Maybe you do, Dr Gunnyeon.

Robert Devereux: No, what he is paid I am sure we know. I am not sure quite where this conversation—this is a £100 million contract. The profit margin is a material sum.

Q47 Chair: I'll tell you why it is relevant. It is relevant because you worry about whether this is a contract that is providing value for the taxpayer.

Robert Devereux: Shall we move on to what value it is providing, rather than starting with the case that it is false?

Q48 Mr Jackson: Mr Devereux, perhaps I can be helpful. I agree that we cannot question you on the basis of anecdote and other programmes; we are here to look at this programme specifically.

It is fair to say, because you conceded it yourself, and it is in the NAO Report, that prior to summer 2011, the management of the contract lacked sufficient rigour. In order to move on and to try to be helpful, in what ways have you addressed that issue so that better value for money has been delivered for the taxpayer since then?

Robert Devereux: A normal part of my Department's operation, as you would imagine, is an internal audit function, which is going round and seeing what areas might be at risk, and checking on them. You cite September 2011, and I have brought the document with me. My internal auditors alight on the particular contract, look at how it has been operated and make suggestions about it. One thing they observed was the way in which the governance was operating in terms of who was meeting where, what were they talking about, were they the right things to focus on, and could they be tightened up. We have done precisely that, and we now have a system in place. Previously the internal auditors were saying that the executive board had not met for six months or so, but it has now met every month since the report came out. Similarly, and contrary to some of the phraseology, it said that although there were audit trails in place to make sure that what was paid to Atos reflected facts that we knew, we could tighten up on that, so we have done precisely that.

Q49 Chair: Do you now check invoices?

Robert Devereux: We were checking invoices previously.

Q50 Chair: The suggestion was that you were not.

Robert Devereux: I have the National Audit Office's own words, and they do not say that we were not checking. It said that the validation of Atos invoices performed by the commercial management team at Norcross had included verifying the correct unit costs were charged. Verification was going on, according to the National Audit Office. So what we have put in place is to make sure that a representative, controlled sample of every month's invoices is now gone through in great detail and checked back to our own systems.

Q51 Chair: How many do you check now?

Robert Devereux: For the months of May, June and July, I checked 139 invoices in May—¹

Q52 Chair: One hundred and thirty nine.

Robert Devereux: Invoices. Yes.

Q53 Chair: Out of how many?

Robert Devereux: I don't know, but enough to give me 95% confidence in the answer. The statisticians decided that that was an appropriate level.

¹ Note by witness: The figure 139 refers to cases checked. A statistically valid sample of 139 cases is selected each month for ESA/IBR assessments to validate the value and type of payments made to Atos.

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Q54 Chair: My guess would be that in a month—

Robert Devereux: You have no idea what the numbers are, because they might bill me monthly.

Q55 Chair: We know how many assessments they do a year.

Robert Devereux: Yes, but they do not bill me per assessment. Perhaps I can finish the story—137 is a valid sample, as proven by my own auditors.

Q56 Chair: Well, I think we need information as to the basis.

Robert Devereux: I will happily tell you what the basis is.

In May, in June, in July, and in August, not a single one of the sample that we took had any incorrectness in it. Not a single one, so when I sat here previously and—as Mr Mitchell correctly said—said we had been through some history back in the early part of the 2000s when employment contracts were sending invoices that, with the benefit of hindsight, had not been properly validated—

Q57 Austin Mitchell: You haven't put in the provider assurance teams that you have on the Work programme.

Robert Devereux: No, I haven't.

Q58 Austin Mitchell: Why?

Robert Devereux: I am coming to that, but I am trying to answer the questions one at a time.

On invoice checking, the evidence of the last four months is that every single one of the representative sample that I have checked has been perfectly correct. I think we should be pleased about that, Chair.

On provider assurance teams, there is a more general observation in the Report that a lot of the performance data comes from Atos, which we then manage against, and the challenge is to say why we would not quality assure that information directly, rather than taking its word for it. As I say, there is one spectacular example in the invoices, and its word is right. However, I accept the point, so we have done the following. We have a range of contracts, and provider assurance teams—we went to great length on that with the Work programme—are pretty much top of the range when it comes to what we do here, so I have asked my head of procurement to look at all our contracts and to ask whether those provider assurance teams could play any role on those contracts in a similar fashion. That is the work he is doing now, so my expectation is that you will not find us having to rely on other people's QA-ing of our own data.

Q59 Austin Mitchell: I accept that. Just to round off the earlier discussion, are you saying, as Peter Mandelson would put it, that you are totally relaxed about the rate of profit made by private firms taking over public functions?

Robert Devereux: No, I am not totally relaxed, because I know what their profit is, and in my professional—

Q60 Austin Mitchell: You may not be totally relaxed, but you do seem very relaxed.

Robert Devereux: Then I am giving the wrong impression. If I let a commercial contract to a commercial company, oddly enough it expects to make a profit. Short of that ground rule changing, there will be a profit. My commercial colleagues, who are well experienced in this, therefore have a judgment to make as to whether that is a reasonable amount of profit, given the nature of the market and the nature of the service. That judgment is that it is a reasonable level, and I am prepared to go with that. I am happy to explain that in more detail in a confidential note, but I do not want to read it in the newspapers—

Q61 Austin Mitchell: There are far too many occasions when we have found that commercial companies, with their greater legal and actuarial expertise, have been able to run rings round the civil servants negotiating the contract with them.

Robert Devereux: Well, okay; fortunately, I have one of the best procurement people in government working for me.

Q62 Chair: You need to convince us about that.

Robert Devereux: Since he is head of the international procurement body, you might at least give him some slack for being competent.

Q63 Chair: I don't even know who it is.

Robert Devereux: David Smith. You will recall him from when you were there.

Q64 Chair: We haven't seen him—has he been before us?

Robert Devereux: I am sure he would be delighted to come. Shall I whistle him up now?

Q65 Chair: Maybe the next time we look at the Work programme he will come.

I have got some value-for-money issues remaining, because on the PIPs contract—the £238 million contract—I understand that there, sub-contracted to Lanarkshire, has been all the £20 million of it. What makes you sniff, I suppose, if you are me, is: why are we, the taxpayer, having to pay double? We presumably pay a profit element to Atos, and then it passes on to NHS Lanarkshire a contract where it will make a bit of money. You are then left worrying that there is too much slack in the contract—a bit too much profit. Can you take us through that, please?

Robert Devereux: Okay. We did have some interest from NHS trusts in this contract. At the end of the day, none of them bid directly, in part because the PIP contract is unlike the one we are talking about now. We have made a series of changes to the nature of the contract, so, in the particular, we do not have any payments being made to fixed costs in the PIP contract. Everything is based on outputs, so there is a degree of risk, if you bid for this contract, that there would not have been previously. So you have to have somebody who is prepared to shoulder that risk, and by inspection—since it actually did ask about this contract, but did not bid—the health trust did not want to carry that risk. So, if somebody is standing in between them and me—taking some risk off me and

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standing between the health service—I don't count that as paying double.

Q66 Chair: With this open contract you have, do you understand how much profit it makes out of the Lanarkshire business?

Robert Devereux: You are talking about the prospective PIP one.

Q67 Chair: Yes. Well, it is one that is mentioned in the Report, as well.

Robert Devereux: We may be talking at cross purposes, then.

Chair: Okay. Well, I have clearly picked it up somewhere.

Robert Devereux: I think it is prospective, so I do not know—

Q68 Chair: But you have agreed the contract with Atos on PIP.

Robert Devereux: I have agreed the contract with Atos and with Capita in their different regions, so I dare say, actually, we know what the financial model profit level is in that. I do not have it in front of me.

Q69 Chair: And you can let us have the details of that so that we can satisfy ourselves that the value for money in the sub-contracting, relative to your assertion that it is a transfer of risk, is appropriate for the taxpayer.

Robert Devereux: I am just trying to see how you would do that calculation from information that I hold. I was answering a different question. You wanted to know why I had not contracted directly with the health authorities, and the answer is that they did not bid. They did not want to carry the risk.

Q70 Chair: No, I said how it looks to me if you pass a contract to an organisation and then it passes on a sub-contract. Do you think there is a double profit element in that?

Robert Devereux: If they were adding no value, you would be absolutely correct that in order to bid for this contract—

Q71 Chair: Well, that is what I want you to demonstrate to us, really. That was what I was asking.

Robert Devereux: I will happily write you a note about that.

Q72 Guto Bebb: Can I take you to the issue of the appeals process, because obviously in terms of value for money and a contract that is performing well, I would accept the arguments made by Ministers that there is a need for an appeals process. The question, really, is whether having a level of 40%, almost, is acceptable. What is the cost to the Department of such a level of appeals within the system?

Robert Devereux: In paragraph 3.10 on page 25 of the Report, the National Audit Office comments on the appeals—I thought it put this pretty fairly—that “The level of successful appeals...is often viewed as a measure of the quality of medical ...work...There are dangers in such a comparison”. My view is that the numbers of appeals are too high and that the

numbers of appeals that are succeeding are too high. I share the NAO's view that you cannot simply make the assertion that that is a problem to do with Atos. Shall I expand on that?

Guto Bebb: Yes, please do.

Robert Devereux: The tribunals stand at the end of a process, which is the consequence of all the laws you have passed, the procedures my own staff operate and the contracting out to Atos of a well-defined test, defined by my top doctor. The question you have to ask yourself is: when it gets to the end of that process, and an appeal is upheld and it comes to a different conclusion, what is happening?

Just today—I do apologise that it is today, but the PAC timetable wasn't in mind when this was planned—we have published the first information we have had back following some work we have been doing with the tribunals since July. Since July, we have managed to agree with the tribunal judges that they will give us a principal reason why they have overturned the appeal in order for us to begin to understand what goes on. Their previous practice was sometimes to say as little as, “I've upheld the appeal,” or, “I've turned it down,” and to give us no information.

Some information was published at half-past 9 this morning, which went through all those appeals. If I just stick with ESA for a moment, there were 13,000 appeals in the period from 9 July to 31 October, and in about two thirds of those cases the judges used the little drop-down menu they have to come up with a principal reason. In one third of the cases they did not use the tool. With the figures I am going to cite, I could gross them up as if they were the whole lot, because it is easier to do the percentages. Forgive me; how would you like me to present this? The published figures I have in front of me are expressed as percentages, but the last third have no reasons associated with them at all. Do you want me to allow for that?

Q73 Chair: So you mean that in the ones that do have a reason, the proportion—

Robert Devereux: Adds up to only 66. So shall I express it as if it adds up to 100?

Chair: As a proportion of the 66.

Robert Devereux: Okay. I will have to do some arithmetic as I do this, so bear with me.

In about a third of all cases, the judges are saying, from their drop-down menu, that they reached a different conclusion on substantially the same facts. So in one third of all the appeals on which they are reaching a different view, they are saying, “We have reached a different view on the same facts.”

In around 60% of the cases, they are saying that they reached a different view based on oral evidence presented at the hearing. You will recall that these hearings are, regrettably at the moment, a long time after the event, and whether the condition of the person at the appeal is the same as it was at the test is something we do not know. But then, last of all—this comes back to the question you asked me—when the medical assessment relied on by the decision maker from Atos contained a significant error—

Q74 Chair: And that was in what proportion?

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Robert Devereux: Less than 1%. I am thinking: here is a piece of evidence—all right, it is only one piece of evidence—and, as I said, this is the primary reason they are adducing—

Q75 Fiona Mactaggart: But you said that 30% came to a different conclusion on the same evidence, which means not necessarily that the evidence they have received is wrong, but that the judgment of the Atos assessor has been wrong.

Robert Devereux: Except that the judgments are made by my staff, on the basis of the Atos assessment. Decisions in this Department are made by decision makers.

Q76 Chair: So your staff are incompetent, are they, in a third of cases? You are taking the blame rather than Atos. Is that it?

Robert Devereux: I am not saying that, but we have to be really clear about this, because this was precisely the reason I asked about who was going to appear. The thing that we are looking at is a process based on law and decision makers in my Department, with the contracted-out tests designed by my doctor. I am really keen to be very precise about what evidence there is about what Atos is doing, what the Department is doing, and what the failings in the process are.

I am sure that we will come on to Harrington and all the evidence he has produced about the system. But this business about what the tribunals are saying is only one of probably six different things that give me a general sense about where the Atos testing is, so let me try them quickly on you. We invite our decision makers to send back a report if they don't think they can work with it because it doesn't have the right information on it, and we set a target with Atos that it is not expected that more than 1% will be sent back. They send back 0.1%. The individuals going through this assessment can ask for a copy of this report, and there is a complaints process to Atos. The total number of people who complain to Atos about anything—even including the report—is less than 0.6%. If I compare that with the complaint levels to the GMC at 3.5% and to the Dental Council, which is 1.6%, that is not out of order. I can then say, actually, that even before we got to this drop-down menu with the tribunal, there was already a system in place—it goes under the slightly spy-movie title of protocol 10—by which, having heard the case and made the decision, the tribunal is invited, if they think the report was so shoddy as to give a material cause, to send it back to the Department. We've had 23 back.

Q77 Chair: I can't find the figure now—maybe I can be helped by the NAO—but how many decisions do your decisions makers overturn a year? There is a figure somewhere in the Report about how many are overturned by the Department from Atos's recommendation. You must be able to help me on that, Mr Devereux.

Robert Devereux: I think it is 6%—

Q78 Chair: How many—is it 200,000? What is it? I will find the figure somewhere.

Robert Devereux: Is this the thing that you put into the newspapers?

Q79 Chair: No, it is in the Report. The assessors overturn the Atos view on how many decisions? I will find it somewhere.

Robert Devereux: It is in the key facts paragraph on page 4—well, there is at least one 20,000 there, so that might be the one you are talking about. This is, indeed, to do with quality, and what we have already been discussing is that within the contract itself, there is a threshold that says that I do not expect to see more than 5% of the reports—

Q80 Chair: Here we are—it is 44,000. Sorry, this is from a PQ that I saw. The DWP overturned Atos's recommendation on 44,000 occasions in less than two years, so we find that that is before—

Robert Devereux: Hang on a minute. I have just been told by a colleague—

Q81 Chair: Hang on a minute; you just produced new figures to us. All I am saying to you is that—

Robert Devereux: I am quoting the number in the Report.

Q82 Chair: No, you produced new figures from an analysis—very helpfully—of what happens in the tribunal system. Before it ever gets to tribunal, we find 44,000— Maybe Dr Gunnyeon can come in; he ought to know these.

Robert Devereux: I can explain this, as I suspect that this is the 6% that we just talked about.

Q83 Chair: Is it? Is that 44,000 individuals?

Robert Devereux: A moment ago, your colleague was implying that because it was reaching a different decision on the same facts, it was the fault of Atos. I said that my decision makers make those decisions.

Q84 Chair: Are your decision makers doctors?

Robert Devereux: No, they are decision makers, because the—

Q85 Chair: What is their background?

Robert Devereux: They are social security staff and—

Q86 Chair: They're what?

Robert Devereux: They are my staff. They are just ordinary—

Q87 Chair: But they haven't got a medical background or anything like that.

Robert Devereux: With respect, the decision that they are making does not need them to be a doctor. If I had to have doctors to do that, I would get doctors, but can I just finish answering your question? You were implying earlier on that, somehow or other, whatever Atos does just gets ticked through. It does not get ticked through because the decision makers look at the evidence and make a recommendation. I am fairly sure that that 44,000 will be the number of cases when Atos has recommended course A, after which the decision maker has produced a different answer. That is evidence—

Q88 Chair: What else will the decision maker look at apart from the medical assessment when deciding? Either you are fit or you are not fit for work, or you are—

Robert Devereux: I am afraid—

Chair: Neil, have you got something that you want to add on that?

Robert Devereux: The decision maker is not simply reading a report that says yes or no—

Q89 Chair: But the decision is based on the medical condition of the individual, and therefore their fitness for work.

Dr Gunnyeon: Perhaps I can help the Committee. I think that what you have to remember is that the health care professional is taking into account the evidence that the claimant has provided on the ESA 50, and any further medical evidence provided from the individual's health care professional when doing the independent, objective assessment part of things. All that information is then available to the decision maker. The Atos health care professional makes a recommendation—

Q90 Chair: I don't understand. Let's bring a bit of common sense and not bureaucracy into this. Making a decision about whether somebody is eligible for ESA or should go back to work must be on the medical evidence. What else do you have regard to apart from that?

Dr Gunnyeon: Indeed, but the role of the decision maker is to check that all the evidence has been considered; that the conclusion that the health care professional has reached appears to reflect all the evidence; that the health care professional has taken into account the evidence; and that the health care professional's recommendations are then applied correctly to the descriptors, which is the basis on which points are awarded, which determines entitlement to benefit.

Chair: Frankly, that's gobbledegook. Complete gobbledegook.

Q91 Mr Jackson: Yes, I do not understand that. It is not wholly your fault, because, in a sense, it is the NAO Report's fault as much as anything else. If you look at page 25, paragraph 3.10, it actually mentions, without specifying, the danger of extrapolating too much from this 38%. "There are dangers in such a comparison; an appeal may be successful...In addition, a decision made by the Department on benefit entitlement will draw on other sources of information as well as the medical assessment." You have not told us what that is, and the NAO unhelpfully has not told us what it is, so I think the Chair is right to ask about those other factors that inform your decision, because that would be helpful to all of us.

Dr Gunnyeon: It is not infrequently the case that, in spite of attempts to get further medical evidence early in the process, it has not been received at the time the assessment is done, or indeed even when the decision maker is considering it. The decision maker then has an opportunity to seek further medical evidence.

Chair: But the decision maker is not a doctor, or is not a health care professional.

Q92 Mr Jackson: It does not matter if they are looking at other evidence.

Chair: They are looking at medical evidence.

Dr Gunnyeon: But there may be other evidence as well that is relevant, which the individual will provide, and sometimes this happens. One of the things that Harrington recommended, which has been introduced into the process, is a call from the decision maker when they have reached a decision. That gives the individual an opportunity to indicate that there is other evidence that they would like taken into account. In addition—

Q93 Mr Jackson: Like what? Give us an example.

Dr Gunnyeon: It may be that, for example, they have got evidence from the general practitioner, but actually they perhaps have a mental health problem and their community mental health service's community psychiatric nurse actually knows more about them on a regular basis.

Q94 Chair: But why did the Atos professional not do it?

Dr Gunnyeon: The whole point about this process is to make sure that things are picked up if they are missing.

Q95 Chair: Why did the Atos professional not deal with it?

Dr Gunnyeon: It may be that the individual did not indicate who that individual was. The one source that is almost always provided is the details of the general practitioner. It can be very difficult to get information about other health care professionals.

Q96 Meg Hillier: I represent a number of constituents with particular issues. We are looking at value for money, but that also means the service to the constituent. Let us focus on mental health for the moment. Many of my constituents with mental health problems—I have a very high incidence in my constituency—really want to work, but they need recognition and understanding that they cannot always work full time and that there are a lot of issues.

One of the interesting things to me here, with all this procedure that you can go through in endless detail, is that the experience for the individual is often humiliating. It is cumbersome, and if they knew what they could present at the initial hearing with Atos Healthcare providers, they would do that, but they have gone along with often very false impressions and thinking that they are going to have a chat with a doctor and that it is going to be supportive. They have told me about their feelings of humiliation, particularly the people with mental health problems. Many of them would provide that information, but I do not think they are aware—I was not aware until now—that you could provide that information right at the beginning. Would that not smooth the line and stop all these reassessment costs?

Dr Gunnyeon: And there have been changes along the way, including through the ESA50 form that the claimant is asked to complete, which now makes that much clearer.

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Q97 Chair: To whom? To the individual?

Dr Gunnyeon: To the individual.

Q98 Meg Hillier: The problem is, every time you can add something in, it is good, I suppose, but it is costly and time-consuming and it does not make it good value for money. It is to do with the framework and the way in which the Department has set it. I take what you say, Mr Devereux, that the Department has to take some responsibility, too, but the framework has been set to make it as complicated as possible. While there may be checks along the way, those checks are overused, because if it was done better in the first place, my constituents would not have to go through this pain of constant reassessment, appeal, tribunal and so on.

Robert Devereux: When the legislation for this new benefit was passed, Parliament required, perfectly properly, that it was subject to an annual review as to its efficacy by a leading physician, Professor Harrington. By the way, his third report is out tomorrow and will deal with mental health issues, and fluctuating conditions in particular. Consistently, he has come back to say, "How can I make this process go better?" This is actually quite a complicated thing to do. If anybody thinks that medical testing of benefit claimants is a walk in the park, it clearly is not. On successive occasions, Professor Harrington has come back to us. In his first report, he said, "I think it would be good if the Atos assessment itself wrote a paragraph in English that just explained in words of one syllable why it has reached its conclusion." Prior to that, that was not a requirement. We put in this individual assessment to try to make sure that the individual, at least, could read why the doctor had reached the conclusion they had. We put in calls to people before the decision is made to make sure people understand what their evidence requirements are.

We are trying to improve things. I agree with you: I do not want to do this by adding lots of extra steps, but you cannot turn round and say that the Government have not been trying to have independent reviews of how this is working. Pretty consistently, Professor Harrington is saying, "Look, this would make an improvement, but you paid attention to what I said last time, and things are getting better. You need to keep on this track." To go back to the Chair's point, one of the things he has been particularly interested in is making sure that decision makers—proper decision makers—feel empowered to make decisions based on the collection of things in front of them. If it has been your perception that this is a pure medical test, and all you need is the doctor before you get benefit, end of story, we are all under a misapprehension about how benefits are determined, and we had probably better drop you a proper line to explain why it is that decision making is best divorced from the doctors.

Q99 Mr Jackson: You have made a fantastic job of making something negative when it could be potentially positive.

Robert Devereux: That is not my role.

Q100 Mr Jackson: Actually, what you are saying is that this is not a robotic process, in which a computer says no, which is something our constituents might not agree with. What you have is objective criteria for the strict medical assessment, but as a fail-safe—this accounts for the 37% figure—you also have subjective criteria added into the mix when the assessors make a decision. That is quite a good news story, because it means that there is an element of fairness in the process, or am I being a little naïve?

Robert Devereux: I bow to my doctor colleague. I am not going to split hairs over whether a medical condition is an objective or a subjective one, because it is quite difficult to test some of these things in an objective fashion, particularly fluctuating conditions. None the less, we are trying our very best to set out very clearly, as is done in legislation, what the conditions are under which we might decide you have the capacity to work. That is in a test that has been peer reviewed and that has been tested to the last dot—the right sort of test. Professor Harrington has not said, in his first two reviews, "What a complete waste of time. You made a really bad job of that. I'd start again." He has actually been saying, "It would be better if, in this part of the process, we wrote a paragraph" and "It would be better if, in this part of the process, you rang people up and explained things a bit." He is talking about smoothing through a process that could be improved. We did some work on the descriptors, and he was pleased. Progressively, we are trying to make things better, but I do not think it comes down to a "Doctor says yes, computer says yes, off you go" benefit, because that is not how it works.

Q101 Chair: You will have to drop us a line, because I do not understand the point about the assessor. They are presumably in a Jobcentre Plus office—is that right?

Robert Devereux: No, it is in the benefits system.

Q102 Chair: I do not understand what other information is involved. Just going back, you overturned 44,000 recommendations just between May and December 2010.

Robert Devereux: "Overturned" is a very pejorative word, Chairman.

Q103 Chair: Well, you did overturn the recommendations.

Robert Devereux: No, we reached a decision that was different from what the Atos doctor—

Q104 Chair: You overturned the recommendations. There are two things, actually; we are getting a bit muddled. There is the second chance with the assessor, and then there is the appeal process. First, you get assessed by the doctor. You then get assessed by some DWP assessor sitting somewhere anonymously. You then have an appeal process. We found that, between May and December 2010, 44,000 recommendations—it may have got better—were overturned at the second stage, and 38% were overturned in the appeal process.

Q105 Meg Hillier: It seems to me that when local authorities privatised the IT system behind housing benefit, the assumption was that because the private sector, not the public sector, produced IT, the system could be privatised—problem solved. What that did not take into account was that human beings were in the mix. I am slightly worried, Dr. Gunnyeon—I am not second-guessing your professional qualifications and skills. Assessing people for work is not a new system: occupational health exists across the board in the public and private sectors; and the DWP has done this work before. So it seems to me that even though Robert Devereux says the changes being proposed by Professor Harrington are minor, they could have been better written in at the beginning. You still have this very costly system that you have been operating now for a while, which puts cost on the taxpayer and which humiliates many of our constituents who are having to go through this very long-winded process, when actually—whether it is a good or bad decision for them, one they agree with or not—swifter, generally speaking, has to be better, surely. It's putting people through the mill, or through the ringer.

Dr Gunnyeon: I think you are absolutely right in that assessing fitness for work is not straightforward and the assessment is not—

Meg Hillier: Nor is it new.

Dr Gunnyeon: Stay with me a second. It is not a tick-box assessment. That is one of the challenges, because there is a significant element of judgment and opinion by the health care professionals and that is why their training is quite critical to this, because it is clearly very important that they think about the individual. That is because this is about the impact of an individual's condition on that individual's capability for work. So there is huge individual variation as well. One of the real challenges, because this is an assessment for entitlement to benefits, is to try to ensure that irrespective of where the individual is in the country and which health care professional they are seen by, for the same condition that has the same impact they will get the same outcome. That is a huge challenge, and one of the difficulties in this whole process is managing to set out something that can be encapsulated in a way that can be consistently applied to individuals across Great Britain by a whole range of different health care professionals, and that can provide a basis for a legal appeal.

So, not only do we have the challenges of an assessment that has to be robust from a professional point of view—that is clearly one of my challenges—but in addition that assessment then has to be able to be converted into legal language that will actually work on appeals. And it is incredibly difficult. It is much more difficult than many of the less challenging assessments that may be made about fitness for work, which are not subject to the same level of scrutiny. This whole assessment is heavily scrutinised. An opinion from a doctor or a nurse in general is not subject to the same challenges that this assessment is—going through a whole appeals process, and so on. So we really have to make sure that it can be applied consistently, and that is one of the challenges.

Robert Devereux: One quick point: I don't want to give you a sense that Bill sits in a room and makes

this stuff up, good as he is. The process by which this difficult assessment was brought to fruition was done with the help of all the sorts of people you would expect in good open policy making.

Q106 Chair: That is why you have got to watch all this, because the BMA, in its annual conference, voted against; it said it was a whole load of r-u-b-b—as I remember.

Dr Gunnyeon: Indeed, but I think, to be fair, we have actually had very constructive discussions with the BMA. And the BMA, to be fair, has been involved over the years, as you, Chair, probably remember yourself from way back. The BMA has been engaged constructively. We met the BMA recently, the Minister met the BMA and the BMA is very keen to work with us to help try and ensure that its input is properly captured. So I am hoping that we will have a more positive view—

Chair: We will come back to the BMA a bit later, perhaps.

Amyas Morse: I just want to ask about something. We made a remark that you should not necessarily regard successful appeals or the level of appeals as indicative of something. But just going through some of the evidence we have heard, the witnesses before you came in suggested that their experience was that there was a reasonably high level of appeals where the Department has scored the claim as more or less zero and they have actually gone up to really quite high scorings. Are you aware of that? I don't want to introduce evidence at the last moment, but are you aware of that and are you aware at what level that is happening, and do you think it's significant, may I ask?

Dr Gunnyeon: What you have to remember is that a tribunal often takes place quite a long time after the original decision has been made. The tribunal is looking at the individual many months on. Now, although they are there to assess whether the decision that was made at the time was right, if the individual's condition has not resolved or indeed has progressed, that will inevitably have an influence. The individual themselves will have had time to reflect upon the decision that was made. There are all sorts of things that can influence it. At the same time, there will be cases where we did not get it right, which is the whole purpose of the appeals tribunal. We have tried to learn over time, which is why we did the internal review of the assessment relatively early after the WCA's introduction. There will also be cases where the assessment has not properly captured certain conditions, so there will be elements of that as well. I suspect that there will also be not an insignificant proportion of cases where it is a combination of the individual appearing in front of the tribunal, where the individual's condition may have moved on and where the individual themselves may have thought about it, and the potential for the tribunal to reach a different decision. When they do that, they then allocate points as they see fit.

Amyas Morse: Just to complete that, the other point that was made to us around that was that perhaps the initial assessment was made without a great deal of supporting material and in a pretty rapid interview.

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You might take these relative changes in scores as being indicative of question marks about reliability of the initial appraisal.

Dr Gunnyeon: Certainly further medical evidence, if it was not available originally, will be a factor, and that is why one of the things that we are focused on is trying to get further medical evidence, where appropriate, at the start of the process, where it can actually be taken into account.

Amyas Morse: You would prefer it to be at the start.

Dr Gunnyeon: Yes.

Robert Devereux: It is really important to have a scale question here. We cannot possibly sit in front of you and say that, with 150,000 applying for the ESA and IB reassessment every month, we will not find some cases like this. Having read out six lots of statistics that give you some sense that, quality wise, the Atos contract is doing the test that Bill designed, I am trying to invite you to work out whether the cases that you are hearing, which are bound to be the ones you hear about because they are the most startling, are not actually the ones for which you really hope that the system runs—

Q107 Chair: Jackie wants to come in here, but I just have to come back to you on that. They are not the ones that we are hearing about. We all get them in our constituency surgeries. It is the fact that you overturned so many and the fact that so many are overturned at tribunal. That is a massive number. You know this, Mr Devereux.

Robert Devereux: I have tried to explain—

Chair: You know that they will not go. There are a lot of people who will take it. I can tell you from my constituency that many people are too scared to tackle the system and will not take it to tribunal.

Robert Devereux: I have just told you that the judges themselves are saying that they are making a different decision to my decision maker in a third of the cases.

Q108 Chair: The decision is wrong. It does not matter why. The decision is wrong and gets overturned.

Robert Devereux: I am sorry, but I am afraid that you cannot do it like this. We have a test in place. The tribunal are saying that in a third of the cases that they upheld—let alone the ones that they dismiss—they actually have not argued with the evidence and just reached a different conclusion. In those cases, you have to be careful about adding up all of these percentages and saying that there must be something obviously wrong. That is not the obvious answer at all.

Q109 Fiona Mactaggart: What we are asking is, Mr Devereux, is what is wrong in your Department and not in Atos?

Robert Devereux: What I have been trying to say to you is that this is a complex process, which, according to the way that Parliament passed the legislation, we have consistently had independent review of. The last two reviews—the third comes out tomorrow—have made positive comments about what we have done to try to make this as good as possible. They do not include simply ripping it up and starting again. I

suggest that the Committee look at what Harrington publishes when the review comes out tomorrow, because he will be saying other things about the Department's process. I am saying that if there is an issue with this, particularly around the appeals, it is a process question and you should ask me as the accountable person. I am trying to distinguish between that and whether you have seen any evidence at all yet that Atos itself is not producing quality.

Q110 Jackie Doyle-Price: You are making a point about this being part of a process and you are saying that this idea that we are overturning decisions is meaningless. Typically, how long does a claimant have to wait for an appeal if it goes to tribunal?

Robert Devereux: I am not sure that I have that number with me.

Chair: I think it is six months on average.

Q111 Jackie Doyle-Price: Those six months can have quite a material outcome on that claimant if the decision is ultimately overturned. From a value-for-money point of view, we need to look at whether we are delivering the policy outcome that we are setting out, which is to ensure that those who deserve support get it.

Robert Devereux: So we are all clear what is being paid while the appeal is in process, are we?

Chair: Pardon?

Robert Devereux: We are all clear what is being paid while the appeal is in process?

Fiona Mactaggart: JSA, which is—

Robert Devereux: So in the event that you are put into the work-related group or the support group, you are getting more than the JSA rates—

Q112 Jackie Doyle-Price: Yes, but you might only get contributions-based payments for a finite period of time, depending where you are in the life cycle of your claim. I have had constituents who have had their money stopped.

Robert Devereux: We are going to be in exactly the same place, as the Minister will be when he appears before the Select Committee in two days' time, on wanting this to be as quick a process as possible. One of the problems that we had, which is worth pausing on, because otherwise I am not sure we will get there, was, as I said, when Professor Harrington came along with his first report and said that it would be really good if there was a personalised statement so that people could see what is going on. Unsurprisingly, training the doctors to do that and getting them to do it well created an extra amount of work, because they had to become familiar with it, so the time taken to do an assessment went up sharply. That generated some substantial backlogs, which your constituents will be going through now, and that, in particular, is adding to the current elapsed time to get to appeal.

Those backlogs should not be the case when the system is working properly, but we have had two big shocks to the system. One was in terms of constructing the changes that Harrington asked for and the second, which is slightly to do with how the whole subject is reported, was the ability to recruit people to work in this industry, given that the comments being

made about people who work in the industry are negative. In my view, that is wholly misplaced and is part of why I am giving the evidence I am giving today. Without that recruitment, you will not have a functioning system and it will take even longer.

Q113 Chair: No smoke without fire. Neil Sayers wants to come in. I have a whole load of people who want to speak.

Neil Sayers: Just to give a bit of information in answer to the question about how long cases are taking through the MOJ, according to Ministry of Justice information, some 25% of ESA appeals are disposed of in eight weeks or fewer. Some 50% are done in 14 weeks or fewer and the remainder are done in 26 weeks or fewer.

Q114 Jackie Doyle-Price: It is a lottery.

Neil Sayers: Yes, luck of the draw.

Q115 Justin Tomlinson: I want to focus on a comment you made earlier on shouldering the risk and whether you are satisfied with some of the arrangements that are in place. Paragraph 2.11 of the report clearly states that if the referral volumes are more than 20% over or under these volumes for three consecutive months, either party can seek to renegotiate the contract, but surely you should also have a second measure in place that is looked at annually. For example, it could be that you are 50% off for two consecutive months and fine again for one month and that cycle then continues. Has that been considered?

Robert Devereux: Yes, there is quite a bit in the report about forecasting and this is another area where I will explain the Department's role in it. We are pretty good at trying to project, difficult as it might be to imagine, how many people might claim ESA in the course of a year across the nation. Oddly enough, it is quite difficult to work out exactly which city that will be in, month by month.

If I take the example I have here, over the course of April to September we provided monthly information to the contractor and our overall forecast was out by just 3% over that period, which is a relatively small number. The individual figures for an individual area can be anything up to 30% out in one month. With the best will in the world, I have got quite a good grip on a rather difficult subject—how many people are ill and poor enough to want to claim benefits—and I am not sure about trying to disaggregate that individually. These humps and kinks will smooth out over time, obviously, because that is the whole point of them. The reason why we talk about it in annual terms is because I am not sure anything much finer than that will have any validity.

Q116 Justin Tomlinson: I get that; we accept that the system will fluctuate up and down. On the specific point about it shouldering the risk, we are making an assumption that the risk is potentially 20% either way, either time. How confident are you that Atos has the capacity and flexibility to meet that 20% variation?

Robert Devereux: The evidence is—not least because I do not want to have to pay for it—that it has not

bought 25% more capacity than it needs so that every time the forecast hits plus 25% they can do it at the same speed they normally do, but when it hits minus 25% they are all twiddling their thumbs. They are basically making judgments about how many they need across the system. The number of health care professionals that Atos has deployed has consistently risen since the contract was created right up until today—even though the amount of money we are spending on Atos has stayed pretty much constant, by the way. What they are trying to do is to say, “How many do I need, given what I am being told about the year ahead?” The comment I made about risk was a particular one to do with standing between them and a supplier. In this particular case, we are saying to them, “Look, this is the price we are prepared to pay if you meet these targets. If you are not meeting these targets we will not be paying it.” The volume adjustment in an ordinary month, you would expect them to try to win that back by managing the other things.

Q117 Justin Tomlinson: On that point, at 2008–09 when they were running at 68% of capacity, why were they rated so poorly?

Robert Devereux: Why were they rated so poorly?

Justin Tomlinson: Yes, for service.

Robert Devereux: Because I suspect what you are quoting is the overall size of—I am trying to find the right paragraph.

Q118 Chair: Para 2.12, isn't it? At the end of the paragraph: “In 2008–09, actual referrals for all service lines were 68 per cent of contract forecasts.”

Robert Devereux: From memory, 2008–09 is when ESA was introduced. October 2008 is when ESA was introduced.

Q119 Chair: And now it is at what per cent?

Robert Devereux: I have just quoted you the figure.

Q120 Chair: But that was for a month, wasn't it?

Robert Devereux: No, that was for six months. To be clear what I have just quoted you, I have got in front of me, for the service lines for ESA across the country, the forecast we offered them for April, for May, for June, for July and so on. In aggregate over that period, our forecast is 3% out compared with what actually turned out. In practice, we are pretty much on the money for what the numbers are in today's world. In the year in which you introduce a brand new benefit and run off an entirely old benefit, I am possibly not surprised, with the benefit of hindsight, that we were a bit further out. But that is not where the centre of gravity is today.

Q121 Justin Tomlinson: That is a fair point. Turning to figure 3 on the following page, you made the point just now that you will pay a fair price; that there is an element of risk for the supplier, Atos, because of the variation that comes into place; and that you are relaxed for them to make a profit. If we just look at 2010, they barely make a quarter of the year where they are above forecast, and three quarters of the year they are below forecast. That suggests to me that they

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have not got the capacity or the flexibility, but they are still making a profit. Are you satisfied with that?

Robert Devereux: The contract has been set on the basis that about half the money is paid in respect of their fixed costs, and half of it is based on variable costs. Those variables have got prices associated with them, and those are the prices that we are paying. This picture to do with where the volumes are is showing you variation against a forecast, and if you actually look at the volumes that are getting through here, as opposed to the variation against a forecast, you get a completely different story.

I did wonder whether I could just hold something up and show you, but I do not think that is going to work. Throughout this period, the volume of things that we are asking the company to do is growing. It is growing because, first of all, we have put the IB reassessment in there, so we have added a whole new million cases to go through. It is also growing timewise because we are asking them to do more. If Harrington comes along and asks them for the personalised paragraph, and it starts to take them 65 minutes instead of 50, all of a sudden the amount of work that needs to be done is growing. The numbers of health care professionals have risen from something like 500 to 1,000, I think. No, that is wrong; forget that. It has risen strongly. The volume of work they are doing—this chart is simply comparing the forecast against that, which does not tell you anything about the underlying effort that Atos is having to put in to make it go.

Q122 Justin Tomlinson: I want to return to the subject of invoicing, which we touched on earlier. Can you explain why not all invoices are checked? I owned only a relatively small business, but I can assure you that when I was providing invoices and supplier ones came in to me, every last one was checked over with a fine toothed comb and I found that an alarming amount of mistakes were made. Why would it be any different here?

Robert Devereux: Well, that is a good question. I guess the answer will turn out to be whether or not the amount of risk that you perceive in the system is worth the additional cost of doing the further checking. If in the 137—which the Chair thinks is very low, but is, none the less, a statistically significant sample—I find there are no errors, would you rather that I hire more civil servants to check every single one of them when, on the evidence, I can get a statistically reliable answer that there is no problem? You might choose that, but that is not the way I have been funded to operate.

Q123 Justin Tomlinson: On that particular point, presumably Atos was aware that it would then be audited? Those 137 had advance notice of that, so we can be sure that they would make extra effort to be reliable. How confident could we be before we were doing that?

Robert Devereux: The internal audit report said that you can only have limited assurance of it prior to that, because they were not doing the same sort of checking; they were doing different sorts of checking. If you run an organisation as large as mine, you are dependent on people thinking about risk and control

of control environments. We have recorded perfectly explicitly in the 2010–11 statement of control in our accounts that that was one of five or six areas that we were bothered about, because we knew it ourselves. We have done something about it, and we have fixed it. I regard that as a good story, but in a very large operation there will always be something that is just at the point at which it needs some attention, I am afraid.

Q124 Justin Tomlinson: You set at 5% the level you would consider to be acceptable for unsatisfactory medical assessments. What made you set that figure, rather than, say, 3% or 7%?

Robert Devereux: I am going to get Bill to answer that, but I want to make an observation because, again, I want to be really clear about what it says. We ask them to produce reports of a certain professional quality. The fact that on occasion they fail that is not synonymous with “the answer was wrong”. I need you to clock that, because you can have something that is ill prepared or ill thought through, but is, none the less, still right when you look at the evidence. As to why the level is set at 5%, which is by comparison with other things in the rest of the medical section—

Q125 Chair: Before you answer that, may I add a further question? Who does the 5%? As I understand it, somewhere in the report it says that Atos themselves do it? So there is 5% that they self-check, and then you presumably check a tiny sample of the ones they check. Perhaps you could answer that, too.

Robert Devereux: You are comparing two different things. The 5% is the quality target, which is different from the sampling rates. But you are absolutely right that they sample, and we check the sample.

Q126 Chair: How much do you check? Do you check all the samples?

Dr Gunnyeon: We check a proportion of it.

Q127 Chair: What proportion? I would like you to break that down. The two questions go together.

Robert Devereux: We check 6%².

Q128 Chair: Six per cent. of their sample?

Robert Devereux: Yes.

Q129 Chair: How big is their sample?

Robert Devereux: It is 10,636.

Q130 Chair: Which is what proportion?

Robert Devereux: It is 0.58%.

Q131 Chair: They check 0.58%, and you check 6% of that? My arithmetic is terrible, so what does that make it?

Robert Devereux: About 0.1%. No, it is not. I'm sorry.

Q132 Chair: Which isn't very good.

² Note by witness: The national audit sample size is approximately 0.58% of all assessments which in 2011 represented 10,636 cases. In 2011 DWP independently checked 651 cases (6%) of all audited assessments.

Robert Devereux: Sorry, when you say not very good, can we just come back to what figures and statistics mean? The point of audit is to find a percentage that works to the satisfaction of the auditor in audit completeness. Please ask the National Audit Office whether a number, in an absolute sense, is not very good.

Q133 Chair: I will tell you why I do not think it is very good. A high proportion are overturned by you internally, and then 38% are overturned at appeal. You cannot get away from that. You can say you are doing better.

Robert Devereux: I can get away from it, because you keep chopping and changing between different things. On the question of whether there is a basis on which we can make a decision about whether a system is working properly, it is absolutely fair cop to use an auditing system. You would expect the auditor to draw a percentage sample. You cannot simply say, for example, "That number sounds too low." You have to know what the figures are.

Q134 Chair: I judge you on the fact that your internal assessors—goodness knows, I still do not understand on what basis—overturn some of the Atos assessments, and you lose 38% of cases at appeal. That suggests that the decisions are not accurate.

Robert Devereux: I have tried to explain, but I clearly have to keep going at it. There are more things going on here than just what happens in the medical assessment tests. I told you, as I have before, that a third of all the cases that the tribunal overturns, because they use the same facts and reach a different conclusion, are not to do with the evidence.

Q135 Chair: It is to do with the judgment of the professionals.

Robert Devereux: No, it is to do with a judgment of how the law applies to those facts. You can screw your face up at it, but this is the way the world works. Maybe you would like to ask Judge Martin—

Q136 Chair: It isn't a legal issue.

Robert Devereux: Maybe you would like to ask the president of the tribunal to come to explain how it works.

Q137 Chair: I had hoped he would come, but he was not available. You have to just understand that that level of tribunal success for individuals leaves you very sceptical—which you clearly are not—about the efficacy of your systems.

Robert Devereux: I will accept that. The appeal levels are too high. That tells you that the whole shooting match is not working properly, but it also tells you that since the only data you have are data for appeals now, which we have just established are six to nine months after the fact—

Fiona Mactaggart: We were just told that they were decided within six or nine months.

Robert Devereux: But some way after the actual assessment was made. There is a long process in this, including preparing for the appeal itself.

The point is that we are looking at the appeals. One of the things I have asked the Department to do, because this ought to be a bit of information that we both want, is to try to tie up at what point, in that appeal that I now have a decision on, does that individual go through the system. Was it pre the first Harrington report, or pre the second Harrington report? Which process are we testing? You are eliding the two at the moment in saying that everything that happens in appeal must be telling me something about today's process, and I do not accept that, because we have consistently improved.

Q138 Chair: I do not know where you got your information from, but the PQ answer from DWP says that from April to June 2012, the average wait for an appeal was five months, or 19.3 weeks. I do not know where you got your data from.

Fiona Mactaggart: I was told in my region that they do not open appeals for 190 days.

Robert Devereux: Are we not agreeing with my point? My point is that you are seeing in the tribunals a decision being revisited that was made many months earlier.

Q139 Chair: I do not know when you implemented the whole of Harrington 1 and 2.

Robert Devereux: June 2011.

Q140 Chair: So the appeals in 2012 should have reflected that. Five to six months is the average.

Robert Devereux: We would hope so, but when there is a backlog, people are trying to get this right.

Q141 Chair: Yes, that is the five months' backlog. I am talking about April to June 2011.

Robert Devereux: And the changes we made are consequent upon all the other things that we have been doing. The point of the story is that we need to track, for appeals, what dates the actual decisions were made.

Q142 Justin Tomlinson: What was the professional evidence that determined you to set at 5%? The reason I am asking is because with any commercial contract, you as the supplier will gear up to ensure that you hit that target. What was the professional evidence that set that 5% in the first place?

Dr Gunnyeon: First, I clarify that in that 5%—these are the grade C reports—are reports that are unsatisfactory, so they do not meet the standards that we have set. That does not mean that the recommendation is not sound. There can be all sorts of things in there that mean that it does not meet the standards. That is the first thing to recognise.

In any system in health care, you will never get 100% perfection. We know that across health care you have a range of health care professionals' performance. Individuals are individuals; that is one of the challenges as well, as they respond to things in different ways. It is a question of trying to continuously improve, but to set what you think is an absolute minimum standard. That is what was chosen here.

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I think it was a reasonably stretching one at the time it was set. We now have evidence that Atos is trying to improve on that, and over the past year we have had occasions when it was only 3.5%, so it is doing better. We have taken on board Professor Harrington's recommendation and the recommendations of the National Audit Office, so they are both in agreement that we should be looking to make that more stretching. We are in discussions with Atos about how we move to that.

What we need to do is ensure that we are doing it in a way that is achievable and that does not drive perverse behaviour. We want to ensure that this is seen as continual quality improvement and that, as we audit, we do not find that things that might have rendered something a grade C are being ignored in order to meet the target. That is why audit is important—we have absolutely no evidence of that. We want to do this in partnership with the contractor, because that is very important.

We are on the case. I think it was entirely reasonable and comparable with the sort of levels you would expect of unsatisfactory reports or performance in other aspects of health care, but we have demonstrated now that Atos are able to do better, and we are working with them to look at how we drive down that to below 5%.

Q143 Justin Tomlinson: We took evidence earlier, and dystonia was mentioned as one of the many rarer illnesses that might come up. Even the best paid medical assessor might not necessarily have the answer every single time. You have alluded to the fact that you are now starting to change the system to advance notice. Are you satisfied that we are now at that place whereby they will know in advance that they can get that research or the evidence on something that they might not otherwise know in their assessment?

Dr Gunnyeon: Sorry. Do you mean the individual claimant?

Q144 Justin Tomlinson: The assessor. As it stood before, I would be assessing someone and they could have an illness with which I was not familiar, and therefore I would not necessarily make the right judgment. If I am right, there was not the ability to pause the process and say, "You will need to come back because I am not satisfied that I can give an honest and true reflection of what is going on." First, there is the ability to pause and, secondly, are you satisfied that enough advance notice is given where there might be a more challenging illness to diagnose?

Dr Gunnyeon: We are getting much better at it. Would I say that it is absolutely perfect yet? I am absolutely sure that it is not because there will be things that we still have not captured. Certainly, a process is in place now. There is a recognition that we have to capture those conditions in which the impact is less predictable—perhaps fluctuating in nature. We must remember that it is the impact of that condition on the individual's capability to work that we are assessing, but it is clearly important that we understand the specific implications of that condition, and that is where expert input is important.

As we develop our guidance for the health care professionals, we are involving user-led organisations, disability organisations, to help quality-assure that guidance so that we can get better at ensuring the health care professionals have the right advice, that they can pause the process, send the claimant home and start the process again if they do not feel that they have the right information or the right understanding. We are also trying to ensure that we get better medical evidence. Factual medical evidence in those particular cases is very important. That means identifying at the time the individual submits their claim and their ESA50 that there is a condition there where it is particularly important that we get factual medical evidence so that when the health care professional does the assessment, they can understand fully the implications for the individual.

Q145 Justin Tomlinson: Surely that would save an incredible amount of money, time and effort for everybody, particularly people in very vulnerable circumstances?

Dr Gunnyeon: The numbers are likely to be small, but, absolutely, we must capture them.

Q146 Justin Tomlinson: A final question. Where they have not met expectations, there are obviously the service credit arrangements, yet only a shade over 10% of those have been applied. I understand that there is the flexibility in the system where they may more than make up for it. Are you satisfied that the 10.1% was a reasonable punishment?

Robert Devereux: Okay. You are smiling at me already, Chair. Let me explain what the contract provides for and then you can decide. The service credit regime, which is a pretty common regime in many contracts, is simply trying to identify what the essential cost to us would be of non-performance against a particular target. We are not allowed to make it penal under contract law; it is just a number—the cost to us. We have a schedule of service credits that apply to things that are related to performance. The service credits that we have not charged—in the picture in this question, and subsequently in Harrington and in the period beyond what we have here—are all in respect of old cases, of things taking too long. The reason for that is that the contract, perfectly properly and entirely consistent with contract law, requires that we have to think about whose fault it was. Is this case late because the contractors wilfully did not get in enough staff or is there some other reason? In the case of the period that you have in the graph in the picture here, you are looking at a period in which, with the introduction of ESA and our calculations of quite how long this would all take to make sure that it was done properly, we just ended up with a huge quantity of work coming along—much more than we had previously anticipated.

It was our judgment, from the conversations about whether they had therefore fallen down on the job or whether we were actually in the wrong place, that we could not apply these service credits and that they would not have been applied in a court of law. The test we are trying to say to ourselves is, "I've got a

perfectly good contract here. Can I win this if I go to a court of law?" The conclusion is that, no, we would not win, because a court would say, "Hang on a minute, what was going on? What was the rationale? Who did what?" That is what goes on.

It is a very stark answer when you end up with 10% having re-applied, but 10% re-applied because in 90% of the cases, we essentially accepted the mitigation.

Q147 Chair: So 90% was your fault?

Robert Devereux: Correct.

Q148 Chair: How much money did we lose?

Robert Devereux: Well, you lost no money.

Q149 Chair: You did, because you paid out for a contract that they did not fulfil.

Robert Devereux: With respect, that is not what I have said, is it? The contract was for them to provide services, under certain assumptions about volume. When we come to this particular case, we are talking about one metric only; there was no giving anything away on quality, customer complaints or anything else. In respect of the time that it takes to do things, when a backlog occurs consequent upon changing what we require of them, it does not seem to me an unreasonable observation on our part—

Q150 Chair: Just take me through it. As I understand from the Report, there were no credits from September '09 to March '10 and from June '11 to December '11. That is from the Report. That is correct, isn't it?

Robert Devereux: The regime was suspended then, yes.

Q151 Chair: It was suspended, because there were no credits. That is a long time after the new system was introduced in '08. In particular, June '11 to December '11 cannot be related to June '08.

Robert Devereux: As I am sure your constituents will know, there was still a very substantial backlog at that point.

Q152 Chair: From June '08 on to June '11 to December '11? That cannot be right.

Robert Devereux: I am trying to explain what we did. We looked at what was going on in this period, and in that period—

Q153 Chair: From June '11 to December '11, you suspended—

Robert Devereux: I am sorry; I misheard you. I thought that you were talking about the first suspension. Can you just tell me the question?

Q154 Chair: One suspension was from September '09 to March '10, which—stretching a point—you could just about say was due to the introduction of the new scheme, and then there was another when you suspended from June '11 to December '11.

Robert Devereux: Yes, okay. June '11, as you will recall from my earlier evidence, was the point at which we introduced the change in respect of

Harrington, and in April '11 we started to push through all the IPR values.

It was not our expectation, in the decision to change the request for that personalised paragraph, that that of itself was going to change the time of the assessment. By about November '11, they had got sufficiently used to knocking these things out that, in November '11, the time to the assessment was back to where it was before Harrington.

In the period in between, they actually went through quite a long period when it was taking them a lot longer to do that. That is the point at which the backlog emerged, and that is why that suspension is there.

Q155 Chair: How have you renegotiated the service contract provisions for credits? It says that you have in the Report. How have you renegotiated them?

Robert Devereux: There are two answers to that. At present, we are running a different system from the service credit that sits on the face of the contract, because we have negotiated the so-called interim service credit regime, which is focused very directly on making sure that they are delivering as many exams as possible. Through a combination of looking at how we can incentivise them to be doing work in overtime or weekends and getting more out of the doctors they already have, we are trying to get that backlog down.

Q156 Chair: So they lose money if they do not meet numbers?

Robert Devereux: The interim service credits are all around the fact that if they fail to deliver the additional exams that we are after, we will take cash off them, and we are.

Q157 Chair: Have you taken cash off them this calendar year?

Robert Devereux: I believe we have. I think that is one of the numbers I have left on my desk, so I cannot tell you what it is.

Q158 Chair: Maybe Dr Gunnyeon knows how much cash?

Robert Devereux: I doubt it very much.

Dr Gunnyeon: That is not an area I get involved in.

Q159 Chair: Will you let us have a note on that?

Robert Devereux: I will, certainly.

Q160 Guto Bebb: You mentioned the medical qualifications of the Atos staff who do the reviews. Can you clarify for the Committee what those qualifications actually are? What qualifications do the medical assessors have?

Dr Gunnyeon: The doctors are required to be registered with the General Medical Council to hold a licence to practise, and normally to have at least three years' post-registration experience. The nurses are required to be registered with the Nursing and Midwifery Council on the same basis. They use a small number of physiotherapists as well, and physiotherapists are regulated by the Health Professionals Council. They are all regulated health

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care professionals with some practice experience post-qualification.

Q161 Guto Bebb: What percentage would be doctors then?

Dr Gunnyeon: The doctors now, in terms of percentage—I cannot actually give you the numbers. We now have around 600 nurses. The doctors are a combination of sessional doctors and doctors employed by Atos. They use both in the doctors. The physiotherapists are a very small number—only 40 or 50.

Q162 Chair: Six hundred nurses, how many doctors?

Dr Gunnyeon: Out of the total—my apologies, I will provide that. I am not going to rifle around for figures; I should have the numbers at my fingertips. It is the combination of sessional and full-time that I am going to get confused with, I suspect.

Robert Devereux: I think we have full-time health care professionals—

Dr Gunnyeon: That is the combination.

Q163 Guto Bebb: The concern I have is that we have heard the figure of about £78,000 for a GP-equivalent qualified person working for Atos. I am wondering whether that is a false economy, if that is the case. If a doctor working for Atos is paid significantly less than somebody working for the NHS for example, are we getting the right people into these positions?

Dr Gunnyeon: We are careful. Atos have a very robust recruitment process for their health care professionals. Out of all those who apply, the acceptance rate is less than, I think, 17%. They are then put through the training process, which they do not necessarily all come through. They are not all approved at the end of the day, and that is partly because they are also very closely audited until they are deemed to be fully competent, before they are allowed to do assessments on their own.

Q164 Guto Bebb: You will write to us with these figures. For the final question: would it be possible for you to clarify from Atos what percentage of their doctors qualified as professionals have English as a first language?

Dr Gunnyeon: I am sure they will have that information, yes.

Robert Devereux: Could I just give you the answer to the previous question you asked me? I do have that with me after all. The interim service credits that we have secured from the company in the current financial year to date: £285,000.

Q165 Fiona Mactaggart: It was pointed out that this Report is dated. We have looked at delays in appeals, but I would like to know how long the average case takes now. We see from the Report that “a significant proportion of cases have been with ATOS...for more than 56 days (25 per cent compared with a target of 3 per cent”. What are those figures today or at the most recent possible moment?

Robert Devereux: I think I have just about every number apart from one that is about the older cases. I will have to let you know that.

Q166 Fiona Mactaggart: It is very important that we know what today’s delays are. My experience here is that when bureaucratic systems allow—I am not accusing you of being unreasonably bureaucratic, but you are running a bureaucratic system—delays to build up, fixes create whole new problems. It would be really helpful for us to know the degree of delays within the system, as well as the degree of delays in appeals. Is it a matter that you are at all concerned about? I am slightly anxious that you do not know about the current degree of delay in the system.

Robert Devereux: You asked me a particular question about the number of days. What I have in front of me is the percentage of cases older than 56 days.

Q167 Fiona Mactaggart: And that would be helpful. What is the percentage?

Robert Devereux: It varies by region of the country, so two of them—the north-east and the north-west—have percentages at 1% and 2% respectively.

Q168 Fiona Mactaggart: Tell me about the south-east, which is where the area I represent is.

Robert Devereux: South England is—let me just check which month we are in here. Just bear with me. What have I got here? London and the home counties, 28%.

Q169 Fiona Mactaggart: Exactly, and the target is still 3%. So there is a real problem in the south. What are you doing about it?

Robert Devereux: We have put in place, as I said earlier, two systems, in negotiation with the company, to get more work done by the people they have already recruited, as well as seeking to encourage them to recruit more people. If I can just talk about the first bit, we have negotiated arrangements with them that ensure that further payments are made to make sure that people actually will work at the weekend and deliver more tests than they would otherwise have done in order to eat into the backlog. The second thing is that I am very keen to make sure that people think this is a profession into which they want to come and work. Part of the exchange I was having previously with the Chair about the hearings was to make sure we are all clear that, given the evidence I have just been presenting, working for this company doing these tests, which society needs to have done in order to give benefits, is a perfectly respectable thing to do. In a world in which people think that this is actually all complete chaos, nobody will come and work for them.

There is very strong evidence right now that, in so far as media attention elides whatever may be wrong with the system itself with the performance of the company, that has a negative impact on the way recruitment operates. I do not think that it is in my or the nation’s interest for that to be the case, so it is really quite important that we make very clear the distinctions I have been trying to make today between things we are trying to fix in the system and whether the company is delivering the sort of tests we invited them to do.

Q170 Fiona Mactaggart: When do you expect you will reach the target of 3% in the south-east?

Robert Devereux: I genuinely find that a hard question to answer, because, as I explained to your colleague earlier regarding trying to sort out even a monthly forecast, I had hoped that we might be doing that by the turn of the financial year, which is three or four months' time, but the number of referrals in the last two months has been significantly higher than we forecast. Because of the reasons I have been through, trying to project exactly how many people will turn up to claim ESA in London and the home counties in the month of November is not a precise science. A number that we had hoped would be lower—and therefore they would be back on track earlier—has turned out to be higher. So I am not going to give you a sense that I know exactly when it is going to go. I'm afraid it is going to depend on the ability to recruit, which is absolutely the most critical thing that needs to be focused on, because without that we will not get anywhere. Secondly, it will depend on making sure that the people who are already employed by them are doing the maximum possible number of exams.

Q171 Chair: Is the south-east the worst on your little list there? Which is the worst?

Robert Devereux: It is London and—

Q172 Chair: What is London like?

Robert Devereux: I have quoted you the London number. London and the home counties are 28%. Sorry, I have too many numbers. The south of England is higher.

Chair: Say that again.

Robert Devereux: It is higher. It is more like 40%.

Q173 Chair: It is the highest?

Robert Devereux: The highest, yes: 40%.

Chair: 40%?

Robert Devereux: Yes. The south of England is the bit in the south-east that isn't London.

Q174 Fiona Mactaggart: Yes, the bit that includes my constituency. May I ask one question? I know, Mr Devereux, that you hate anecdotes, but I really feel that I should share with you a letter I have from a GP who wrote to Atos about somebody in my constituency. It says: "She tells me that unless she attends a medical examination in Reading on 16/08/2012"—which is not very long ago—"or is able to fax a letter from me to you by 07/08/2012"—this letter was dated 6 August—"you would stop her benefits." He goes on to point out that the reason she serially fails to turn up to appointments is her back pain, which means that she cannot walk; she doesn't see her GP, she doesn't go to the pain clinic and so on because she actually cannot move, and so she doesn't go to Atos for exactly the same reason. He suggests—I've yet to see this happen—a home visit for her. He goes on to say: "You must stop frightening genuinely incapacitated patients like this, forcing the time-wasting of valuable medical resources like mine in demanding that the patient produces a letter urgently at such short notice. This calls the system into

disrepute and does a great dis-service to a proportionate and civilised society. You should be ashamed of your ilk." This is an expensive use of his time, desperately trying to get this letter out to the timetable required. I wonder whether you have looked at the additional costs that this system has put into the Ministry of Justice, with the appeals system, or the Department of Health, with this kind of letter that the GP objected to having to send.

Robert Devereux: Shall we just wind back on the process? The Report talks about people who turn up and are then sent home. It does not in any way comment on the fact that we have vast numbers of people who do not attend for a scheduled appointment. One thing we have done and that the company does is seek to make telephone contact with everybody, to check that they can make the date, that they can get there. I am guessing that in that anecdote, telephone contact was not made.

Q175 Fiona Mactaggart: No, I think it was. I think that was why she realised that she had to have a letter from her GP at that kind of notice to say, "I have got to have a letter from my GP saying I can't make it." Or get no money, which is what she said.

Robert Devereux: I don't want you to think that I don't like anecdotes. I spend at least as long as you do answering individual calls as well. They are important dipsticks. The point is I don't know the facts here. If it is the case that we have genuinely caused this person to think that there is no alternative, that we have never heard of a thing called home visit, that we never tried to rearrange the arrangement, and that is the letter that has gone out, then I agree with you that that would be a bad thing to do. However, I don't know what led up to that exchange and the way it has been reported by your constituent to her doctor. If we take it at face value it seems not a good story, but I don't know what led up to it.

Q176 Fiona Mactaggart: My question is, have you made an assessment about the financial burden on other Government Departments? A question I often ask at this Committee concerns when a particular Department makes decisions that set costs outside its own budget. It seems to me that there are two sets of decisions in this process where the costs rest outside your budget, Mr Devereux. One is in the NHS, requiring this GP to write this letter. I use that as an exemplar. Another is in the Ministry of Justice with the number of appeals that this process has generated. I wonder whether you have looked specifically at the financial impact on other Government Departments' budgets of this process and whether you have done anything to diminish that.

Robert Devereux: The short answer is that I personally have not looked at that. As you have already observed, the system we are running now in ESA replaced a system of incapacity benefit, replaced a system that went before that. The Government have been testing people's health and drawing on the health system to do that for decades. I have not got a fresh assessment of the burden of that. It is not in my interests to be generating gratuitous work on behalf of GPs.

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Q177 Chair: But you will know, for example, that if there is an increase in appeals that impacts on MOJ and it also impacts on you guys.

Robert Devereux: Again, I am trying to answer the questions one at a time. On the health service point, it is already the case that we invite people to say if there is any evidence they want to produce, including from their GP. I am hoping he is spending rather longer supporting them in completing the form in the first place than answering the phone.

Q178 Fiona Mactaggart: Have you looked at how you could do it at less cost—for example, through data-sharing and things like that? Because suddenly requiring a GP to write a letter is very financially inefficient. There could be other ways and there are reasons for not necessarily doing them—I accept that—but there could be other ways that are much less financially burdensome.

Robert Devereux: Would you genuinely rely on the Department to take data that are in the health service's electronic record and make decisions based on that without asking the GP? I doubt it.

Q179 Fiona Mactaggart: I am saying, have you looked at other ways? I have just pointed out that there are reasons why they might not be appropriate, for example, data-sharing. I am struck that, on the taxpayer's part, this is a very expensive way of doing it.

Robert Devereux: If, consistently across the country, we were demanding faxed letters at short notice from GPs, I agree that would be a material burden. I simply don't know to what extent that is a common story or anecdote. I do agree that, if it were the case, that there is a piece of process here that we can improve, let's improve it. I have not heard a great clamour that that is indeed what is going on. We do try to listen to what is happening.

Q180 Chair: Just to go back to the question you said that wasn't being asked. What is the extra cost of appeals to the DWP from the level of appeals in 2009–10 to the level in 2011–12?

Robert Devereux: I believe that we paid £26.3 million to the Courts Service in recognition of the additional work generated by ESA and IBR review appeals.

Q181 Chair: £23 million?

Robert Devereux: £26.3 million, which is recorded in note 10 of the programme costs of our accounts and the services are on page 132.

Q182 Chair: And that includes your costs? You have to provide professional advice as well.

Robert Devereux: No, that is the cost of HMCTS—

Q183 Chair: Pardon?

Robert Devereux: That is the money that I believe we paid to the court service in recognition—

Q184 Chair: And you will have extra costs within your own organisation?

Robert Devereux: We will have extra demand, yes. Can I come back to the cost of running my

Department? I have a £3 billion pay bill. We are dealing with tens of hundreds and thousands of people daily. I don't want the appeals to be at the level they are at. I am trying to do something about it.

Chair: My understanding from the figures I have seen is that it has gone up more than twice—two and a half times.

Q185 Meg Hillier: On this point, this is not just an anecdote, but a real-life situation and one of many I am dealing with. I have somebody who is a very vulnerable individual. Every professional involved with this individual's life, including the DWP jobcentre staff, believe that this individual will never be capable of work. The DWP jobcentre staff are spending a lot of time on a case that has been decided by the DWP and it seems to me a crazy, byzantine system that people who deal with this individual regularly and have all the professional advice in front of them have a different decision from their own Department's decision making. You cannot comment on that particular case, but it seems—

Robert Devereux: A moment ago I was being criticised for having staff who were making decisions on this. Now you are saying my staff are good enough to decide that they should not be in this position, but a moment ago I was told that I could not—

Q186 Meg Hillier: Again, it is a mental health problem. It is one that is quite complex, as many mental health problems are. I wonder whether Dr Gunnyeon can tell us how many mental health professionals are employed by Atos. I could go on about many other issues, but it seems to me that the mental health issue is a real concern. It is costing time and money for the DWP and time and money for the many professionals involved. Mental health charities are at full stretch and the various advice charities also take longer, very often, to deal with someone with a mental health problem because the anxiety this produces creates more anxiety. So it becomes this really vicious circle of creating more anxiety for the individual and more time for all the professionals involved. It keeps going round like that. It does not seem to me that this system, like many systems in government—that is a cross-party point—has ever really worked for people with mental health problems. Professor Harrington's report tomorrow will, I hope, help that. Do you have any comments about those costs that are being generated, particularly on mental health?

Dr Gunnyeon: Can I take this back to the development of the work capability assessment in the first place? One of the reasons why employment support allowance was introduced was that the personal capability assessment that was used then was very poor in terms of addressing the needs of people with mental health issues and learning difficulties. Indeed, although this assessment is not perfect and we are working at it, it is much better at identifying people with mental health conditions. The world has changed. People are much more aware of issues. But the reality is that we have done a lot to try to improve the situation.

The Atos Healthcare professionals get quite intensive training on dealing with mental health conditions. Remember it is not about being expert; it is about assessing the impact. However, Atos put in place mental health champions who have mental health knowledge and are available to all the health care professionals carrying out assessments. There are 60 of them. They are contactable when somebody wants advice while doing an assessment, or in advance of starting an assessment, or, indeed, at the conclusion of the assessment when they are formulating their recommendation. So a lot of work has been done on that side. We made significant changes to the assessment itself as a result of the internal review when the amended WCA was introduced last April, to take better account of the challenges of people with mental health conditions.

As you will be aware, Professor Harrington in his year 2 review had invited mental health charities to look at whether there were things they felt would improve the descriptors, which he recommended should then be the subject of a gold standard or evidence-based review. That is under way now and we have been working very closely with the mental health charities. So there is a huge amount of work focused on people with mental health conditions. In spite of the concern about appeals, for example, if you look at the published figures for quarter 4 of 2005, which is entirely incapacity benefit using the personal capability assessment, the appeals overturn rate there was 49%, which is higher than it is now for employment and support allowance.

Chair: Can Fiona finish her point?

Q187 Fiona Mactaggart: Actually, my last point was a slightly different one. It is about a letter that I have seen, from Richard Presland, saying that you intend to treble the number of ESA claimants who are referred to a mandatory work programme. I am interested in this because of the 30% figure that you focused on a lot, Mr Devereux. That implies to me that when a tribunal has perhaps seen someone in front of them, then, on the same facts, they can make a different decision to a decision maker who hasn't. Therefore, a large number of these cases are people who must be close to some margin, about whom it is actually a narrow decision to make, not a factual decision. Therefore, they are people who might be very negatively affected by a mandatory work programme if the work programme is inappropriate—I am not suggesting that it would necessarily be. I am wondering what you are doing to ensure that the work programme that they are mandated to is appropriate, because if not, I think you will see a huge leap in the number of appeals.

Robert Devereux: Appeals to?

Q188 Fiona Mactaggart: Appeals about being put into the work capability programme rather than the other group of people in ESA. You know what I mean?

Robert Devereux: I am not sure—let me just check that we have the same issue, then. We have spent the entire afternoon talking about the process by which we decide whether somebody is eligible for ESA in

the first place, which can put you into one of two categories, as you know.

Fiona Mactaggart: Exactly.

Robert Devereux: That is one conversation. We are seeking to make that process work as well as possible, to get to a good answer, but, with the best will in the world, it is complex—but it must be done, because somebody is going to have to deal with this. Having reached the best decision we have, there is another question, which says, “Work-related activity group is the route”—we are putting them there because we think in due course they should be capable of looking for work. Consistent with the design of the Work programme in the first place, we have said that people with a certain prospectus should be put into the Work programme. That is where the 30% comes from.

Q189 Fiona Mactaggart: At present, we are mandating about 5,000 a month, and this letter suggests that it should be 15,000 a month who are forced into the Work programme.

Robert Devereux: I think we had this conversation when we were talking about the Work programme to start with. When we thought about the volumes we thought would be going into the Work programme, we had some numbers for those I call ordinary jobseekers and we had some other numbers for employment support allowance. To date, those numbers have in aggregate been about the same, but jobseekers have been higher and employment support numbers have been lower. There have been quite a lot of requests, including from Work programme providers and their sub-contractors—many of them within the charity and voluntary sector—to get more ESA customers. The change in the boundary we have done here is to say, “Well, are there other people in the ESA space who we can send to the Work programme because we think they could actually usefully be helped by the Work programme?” Remember, all that happens by going into the Work programme is I am giving somebody some incentive to help get you into work, right? I am not changing your benefit; you are still entitled to ESA.

Q190 Fiona Mactaggart: I understand that. That is why I was asking whether you would be confident that what they are referred to would be appropriate. From earlier evidence sessions, I believe that some of the things that people have been referred to would be inappropriate for some of the groups of quite vulnerable clients who we are referring to here, who would be capable of work but nevertheless have conditions that make them vulnerable.

Robert Devereux: At the risk of repeating earlier hearings, the way we have structured the Work programme is to say, “We would very much like you to get as many people as possible into work and we are prepared to pay substantially more for when you get any person, particular an ex-IB person, to do that”—otherwise all the evidence is that they would stay on benefits for a lot longer. So there are financial incentives in the system. The question you were asking last time I came was, “Are you absolutely sure that these providers are doing everything they possibly can for all possible people referred to them?” All I

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can say is I have set them the clearest possible indicator that society will value them getting these people into work. But I am not micro-managing the provision that they actually go through.

Q191 Austin Mitchell: Doctor, you have told us that it is a challenge to put in some universally agreed measure of whether people are capable of work or not. It is a challenge you are failing, isn't it? If there are 38% of the verdicts changed on appeal, plus a proportion—we don't know how high—changed by the Department when it reviews them, and a proportion that might have had a chance of reversal of the verdict had they applied and gone to appeal, but they did not want to, it is a challenge you are failing. As a medical man, you can't be proud that there is such a discrepancy between the verdicts of Atos and those of the tribunal.

Dr Gunnyeon: Can we be clear, first, that if we look at all the fit-for-work decisions that are made, only 15% of them are ultimately changed—with those who appeal and those whose appeals are successful? That is of all the people who are found fit for work.

Q192 Chair: Only 15%. Only?

Dr Gunnyeon: Yes, but remember what I said to you: this is an incredibly difficult process. Of course, I would like to see that—we are working to see that—come down, but at the end of the day, this is something that is difficult. The challenge as well is for people to understand that the criterion for fitness for work is not based on someone being 100% fit and not having any health condition. That is one of the things that are often misunderstood. The assessment has been designed to try to identify those for whom, in spite of having some ongoing health condition, it is not unreasonable to work or to look for work, on the basis that other people with the same condition with the same impact do work. Remember that about 26% of people who are in work have a long-term health condition or disability, and a significant proportion of those who are looking for work on JSA similarly have long-term health conditions and disabilities. It is that that is used as the criterion.

I clearly take it very seriously. You have pointed out that I am a doctor myself. I care passionately about what happens to people. I also believe that what we are trying to do—difficult though it is—is right, because I also have seen the evidence about the impact that long-term worklessness has on people's health and well-being. Therefore, there is a real challenge in balancing, on the one hand, putting people through the process—let's be clear that this is going to be an incredibly distressing process for anyone. If you, I or anyone here suddenly faced the prospect that, in going for an assessment tomorrow, we might lose a large proportion of our income, that would be pretty difficult and distressing.

So we have to accept that it is going to be distressing, and to do all the things we can to make sure we make it as comfortable a process as possible, but it is going to be difficult. But, at the end of the day, for me as a health care professional, allowing people needlessly to fall out of work and then get trapped on benefits, with all the consequences of that, isn't a good option

either. That is one of the things that has convinced GPs. We have worked very closely with general practitioners to get the sort of feedback that the Member was referring to about the impact of the work capability assessment. We work very closely with GPs, but it is important that we can, whenever possible, help people back to work and prevent people from finding themselves trapped on benefits in the first place. That is why the whole process of the ESA was important—picking up those who were coming into the system and making claims in the first place, and trying to get the decisions as right as possible there. It is much more difficult with IB reassessment cases because these are people with more complex problems who have been away from work for a long time and for whom the barriers are much greater.

Q193 Chair: That is an interesting point. What proportion of the 38% success rate are IB claimants who have had a reassessment, or are new people on ESA?

Dr Gunnyeon: The 38% success rate?

Chair: The 38% of tribunal cases that get overturned. You have said that it is more difficult if someone has come off IB and you are reassessing their capability for work than it is for someone who is new into the system—a new ESA claimant. What proportion—

Robert Devereux: Not more difficult to assess. What he said was that the—

Q194 Chair: I just want to know the proportion. I am not asking you a trick question. How many of those are people coming off IB—those who were on IB—and how many are new?

Dr Gunnyeon: With the IB reassessment appeals data, we have obviously only been doing the process—

Q195 Chair: How many?

Dr Gunnyeon: Of the new claims appeals, there is very little difference in the success rate between those with mental health conditions and those with physical health problems.

Q196 Chair: That is a different question.

Austin Mitchell: That is a different answer.

Robert Devereux: I don't think we have that information with us.

Dr Gunnyeon: We don't have the appeals data for IB.

Robert Devereux: Not broken down.

Amyas Morse: I will tell you one thing that I was a bit struck by. There is a difference in your probability of winning an appeal if you are supported by the citizens advice bureau or if you are not. It is a marked, statistically significant difference. If appeals are primarily a matter of timing difference, how could that be, doctor?

Dr Gunnyeon: There are all sorts of things one could speculate on. We know in other areas of medical practice that it is possible to help to prepare individuals. It is classic, for example, in litigation—you can help to prepare individuals to present the most compelling story about themselves. If you are a body that is trying to help somebody produce the best outcome—in terms of, for them, the financial outcome—you are likely to have an impact, so it does

not surprise me that if a citizens advice bureau representative is supporting a claimant, that may increase the chance of success.

Q197 Chair: That is terrible—

Dr Gunnyeon: Why? You have somebody there supporting you.

Q198 Chair: Because that suggests there is a total lack of objectivity in the system.

Dr Gunnyeon: No.

Q199 Chair: Go off and get yourself a bit of help from a CAB and you are more likely to hang on to your ESA. That is awful thing to say.

Dr Gunnyeon: But that is what the CAB is claiming, is it not?

Q200 Chair: That is awful way to run an objective process. It is awful.

Robert Devereux: Let us wind back a bit. I expect it is the case that, with practice, you will get a better answer. I agree with you that it ought not to be the case. We would like to think that it was all objective. Since I have just observed that in a third of all the cases the judges see, they reach a different conclusion on the same facts, there is actually a lot more judgment in this system than you or I might prefer to have.

Q201 Austin Mitchell: Yes, but a practitioner knows them better, has a longer experience of them and knows more about it than a perfunctory examination on a tick-box basis.

Robert Devereux: But the GPs do not want to be making benefit decisions. Ask the BMA.

Q202 Austin Mitchell: I would hope mine wants to help me. He still knows the patient better.

Dr Gunnyeon: That is in terms of actually providing the factual evidence. The role of the health care professional in Atos is as a disability analyst. It is to assess the impact of that condition on somebody's capability to work. That is not the GPs' strength, and the GPs admit that. Mr Devereux is right: the BMA has made that very clear.

Q203 Austin Mitchell: The point is that the medical practitioner working for Atos must feel themselves under a certain pressure, whatever it is. They want to keep their jobs, I suppose. They get £78,000, which is low by the general standards of the profession. They do not want to be certifying that too many people are incapable of work because they are not going to keep their jobs.

Robert Devereux: Okay, let's just nail this. The implication there is that we have a contract that is incentivising contractors to find health care professionals who find a certain number of people passed. That is not the case—full stop. These are health care professionals. If you want to impugn their professional ability, that is the best way to go about it, but that is not the position.

Q204 Austin Mitchell: You can't say that, because you don't look at the cases that have been rejected by a tribunal. There is no examination by the Department of what went wrong, what mistake was made, or where the misjudgment was. Why don't you re-examine cases?

Robert Devereux: The point you made a moment ago was that, somehow or other, there were incentives in the system or that the health care professional would lose their job. That is completely false, and I will not have it.

Q205 Austin Mitchell: Okay. Why don't you re-examine all the cases that are rejected by a tribunal and say what went wrong—what was the mistake?

Robert Devereux: Good news. We managed to sit down with the president of the first-tier tribunal, Judge Martin. I agree with him that these judges—

Q206 Austin Mitchell: The Report says you do not.

Robert Devereux: No, the Report said it would be a good idea if we did. And guess what? We have. Hooray!

Q207 Austin Mitchell: I would just like an assurance, because I am worried about this, that there is nowhere in the system—on the part of doctors, Atos, the Department, or Ministers—any target for the number of people, or the proportion of people, who have to be got off benefits in this fashion. Ministers have been talking for some time about the number of people who have been running in the Olympics or lying in bed with a stubbed toe or something who should not be on benefits and should be out working. Is there any target in the system?

Robert Devereux: No.

Dr Gunnyeon: Can I, as a medical professional, confirm that in terms of what we ask Atos to do, there are no targets? I can confirm as well that the doctors, nurses and physiotherapists doing the assessments at Atos have no targets in terms of how many people they are to find fit for work, or to put in the work-related group or the support group.

Q208 Chair: And Atos does not set any targets itself?

Dr Gunnyeon: No.

Q209 Chair: You are 100% sure?

Robert Devereux: There is no incentive in the system for that.

Dr Gunnyeon: Where the confusion has arisen around this is that because it is important to monitor quality, as we do in other areas of health care, we look at individuals at the extremes. If somebody is putting nobody in the support group, for example, we want to look and see whether that is because of the case mix they got, or whether they are not actually applying the criteria correctly. That is different, because it is about monitoring quality and consistency, and you do that in all areas of health care—it happens with GPs' prescribing practice, for example. That is what has caused confusion sometimes about whether or not there are targets. There is no target. It is about trying

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to make sure that we have the right quality and consistency.

Q210 Mr Bacon: Mr Devereux, the first thing I thought of when I heard that we were seeing Atos was the hearing that we had nine years ago in October, on the basis of the NAO Report in October 2003. As well as looking at this Report, I went back to look at that one. It is amazing how many of the themes are similar. That Report of the 2002–03 Session, which was published in October 2003, said that “the President of Appeal Tribunals reported that an appeals tribunal formed a different view of the same medical evidence in 24% of successful Disability Living Allowance and Attendance Allowance appeals, and 27% for Incapacity Benefit”.

It is quite obvious that there is an enduring issue here. Can you explain? This might be for Dr Gunnyeon. You referred to the issue of mental health, which Meg Hillier brought up earlier, and said that there were reasons other than the medical assessment why the tribunal might come to a different decision. You referred to mental health in that context earlier today. Is that right? Can you remind me?

Dr Gunnyeon: I do not think I said mental health specifically. I think what I was trying to clarify was that when the tribunal has somebody to whom the process of appeal itself is distressing and there is a time lag, by the time they come in front of the tribunal they will be more distressed. Even if they do not have a mental health condition, they will clearly be distressed and emotional. There are all sorts of things that come into account, in addition to the fact that the individual’s condition may have progressed. It may be that at the time when the decision was made, they were fit for work, but six or nine months later, that situation may have changed. That will inevitably influence the tribunal, because it would be very difficult to look at someone and try to project back how they think that person was at the time when the decision was made.

Robert Devereux: Which I do not think they do, by the way. It is a general principle of the tribunal that they work it out from first principles, starting with the evidence today. This, I am afraid, comes back to your colleague’s comment about how long the process takes. If the appeal was much more contemporaneous with the original decision, some of the noise in the system would not be there, but the reality is that it is.

Q211 Chair: It just occurs to me that it also means that when you do the original assessment, you ought to look at whether or not it is a progressive illness or a fluctuating illness. One criticism at present is that you do not look at that, which is why—

Dr Gunnyeon: I do not think that is entirely fair.

Q212 Chair: It must be right if you are saying that one of the reasons why they get overturned is that it is six months later. When you looked at it six months before, either you did not understand that it was progressive—

Robert Devereux: Remember we are still talking about a small proportion of the decisions we make.

Q213 Chair: A lot of people.

Robert Devereux: The ones who end up in appeal are likely to pick up the ones for which that is the case.

Dr Gunnyeon: In terms of the fluctuating nature of conditions, when we amended the WCA last year, we did things that were designed to take into account, for example, fatigue, one of the challenges that we knew was an issue for people. Going beyond that, again, Professor Harrington got a group of charities to look at the issue of fluctuating conditions, and the same with mental health conditions. We have combined it, and we are looking at an evidence-based review of the mental health descriptors and the things that affect fluctuating conditions. So the fluctuating nature is one aspect.

The other issue is that, when the health care professionals do the assessment, one of the things that they give a view on at the end is when it is reasonable to review the individual. That is based on an assessment of, all things being equal and the expectation of how the individual’s condition will progress, when it is likely that that individual might get to the point again of being fit to look for work. That is the prognosis bit. Now, prognosis in medicine is always difficult, and therefore people who you think are going to improve do not improve for a long time, or deteriorate, while other people who you think will actually take a long time then improve much more quickly than expected. There is still—I was going to say “sadly”, but it is probably an attribute—an element of art in medicine. It is not all science still.

Q214 Mr Bacon: And a lot of that is to do with mental health, is it not?

Dr Gunnyeon: Mental health makes it more of a challenge—

Mr Bacon: Someone who is very determined, come what may, to go back to work—

Dr Gunnyeon: Although the physical health conditions—

Q215 Mr Bacon: Of course, but there are people who are ill or who have problems who are absolutely rigidly determined that they will work, and that mental attitude presumably influences whether they end up going back to work.

Dr Gunnyeon: Indeed. One of the things we have been doing, because obviously the evidence-based review around the mental health and the fluctuating conditions will take some time, is that we have been reviewing the ESA 50 for the claimant, along with disability organisations, to try to ensure that we get much better information about the fluctuating nature of conditions right at the start of the process.

Q216 Mr Bacon: Right, this was my earlier question. I was really driving at what I understood you to have said—correctly or not perhaps. I thought I heard you saying that there were sometimes reasons other than the medical assessment for the appeal overturning the original decision, and you adduced mental health as one of those. Did I hear that wrongly?

Robert Devereux: We have spent a long time, partly on my direction, on that third of cases that are overturned because they take a different view of the

same facts. There is another group—more or less the two thirds—where what the judges are saying is that, on the basis of the oral evidence on the day, they are compelled to find in the name of the claimant.

Q217 Mr Bacon: There is something else.

Robert Devereux: Right. The question that none of us knows and we can hypothesise about is whether, on that day, the information in front of them was exactly the same as the decision maker had, in terms that the doctor had originally, or the elapse of time and the way that it is done is pushing the answer—

Q218 Mr Bacon: Meaning that they were more likely to have had a bad day.

Robert Devereux: Either a bad day or the information has been presented differently. I have a sympathy for the line that an appeal ought to be an appeal against whether the thing that was done originally was done incorrectly. With the passage of time, we are basically going back over the judgment. Now lots of judgments in life, I am sure, could be different with the passage of time or with a different audience, especially when it is not—as the Chair has established—a matter of precise science.

Q219 Mr Bacon: And do you know what proportion of those two thirds of cases involve a mental health issues?

Robert Devereux: I do not, and I do not think that—

Dr Gunnyeon: We do not have that information.

Robert Devereux: All we have at the moment is, literally, this minimalist set based on the data, but it is certainly high on my list of things to understand about how we take this forward.

Q220 Mr Bacon: Did I understand you to say that you do not know how many doctors there are doing this?

Dr Gunnyeon: No. We do know how many doctors there are. Sorry, I apologise for the fact that that is a figure that has gone from my mind at the moment. I think it is about 1,500 involved in total—

Q221 Mr Bacon: There are 1,500 medical staff, 1,500 health care professionals.

Dr Gunnyeon: Yes. A small proportion is physiotherapists and I am sure about 600 are nurses, therefore—allow me to correct it, if wrong—it is about 900, a combination of employed doctors and sessional doctors. I did not wish to mislead the Committee because I did not have the figures to mind, and I would rather confirm it accurately for you.

Q222 Mr Bacon: Is there a shortage of doctors or not?

Dr Gunnyeon: The challenge is now for it to be attractive for health care professionals to do this work. Atos is finding it more difficult to attract doctors and indeed other health care professionals. Mr Devereux referred to the fact that you cannot blame health care professionals when they are being subjected in the media to some of the clearly unfair criticisms that there are about the job they are doing. It is a real concern for me, because we need health care

professionals who are willing to do disability benefit assessment work, and that includes work in the new PIP contracts—

Q223 Chair: I have to say, Dr Gunnyeon, all the evidence that we have from the health service is that there are lots of people who cannot get jobs, so I cannot believe that there is a whole load of people in training because the health service got the figures wrong—

Dr Gunnyeon: But it is not because there are no doctors and nurses around, it is because they do not wish to step into the sort of arena in which they are subject to all sorts of abuse.

Chair: They have got to work somewhere if they have not got a job elsewhere. Maybe they need to go on the Work programme to get them into the job.

Q224 Mr Bacon: Mr Devereux, I am not absolutely clear about the answer to my question. It all sounded very articulate, but when you unpack it, my question was—

Dr Gunnyeon: Unusual, I know. *[Laughter.]*

Q225 Mr Bacon: Politicians themselves—“we-selves”, ourselves—are quite good at sounding articulate without saying anything, so I don’t blame you for that. But what I am trying to get at is this: what is the answer to my question? My question was this: is there a shortage of doctors?

Dr Gunnyeon: There’s not a shortage of doctors.

Q226 Mr Bacon: Is there a shortage of doctors doing this work?

Dr Gunnyeon: It is becoming difficult to—

Robert Devereux: Yes.

Q227 Mr Bacon: There is a shortage of doctors doing this work. That is exactly the same as it was in 2003. The NAO Report that I referred to earlier said, “Delays and backlogs existed before the Department outsourced the medical assessment part of the process in 1998. Shortages of doctors since then have added to the problems, but the root causes of many delays lie within the Department and the Benefits Agency.” It sounds depressingly familiar, does it not?

Robert Devereux: One of what I thought were the rather good bits of work that were done in preparation for the personal independence payment looked very clinically—sorry, wrong word—at the health care profession. It looked forensically at the individual professions and asked questions about what people’s propensity was to want to do work in this space, because typically—I think this goes back a long period, including to the period that you are talking about there—we have been employing people full-time to do benefit assessment work. The trouble with that is you then have to find people who want to do that for a living and in the current climate—unsurprisingly—very few people do, especially in London and the south-east.

Q228 Mr Bacon: It depends on how much you pay them.

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Robert Devereux: We then asked the question, “How many other health care professionals would like to do this for three hours a week as an extra shift to earn some cash?” Actually, very large numbers are there. So one trick in making the PIP contract go is to set it up on the basis that we get people doing the sort of labour supply with which they are comfortable rather than saying, “You will do it on these terms.”

Now, be careful, because at that point obviously Bill has got a problem, because he needs to make sure that it is all done at quality, because you won’t have a postcode lottery—

Q229 Mr Bacon: You will never see the same results twice.

Robert Devereux: But none the less there is evidence that if we think laterally about the amount of hours I need to do, because this is essentially—you do an hour here, an hour there and you can do it in that sort of way. We believe that there is a deep enough market to sustain the benefit testing. The critical factor is that I need people to think that this is a perfectly decent calling and it is not for the work of the devil.

The conversations we have had today where I have been asked, “You’ve got targets for getting people off benefits” and all the rest of it, you can see why I am anxious to establish some facts about the nature of the process, which I am accountable for and which Bill has helped me support with his depth of knowledge, from the actual action, which is part of the contract. It is in all of our interests to ensure that good health care professionals are helping us manage the benefit system.

Q230 Chair: Let me just tie it up. There are a few things that we haven’t covered. I have one question on the mental health side. I read a report—the BMA reports that eight out of 10 doctors said that they had seen patients develop mental health problems as a result of the stress of the test. Do you accept that, Dr Gunnyeon?

Dr Gunnyeon: I think I said earlier that it would be—whether people develop mental health problems or not, it is a distressing process which will cause people not insignificant anxiety, and that is a clear area of concern—

Q231 Chair: That’s scary, though, isn’t it?

Dr Gunnyeon: It is, but of course one of our challenges as well is that the more people believe that this is a dreadful process, that it is unfair and so on, the more that anxiety is increased. I think that is why it is important that we try and actually present the facts.

Q232 Chair: It is also the way that they deal with it. Can you just tell me something? With your nurses, how many days’ training do they get on mental health issues before they are let loose on claimants?

Dr Gunnyeon: The training course that Atos gives for their nurses is—I think, off the top of my head—something of the order of 20 or 21 days.

Q233 Mr Bacon: How many medical professionals end up having mental health problems as a result of doing this work? *[Laughter.]*

Robert Devereux: There is a limit to the questions that even we can answer.

Dr Gunnyeon: I don’t have any figures for that, and in fact the medical profession and we as health care professionals are very bad at admitting when we have problems, but it wouldn’t surprise me at all if people had—

Q234 Chair: Just to kill some myths, is it true that you get points for intravenous chemotherapy but you don’t get points for oral chemotherapy?

Dr Gunnyeon: We have changed the process, and as you know we are introducing changes, hopefully in January, to the way that we deal with people with cancer, because at the time—

Q235 Chair: So is it true that you get points for one and not the other?

Dr Gunnyeon: Yes, but hold on: when the assessment was developed oral chemotherapy did not have the impact that intravenous chemotherapy had. Now, the world of cancer treatment changes on a monthly basis. It has advanced rapidly. That is why we reviewed the process. Professor Harrington asked Macmillan to do it. We then had a consultation on it. We have got regulations that we are ready to lay, that will come into effect, hopefully, early next year, which actually now change the basis on which we deal with cancer treatment.

Q236 Chair: So they will get points for both.

Robert Devereux: There is an implication in your question, Chair, that perfectly upstanding professional doctors deliberately come up with some gash answers to things as important as cancer.

Fiona Mactaggart: I don’t think there is.

Q237 Chair: I tell you what there is in it. If you are a patient and you are getting oral therapy, as one of my friends is at the moment, as opposed to intravenous therapy, I can tell you the impact of that on her health and her ability to work is not that different—and I have seen people with both.

Dr Gunnyeon: But there is an opportunity for the health care professionals also, if they do actually believe that in spite of the fact that they would not be allocated points, the impact on the individual is such that clearly they are not fit to work, they do have the opportunity to address that. So it should be picked up anyway.

Q238 Chair: Can I just ask: another myth that I hope you can kill is that the assessors are not allowed to touch patients or carry out physicals. Is that true or not?

Dr Gunnyeon: That is definitely not true.

Q239 Fiona Mactaggart: Can I just ask what I asked earlier of Citizens Advice: am I right in thinking that Atos do have the responsibilities passed on by the Department for ensuring compliance with the

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Disability Discrimination Act? Atos have to comply with the DDA.

Robert Devereux: I thought it was the law of the land.

Q240 Fiona Mactaggart: Yes, exactly; but our earlier witnesses suggested that they were not confident that that was passed on to them by the DWP.

Robert Devereux: I don't think the Disability Discrimination Act is passed on to anybody. It is the law of the land.

Fiona Mactaggart: Okay. Thank you.

Q241 Chair: I am just going to ask a cheeky question: are we getting the Work programme stats this week?

Robert Devereux: Are you getting the Work programme stats this week? It depends what the date is. I think it is next week, but I cannot quite recall. I have a feeling it is the twenty-something-quite-high, so it would be next week. It was pre-announced by the Office for National Statistics, so it is not in the gift of the accounting officer to change it.

Q242 Chair: Right. Well we are looking forward to having you back on that.

Robert Devereux: I can't wait.

Dr Gunnyeon: I am not coming with you then.

Q243 Chair: The final thing is a question on the PIP assessment contract, because we have all been given information that suggests that what Atos submitted in their tender document was not entirely true in relation to their relationship with claimant representative groups. We have all read an article by Disability Cornwall, for example.

Q244 Robert Devereux: Did you read the tender documents as a consequence of that article?

Q245 Chair: Well I am hoping you can tell me.

Robert Devereux: Well, I did, you see.

Q246 Chair: I will tell you the thing on the tender documents; I think people have referred to a DWP in-house e-news *Touchbase*, which says—this is your own document, Mr Devereux—that the “successful bidders clearly understood DWP’s requirements, demonstrating strong evidence of working with a range of partner organisations including health groups and the voluntary sector. They also demonstrated close working with disabled people’s representative groups.” So it is not just the tender documents. It is your own assertion.

Robert Devereux: No, the criticism seems to be that somebody thinks that untruths were told in the tender documents, consequent upon which somebody got a contract they should not have got. That is simply false.

Q247 Chair: The only thing I would say to you is that the organisations have denied any co-operation with Atos, and you yourself, in your DWP news, suggested it was there. I will read it to you again: the DWP house e-news, *Touchbase*, says—

Robert Devereux: I do not know what these words mean: can you speak a bit slower—

Q248 Chair: “They also demonstrated”—I assume that is Atos—“close working with disabled people’s representative groups.”

Robert Devereux: With one eye on delivering a brand new system, perfectly respectably, we were asking them, “How are you going to work with the sort of people we would like you to work with, such as disabled bodies, to make sure that we get to the right answer?” So in answer to the question, most of the bidders, Atos included, listed the many people they already have contacts with in respect of their ordinary business and went on to explain in some detail what they proposed to do by way of developing what is a new test and a new service using a different supply chain to the current one.

Q249 Chair: I have to say to you on that it just does not fit with what you said in your news. I will read again from the DWP *Touchbase* e-zine: “They also demonstrated close working with disabled people’s representative groups.” That is what all the voluntary organisations have denied.

Robert Devereux: In respect of PIP?

Chair: Yes.

Robert Devereux: They have not started doing it. This was a tender document for a contract that has not been let at the point at which there are tender documents.

Q250 Chair: They were asked there to demonstrate that they had—not that they were going to—had close working relationships with disabled people’s representative groups.

Robert Devereux: The way that the story was reported when I read it was that they had not actually been in touch with them about preparing to deliver PIP. People were saying that, under no circumstances, were Atos to do PIP. That is not the question that the tender document asks.

Q251 Chair: I am just reading your own stuff back to you.

Robert Devereux: My own stuff is saying that they demonstrated that they work with disabled bodies. At the moment, the only way to falsify that would be to find that there is no contact at any level with anybody between Atos and these people and that is not what has been alleged.

Q252 Chair: I hear what you say. I am not sure that I am convinced by it, but—whether that is right or not—I am worried about whether, in determining the new contract, you have a good system of checks in the procurement process in case there is anything else that you missed.

Robert Devereux: Okay, I suggest that we have a proper hearing on how on earth a large Government Department runs proper procurements, but I have told you—

Chair: I hate to talk about the Work programme—

Robert Devereux: What procurement failing do you observe in the Work programme? I did not observe any.

Q253 Chair: It just strikes me that, however you say it, looking at your own thing suggests that they had

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close relationships. It looks at their trustworthiness. That is how it feels to me. They were asked a question. They said something. All the disability groups have denied it. There have been articles all over the press about it. Yet you give them the contract. So I think, "Are they a trustworthy company?" and then I think, "What sorts of checks do you do to ensure that what they tell you is right?" It is called due diligence.

Robert Devereux: Yes, okay. Oddly enough, we do due diligence, but I have not come prepared to go through the long route of how we do the due diligence. However, we keep coming back to the same observation. The tender documents asked a specific question. There are references in here to disability organisations. They are not references to say, "We have worked closely with them on the preparation for this bid." Therein lies most of the anxiety on the part of the disability organisations. I do not think that Atos has discussed this with people yet.

Q254 Chair: Even though it has been working on the ESA? It has had a contract with the Department since 2005.

Robert Devereux: I am sorry. I am only picking up the narrow nature in which the press story ran. If you are telling me that the press story was that people said that they had never seen Atos before in their life, that would be a problem. The stories that I saw were about not having worked with Atos on their bid.

Q255 Chair: I will finally read it once more. It is not that they were going to work together under PIP; it

states: "They also demonstrated close working with disabled people's representative groups." It was obviously not under PIP, because you had not let the contract.

Robert Devereux: With respect, you have not told me what says that that statement is not true. You have told me that I am asserting that they work with these people. I have not yet seen the evidence that you are trying to ask me to comment on.

Q256 Chair: The organisations themselves.

Robert Devereux: Okay, could you perhaps tell me what they said? So we can be really clear about what it is that they are contesting, where is the documentary evidence of what they said?

Q257 Chair: Disability Cornwall said, "We were horrified to hear that our name was mentioned by Atos on their tendering documents. We were never asked by them". GMCDP—whatever that is—said, "It does damage to our brand to be associated with them."

Robert Devereux: Yes, okay. I cannot comment on allegations that you are just reading out. If there is something that you want me to do, by all means drop me a line as we did when we went through all those fraud things, which we diligently tracked down and found nothing. Do come back and show me what they are and I will be happy to respond. We do not take lightly what people put in their bidding documents and we do ensure that we can have some confidence in them. That is the case with this contract.

Chair: Okay. Thank you very much.

Written evidence from the Department for Work and Pensions

VALIDATION OF INVOICES

What is the total number of invoices from which the sample for validation is selected?

Routine contract payments are based on three invoices, submitted to the department by Atos each month:

- a fixed Costs invoice. This invoice covers all the fixed costs incurred by Atos, and by its nature is of known value;
- an interim variable costs invoice paid mid month. This invoice is for the assessments Atos have conducted in the first half of the month; and
- a final variable costs invoice, paid at the end of the month. This invoice is for the variable charges due in the second half of the month.

PRE-PAYMENT VALIDATION CHECK

Before any payments are made, all invoices are checked to ensure that the number of cases requiring payment matches the number of cases the department is expecting to pay for. Where the numbers do not match, this is referred back to Atos for resolution before payment is made.

POST-PAYMENT VALIDATION CHECK

The final variable cost invoice shows all the assessments undertaken by Atos during the month (including those paid for via the interim variable cost invoice). In a typical month, this invoice will include some 128,000 individual cases (77,000 Work Capability Assessments, 47,000 ESA/IBR paper scrutiny assessments & 4,000 other outputs).

Each final variable cost invoice is validated by a sample check of the cases on the invoice, against the Department's own records. The invoice passes the validation if every case in the sample matches against the Department's own records. If any of the sample records fail to match, the Department would seek an appropriate

credit from Atos: but, in practice, not a single error has been found in any of the monthly Invoices since this validation began in May 2012 (up to and including the invoice of October 2012).

In more detail, the monthly sample is of 139 cases on each invoice, which allows the Department to be 95% confident that 90% of all the records on this invoice match the Department's records, with a 5% margin of error.

ROLE OF THE DECISION MAKER

Why are we using non-medical decision makers to make "medical" decisions?

The role of a Decision Maker is to take a decision on entitlement to benefit in accordance with the regulations laid down by legislation. As such they are trained in assessing evidence available to them against the requirements of relevant legislation based on their understanding of the law and the benefits system. The decision to award a claimant benefit is not, therefore, a medical one, but a benefits decision, based on all the evidence available including that provided by the claimant themselves and from advice provided by Atos Health Care Professionals (HCPs).

Claimants are encouraged to provide all evidence that will be relevant to their case, including medical evidence supplied by their GP or other medical professional, at the outset of the claim. HCPs are expected to seek further medical evidence in situations where that would help them provide advice without calling a claimant in for a face-to-face assessment. It is important to point out that the HCP report on the functional limitations imposed by a claimant's illness or disability is not a medical assessment but rather a functional one, designed to assess the impact of a claimant's health condition or disability on their capability to undertake work. The DM will assess all this evidence, and seek more if that is required, in order to reach their decision.

What training do HCPs receive?

All HCPs are registered with a professional body such as the General Medical Council or the Nursing and Midwifery Council and must have at least three years post-qualification experience. In addition, all HCPs are fully trained in disability assessment. They receive comprehensive training (doctor nine days, nurse 18 days, physiotherapists 21 days) before being approved by DWP Chief Medical Adviser.

Once approved, all HCPs are subject to ongoing quality checks through audit, which the Department validates. There have been approximately 20,000 such checks in the last year.

Training of HCPs consists of three distinct areas:

- *Generic training*—includes principles of disability analysis, professional standards (including manner & behaviour) and multi-cultural awareness;
- *Training to undertake benefit-specific assessments*—includes ESA and other benefit, assessments, with modular training and competency testing at each stage; and
- *Scrutiny/filework training*—includes provision of advice to the decision maker on the basis of available documentation within a customer's file, with theory and casework exercises, followed by supported individual casework.

Following the WCA training course, HCPs will, for a variable period, complete assessments under the continual supervision of an experienced trainer. Only when they are considered to have achieved competency will they progress to unsupervised assessments. At this stage every assessment is audited until they produce four consecutive A-grade reports, meaning that their reports have reached a high standard. At this stage they are referred to the Chief Medical Adviser for approval on behalf of the Secretary of State. Following approval, audit of their performance continues, at a reduced frequency.

All training material for HCPs is quality assured by the DWP Chief Medical Adviser.

What is the number and type of HCP employed by Atos?

ESA regulations allow for assessments to be carried out by a wide range of HCPs, including doctors, nurses, occupational therapists, physiotherapists or any other healthcare professional regulated by the Health and Care Professions Council.

For ESA, Atos use doctors, nurses and physiotherapists. This consists of a mixture of employed HCPs and self-employed doctors, some of whom work for the NHS.

The number of HCPs employed by Atos in the current DWP contract (across all benefits including those for the WCA) is around 1400: approximately 750 doctors (including approximately 500 contracted doctors) 600 nurses and 50 physiotherapists. This equates to 962 full time equivalents (628 nurse/physiotherapists, 199 employed doctors, 135 sessional doctors).

What percentage of Doctors employed by Atos on this contract have English as a first language?

We are unable to hold information on the first language of any HCPs, but all HCP's undertaking Work Capability assessments speak English. Atos Healthcare operates strict recruitment criteria, which includes the assessment of an applicant's oral communication skills during a formal interview, conducted by experienced

medical and administrative managers. If the applicant's oral skills are not deemed to be to the required standard, the applicant will not be successful at interview.

Of the 38% of cases overturned by tribunals, what proportion are people coming off of IB?

Data specifically relating to cases overturned by tribunals in relation to Incapacity Benefit reassessment is not available.

Robert Devereux
Permanent Secretary

4 December 2012
