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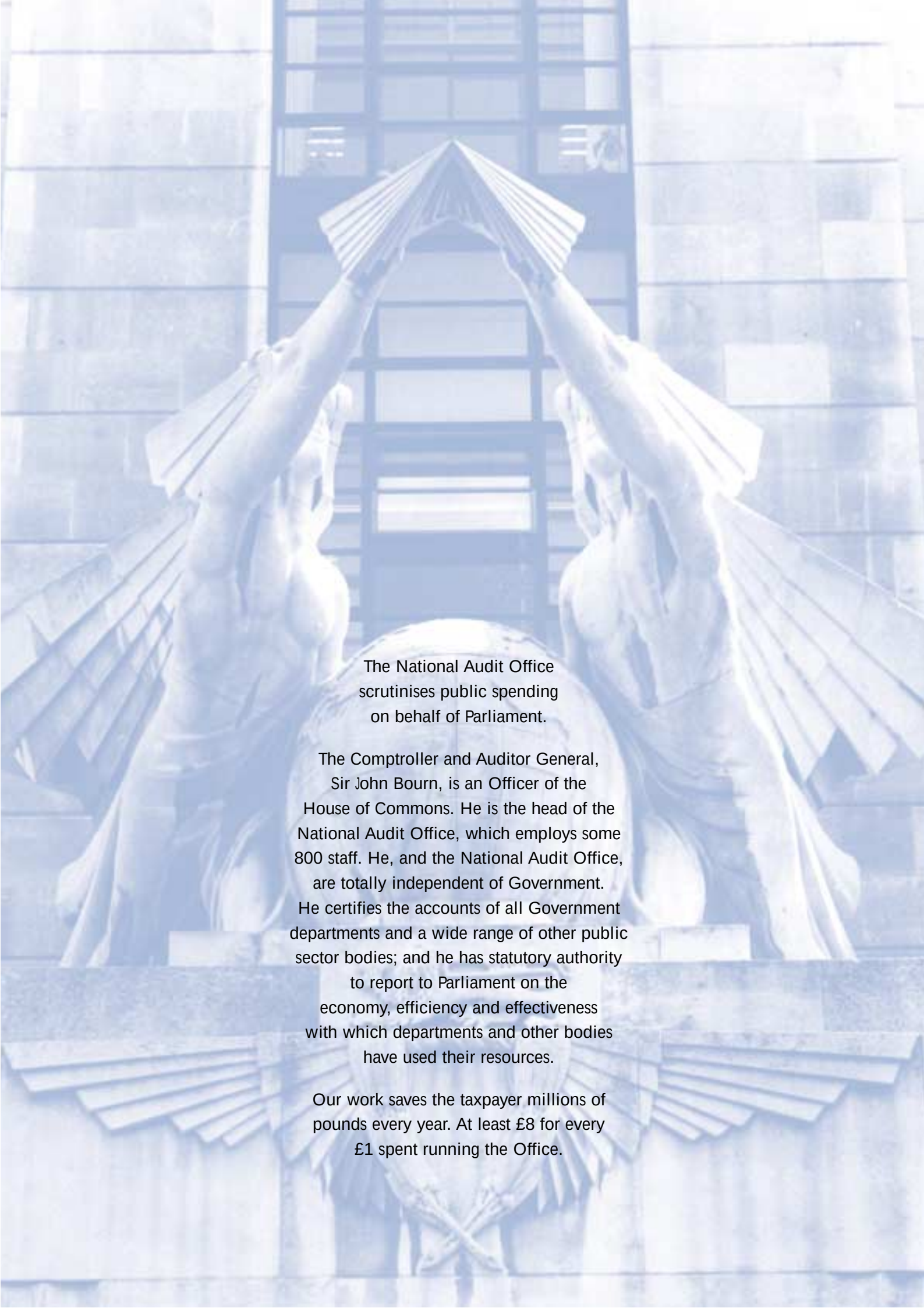
Progress in improving the medical assessment of incapacity and disability benefits

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL
HC 1141 Session 2002-2003: 17 October 2003



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John Bourn
Comptroller and Auditor General

National Audit Office
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Preface

Disability and incapacity benefits costing over £18 billion a year are paid to some of the most vulnerable members of society. Ensuring good quality medical evidence is an essential part of assessing eligibility for these benefits. The Department for Work and Pensions contract with Schlumberger (previously SchlumbergerSema and SEMA Group) to obtain medical reports to assist with these benefit assessments. In 2001, the National Audit Office reported to Parliament on *The Medical Assessment of Incapacity and Disability Benefits*, and the subsequent Public Accounts Committee report (27th Report 2001-02), highlighted areas where they expected improvement in relation to the speed of benefit processing, the quality of medical evidence, and the quality of service to the public.

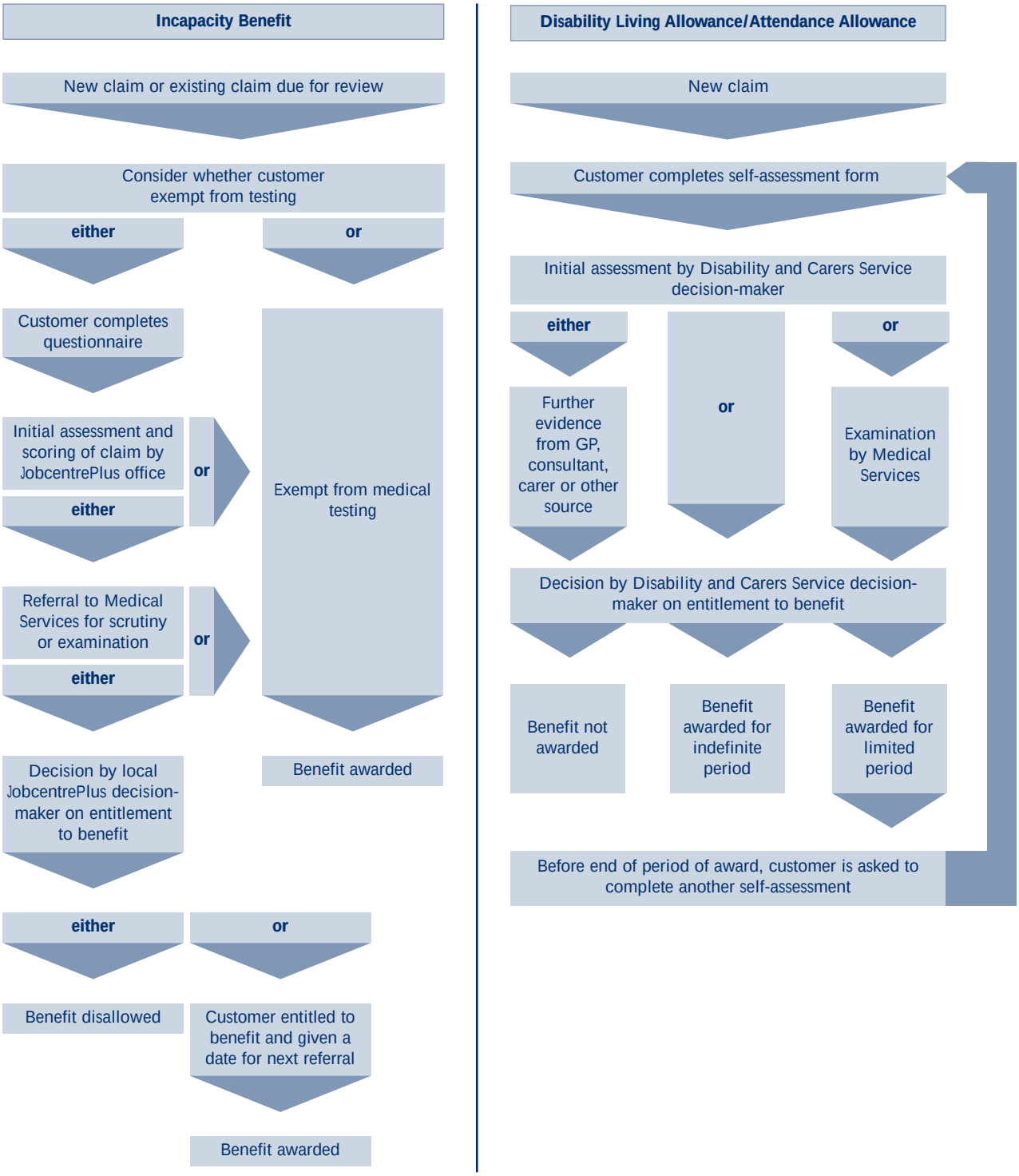
This report examines the progress made by the Department in addressing the issues raised by the Committee. In particular, it looks at:

- what progress has been made towards eliminating delays in making decisions on incapacity and disability benefit claims, and ensuring the availability of professional staff to deliver the medical service workload;
- whether improvements have been made in the quality of medical evidence and the accuracy of decisions; and,
- whether improvements have been made in the quality of service to customers.

Against these we have found that:

- following significant changes to the original contract and with the introduction of new targets, performance improvements have been achieved;
- processing times have improved for all the benefits. We estimate that this has resulted in a one-off saving to the taxpayer of some £29 million and an annual saving of some £21 million;
- the standard of medical reports has improved, and steps are being taken to improve the range of other medical evidence used to assess benefit claims, but the number of appeals lost as a result of problems with medical evidence remains high; and
- most customers are satisfied with the service they receive from Schlumberger, but a small percentage of customers continue to be sent home unseen because of over-booking of appointments arising from continuing high levels of non-attendance.

1 The process of assessing incapacity and disability benefit claims



executive summary

1 Incapacity and disability benefits are available for people who are either unable to work owing to illness or disability, or who need help because of a disability. An important element of establishing eligibility for these benefits is a medical assessment. The main benefits requiring an assessment are Incapacity Benefit, Attendance Allowance and Disability Living Allowance, on which the Department paid out over £18 billion in 2002-03. **Figures 1 and 2** show when an examination is needed for these benefits. Given their significance, it is crucial that assessments are undertaken fairly and efficiently, by well qualified staff who provide a good quality of service, while ensuring that benefits are paid only to those genuinely entitled to them.

2 Use of medical examinations for incapacity and disability benefits

	Incapacity Benefit	Disability Living Allowance and Attendance Allowance
Who?	Customers already in receipt of Incapacity Benefits and National Insurance credits as a result of incapacity	Customers making a claim for either benefit
When?	On a date set when the benefit is first awarded	Before benefit is awarded, when a claim is renewed, or on reconsideration or supersession of a decision
Why?	All recipients are referred to Schlumberger Medical Services for periodic review unless exempt because of their condition. Medical Services scrutinise the case and decide whether an examination is necessary	Departmental decision-makers refer customers for examination if they have insufficient information to decide on a claim
Where?	Normally in Medical Examination Centres	Normally in the customer's home
How many examinations?	520,000 in 2002-03	220,000 in 2002-03

Source: National Audit Office

2 In March 2001, the Comptroller and Auditor General reported to Parliament on the service provided to the then Department of Social Security by SEMA (SchlumbergerSema from 2001, and Schlumberger from 2003) to provide medical evidence to assist social security staff in making decisions on benefit claims. The report made a series of recommendations on improving performance under the contract and on processes within the then Benefits Agency. The subsequent report by the Committee of Public Accounts (27th Report 2001-02), highlighted areas for improvement in relation to the speed of benefit processing, the quality of medical evidence, the quality of service to the public, and contractual mechanisms to ensure quality. In 2002, the Department for Work and Pensions extended their contract with Schlumberger until August 2005, with new contractual targets.

3 This report examines progress in the areas highlighted by the Committee. **Figure 3** summarises developments to date against their recommendations. The Department have taken action on all the Committee's recommendations. Our work confirms that the Department's new relationship with Schlumberger and the introduction of new contractual targets have improved the service they receive. They have introduced new targets, monitoring arrangements, and action plans to improve the speed of processing, the standard of decision-making and the quality of service provided by Schlumberger. However, both parties could learn more from the results of appeals, work to obtain better evidence from general practitioners and others, and deal with the issues of overbooking appointments and non-attendance of customers. Appendix 3 (available at www.nao.gov.uk) lists the Committee's conclusions in full, together with the government's response and subsequent progress. Appendix 2 summarises the chronology of the main developments.

3 Summary of progress against the Committee's recommendations

Recommendation	Progress
Delays in making decisions about benefit, and variations across the country, impacted on customers and the taxpayer. The Department should set clear targets for improvement (conclusions (i) and (ii)).	**Implemented.** New performance targets have been set and are being met or are on track to be met by April 2004.
Explore the use of other healthcare professionals to offset shortages of doctors, speed up assessments and reduce costs (conclusion (iii)).	**Ongoing.** The Department experimented with using other professionals but they did not speed up the process or reduce costs. Increased recruitment and more flexible deployment have dealt with doctor shortages in the short term. The Department are exploring how to use more evidence from other professionals in the assessment of disability benefits.
Reduce the number of appeals that are successful because of mistakes in interpreting medical evidence (conclusions (iv) and (v)).	**Ongoing.** Feedback from appeals tribunals has been improved, but these have not resulted in a reduction in appeals overturned because of the medical evidence or its interpretation. The Department are taking further steps to learn from the results of appeals.
Improve the quality of medical reports, especially those carried out in customers' homes, with tighter Departmental oversight of standards (conclusion (vi)).	**Implemented.** Targets for reducing the number of substandard reports have been built into the contract and are monitored by the Department. The proportion has halved since September 2000.
Resolve the conflict of interest for general practitioners to overcome their reluctance to provide medical evidence (conclusion (vii)).	**Ongoing.** Reports requested from general practitioners have been revised to focus on clinical information only. A number of pilot schemes are trialling a range of alternative ways of obtaining medical evidence.
Pay compensation if customers are turned away unseen as a result of overbooking of appointments (conclusions (viii) and (ix)).	The Department do not consider compensation appropriate. They have attempted various measures to address overbooking, but have not improved the proportion of customers sent home unseen. They are doing more work to understand why customers do not attend examinations, the underlying reason for overbooking.
Ensure that Schlumberger provide a responsive service to all customers and respond to special needs (conclusion (x)).	**Implemented.** Medical Services meet nearly all special requests and the number of complaints against them has reduced steadily.

Actions taken on speed of decisions - reducing delays and backlogs (Part 2)

4 The Department have introduced and met new performance targets for accurate and timely processing of the key incapacity and disability benefits. These have, for example, reduced the processing times for Incapacity Benefit, Disability Living Allowance and Attendance Allowance and reduced the backlog of Incapacity Benefit cases from around 368,000 in 2001 to under 40,000 in June 2003. For Incapacity Benefit, where delays mean some claimants continue to receive the benefit to which they are not entitled, the improvements in processing times represent a saving to the tax payer of some £21 million a year. The number of Incapacity Benefit examinations performed is increasing year-on-year, and reductions in eliminating the backlog achieved so far represent a saving of some £29 million. The Department aim to eliminate the backlog by 1 April 2004, which will result in a further £8 million saving.

5 At the time of our previous report, processing times were severely affected by shortages of doctors. Schlumberger have since taken a number of measures to ensure they have sufficient doctors to meet requirements for 2002-03 and 2003-04. These included a recruitment drive, improved resource management and more attractive pay and conditions. The Department no longer consider a shortage of doctors to be a key driver to utilising other healthcare professionals, but they have experimented with ways of using other healthcare professionals in the medical testing process. However, these led to an increase in the length of examinations. They are still looking to identify ways of using other healthcare professionals in the evidence gathering process for Disability Living Allowance and Attendance Allowance claims.

Actions taken on improving the quality of medical evidence (Part 3)

6 The number of cases ending in a successful appeal has continued to be high. In September 2002, 54 per cent of Disability Living Allowance appeals, 47 per cent of Attendance Allowance appeals and 43 per cent of Incapacity Benefit appeals were successful. The most common reason was new evidence being available to the appeals tribunals, but the President of Appeal Tribunals considers that in some cases, medical reports (not all of which have been provided by Medical Services) underestimate the severity of disability. Currently, Departmental decision-makers and doctors from Medical Services receive little or no feedback on the outcome of appeals where medical evidence was challenged.

7 New contractual targets have been put in place for the quality of Schlumberger medical reports. They have introduced rigorous quality control mechanisms and developed computerised support for the completion of the most common types of medical assessment for Incapacity Benefit. The percentage of medical reports assessed as substandard has fallen from some 6 per cent to 3 per cent since our previous report. Ultimately, doctors who fail to meet Medical Services standards in disability assessment may be suspended from carrying out examinations for the Department. This happened on 22 occasions in 2002, with another 40 doctors following improvement action plans.

8 The Department have introduced a new form of Factual Report for general practitioners, with the main aim of reducing the burden on general practitioners and the expectation that it may reduce the number of people requiring medical examination. They and Schlumberger worked together on a series of pilots designed to gather better medical evidence from general practitioners, and provided additional training for decision-makers. To date, the outcomes of these are not clear, and improvements in the quality of medical evidence have not yet been translated into a reduction in the number of appeals lost where tribunals considered there had been weaknesses in the medical evidence, or it had been misinterpreted.

Actions taken on improving the quality of service to customers (Part 4)

9 At the time of our previous report, new contractual incentives were put in place to improve the quality of service Schlumberger delivered to the public. These included targets for waiting times, special needs requests such as same gender doctors, and levels of customers sent away unseen. Most targets have been met, and the number of complaints against Medical Services reduced. Despite the introduction of a more flexible approach to scheduling appointments and a revised doctor pay structure to encourage doctors to stay longer to see additional customers, there has been little progress in reducing the number of customers sent home unseen on account of overbooking. In the main, overbooking is a response to high levels of non-attendance by customers. Around 20-25 per cent of Incapacity Benefit customers fail to attend an examination and the Department together with Schlumberger are undertaking further research to try to find more effective ways of identifying likely non-attenders.

10 Overall, Medical Services report high levels of customer satisfaction - since 2000, 95-97 per cent satisfaction for examinations at medical centres, and around 92-95 per cent for home visits. Complaints have fallen steadily over the same period. Examinations for Disability Living Allowance and Attendance Allowance, normally carried out in customers' homes, generate the most complaints, which usually relate to the doctor's manner, the content of examinations, clinical findings and administrative matters.

Recommendations for further improvements

11 Good progress has been made since our previous report. In order to make further progress, there is scope for further attention to the issues described above. In addition, to process medically-assessed benefits more efficiently, improve the accuracy of decisions and the further improve the quality of service provided to customers, the Department should look to:

1 **Make better use of information technology.** Electronic sharing and transfer of case files and other customer data between decision-makers and Medical Services offer the best scope to achieve further reductions on processing times without affecting the time available to carry out medical assessments.

2 **Integrate a wider range of evidence into the assessment process.** Although trials suggest it may be impractical to use other professionals to carry out medical assessments, the Department should look to obtain more evidence about customers' conditions from professionals involved in their treatment, such as consultants, occupational therapists, social workers and community psychiatric nurses, to help achieve better decisions, as well as reducing the need for medical examinations.

3 **Develop better feedback on the outcomes of appeals.** Decision-makers and doctors receive little or no notification of the outcomes of appeals, where customers have often challenged medical evidence. Greater feedback would assist doctors and decision-makers in learning from past cases and spreading good practice, and would ensure they are aware if they are systematically misinterpreting the guidance. The Department should put in place a mechanism by which decision-makers and Medical Services are routinely informed of the results of appeals against their assessments.

4 **Clarify and promote the role of Medical Services in advising decision-makers.** New ways of obtaining evidence from general practitioners and other sources may improve the quality of medical evidence, but they also mean decision-makers will need to make more and better use of Medical Services as a source of advice and help in interpreting the evidence from this wider range of sources. In some areas, decision-makers have little contact with Medical Services, and the Department should seek to clarify and promote the role of Medical Services in providing advice to decision-makers.

5 **Tackle non-attendance.** Non-attendance of customers for examinations remains a problem, and encourages offices to overbook in anticipation. People may be unable to attend for good reasons, but Incapacity Benefit recipients may not attend an examination if they think it will lead to their benefit being withdrawn. Non-attenders may, therefore, remain on benefits to which they are not entitled. The Department should reinforce with customers their responsibility to attend their examination, unless they have good cause not to do so. At a local level, they should work more closely with Schlumberger to identify those who are genuinely avoiding examination and deal with those cases effectively.

6 **Address weaknesses in accommodation used for examinations.** Schlumberger have proposed that they carry out more assessments in medical centres, and fewer in people's homes. This is currently being evaluated. In doing this, they and the Department should examine the scope for improving the quality of accommodation given that this receives the lowest satisfaction rating amongst customers.

Part 1 Introduction

1.1 The Department for Work and Pensions (the Department) administer a range of benefits for people unable to work as a result of sickness or disability, or who need help because of a disability. The Department's decision-makers use medical evidence in determining eligibility for these benefits. Schlumberger Medical Group (SEMA Group until 2001, SchlumbergerSema from 2001 to 2003) delivers a medical examination and advice service under contract to the Department to assist in providing this evidence.

1.2 In March 2001, the National Audit Office reported on the medical service provided by SEMA Group to the then Department of Social Security[1]. The report made a series of recommendations on improving performance under the contract and on processes within the then Benefits Agency. The subsequent report of the Committee of Public Accounts[2] highlighted areas for improvement to the accuracy and timeliness of assessments, quality of service to the public, and contractual mechanisms to ensure quality. In 2002 the Department for Work and Pensions extended their contract with Schlumberger until August 2005, with new targets.

Medical assessments

1.3 Medical assessment is required to establish eligibility for the main disability and incapacity benefits **(Box 1 overleaf)**. The Department assess some 2 million such claims every year. This report focuses on the three main benefits - Disability Living Allowance, Attendance Allowance, and Incapacity Benefit - which together account for 95 per cent of the relevant cases and expenditure.

1.4 Disability Living Allowance and Attendance Allowance require completion of a form about the applicant's disability and its effects. Questions cover whether the customer can safely and unaided carry out everyday tasks. Claims are assessed by decision-makers in the Department's Disability and Carers Service. The responses provide the core evidence on which they decide eligibility, but they may seek other information from the customer's general practitioner or another health care professional. In about one-fifth of cases they ask Schlumberger Medical Services to examine the applicant and complete a medical report. The examination normally takes place in the customer's home. The doctor interviews the customer in order to establish how their condition affects them, and feeds this information into the medical report along with details of the physical examination. The decision-maker may make a permanent or time-limited award of benefit. In the latter case customers may claim again using the same procedure when their award ends.

1.5 Incapacity Benefit is claimed by people who are unable to work as a result of sickness or disability and is administered by Jobcentre Plus. Employees normally receive Statutory Sick Pay for the first 28 weeks of such an absence from work. Those not entitled to Statutory Sick Pay, because they are self-employed or unemployed, are initially awarded Incapacity Benefit, normally on the basis of a certificate from their general practitioner confirming they are unable to do their normal work.

1.6 Most customers are subject to a Personal Capability Assessment early in their claim dependent on their incapacity, after 28 weeks if they have a regular occupation or immediately for those who have been on Statutory Sick Pay for 28 weeks. Customers with severe medical problems - around 17 per cent - are exempt. This examines the customer's ability to carry out everyday work-related activities. Evidence for the test can be obtained from the customer's doctor, a self-completion questionnaire, consideration of the paper evidence by a Medical Services doctor or, in about 40 per cent of cases, a face-to-face medical examination at a Medical Services centre. Customers are normally scheduled for a further test, which could be from three months to five years later depending on the recipient's condition. Figure 1 on page 2 outlines the claim processes for these benefits.

1 *The Medical Assessment of Incapacity and Disability Benefits (HC280 2000-01).*
2 *The Medical Assessment of Incapacity and Disability Benefits. Public Accounts Committee 27th Report 2001-02.*

BOX 1 **Description of Disability Living Allowance, Attendance Allowance and Incapacity Benefit**

		Number of claimants in 2002-03 (million)	Expenditure in 2002-03 (£ billion)
Disability Living Allowance	A non-contributory, tax-free benefit paid to customers under 65 years of age who because of an illness or disability need help with personal care, getting around or both. The rate of benefit depends on the level of care required. People receiving the benefit at 65 can continue to claim it.	2.4	7.05
Attendance Allowance	A non-contributory, tax-free benefit paid to customers of 65 or over who because of an illness or disability need help with personal care. As with Disability Living Allowance the rate of benefit depends on the level of care required.	1.3	3.25
Incapacity Benefit	The main contributory benefit for those people unable to work because of illness or disability, below pension age.	1.5	6.79
Industrial Injuries Disablement Benefit	A non-contributory benefit to compensate people who are disabled as a result of an accident at work or are ill or disabled because of a disease or deafness caused by work.	0.3	0.72

1.7 In total, in 2002-03 Schlumberger produced around 1.15 million medical reports for the Department, of which about 810,000 involved a medical examination. In May 2003 Schlumberger employed 220 full-time doctors on the Medical Services contract, but most medical assessments are carried out by about 1,950 independent doctors contracted to work for them part-time.

Medical assessment is affected by other developments in the way the Department deliver benefits

1.8 In 1999 the Department introduced major changes to their decision-making and appeals procedures in order to improve the accuracy of decisions, reduce the levels of appeals and reduce waiting times for appeals. These changes are the subject of a separate National Audit Office report, *Getting it right, putting it right: improving decision-making and appeals in social security benefits*.

1.9 From April 2002, the Department for Work and Pensions reorganised their agencies to replace the Benefits Agency with The Pension Service and Jobcentre Plus, which also took over the functions of the Employment Service. At a local level, the social security offices which processed benefit claims under the Benefits Agency are transferring their functions to Jobcentre Plus offices over a four year period to 2006. Disability Living Allowance and Attendance Allowance will continue to be processed at a central Disability Benefits Unit and eleven Disability Benefit Centres, which are part of the Disability and Carers Service within the Department.

1.10 The 2002 Green Paper *Pathways to Work* contained proposals to pilot ways of improving the prospects of Incapacity Benefit recipients returning to work. The changes being piloted from October 2003 will alter the pattern of medical assessments for Incapacity Benefit claimants in the pilot areas, who will have an earlier medical examination to feed into a decision about benefit entitlement. A personal adviser will then discuss with claimants the options open to them, informed by the results of the medical examination, which will therefore need to identify claimants' capabilities as well as the extent of their incapacity. The pilots will assess the effect of this change on demand for Medical Service resources.

Since 2001 there have been significant changes in the contractual relationship

1.11 The Department awarded a contract to the then SEMA Group for the provision of the medical service for five years from 1 September 1998. In 2001, we reported that outsourcing had reduced the cost to the Department and led to valuable improvements in the speed with which work was processed. However, the viability of the business was under acute cost pressure and this affected the efforts of the Department and the company to improve the quality of medical assessments and customer service. Although the Department had strengthened quality measures in the contract, they were not as robust as those requiring fast turnaround.

1.12 More broadly, we reported that bottlenecks existed throughout the system, resulting in delays in paying some disability benefits; continued payment to those who were no longer eligible; and a highly variable quality of service to claimants. There was a risk that these would get worse as the business faced a major strategic threat in terms of shortages of doctors.

1.13 In April 2001, SEMA were subject of an agreed take-over by Schlumberger to form SchlumbergerSema (Schlumberger from 2003). As an incentive for the new company to deliver service improvements, the Department offered to extend the contract from August 2003 (when it was due to expire) to August 2005. The extension included amendments to the contract, which revised or introduced new targets in:

- customer service (the level of complaints, waiting times for examination and numbers of customers sent home unseen);
- managing the medical assessments (throughput of examinations and adequacy of medical reports); and
- the recruitment, retention and skills of the doctors employed.

If not met, these targets carry financial remedies, known as service credits. **Box 2** summarises key features of the contract.

1.14 The extension was subject to confirmation in May 2002, provided Schlumberger could demonstrate performance improvements. The Department decided to confirm the contract extension, as the company met 43 of the 45 targets set for them in 2001-02. The remaining two were achieved in April 2002.

1.15 As well as introducing new contractual targets, the Department and Schlumberger worked together to build more effective relationships between their staff. The company appointed new staff at senior levels and new governance structures were established under which responsibilities for improving the medical service were shared between the Department and Schlumberger. These included arrangements for escalating disputes to a senior joint board.

1.16 Jobcentre Plus and the Disability and Carers Service have business targets which depend partly on the performance of Medical Services, and senior managers told us that the relationship with Schlumberger had improved considerably since these developments. This confirmed an annual survey carried out for the Department of the effectiveness of the business relationship. At an operational level, the survey and our interviews found that there were still some unresolved problems but managers felt the service had been improving, in particular because Schlumberger were becoming more responsive to problems and there was more local interaction between managers.

BOX 2 The medical services contract with Schlumberger

- Schlumberger are a multi-national company with interests in the oil industry and information technology. When they acquired SEMA Group in 2001, they took over its subsidiary Medical Services, now Schlumberger Medical Services, which held the contract to provide a medical assessment service to the Department for Work and Pensions. Schlumberger Medical Services also provide medical assessments for insurance companies and occupational health and medical screening services.
- Under the contract, Medical Services are required to:
  - provide professional medical advice on cases referred to them by the Department for Work and Pensions or other departments;
  - carry out physical medical examinations where they deem it necessary and supply written reports to agreed standards;
  - provide enquiry services for claimants, general practitioners and departmental customers; and
  - provide support services, such as professional training, information technology, and other general management backup.
- They receive payment based on a unit price for each type of report produced, plus a fixed element covering some overheads and management costs.
- They are required to meet service level targets relating to:
  - throughput of medical reports;
  - accuracy and quality of reports;
  - response times for dealing with enquiries;
  - customer satisfaction;
  - quality of service to customers attending examinations;
  - medical staff training; and
  - quality of responses to complaints.
- Contract payments can be reduced by service credits if they fail to achieve target levels of service.

What this report covers

1.17 This report examines the progress made by the Department to meet the concerns of the Committee of Public Accounts and improve the delivery of medical assessments since our previous report. The Committee's conclusions were in three main areas:

- on improving the speed of decisions on benefit entitlement (Part 2);
- on improving the quality of medical evidence and benefit decisions (Part 3); and
- on improving the quality of service to customers (Part 4).

1.18 The methodology for this follow-up examination is set out in Appendix 1. We:

- examined relevant project documentation, including the performance information produced by Schlumberger under the contract;
- examined the Department's management information on their performance in processing Disability Living Allowance, Attendance Allowance and Incapacity Benefit claims;
- interviewed key staff at Schlumberger and in the Department responsible for the delivery of the above benefits, and implementing the Committee's recommendations;
- interviewed decision-makers in Disability Benefit Centres and social security offices;
- reviewed the outcome of a number of pilot projects;
- ran two focus groups with doctors working for Medical Services to discuss a range of issues including recruitment and retention of doctors, the role for other healthcare professionals in the medical assessment process, and the scope for further improvements; and
- examined a sample of files held by Citizens Advice on medical assessment cases dealt with by their advisers, and held group discussions with benefits advisers and disability group representatives.

1.19 We also consulted with the Appeals Service and the Department for Work and Pensions Standards Committee, which provides independent advice and assurance to the Department on the standard of benefit decision-making. We sought the views of key third parties with an interest in medical assessments, including Citizens Advice, the Disability Alliance, and the British Medical Association.

Part 2

Improving the speed of decisions

2.1 This part examines the progress made in dealing with delays in making decisions on benefit claims. The Committee of Public Accounts raised concerns about:

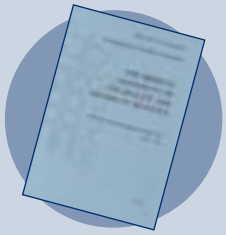
- Delays in processing within the then Benefits Agency, and their impact on customers and the taxpayer (conclusions (i) and (ii)).
- How to overcome shortages of doctors, including the scope to use other healthcare professionals in the medical assessment process (conclusion (iii)).

Dealing with delays in processing

Targets for performance improvement have been set and achieved

2.2 To address delays within the Department and their agencies, the Department have set new targets for improving benefit processing performance as recommended by the Committee. Prior to April 2002, the Department's targets for Disability Living Allowance and Attendance Allowance claims were of the form X per cent of claims processed in Y days. However, the new targets take the form of Actual Average Clearance Time. This is the average time between registering the claim and notification being sent to the claimant. The targets and progress made against them are set out in **Figure 4 overleaf**.

2.3 Accurate and timely processing of Incapacity Benefit decisions following Personal Capability Assessments forms part of the Jobcentre Plus Business Delivery Target from 2002-03. The national target was for 95 per cent of cases (increasing to 98 per cent for 2003-04) to be cleared within 15 days of the receipt of documentation from Medical Services, and found to be accurate. Both targets were met for 2002-03 at a national level. Accuracy levels exceeded 99 per cent for the year, and timeliness reached 98 per cent in February 2003. This is significantly better than data reported in our 2001 report, which found that the average time from examination to decision on entitlement was 27 days, with a range from 11 to 71 days.



At the time of our previous report, significant delays in making decisions about benefit meant that many claimants for Disability Living Allowance wait longer than they should to receive their money, and £40 million a year or more may have been lost because the Department continued to pay Incapacity Benefit to people when they are not entitled. Variations across the country meant that claimants waited longer in some areas than others.

Delays and backlogs existed before the Department outsourced the medical assessment part of the process in 1998. Shortages of doctors since then added to the problems, but the root causes of many delays lay within the Department and the then Benefits Agency. As in other parts of the social security system, poor management information and outdated information technology were likely to hinder progress for some time. But the Committee considered that there was action the Department could take to improve their performance, drawing on work already done on Income Support and Jobseeker's Allowance and on the recommendations made by the Comptroller and Auditor General. They expected clear targets to be set and reported for performance improvement (27th Report 2001-02, conclusions (i) and (ii)).

2.4 In addition to their Business Delivery Target, Jobcentre Plus set specific targets for dealing with the Incapacity Benefit backlog. Once a decision has been made on a new Incapacity Benefit claim and the customer is receiving payment, a referral date is set at which the case will be reviewed and medical evidence sought as necessary. At the end of 2000, there were substantial backlogs of Incapacity Benefit cases that were due for review but were being deferred. The Department therefore created a team of managers from the Department and Schlumberger to examine the problems and set targets to reduce the backlog to 250,000 by 1 April 2002, 100,000 by 1 April 2003 and 50,000 by October 2003, eliminating it by 1 April 2004. Non-contractual targets were also set for the volume of Incapacity Benefit examinations performed each day by the different examination centres. At a national level this target was around 2,000 per day.

4 Processing targets and progress made for Disability Living Allowance and Attendance Allowance

Benefit type	Targets for processing times		Progress made	
	Effective from:	(days)	Period:	Annual average clearance time (days)
Disability Living Allowance				
Normal rules			2000/01	46.8
			2001/02	44.0
	01.04.02	43	2002/03	42.0
	01.04.03	42		
Special rules[1]			2000/01	9.7
			2001/02	7.9
	01.04.02	8	2002/03	7.0
Attendance Allowance				
Normal rules			2000/01	30.5
			2001/02	27.1
	01.04.02	27	2002/03	24.2
	01.04.03	26		
Special rules[1]			2000/01	6.2
			2001/02	6.5
	01.04.02	8	2002/03	5.6

NOTE

1. Special rules cases are those involving customers who are terminally ill and therefore these cases are treated with priority.

Source: Department for Work and Pensions

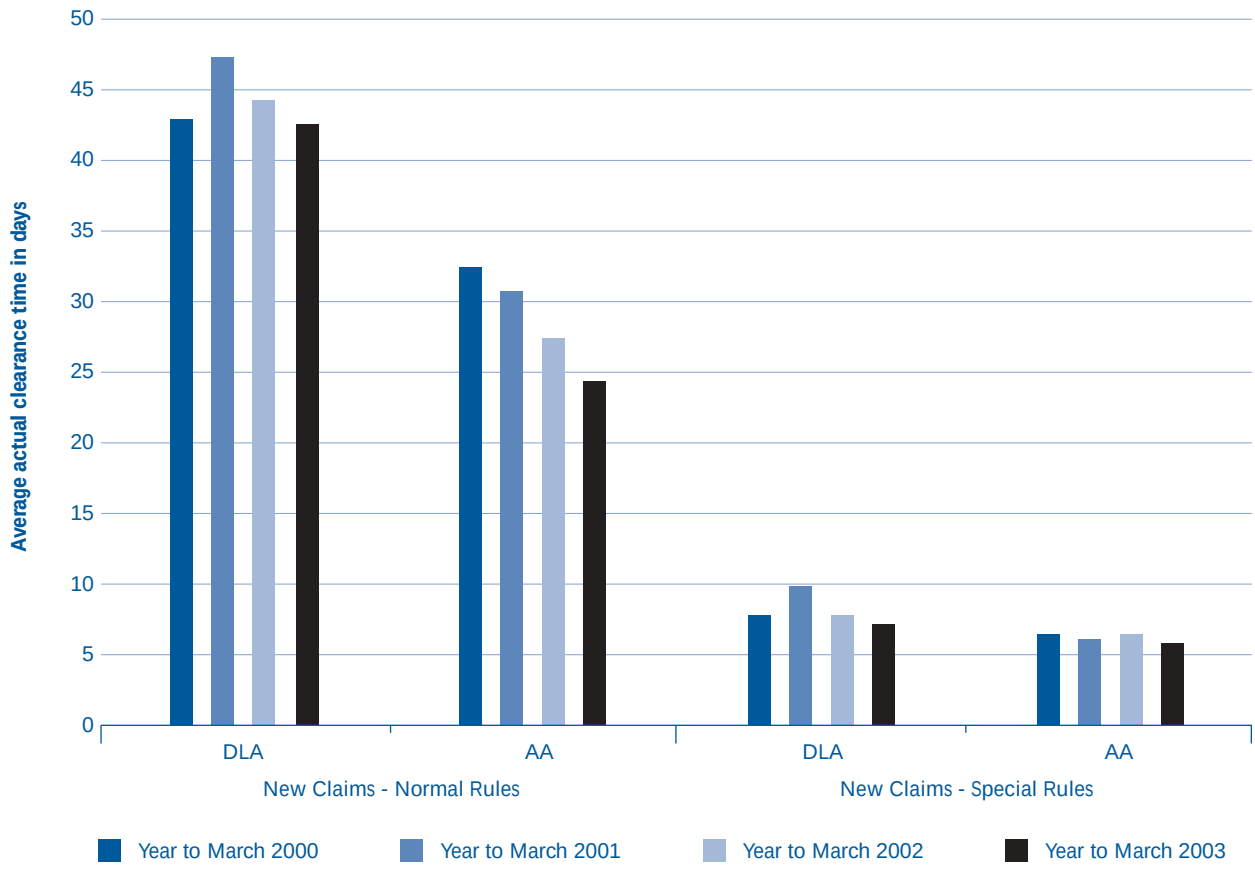
Processing times for Disability Living Allowance and Attendance Allowance have improved

2.5 There has been a steady improvement in processing times for Disability Living Allowance and Attendance Allowance since early 2000 **(Figure 5)**. These improvements have an impact on the cash flow of customers. It means that in 2002-03 customers under normal rules received cash on average nearly 5 days earlier than in 2000-01 for Disability Living Allowance and 6 days earlier for Attendance Allowance.

2.6 In our 2001 report we highlighted the variation in the time taken to clear cases at different Disability Benefit Centres for the year to March 2001. **Figure 6 overleaf** shows that there was still considerable regional variation in the year to March 2003. The Disability and Carers Service introduced targets from March 2001 to reduce the differential between the worst and best performing business areas by 20 per cent by October 2001, 33 per cent by the end of March 2002 and 50 per cent by the end of March 2003, for Disability Living Allowance and Attendance Allowance claims and appeals, using the year to November 2000 as a baseline. All regions had met the targets by the end of March 2003, as shown for Disability Living Allowance normal rules cases in **Figure 7 on page 17**.[3]

3 *Analysis of the variation in performance, as measured by the standard deviations of the key performance measures for each office, also shows that variations have decreased.*

5 Trend in actual average clearance times for new Disability Living Allowance and Attendance Allowance claims



Source: National Audit Office analysis of Department for Work and Pensions data

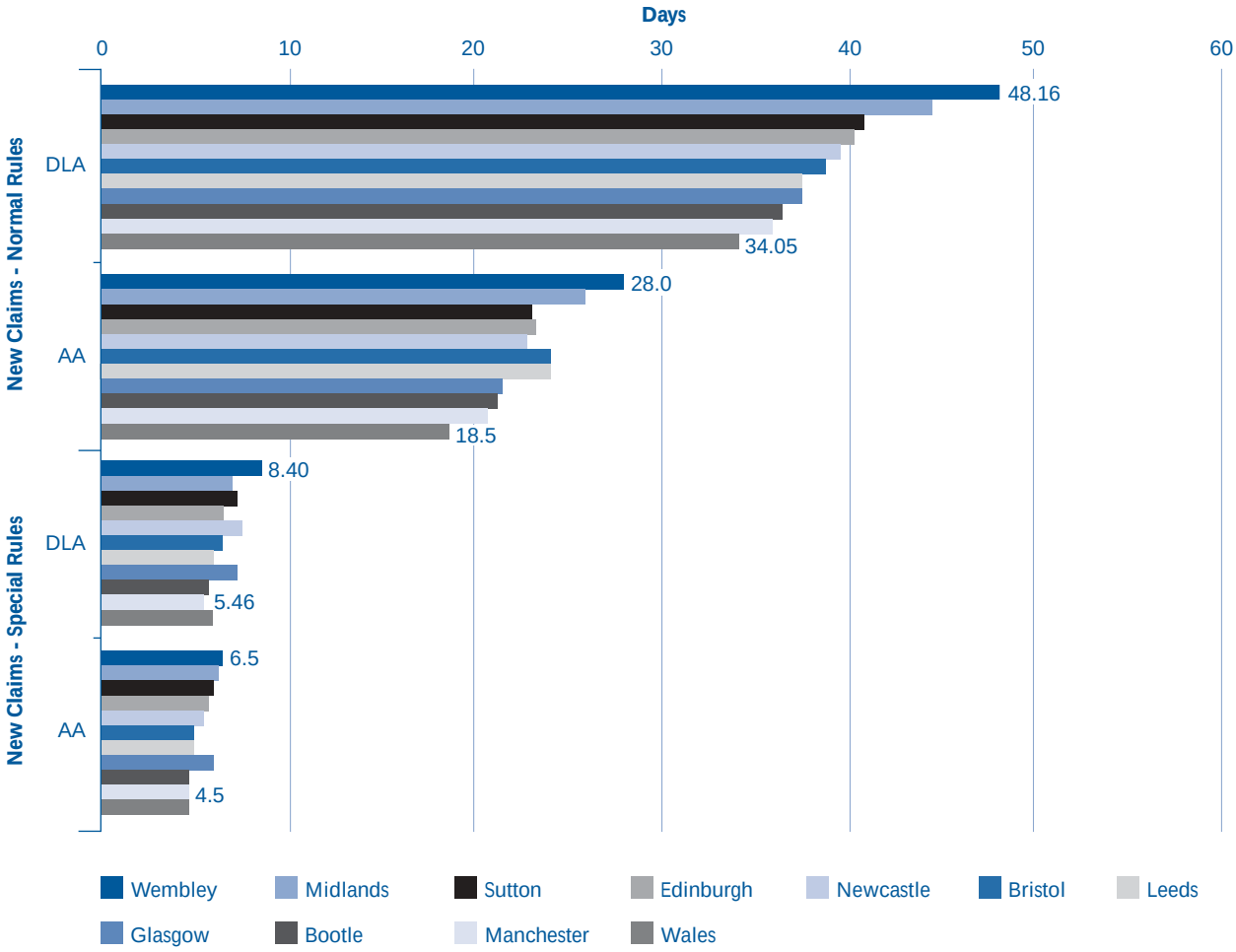
2.7 A simplified claim process for Attendance Allowance has been trialled in Bristol Disability Benefit Centre, including use of a shorter claim form. A new Disability Living Allowance claim form, including automation, has been trialled in Glasgow Disability Benefit Centre. Additional information to the application form is collected by telephone, reducing the need for other evidence to be sought. The shorter claim form may also lead to it being completed more fully, so saving time chasing the customer for further details. An evaluation of early findings from the Bristol pilot has shown processing times were reduced by up to six days without affecting decision accuracy. Other impacts are still being investigated.

Further improvements may be possible in the future

2.8 The time taken for the Department to gather medical evidence is a constraint on the scope to further improve processing times, but tightening targets further may put accuracy at risk. Within Medical Services, new targets were introduced for average clearance times for 2002-03, but the majority of Disability Living Allowance and Attendance Allowance cases rely on other evidence. The Disability and Carers Service are currently considering ways of allowing more sharing of management information with Schlumberger through information technology improvements, including an interface between the two enabling immediate passing of information. This may offer the best scope for improving processing efficiency without jeopardising accuracy.

6 Variation in clearance times between Disability Benefits Centres

Variation in clearance times for Disability Living Allowance and Attendance Allowance claims for the year to March 2003



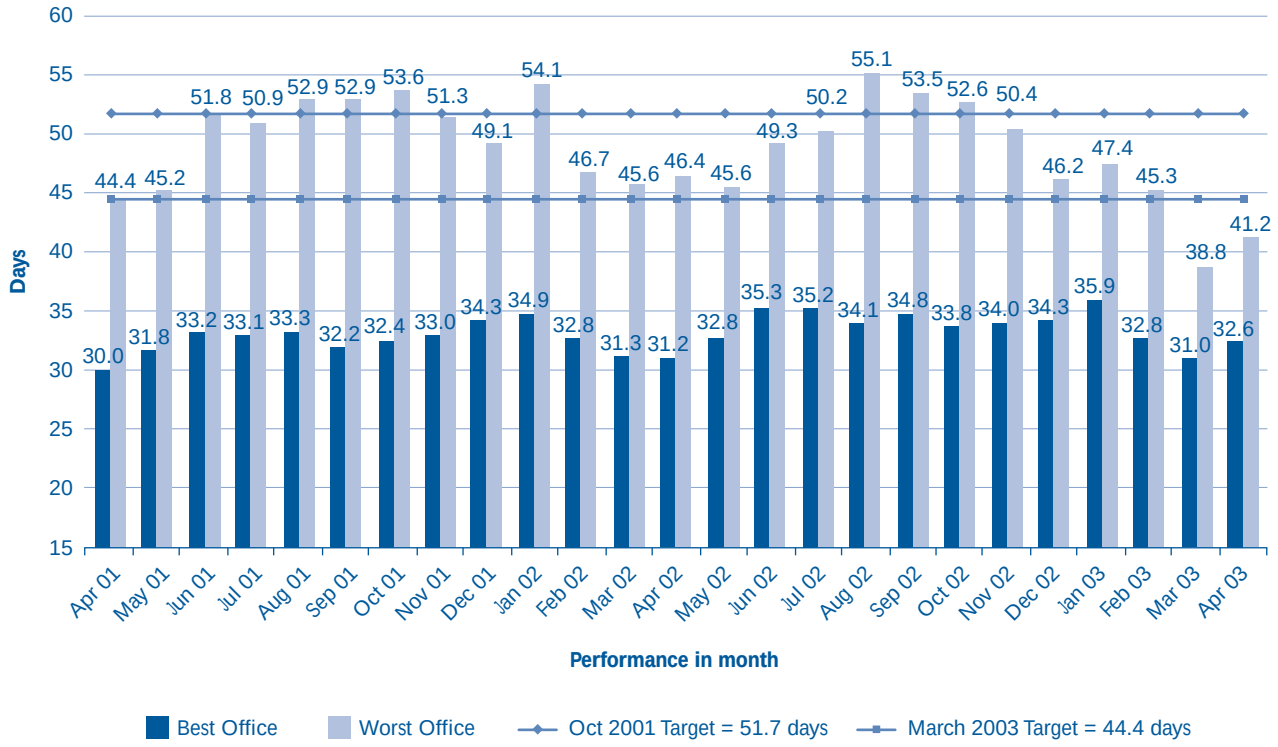
Source: Department for Work and Pensions

Major progress has been made towards eliminating Incapacity Benefit backlogs

2.9 The volume of deferred Incapacity Benefit medical tests rose to around 368,000 cases in June 2001 **(Figure 8)**. To achieve the targets for reduction of this backlog set out in paragraph 2.4, each region was required to produce an action plan jointly with Medical Services, which included commitments to increasing the number of referrals and reducing backlogs. The Department achieved the overall target ahead of schedule, reducing the backlog to below 250,000 by February 2002 and below 100,000 by December 2002. The level of remaining backlog varies across the 11 regions.

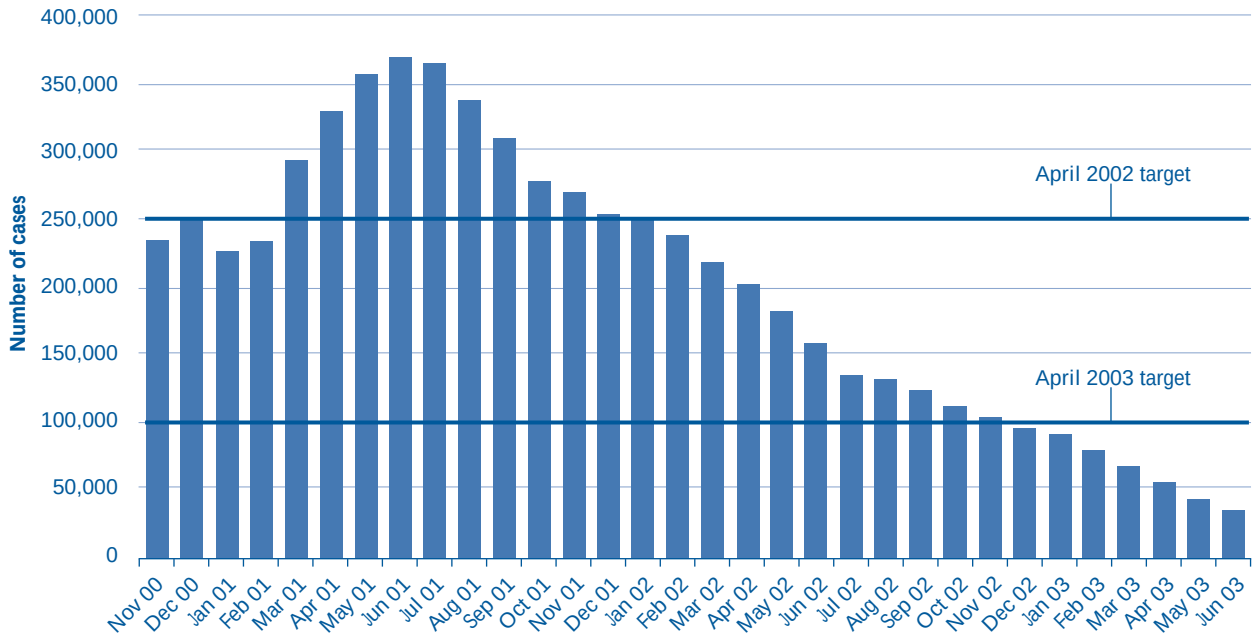
2.10 This reduction in backlog has been helped significantly by the contribution from Schlumberger, as the number of Incapacity Benefit medical examinations rose from 33,915 in June 2001 to a peak of 52,172 in October 2002 **(Figure 9 overleaf)**. This has resulted from improved workforce planning. Whereas in the past workload management was supply driven, based on the number of doctors available, the Department have more recently set a monthly quota, taking into account the current workload of cases due for examination, the planned reduction in backlog, the effect of projects and initiatives and local factors.

7 Progress in reducing regional variations in processing Disability Living Allowance claims



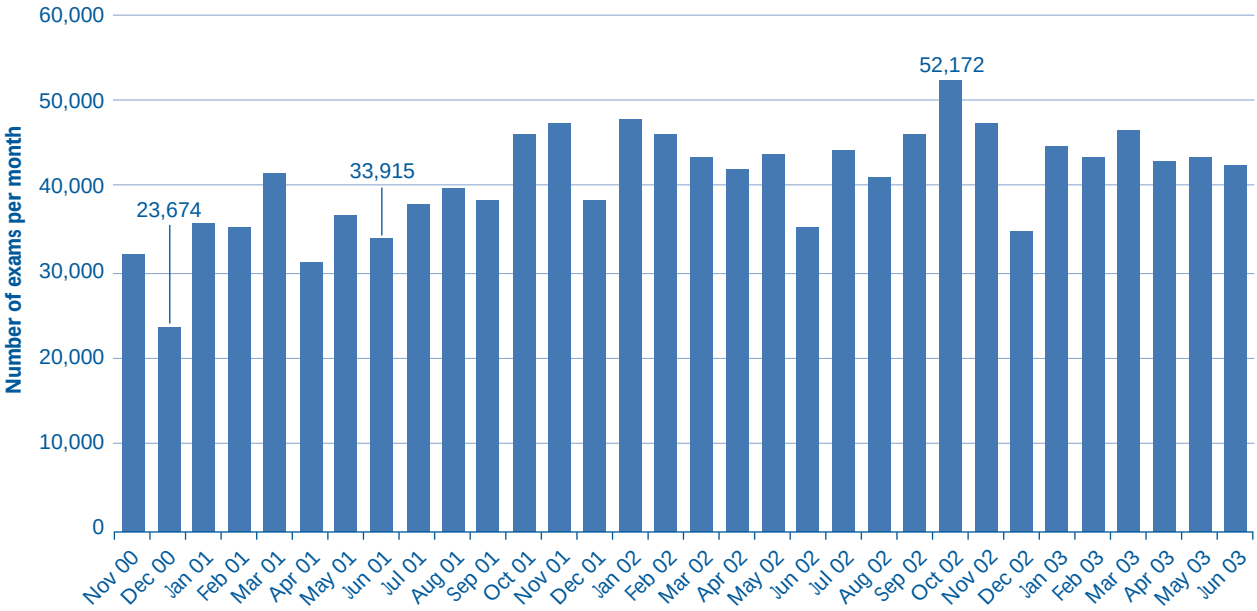
Source: National Audit Office analysis of Department for Work and Pensions data

8 Progress in reducing the backlog of Incapacity Benefit cases



Source: Department for Work and Pensions

9 Number of Incapacity Benefit examinations carried out



Source: Department for Work and Pensions

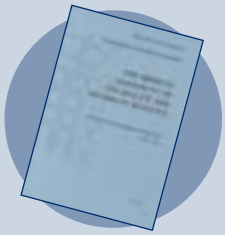
The improvements in processing Incapacity Benefit result in savings to the taxpayer

2.11 Incapacity Benefit customers who meet basic eligibility criteria are paid benefit immediately, and those found subsequently to be capable of work do not have their benefit payments recovered. The benefit can only be disallowed following an examination, so a backlog of cases awaiting assessment means there are potentially some customers receiving benefit who are no longer eligible for it. Reducing the backlog therefore results in a financial saving by reducing payments to ineligible customers. We estimate that the reduction in the backlog to date represents a one-off saving to the taxpayer of £29 million. If the backlog is eliminated by 1 April 2004, there should be a further saving of £8 million.

2.12 Speeding up the processing of Incapacity Benefit cases after they have been referred for examination also results in a saving, as those who are ineligible will have their award withdrawn sooner. As noted in paragraph 2.3, with the introduction of targets following the Committee's report, the time taken from completion of a Personal Capability Assessment to decision on entitlement has reduced from 27 days to under 15 days since 2000. The average time taken for Medical Services to carry out the medical examination has also fallen, from 52 days to 30 days. This is a reduction in the time taken to process these assessments of nearly seven weeks, which we estimate represents a further annual saving of some £21 million.

Ensuring the availability of sufficient professional staff

The Committee felt there was scope to do more in exploring ways of using healthcare professionals other than doctors in the medical assessment process. This had the potential to offset shortages of doctors, speed up the assessment process and reduce costs. The Committee recommended that the Department look again at the requirement in legislation for the use of doctors in the medical assessment process to ensure that unnecessary red tape is not holding back progress (27th Report 2001-02, conclusion (iii)).



Improved recruitment and better resource management have alleviated doctor shortages

2.13 At the time of our 2001 report, doctor shortages represented a major strategic threat to the Medical Services business. Schlumberger responded by setting up a project, the Viable Doctor Pool Project, to ensure sufficient doctors to meet the volume of referrals required by the Department for 2002-03 and 2003-04. The main elements are:

- improvements to doctors' pay;
- recruitment of new full-time doctors;
- improving the image of Medical Services;
- ensuring that doctors met professional standards; and
- improving the training offered to Medical Services doctors.

2.14 Schlumberger have been successful in recruiting new doctors. There is a continuing national recruitment campaign and activity between August 2001 and June 2002 resulted in the appointment of 100 new doctors by January 2003. In May 2003 Medical Services employed 220 doctors to work on medical assessment, of whom 38 per cent were women. In 2002, 83 new doctors joined Medical Services as employees and 16 left. Recruitment of part time doctors continued in parallel. Over the six months to May 2003, 1,947 such doctors carried out work for Medical Services on medical assessment. Of these, 16 per cent were women.

2.15 Our focus groups indicated that doctors were attracted to working with Schlumberger because they offered regular and flexible hours with no requirement to be 'on call', varied work, and training and personal development opportunities. We also found that doctors felt Schlumberger had developed a more positive image since our 2001 report.

2.16 However, regional variations remain in the availability of doctors to carry out medical assessment. Medical Services have introduced a new capacity planning model to help manage these shortages. This generates data on the number of doctors likely to be needed per month in a given area, broken down by the type of benefit. This analysis provides forecasts for up to two years in advance, with an indicative number of doctors rather than an actual number. The Department predict how many cases they expect and agree a figure each quarter with Medical Services. This process has required close local liaison between Medical Services and the Department.

There are obstacles to employing other professionals to carry out assessments

2.17 The Department have examined the scope for using health care professionals other than doctors and general practitioners in the medical assessment process **(Box 3)**. However, shortages of other professionals and their costs have meant they were not an easy answer to doctor shortages. Pilots also suggested that it took longer to carry out the examination process using nurses, offsetting the benefit of expanding staff numbers. Doctors who took part in our focus groups suggested that in order for other health care professionals to play a cost effective role in the medical assessment process, there would need to be changes in the process and medical criteria for assessing benefit entitlement, as well as the training available for medical staff.

2.18 For these reasons it may be unrealistic for Schlumberger to consider employing additional professionals to carry out parts of the medical assessment process, particularly if each medical centre were staffed with a range of specialists. However, disability advisers have told us there might be more scope to use other professionals as alternative sources of medical evidence, rather than to carry out assessments. They thought this applied in particular to cases involving customers with mental health problems as doctors may not always be qualified to provide evidence on these cases.

BOX 3 Pilots undertaken by the Department to explore the use of other health care professionals

- Between February and June 2001 SEMA piloted **the use of nurses in the Incapacity Benefit scrutiny process**. They concluded that this option was not feasible and the pilot was terminated. They experienced difficulties recruiting nurses, and found that the examination process was significantly lengthened, with no corresponding benefit in the overall throughput of cases. The operational performance of the pilot office was affected and it was terminated.
- In 2002 Schlumberger undertook a feasibility study into the use of **Community Psychiatric Nurses in the Disability Living Allowance and Attendance Allowance evidence gathering process**. They concluded that the cost for each report would exceed the cost of using a Medical Services doctor by two to three times because of the contract pricing structure and the time taken to complete examinations. However, the costs used in the pilot more accurately reflected the true production cost of the report. Because customers identified by the Community Psychiatric Nurse as having both mental and physical disabilities would require two examinations, it was not clear to the Department that the requirement for doctors would be significantly reduced. However, the Disability and Carers Service are exploring, as part of their Modernisation Programme, the scope for requesting factual reports from Community Psychiatric Nurses rather than employing them to produce medical reports.

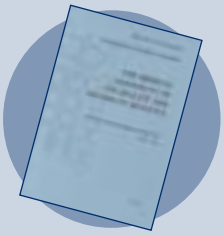
Part 3

Improving the quality of medical evidence

3.1 This part examines whether improvements have been made in the quality of the medical evidence used to assess benefit claims. The Committee raised concerns about:

- The number of appeals that were successful because of errors in medical evidence, and what could be learned from them (conclusions (iv) and (v)).
- The quality of examinations by Medical Services doctors (conclusion (vi)).
- Difficulties obtaining accurate and up-to-date medical evidence from other sources (conclusion (vii)).

Learning from appeals



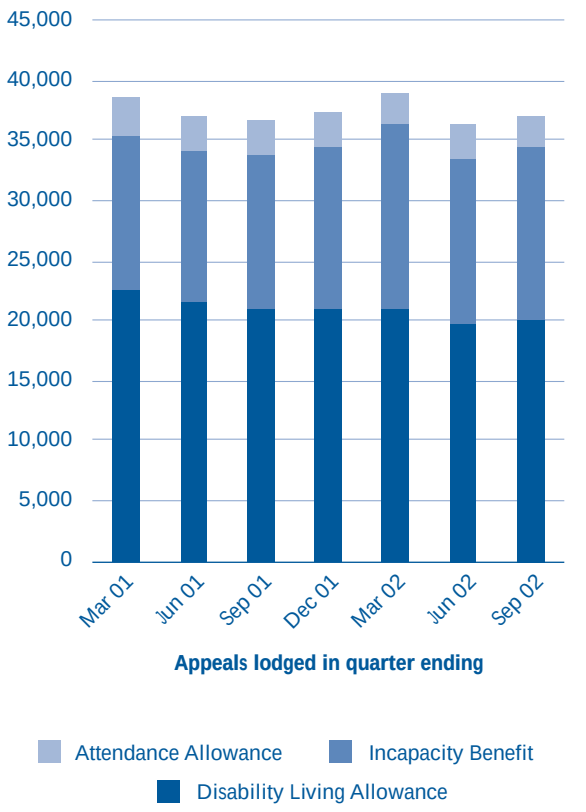
The Committee felt that the high proportion of cases where appeals were successful (over 50 per cent appeal and more than 40 per cent of those succeed) created confusion for claimants. Some appeals will always succeed because new evidence comes to light. But in a quarter of cases successful at appeal the Benefits Agency decision-maker misinterpreted the evidence.

The Department had taken action to improve the end-to-end process of decision-making, including learning from successful appeals through feedback from the Appeals Service. The Committee recommended building on this by introducing targets for reducing the number of appeals that are successful because of mistakes by the Benefits Agency (27th Report 2001-02, conclusions (iv) and (v)).

The number of appeals lost as a result of problems with medical evidence is still high

3.2 Since the Committee's previous report the number of cases ending in a successful appeal has continued to be high **(Figure 10)**. In the year to September 2002, 54 per cent of Disability Living Allowance appeals, 47 per cent of Attendance Allowance appeals and 43 per cent of Incapacity Benefit appeals were successful. However, there are several reasons why claims are successful at appeal, including that evidence becomes available at the appeal stage that was not available to the decision-maker. This means that the quality of the earlier medical evidence is often not in question **(Figure 11 overleaf)**. For this reason, and because a target might distort the decision-making process, the Department do not consider targets for numbers of successful appeals to be appropriate.

10 Number of appeals lodged against incapacity and disability benefit decisions



Source: Department for Work and Pensions, Quarterly Appeal Tribunal Statistics

11 Factors contributing to the success of appeals against incapacity and disability benefit decisions

Statement	Responses	
	Disability Living Allowance/Attendance Allowance (516 cases)	Incapacity Benefit (199 cases)
1. Additional evidence: The tribunal was given additional evidence not available to the decision-maker.	373 (72%)	118 (59%)
2. Accepted evidence: The tribunal accepted evidence that the decision-maker had available but was not willing to accept.	111 (22%)	43 (22%)
3. Incorrect weight: The decision-maker did not give relevant facts/evidence due weight.	67 (13%)	28 (14%)
4. Different view: The tribunal formed a different view of the same evidence.	214 (42%)	85 (43%)
5. Different view (medical): The tribunal formed a different view based on the same medical evidence.	127 (24%)	53 (27%)
6. Under-estimated disability: The medical report under-estimated the severity of the disability.	138 (27%)	96 (48%)
7. Avoid the appeal: The Agency could have avoided the appeal.	34 (7%)	14 (7%)

NOTE

Percentages add up to more than 100 because tribunals could identify more than one reason for a decision being overturned.

Source: Report by the President of the Appeals Service on the Standards of Decision-making by the Secretary of State 2002-03

3.3 In 2003, the President of Appeal Tribunals reported that an appeals tribunal formed a different view of the same medical evidence in 24 per cent of successful Disability Living Allowance and Attendance Allowance appeals, and 27 per cent for Incapacity Benefit (Figure 11). In about a third of cases, tribunals considered the medical report had underestimated the severity of the disability. The survey did not always identify the source of the medical evidence which was overturned, but in at least 51 per cent of cases the overturned evidence was from Medical Services. The remainder were from general practitioners, consultants or a combination of sources.

3.4 The Department have put in place a number of mechanisms to obtain feedback from appeals. Since August 2001 tribunals have been able to refer medical reports they consider seriously substandard to Schlumberger for feedback, initially through the Chief Medical Adviser. Since December 2002 feedback has been directly to Medical Services managers. Tribunals are asked to return submissions to decision-makers if they are considered deficient.

3.5 However, departmental managers told us these feedback mechanisms had rarely been used and had not had a significant impact. Our fieldwork indicates that decision-makers and individual doctors receive no notification and are not aware of how many customers with whom they had contact challenge their medical evidence. Nor are they aware of the outcome of these appeals. Doctors suggested that it is at this level that feedback needs to be improved to ensure that both they and decision-makers are aware if they are systematically misinterpreting the guidance. This would also help to spread good practice so that more doctors and decision-makers learn from collective experiences. The Department are also keen to work more closely with the Appeals Service to promote a clearer understanding of issues that affect the assessment of disability when providing evidence for decisions about benefit claims and in the context of appeals hearings.

3.6 In 2002-03 the Department sent presenting officers to represent their case to 20 per cent of Disability Living Allowance appeals. Internal guidance states that they should attend on complex cases. The President of Appeal Tribunals however has argued that higher attendance at appeals might improve feedback on their findings. The Department are piloting attendance at 100 per cent of appeals for Attendance Allowance and Disability Living Allowance, and will do the same for Incapacity Benefit following the Personal Capability Assessment as part of the Incapacity Benefit reform pilots (paragraph 1.10).

3.7 However, the Department do not view the attendance of presenting officers at tribunals as the only solution to making the current system more robust. Having a presenting officer at every tribunal would be a major resource investment, and they consider presenting officers would not always be well-placed to provide direct feedback to decision-makers. A different approach being piloted in Wales involves representatives from the Disability and Carers Service, the Appeals Service, Medical Services and Jobcentre Plus meeting to discuss

the overarching issues emerging from tribunals, rather than adopting a case by case approach. The Department intend the findings from these meetings to help identify the potential for improvements to the current system, but they do not plan to deliver feedback on an individual basis.

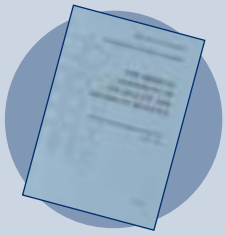
Improving the quality of medical assessments

The standard of medical reports has improved since 2001

3.8 The Department and Medical Services measure the quality of medical reports using an audit of a monthly sample of randomly selected reports. The audit is carried out by a team of doctors employed by Medical Services, but unconnected with the cases being considered. The Department's medical staff periodically audit the results of the quality auditors to check the reliability of the work undertaken. The auditors assess the medical quality of the reports, including their legibility, completeness and consistency, and grade them as a result. A 'C' grade indicates that the report is below Medical Services' professional standards.

3.9 From September 2000 the Department and Medical Services introduced contractual targets for the number of substandard medical reports produced by Medical Services[4]. From September 2000 the overall target for C grade reports was no more than 6.49 per cent. This was reduced to 5.84 per cent from March 2001 and 5 per cent from September 2001. Benefit-specific targets of less than 5 per cent C grade medical reports have now been introduced - from June 2002 for Incapacity Benefit examinations and from December 2002 for Attendance Allowance and Disability Living Allowance examinations.

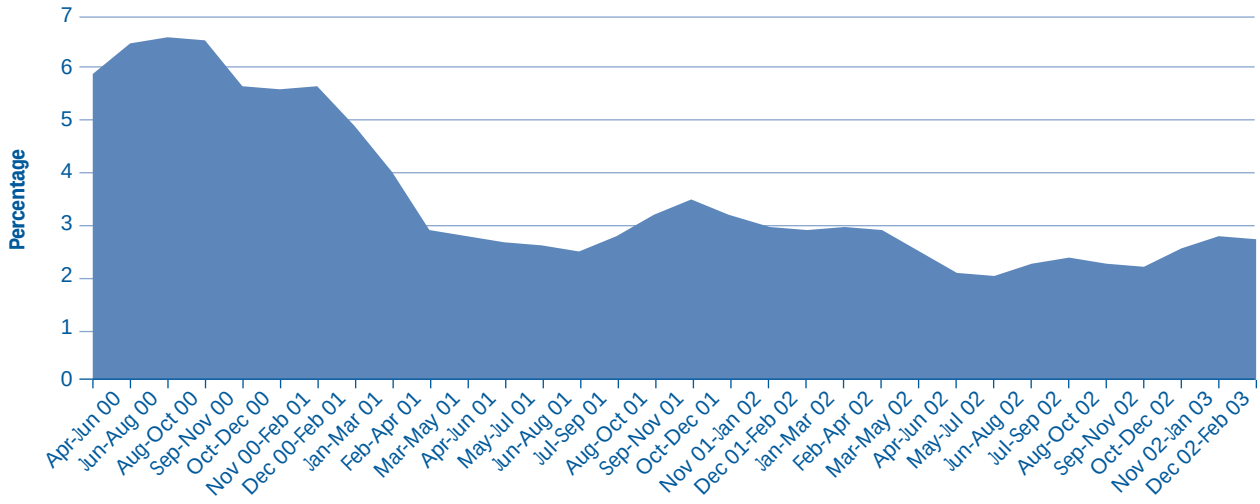
Another key factor in getting decisions on eligibility for benefit right first time is the quality of medical assessments. SEMA's own monitoring showed a need to improve the quality of medical reports provided by their doctors, up to 10 per cent of which were substandard.



The Committee considered that the Department should strengthen their oversight of SchlumbergerSema's quality assurance arrangements, particularly over the quality of examinations carried out in the customer's home, and ensure that all sub-standard reports were returned to the contractor for improvement (27th Report 2001-02, conclusion (vi)).

3.10 Since the introduction of contractual targets, the overall level of substandard (C grade) medical reports has fallen from 6 per cent to under 3 per cent **(Figure 12)**. In particular, the number of substandard reports on Attendance Allowance and Disability Living Allowance examinations, which normally take place in the customer's home, fell from 12 per cent at the time of our 2001 report to 4.2 per cent for the most recent three month period.

12 The percentage of substandard medical reports since 2000



NOTE

Rolling three-month average. Results from September to November 2002 onwards use a new method of sampling reports for quality monitoring.

Source: Department for Work and Pensions and Schlumberger quality monitoring system

4 *The level of C grade reports identified above is extrapolated over the whole population and is monitored on a three month rolling basis.*

3.11 Decision-makers are required to return reports for rework if they are not usable. This does not necessarily reflect the medical quality measured by the process described above but reports are returned if, for example, they are illegible or not completed fully. Schlumberger accrue service credits if more than one percent of reports are returned for rework. In recent years, the rate of reports returned has been consistently below one per cent.

3.12 In our 2001 report we found that decision-makers were not always returning reports for rework and the Department subsequently issued bulletins encouraging them to do so. However, discussion with decision-makers suggests that some still do not return all poor quality reports because, for example, they would rather reach a decision quickly, or see that by returning reports they can negatively affect their performance against targets. The Department have provided decision-makers with additional training explaining the medical examination process, including the use of rework. This is currently being evaluated.

3.13 The reasons for reports being returned to doctors for rework by decision-makers vary. Decision-makers told us that the most common reasons were doctors not fully answering the questions in the report, poor handwriting (30 to 40 per cent of cases returned according to Medical Services doctors); and contradictory information. Citizens Advice Bureaux representatives had also encountered these problems and told us that medical reports did not always describe the customer's condition in such a way as to allow eligibility for benefit to be determined, and did not report on the customer's prognosis, which was relevant to assessing the length of the award.

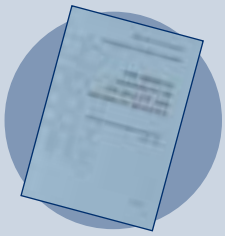
The Department and Schlumberger have responded to the remaining issues

3.14 Doctors in our focus groups said they had been able to pay greater attention to quality issues since Schlumberger took over the contract. Schlumberger have responded to criticisms of the quality of medical reports by putting in place mechanisms for monitoring the quality of each doctor's work, taking into account rework cases, C-grade reports, complaints and attendance of training courses. Certain triggers result in remedial action, which may involve counselling, training, supervised examinations or targeted quality monitoring of the doctor's reports. Ultimately, doctors may be stopped from carrying out examinations, which happened on 22 occasions in the last year. Another 40 doctors have improvement action plans.

3.15 In some areas, local discussions between decision-makers and doctors have resolved the types of issues raised in paragraph 3.13. Arranging 'ward rounds' has been one approach adopted in Leeds to encourage better dialogue between local disability benefits offices and Medical Services. These involve doctors visiting decision-makers to assist them in their interpretation of reports. In areas where both parties are co-located this is found to be easy to arrange and occurs regularly.

3.16 Over the last three years the Department and Medical Services have worked towards the design and development of an information technology system with supporting evidence-based medical protocols to improve the quality of assessments and doctor reports on people being examined in connection with their claim for Incapacity Benefit. This is known as the Evidence Based Medicine project and presents a package of measures aimed at improving the standard of evidence that Medical Services provides to decision-makers. As well as providing jargon-free typed medical reports and listing all clinical findings, the system is designed to inform and direct medical activity to ensure that doctors use best evidence in all areas of medical practice. The pilot phase of this project commenced in May 2002 and should be finalised by March 2004. The Department and Schlumberger anticipate that the increased consistency of reports will lead to more decisions being upheld at appeal.

Obtaining other medical evidence



General practitioners are paid for supplying medical evidence on Incapacity Benefit cases through their NHS contract, and directly on cases of Disability Living Allowance. Yet difficulty in obtaining accurate and up-to-date medical evidence led to some 25,000-30,000 people a year unnecessarily being called for examination. The Committee considered that although action to clarify the information required and ease the burden of bureaucracy on general practitioners might help improve their responsiveness, this would not overcome their reluctance to provide reports, either because of the effect they might have on relationships with their patients or because there might be a souring of relationships with the patient's family. They expected the Department to work with the Department of Health to resolve this potential conflict of interest (27th Report 2001-02, conclusion (vii)).

The Department are trialling different ways of gathering medical evidence

3.17 Decision-makers may choose to use evidence from a customer's general practitioner, consultant or other healthcare professional as well as or instead of a medical examination. But customers might be called for examination where evidence from their general practitioner would have sufficed, for instance if the general practitioner fails to provide a timely and detailed response. However, general practitioners may not be able to supply all the information required. Many people with disabilities or severe medical problems may be treated by one or more specialists and may rarely see their general practitioner, yet claim forms did not prompt claimants to provide consultants' reports[5].

3.18 The British Medical Association told us that general practitioners can be unwilling to complete reports because they do not want to act as referee over a person's benefit and did not see this as consistent with a normal doctor-patient relationship. Time constraints are also a factor. Interest groups also queried why customers are called for examination when other evidence might be available.

3.19 The Department have issued new guidance for decision-makers to advise on where best to seek written evidence. This means that general practitioners should not necessarily be the first choice, and other options may include community psychiatric nurses in cases where the patient has a mental health illness. Specialist training on mental health issues is available to decision-makers which includes guidance on seeking appropriate sources of evidence and information.

3.20 The Department and Schlumberger have addressed the difficulties in obtaining reports in a range of ways. For Attendance Allowance and Disability Living Allowance cases, they have developed a new form of report in which general practitioners are asked to provide objective medical evidence rather than opinion. Introduction of this new report was completed in May 2003. Experience from the areas it was first introduced indicates that there may be some reductions in the need for examinations by Medical Services, although this is still being evaluated. In our focus groups with Medical Services doctors, those doctors who had piloted this approach thought that it was a great improvement. However, the new reports require decision-makers to have better access to medical advice. In some areas, decision-makers seek and obtain regular advice from Medical Services, but in others contact was limited.

3.21 Further ways of obtaining medical evidence have been piloted. In Glasgow, the use of evidence obtained for Incapacity Benefit claims to assess Disability Living Allowance claims is under trial. In Sheffield and Rotherham, a trial involves customers' General Practitioner medical records being requested and scanned by Medical Services doctors, who examine them for relevant information for the customer's benefit claim. An evaluation of this pilot has shown that although it resulted in reduced workloads for general practitioners, it led to an increase in the number of examinations, and longer processing times. The Department plan to follow up these pilots with further work to improve evidence gathering, especially through building better links with the general practitioner community.

5 *Benefits Agency Standards Committee Annual Report 2000-01.*

Part 4

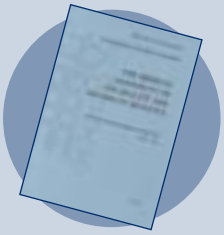
Improving the quality of service to customers

4.1 This Part examines whether improvements have been made in the quality of the service delivered by the Schlumberger's Medical Services. The Committee previously raised concerns about the following issues when the contract was managed by SEMA:

- A lack of contractual incentives to deliver a good quality of service (conclusion (xii)).
- Overbooking of appointments, resulting in customers being turned away unseen (conclusions (viii) and (ix)).
- The inability of SEMA to respond to customers' special needs (conclusion (x)).
- The level of customer dissatisfaction with SEMA (conclusion (xi)).

Quality of service targets

The Committee reported that a major weakness in the contract with SEMA was the absence of any real incentives to get the quality of service needed. Targets for improvement in quality were subsequently introduced into the contract, but the Committee considered there was a general lesson for those outsourcing services where quality is a key factor (27th Report 2001-02, conclusion (xii)).



New targets have been introduced and most are being met

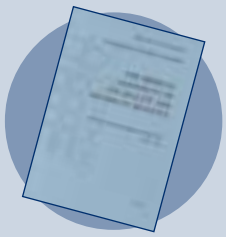
4.2 In June 2001, Schlumberger and the Department agreed to incorporate performance measures linked to financial remedies into the contract for medical assessment. These included targets for:

- improved waiting times;
- meeting special needs requests, such as requests for same gender doctors and interpreters; and
- customers sent away unseen.

4.3 The original target for waiting times was for 72 per cent of customers to be examined within ten minutes of their appointment time. This was increased to 77.15 per cent from August 2001. The targets are currently under review. Since the introduction of these targets there have been widespread improvements **(Figure 13 overleaf)**, although the target was not being met in early 2003 and there is still some regional variation. It should also be noted that customers who arrive late are not counted as waiting longer than ten minutes, regardless of their actual waiting time.

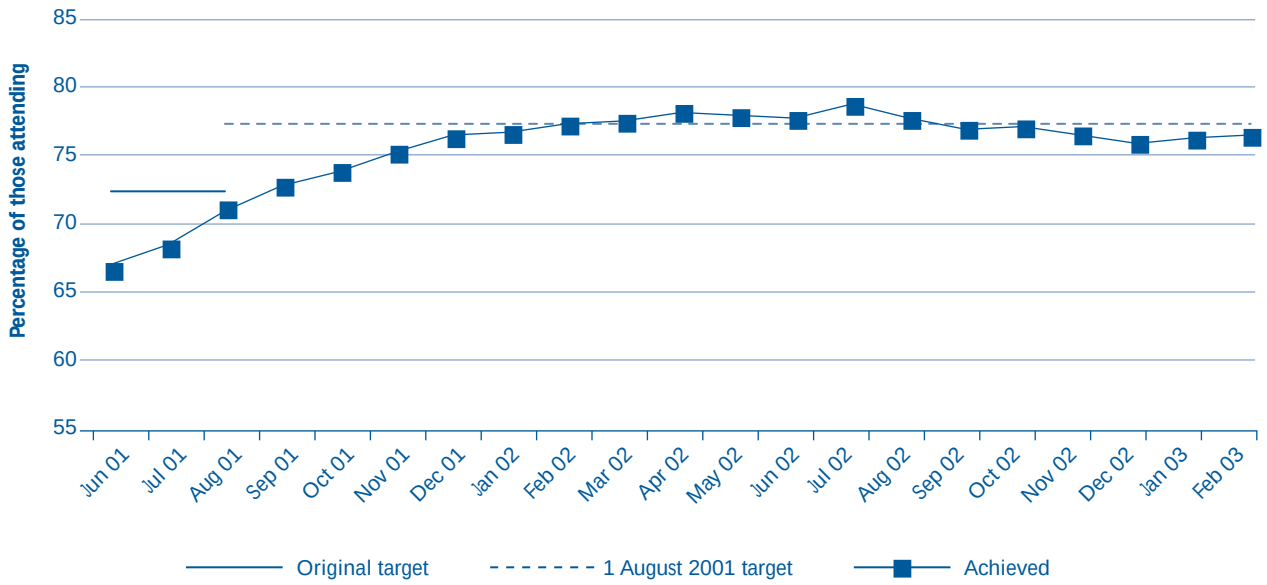
4.4 Targets were set from March 2001 to meet 95 per cent of special requests from customers for an interpreter or same gender doctor. Performance has been consistently above this level nationally, despite generally increasing numbers of such requests. In the 12 months to February 2003, 360 of the 363 requests for same gender doctors were met and 1,823 of the 1,880 requests for interpreters. When such a request is not met, the examination is rescheduled.

Although the contract with SEMA required them to comply with reasonable requests to accommodate claimants who had special needs, the Committee was concerned that SEMA were unable to guarantee same-gender doctors for medical examinations or the availability of interpreters. New targets were subsequently included in the contract, and the Committee expected the Department and SchlumbergerSema to ensure that they provided responsive services to all their customers (27th Report 2001-02, conclusion (x)).



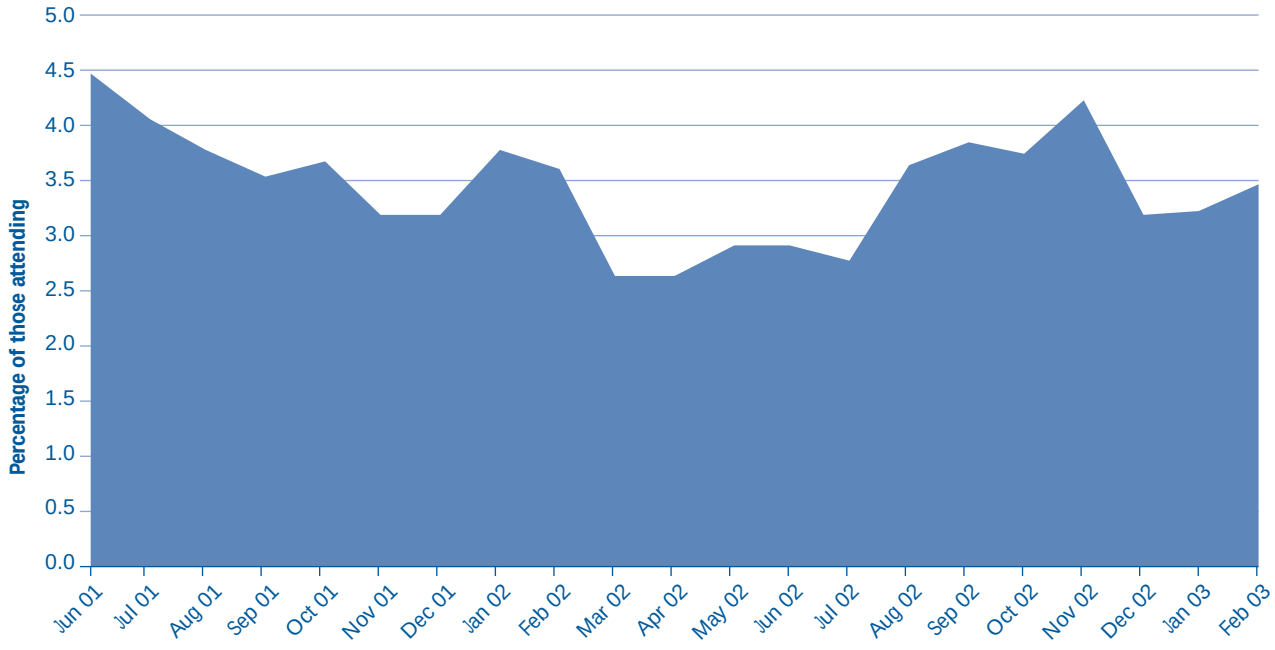
4.5 The target proportion of customers sent home unseen is not more than 3 per cent. There has been a slight improvement in performance since this target was introduced, but it has only been achieved in a few months **(Figure 14 overleaf)**.

13 Percentage of customers examined within ten minutes



Source: Schlumberger contract monitoring reports

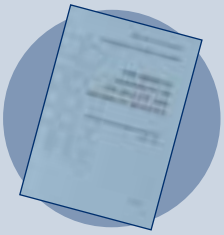
14 Percentage of customers sent away unseen



Source: Schlumberger contract monitoring reports

4.6 When Medical Services fail to meet these targets, service credits accrue under the contract. Since April 2001 Schlumberger's contract payments have been reduced by nearly £1 million as a result of failure to achieve targets, but only £70,000 of this relates to quality of service targets.

Turning customers away unseen



The Committee were concerned that because the Department paid for each completed examination under the contract, there was a financial incentive for the contractor to overbook appointments for medical examinations. This allowed them to cope with a high and unpredictable drop-out rate and uncertainty over the number of attendees, and ensure that they make maximum use of their doctors. But as a result, on average around 3 per cent of customers (over 17,000 a year) were turned away unseen, even though they had scheduled appointments.

While some customers were not seen for valid reasons, the Committee recommended that the Department consider whether SchlumbergerSema should pay compensation if they turned people away because of deliberately overbooked appointments or for examinations that proved to be inferior to what is considered to be acceptable (27th Report 2001-02, conclusions (viii) and (ix)).

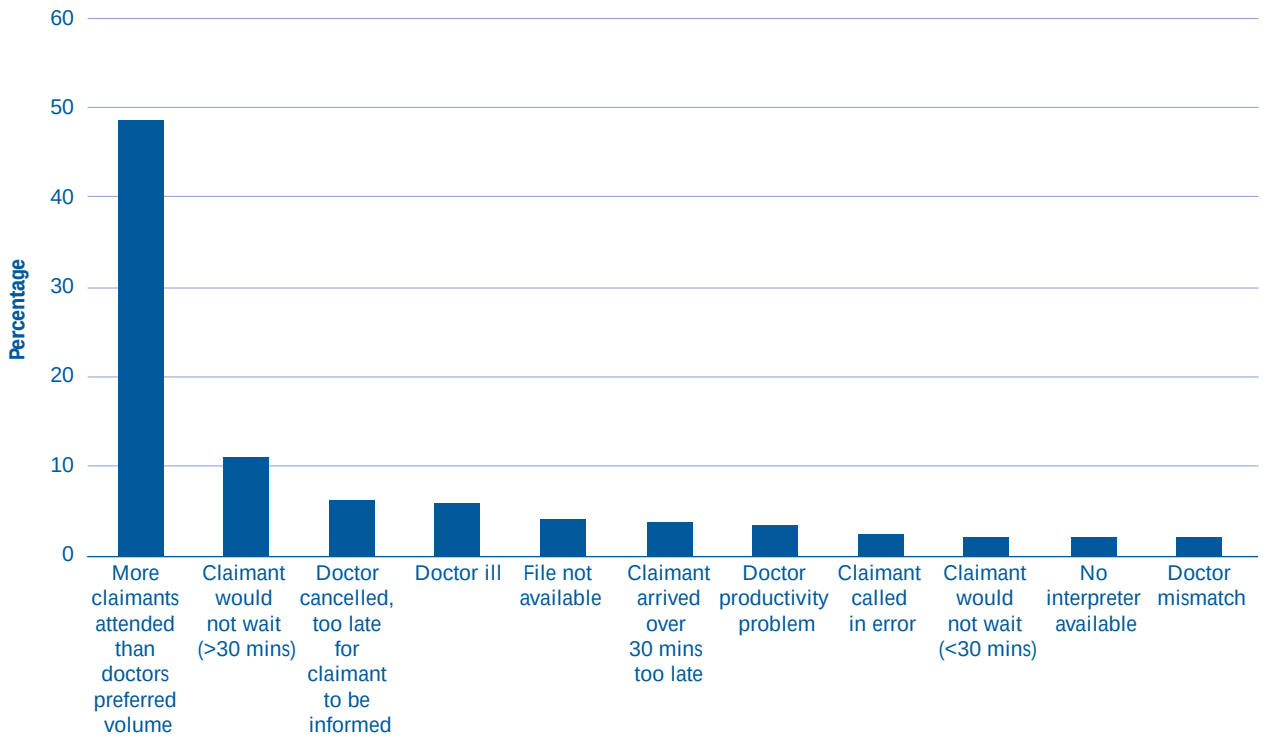
Many customers continue to be sent away unseen because of overbooking

4.7 Our 2001 report explained that Medical Services overbooked examination appointments to cover the appointment time wasted when customers fail to attend. Customers who are turned away unseen having attended a medical centre are reimbursed their travelling expenses and offered transport to attend a further examination. **Figure 15** shows the reasons reported for customers being turned away unseen between June 2001 and February 2003, indicating that overbooking was still the most common reason. The other main reasons were doctors cancelling or the customer not being prepared to wait longer than 30 minutes.

4.8 The Department and Schlumberger have introduced a range of measures to try to improve and better predict attendance rates with a view to reducing the need for overbooking. They expect the introduction of a revised doctor pay structure on a fee per case basis to encourage doctors to stay longer to see additional customers and compensate for overbooking.

4.9 In order to improve procedures, Schlumberger have piloted and introduced telephone booking. In the early pilots, the rate of customers failing to attend examinations in the pilot areas fell from 13 to 16 per cent before the pilot, to about 10 per cent, and the percentage of customers sent home unseen fell by around half. However, these results have not

15 Reasons for sending customers home unseen, year to February 2003



Source: Schlumberger performance monitoring

been maintained since the practice was rolled out nationally despite noticeable improvements in some regions. Nationally the rate of customers not attending has only fallen one per cent **(Figure 16)**, but in Nottingham, for example, there is a non-attendance rate of approximately 16 per cent compared to 23 per cent nationally.

Customers failing to attend examinations are a continuing problem

4.10 Medical centres continue to overbook appointments because relatively large numbers of customers fail to attend. Some 20 to 25 per cent of customers fail to attend Incapacity Benefit examinations, and one office told us that they overbook by 21 per cent to allow for non-attenders. People may be unable to attend appointments, for instance because of failure of transport arrangements or because they are ill on the day, and fail to understand the importance of explaining why they cannot do so. But some Incapacity Benefit customers may not attend because they believe their benefit will be withdrawn as a result of the examination. If customers claim they have good cause not to attend, decision-makers may continue their benefit. The Department told us that decision-makers may be reluctant not to accept the reasons for failure to attend because such cases are often lost on appeal.

4.11 To break this cycle, Medical Services and the Department must work together at a local level. They have introduced close recording of telephone contacts with customers and monitor reasons given for not attending appointments. Medical Services now also provide more robust information which should assist decision-makers in considering good cause for non-attendance. They plan further work to analyse the types of customers who do not attend appointments and the reasons they give for not doing so. The Department also plan to develop more detailed procedures and guidance for decision-makers on how to determine good cause for failure to attend examinations. Until these issues are resolved the Department do not consider it appropriate to introduce further compensation measures.

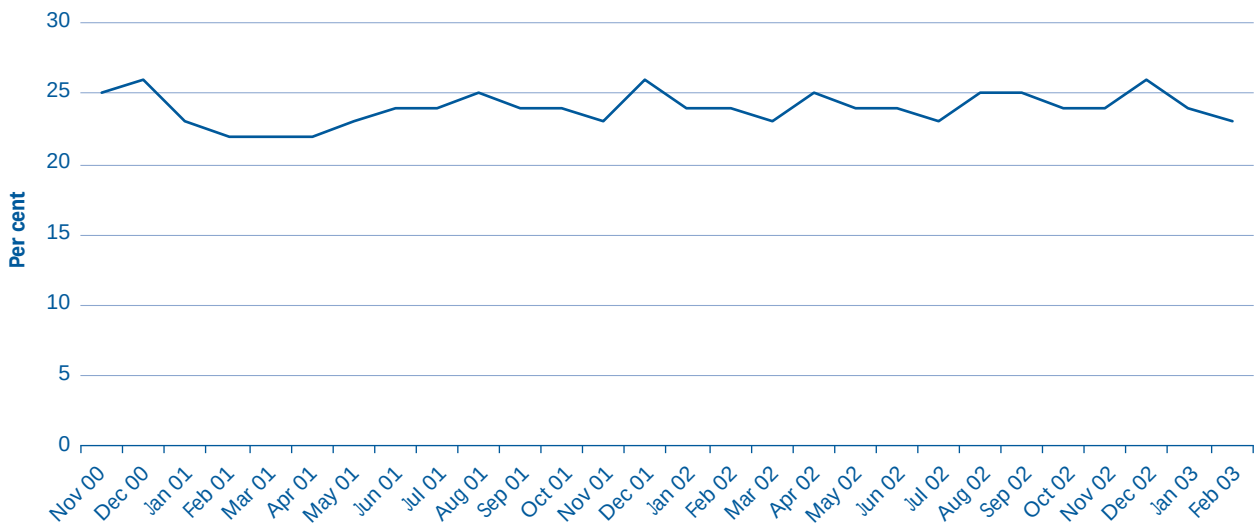
4.12 The Department told us that customers with mental health problems were less likely to attend examinations, and our review of case reports from Citizens Advice indicated that these people often experience problems getting to medical centres for a variety of reasons. More work is to be done by Medical Services on mental health referrals owing to the high propensity for such claimants not to attend.

Providing a responsive service to customers

Medical Services explain to customers what they should expect

4.13 Customers required to have a medical examination either receive a standard letter, or in the case of the telephone booking procedures referred to above (paragraph 4.9), confirmation in the post following initial contact by phone. In the latter case, scripts have been developed for telephone operatives to follow. The operative also attempts to assess any special needs that the customer may have on attending the centre.

16 Percentage of customers failing to attend examinations



Source: Schlumberger performance monitoring

4.14 The appointment letter explains the purpose of the medical examinations and what customers should expect to happen (for example **Box 4**): that the purpose is not to diagnose or discuss treatment of their medical condition; that the doctor may not need to undertake a physical examination; and, that the doctor is not responsible for decisions on benefit entitlement. The letter also explains what happens after the examination and what action customers can take if not happy with the way they have been treated during a medical examination. A notice in 12 different languages accompanies the letter sent to customers from Medical Services to explain that a translation service is available for those who need assistance.

Most complaints concern similar issues

4.15 We examined Citizens Advice records of issues raised by customers about Medical Services and details of complaints against Medical Services. These show a consistent pattern and also identify the same types of complaints as the Medical Services' complaints management system. Medical Services staff have themselves reviewed case reports on medical assessment held by Citizens Advice to take stock of the types of issues raised with them. The main issues raised with Citizens Advice were:

- doctors adopting a brusque or insensitive manner when visiting customers at home;
- conclusions being drawn about mental health problems which are not supported by examination evidence, or mental health problems not fully understood by or discussed with the doctor;
- short notice of home visits, which can cause distress if they feel the need for an advocate to be there with them, but do not have the time to arrange this;
- customers not seeing the doctor's report despite having to sign it;
- the nature of the questions in the report, in particular, that they are too vague and perhaps not always well interpreted by the doctor; and,
- problems where the customer knows the examining doctor and feels the examination is not entirely independent due to previous poor relations between them.

BOX 4 What Disability Living Allowance and Attendance Allowance customers should expect to happen at their medical assessment

Disability Living Allowance and Attendance Allowance customers should expect the following to happen at their medical examination:

- A fully registered and specially trained and approved doctor to assess the effects of the disability in a 20 to 60 minute appointment.
- The opportunity to tell the doctor how their illness or disability affects their everyday life - for example, how much help they normally need during the day and/or the night; what problems they have with getting around; and if the doctor has visited them on a day when their illness or disability is better or worse than usual.
- The doctor to clearly write down what the customer tells them and for this to be either read back to the customer, or for the customer to read it. The doctor will then ask the customer to sign a declaration to agree that the information is correct.
- If necessary, the doctor will then complete a physical examination which may involve the customer having to remove some of their clothing.
- The doctor will then fill in the rest of the report giving their medical opinion, and return the full report to the Disability Living Allowance or Attendance Allowance office.

Customers can request the following assistance if they require it, providing they notify Medical Service in advance:

- An interpreter or sign language interpreter - although customers may wish to arrange for a friend or family member to interpret or sign for them; or
- A doctor of the same sex, for example, on cultural or religious grounds.

Source: Adapted from Medical Services letter to customers (DLA-AL1C / 02-02)

4.16 **Figure 17** shows the issues raised by customers as recorded by Medical Services' complaints management system. For the quarter to February 2003, 0.43 per cent of medical examinations resulted in a complaint, with complaints about the doctor's manner being the most common.

17 Complaints received by Medical Services, Quarter ending February 2003

Complaint issue identified	Percentage
Doctor's manner	35.2
Content of examination	22.7
Clinical findings	18.2
Admin/accommodation	11.8
Length of exam	4.0
Waiting times	3.8
Expenses	2.5
Other	1.6
Cultural insensitivity	0.2

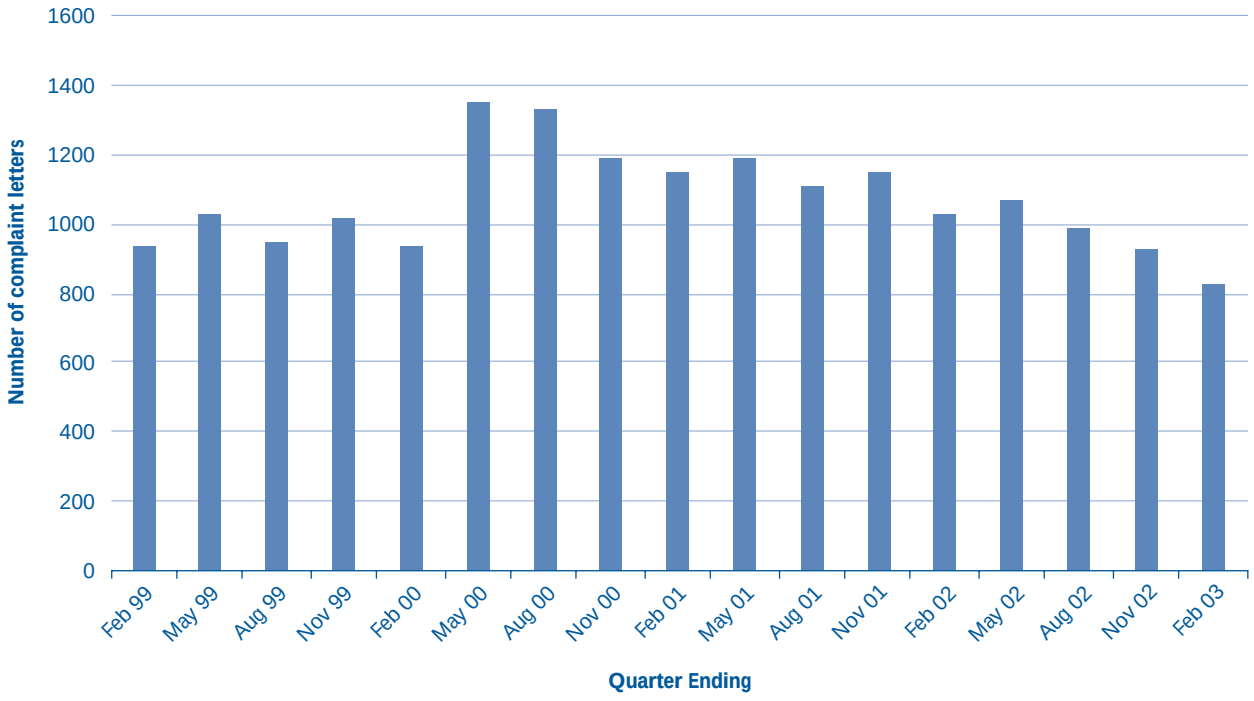
Source: Schlumberger Complaints Monitoring System

Schlumberger are monitoring and acting on complaints

4.17 In 2001 Medical Services introduced a new computerised complaints handling model to replace the previous clerical approach and allow detailed monitoring of the pattern of complaints against individual doctors, including remedial action taken. They have also put in place other measures to improve training and for detailed monitoring of doctors' performance (paragraphs 3.12 and 3.14). Although 35 per cent of all complaint issues recorded in the quarter to February 2003 related to doctors' manner, this represented a 23 per cent reduction since the previous quarter (693 issues recorded, compared with 907 in November 2002), suggesting that the measures to improve the quality of doctors' performance are having an impact.

4.18 Overall, the number of complaints has fallen steadily since May 2000 **(Figure 18)**. Examinations for Disability Living Allowance and Attendance Allowance, normally carried out in people's homes, consistently generate more complaints, but there is more evidence of an improvement in the level of complaints about Incapacity Benefit examinations. Medical Services have proposed that they carry out more examinations in medical examination centres, using the procedures which currently apply to Incapacity Benefit, and fewer in people's homes. A pilot is currently under way.

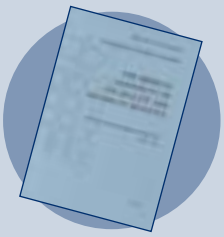
18 Number of complaints received by Medical Services by quarter



Source: Schlumberger Complaints Monitoring System

Customer satisfaction

At the time of the previous report, customer satisfaction ratings on the medical assessment services were around 92-93 per cent. This meant there remained around 5,000 people a year who were dissatisfied by the nature of the medical examinations they undergo. The Committee welcomed the action the Department and SchlumbergerSema were taking to improve information to customers on the examination, to improve doctor training, and to work with the Citizens Advice Bureaux and other groups to improve their understanding of customers' concerns (27th Report 2001-02, conclusion (xi)).



Most customers are satisfied with the service they receive

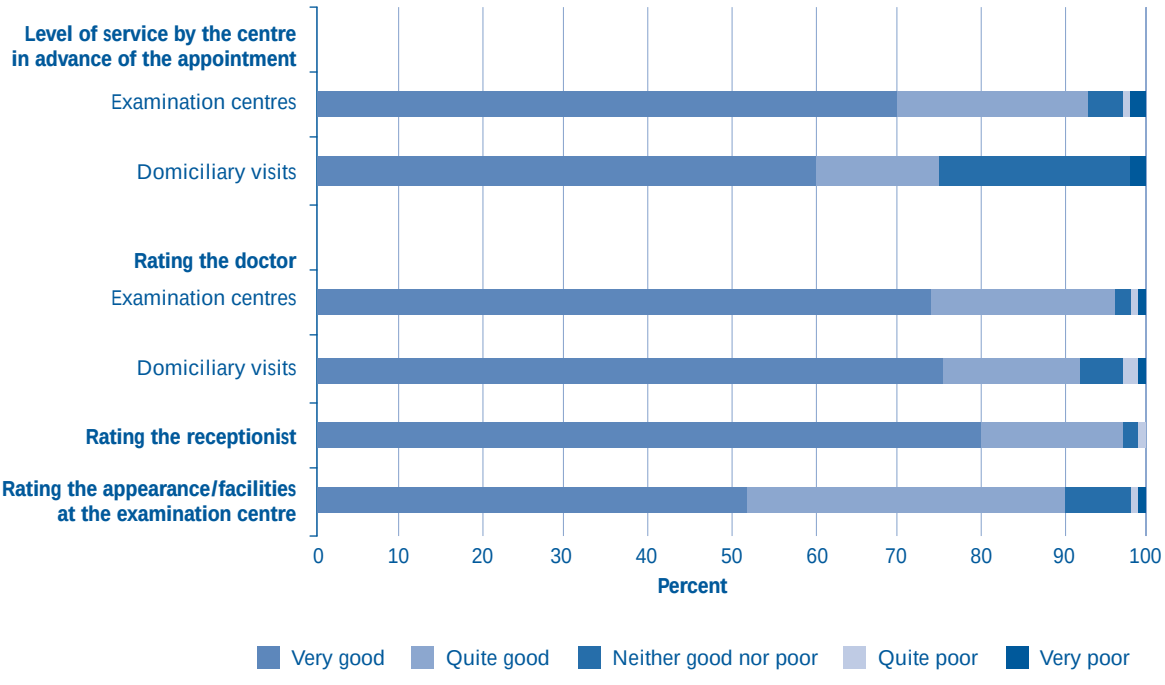
4.19 Medical Services' customer survey process is a key way in which customer satisfaction is gauged. Medical Services have consistently reported a high standard of satisfaction through the current process. Since July 2000, there has been between 95 and 97 per cent satisfaction reported for examinations at medical centres, with a slightly lower level of 92 to 95 per cent for home visits. However, this represents a significant improvement on the levels prior to July 2000. The current survey process does not capture customers who do not attend, and a new survey sampling from all referrals, rather than customers who undergo examinations, was piloted from April 2003.

4.20 Customers are asked to rate the level of service provided by the medical centre in dealing with queries in advance of the appointment either in the examination centre or at home. Customers are also asked to rate their examining doctor, the receptionist, and the examination centre, if a centre was attended. **Figure 19** shows responses to the survey conducted in February 2003. There was no significant variation in the result for February 2003 compared to the previous few months. The facilities at examination centres consistently received the lowest satisfaction ratings of the areas covered. Medical Services doctors also told us they saw scope for improving accommodation to improve access and quality of service.

Schlumberger have taken steps to improve consultation with interest groups

4.21 Schlumberger and the Department consider that interest groups should be more involved in the development of the business. They therefore aim to engage policy officers more directly in developments, such as in developing training packages for doctors. Medical Services agrees all communications sent out to customers with the Department and also discusses them with a number of interest groups. And at a local level Medical Services doctors told us that feedback sessions with local welfare rights groups and disability charities had been valuable and that co-operation had increased.

19 Customer satisfaction survey results for February 2003



Source: Schlumberger Customer Satisfaction Survey

Appendix 1 Methodology

1 We used a variety of methods to collect evidence. The Department provided us with detailed progress reports setting out the actions they had taken towards meeting the Committee's recommendations. We verified these reports by examining performance data, examining project documentation, and interviewing relevant officials. We consulted with a number of external interest groups. The main methods we adopted were:

Interviews with key officials in the Department and at Schlumberger

2 We held meetings with departmental staff and teams responsible for management of the existing contract and procurement of the new contract, the head of operations for Disability Living Allowance and Attendance Allowance within the Disability and Carers Service, and a senior departmental Medical Advisor. At Schlumberger, we interviewed the Managing Director of the Medical Service, the National Customer Relations Manager, and the director of Medical Services' Change Programme.

Review of management information from the Department and Schlumberger

3 We reviewed management information held by the Department, and the performance data supplied to them by Schlumberger under the contract, on a range of issues to evaluate progress against targets, including benefit processing times and accuracy, standards of medical reporting, performance against contractual targets, performance against customer service standards, and complaints made to Medical Services.

Focus groups with doctors

4 In March 2003 we contracted Vivas Ltd to run two focus groups of full-time doctors employed by Schlumberger and part-time doctors employed by Nestor. The focus groups concentrated upon issues concerning:

- the recruitment and retention of doctors;
- the role of other healthcare professionals in the medical assessment process;
- views on training and support provided to medical staff to deliver the service required;
- the relationship between doctors and the staff of the Department and its agencies; and
- the scope for further improvements in the service provided to customers and to the Department.

5 The first focus group took place in Leeds on 19th March 2003 and the second in Bristol on 11th April 2003. A member of the NAO study team attended each focus group as an observer. The doctors participating in these focus groups had worked for Medical Services - or previously with the Department of Social Security - for varying amounts of time ranging from seven months to sixteen years.

6 In the Leeds focus group, the doctors were selected because of their involvement in major programmes and were all full-time doctors. In the Bristol focus group, there were both full-time and part-time doctors as well as an administrator from the Medical Services centre.

Visits to Jobcentre Plus offices and Disability Benefit Centres

7 Between February and April 2003 we visited one Jobcentre Plus district office and three social security offices (which were operating as part of Jobcentre Plus, but had not yet taken on Jobcentre functions) in the West Midlands, Glasgow and London. We also visited Glasgow and Wembley Disability Benefit Centres, and the Blackpool Disability Benefits Unit. We discussed with staff their relationship with, and the services they receive from, Medical Services, their training in medical assessment, the quality of medical evidence, and their experiences of the projects being introduced to improve medical evidence. We carried out these visits jointly with the NAO team conducting the examination *Getting it right, putting it right: improving decision-making and appeals in social security benefits* and selected the offices to ensure that we interviewed a cross-section of staff dealing with the relevant benefits, using medical assessments, and offices where new working practices had been introduced. We conducted interviews with office managers, benefit section team leaders, decision-makers and staff responsible for processing benefits.

Consultation with interest groups

8 We consulted a range of interest groups during our fieldwork stage. These groups have included Disability Alliance, whose representatives attended a discussion forum with the NAO study team; Citizens Advice, whose case reports we reviewed to establish recurring trends in complaints from members of the public about medical assessment for disability or incapacity benefit; and the British Medical Association whose views we sought on the contract for medical assessment and on doctors' views on the current medical assessment process. We discussed the process of applying for medically assessed benefits with welfare rights advisers in the Department for Work and Pensions Standards Committee Consultative Group and in a workshop with Citizens Advice advisers.

Appendix 2 Chronology of developments

Date	Event		
	Contract/Organisation	Targets	Process improvements
February 1998	The contract for medical assessment was awarded to SEMA Group.		
February - June 2001			SEMA Group piloted the use of nurses in the Incapacity Benefit scrutiny process.
March 2001		The Disability and Carers Service introduced targets to reduce the differential between the worst and best performing business areas. All regions had met the targets by the end of March 2003.	
April 2001	SEMA Group were subject to an agreed take-over by Schlumberger to form SchlumbergerSema (Schlumberger from 2003).		
April - June 2001		Additional performance measures linked to financial remedies added to the contract, covering quality of service measures. Other targets were made tighter.	
August 2001		Schlumberger started a national recruitment campaign for doctors to deal with staff shortages.	
March 2002 - January 2003			New Attendance Allowance claim process trialled in Bristol.
April 2002	The Department reorganised their agencies to replace the Benefits Agency and formed Jobcentre Plus.	The Department and Jobcentre Plus introduced new targets for processing claims for Disability Living Allowance, Attendance Allowance and Incapacity Benefit.	

Date	Event		
	Contract/Organisation	Targets	Process improvements
May 2002	The Department confirmed extension of their contract with SchlumbergerSema until August 2005, with new targets established.		
June/ December 2002		New benefit-specific targets introduced for the number of substandard reports.	
June 2002 - January 2003			Introduction of 'teleprogramming' to improve the process of booking appointments and address overbooking.
October 2002 - May 2003			Introduction of a new Factual Report for general practitioners to improve the process of gathering medical evidence.
November 2002 - May 2003			Introduction of first phase of Evidence Based Medicine project to improve quality of medical reports.
December 2002		Jobcentre Plus met their target to reduce the Incapacity Benefit backlog below 100,000 cases.	
January - April 2003			New Disability Living Allowance claim process trialled in Glasgow.
February 2003		Schlumberger met their target of recruiting an additional 100 full-time doctors.	