

The Medical Assessment of Incapacity and Disability Benefits

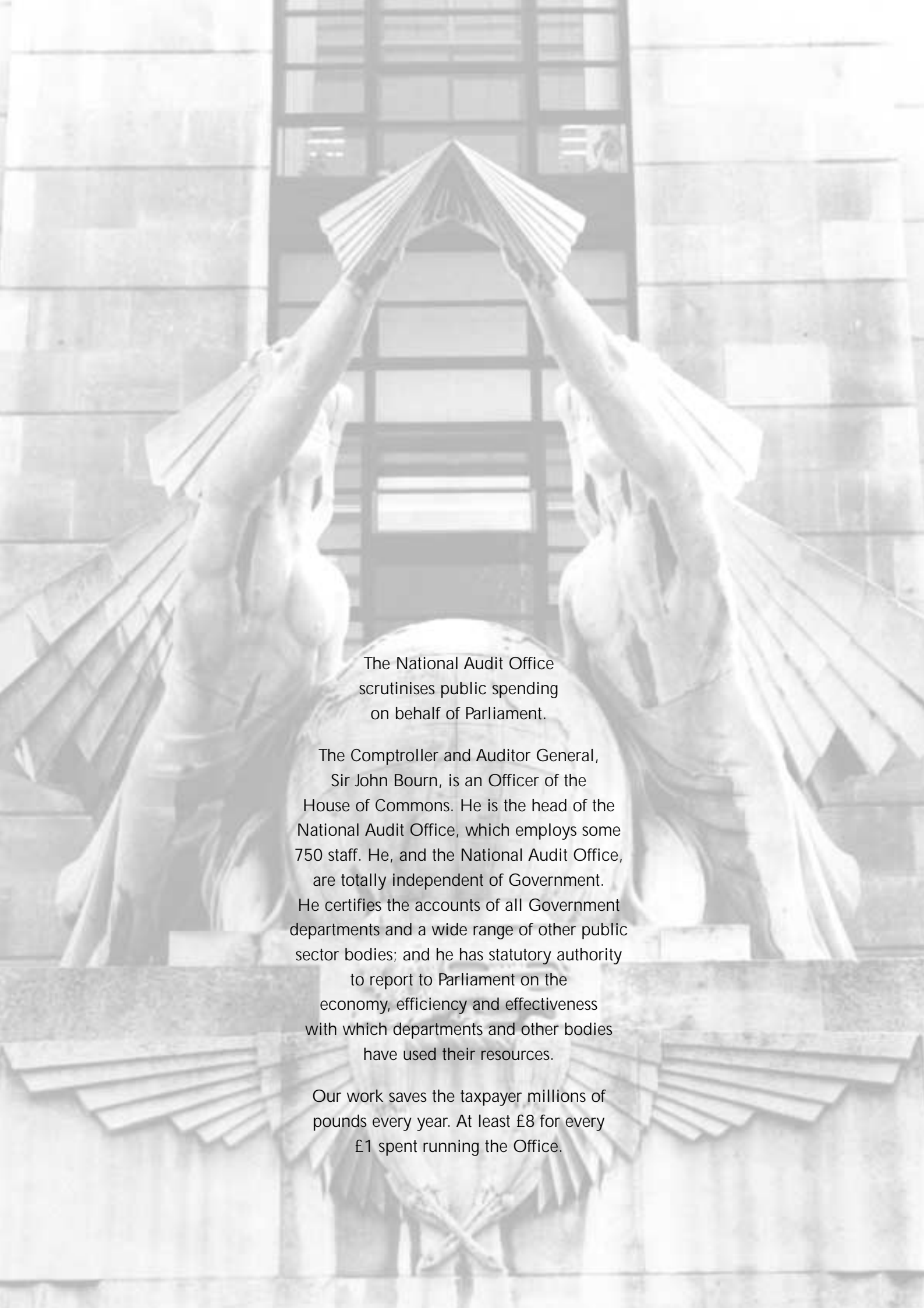
REPORT BY THE COMPTROLLER AND AUDITOR GENERAL
HC 280 Session 2000-2001: 9 March 2001



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This report has been prepared under Section 6 of the National Audit Act 1983 for presentation to the House of Commons in accordance with Section 9 of the Act.

John Bourn **National Audit Office**
Comptroller and Auditor General **28 February 2001**

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executive summary

The Department outsourced the medical assessment of benefits to improve the performance and value for money of this vital service

- 1 Disability and incapacity benefits costing over £19 billion are paid each year to some of the most vulnerable members of society. It is important that their eligibility is assessed fairly and efficiently, and in a way that causes them minimum anxiety and inconvenience. It is also essential to protecting the public purse that such expenditure is incurred only in payments to those who are genuinely entitled to them. Medical assessment is central to the Department of Social Security's (the Department's) decision-making on customers' eligibility for these benefits. In 1999/2000 nearly 3,000 doctors working on behalf of the Department provided advice or reports for the use of lay decision-makers on some 1.3 million cases, nearly half including physical assessments.



- 2 The Department have been responsible for medical assessment of all incapacity and disability benefit claims since 1993, before which the Department of Health had been responsible for some of the work. The introduction of Incapacity Benefit in 1995 highlighted inadequacies in the management, flexibility and performance of the service. Business targets for costs and turnaround times, and quality standards, were not being achieved. After assessing several options the Department pursued outsourcing as the best way to achieve a range of objectives: to improve the quality of reports, speed their throughput, maintain service to customers, lever in investment, and reduce costs. The launch in February 1996 of the Department's wider Change Programme made it imperative that the outsourcing should contribute to delivering improved services at 25 per cent lower cost over three years.
- 3 Following competition the Department awarded SEMA Group contracts totalling £305 million to deliver the service for at least five years. Though two of the five bidders withdrew there was still competition for two of the three regional contracts, and for the third the lack of competition did not result in higher prices. SEMA Group offered the cheapest bid, below the cost of the existing in-house service, and the Department assessed this bid as the highest quality and the most innovative. They obtained further reductions and concessions through additional bidding rounds and estimate that outsourcing will save between 10 and 14 per cent compared to the in-house operation (the public sector comparator).

4 The contract has proven a demanding one for the Department to manage. They prudently allowed six months to prepare for transfer to SEMA Group, but there were still problems in scheduling appointments, where the company's solution proved to be impracticable and had to be abandoned. The contract provides strong incentives to deliver medical assessments to time, but the Department's powers to obtain improvements in the quality of the service are not as robust, despite their achievements in strengthening quality measures. The Department also negotiated a service improvement plan to help ensure that SEMA Group's innovative proposals for developing the service were implemented. But progress in implementing it is not linked to payments and has been patchy and slower than expected. A key aspect of SEMA Group's proposals, the comprehensive reorganisation of all medical centres to work more closely with benefit offices, proved uneconomic and has occurred only at isolated locations. Appendix 1 provides a detailed chronology of events.

5 We examined the medical assessment service to assess:

- whether the speed, efficiency and quality of medical assessment have improved, enabling the Department to pay "the right benefits to the right people at the right time";
- whether the quality of service to benefit customers is adequate; and
- the useful lessons that should be learned for other outsourcing initiatives.

In designing our study we had regard to the work of the Social Security Select Committee, who reported on Medical Services in April 2000. Where possible, we have followed up action taken as a result of their recommendations but, in addition, we looked at the management of medically assessed benefits more widely and the linkage between providing a quality service to customers and effectively protecting benefit expenditure. The approach we used in our examination is described in Appendix 2.

Since outsourcing the speed and efficiency of medical assessment have improved but savings could be made by reducing delays in Benefits Agency processes

6 Incapacity Benefit and Disability Living Allowance with its sister benefit, Attendance Allowance, represent over 90 per cent by value of medically assessed benefits. Disability Living and Attendance Allowances are not paid until evidence (which may take the form of a medical assessment) has been provided to demonstrate that the customer meets the criteria, **so timely assessment is especially important to avoid undue delays in customers receiving their benefits.** Conversely, Incapacity Benefit customers who meet basic eligibility criteria are paid benefit immediately, and those subsequently found to be capable of work do not have their benefit payments recovered. **So for this benefit a timely medical assessment is essential to protect the public purse.**

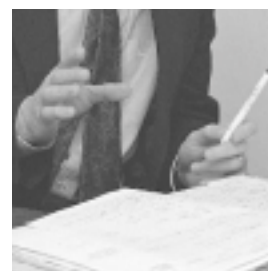
7 SEMA Group's efficiency improvements have contributed to speedier medical assessments. Since outsourcing, the average time taken to provide medical reports and advice has reduced. But workloads in Incapacity Benefit have actually been reducing, albeit offset by some increases in disability benefits. There is also still room for improvement.

8 Medical assessment forms only part of the end-to-end processing of benefit claims. For Incapacity Benefit, the total time taken to process cases due for review ranges from 90 to 170 days across different parts of the country. Most of this variation is due to the variable speed of processing in the Benefits Agency rather than medical assessment. This is partly due to other benefits taking higher priority in local benefit offices, and also because resources allocated are not closely matched to caseloads. Delays also arise because evidence provided by



customers and their general practitioners is often inaccurate or incomplete. Disability Living Allowance/Attendance Allowance cases, the administration of which is more centralised in only 12 locations, are handled more promptly, despite some delays in obtaining evidence.

- 9 If the Agency could reduce the processing time in Incapacity Benefit to the levels achieved by the three top-performing Area Directorates they could achieve savings by reducing payments to customers who are no longer eligible for benefit. We estimate these savings to be around £60 million a year in payments of Incapacity Benefit, which could be reduced to the order of £30 million to £40 million through customers going on to claim other benefits instead. Bringing performance up to the level of the middle performer, which the Department consider more achievable in the medium-term, could bring net benefit savings of around £20 million. Eliminating backlogs in cases awaiting review could achieve net one-off savings of £20 million to £30 million, with further savings if the ongoing level of backlogs could be reduced.
- 10 The Department have begun to focus on improving performance and reducing variations in the time it takes to process claims and make decisions through the Performance Improvement Programme, which was launched in February 2000. The Programme has so far focused on Income Support and Jobseeker's Allowance, two large and complex benefits, but the Department now intend to apply a similar approach to Incapacity Benefit. This will involve:
 - identifying, sharing and implementing good practices from the best performing Areas;
 - Improving management information to track performance;
 - training and changes in procedure to improve workflow management; and
 - support from Performance Improvement Action Teams for those offices with particular difficulties.



Improvements in the targeting and quality of assessments have yet to be fully delivered

- 11 The Department and SEMA Group have recognised that they need to focus more on improving the quality of medical reports, which has been a cause for concern since before outsourcing. During procurement the Department decided that it would be too difficult to enforce contractual clauses relating to quality. This was because of the inadequate quality monitoring systems then in place and the difficulty of defining what actually constituted adequate medical quality - a problem experienced more widely in the medical profession as a whole. Instead, they put in place other remedies, such as the right of decision-makers to return reports that were not usable for rework, at no extra cost.
- 12 SEMA Group's own quality assurance systems suggest that the quality of reports has improved since outsourcing. And, prima facie, this is borne out by the Benefits Agency returning less than one per cent of reports as unfit for purpose. Yet our interviews suggested that staff often fail to send back reports that are technically below standard because of the delays it causes, and because they believe the revised report would probably be no better than the first one. The Department's own monitoring gives no indication that the quality of medical assessments is any better than before outsourcing.
- 13 When outsourcing, the Department aimed to make medical assessment more efficient and to avoid the risk of over or under examination by better targeting of physical examinations and paper scrutinies of cases. They introduced new guidelines for doctors to reduce unnecessary examinations by more clearly

defining the circumstances when a scrutiny of papers would suffice. They also deliberately agreed a single price for all Incapacity Benefit reports, whether or not an examination had taken place, to provide a better incentive to SEMA Group to reduce unnecessary examinations.

- 14 Too low a level of examinations may lead to customers being passed as unfit for work and eligible for benefit when they are not. Because SEMA Group are paid the same price whether assessments are based on paper scrutiny or examination, they make a significantly greater return on the former, a fact of which the Department were aware when they signed the contract. We found no evidence that the company had sought to maximise their profits through a systematic policy of under-examination, but nonetheless there is a general incentive on medical services centres and doctors to opt for the simpler and quicker method. A Departmental review has indicated that between 20 and 30 per cent of scrutiny cases did not meet the agreed guidelines. As a result, SEMA Group are retraining all doctors doing this work and the Department have redrafted the guidance issued to doctors to clarify the policy on when to examine customers. This has already resulted in an increased rate of examination. The Department are renegotiating the contract so that the company will make a broadly similar rate of return from examinations as from scrutinies.
- 15 Even the best medical evidence may result in a poor decision if not interpreted correctly by the decision-maker. The major medically assessed benefits have a high rate of successful appeals against decision to withdraw or reduce benefit. Analysis by the Appeals Service indicated that in some 25 per cent of those decisions they changed, the interpretation of the medical evidence, whether from SEMA or the customer's doctor, was an important factor. The Department are now beginning to look at ways of learning from the results of appeals, but they also need to ensure that decision-makers have access to good quality advice from SEMA Group doctors on medical issues.
- 16 Improving the quality of assessment depends crucially on SEMA Group attracting sufficient numbers of suitably trained doctors. SEMA Group have continued to suffer shortages of doctors. This stems partly from a general UK-wide shortage of doctors, which is expected to worsen before it improves, and also from the fees paid for this work. SEMA Group have introduced higher pay in remote areas where there are particular shortages and have recently given a 3 per cent pay increase to all fee-paid doctors, but rates are still substantially below those paid by other government departments. SEMA Group have introduced various measures to improve professional standards and have recently announced that in future they will pay doctors to attend training.
- 17 The main threat to maintaining a viable workforce is in the longer term. Almost half of the fee-paid doctors are aged 55 or over and could therefore begin to retire in the next five years. Although doctors retiring from general practice could add to the pool from which SEMA can draw, there are risks attached to such reliance on an ageing workforce. Proposals in SEMA Group's bid to make greater use of nurses and other health professionals have made little progress in the face of legislative and other obstacles.

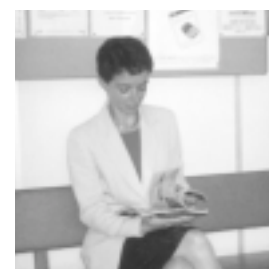
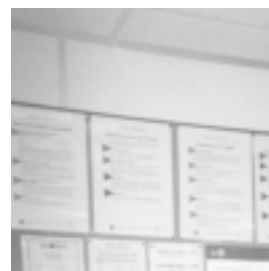


The Department, working through SEMA Group, need to improve service to customers

- 18 While the Department require SEMA Group to meet certain standards of customer service, they have limited leverage through the contract to oblige SEMA Group to raise standards, as payments are not linked with achievement of these standards.
- 19 There is not yet sufficient information available to give an adequate picture of the standard of customer care. SEMA Group's surveys of customers indicate that most are content with the conduct of examinations, but the number of

recorded complaints is increasing. Most are about doctors' attitudes and how they conduct examinations, particularly where customers are examined at home, which raises concerns about the quality of the resulting reports. There is not yet enough evidence on how well the service treats customers from ethnic minorities and those who request a female doctor or an interpreter.

- 20 The scheduling of appointments remains an area of particular difficulty. The contract incentivises SEMA Group to maximise attendance at examinations. Despite this the average proportion of customers failing to attend appointments has risen slightly to 23 per cent in 2000. To compensate for "no-shows" SEMA Group has continued to overbook appointments as practised by the in-house service. This results in over 1,000 customers (around three per cent) being turned away from examinations every month, which can cause inconvenience and distress.
- 21 In response to the Social Security Select Committee's report of April 2000 the Government made a strong commitment to improving the standards of service to customers. The Department and SEMA Group have introduced improved customer survey methods and enhanced monitoring of doctors' performance. They are improving customer information on examinations, have revised guidance for doctors who carry out home visits, and begun recording separately complaints about cultural insensitivity. But these initiatives are at an early stage and there is as yet no evidence as to the effect on the service provided to customers.



Overall conclusions

- 22 Before outsourcing, the Benefits Agency medical service was an underachieving organisation operating within tight resource constraints. Outsourcing has reduced the cost of the operation to the Department and has seen valuable improvements in the speed with which work is processed.
- 23 However, the viability of the business remains under acute cost pressure and this has affected the efforts of the Department and the company to improve the quality of medical assessments and customer service. SEMA Group's prices began lower than their competitors' and were driven lower in rebidding. Moreover, key elements of their strategy to improve efficiency and reduce the cost base, through automated scheduling of examinations and use of nurses, have not yet been implemented. And changes in the balance of work from more profitable Incapacity Benefit towards less profitable Disability Living Allowance/ Attendance Allowance have created another financial pressure.
- 24 The incentives in the contract that require SEMA Group to make qualitative improvements are not as robust as those requiring the fast turnaround of work, despite the Department's achievements in strengthening quality measures. The business is confronted by a major strategic threat in terms of shortages of doctors, which is forecast to get worse over the next five years and requires rapid remedial and preventative measures.
- 25 On a broader front, the system of assessing and paying claims for benefit depends on the effective and timely contribution of different players: Benefits Agency offices; claimants' general practitioners and consultants; and SEMA Group examination centres. Bottlenecks currently exist throughout the system which result in delays in paying some disability benefits to those entitled to them, as well as continued payment to those who are no longer eligible, and a highly variable quality of service to claimants around the country.
- 26 This has been an innovative project for the Department, involving the outsourcing of a service closer to their core business than their earlier procurements. There are lessons to be learned by all Departments. The key recommendations which follow are supplemented in Appendix 3 by more detailed recommendations on ways the Department could secure improvements.

Recommendations to the Department of Social Security

On the quality of medical assessment and preserving their medical assessment capability

- a) The Department should focus more of their management effort on the quality of medical reports. Stronger oversight of SEMA Group's internal quality assurance arrangements is required from the Department's Corporate Medical Group of specialists, and this may require a review of resources.
- b) Unusable reports should always be sent back to SEMA Group for rework to secure continuous improvement in standards. The definition of a usable report should include the requirement that it provides evidence to back up the opinions given. The Department also requires legible reports which do not include inappropriate or offensive comments, especially since customers or a tribunal may need to read them at a later date.
- c) The Department and SEMA Group should continue to work closely with the new Appeals Agency to further develop the new arrangements for feedback from independent tribunals on the standards of medical evidence they expect to see. This should involve piloting ways of ensuring that:
 - decision-makers receive regular feedback on the findings of appeals tribunals and the implications for their work;
 - SEMA Group doctors also receive feedback on relevant findings; and
 - the Department's case is properly represented at appeals tribunals where benefit decisions are being examined. This may involve a review of the cost-effectiveness of sending staff to attend tribunals.
- d) In view of the worsening shortages of doctors available to carry out medical assessment work, the Department and SEMA Group should look further at the proposals set out in the contractor's original bid, to make use of other healthcare practitioners such as nurses to carry out appropriate parts of the work.
- e) The Department should obtain as soon as possible a projection of the demographic and skills mix and location of the full-time and fee-paid workforce at the end of the contract in 2003 to ensure that a viable service can be delivered beyond the end of the existing contract, and to identify any need for corrective action. This may involve looking again at the mix of full-time and part-time doctors doing the work.

On the efficient management of medical assessment

- f) The Department should, as part of their focus on reducing variations in performance, look to speed up processing times in Incapacity Benefit and reduce the size of backlogs of cases awaiting medical referral, across all regions. This will involve addressing the exact causes of backlogs and processing delays, building on the analysis in this report and on the expertise from the Benefits Agency's own work on performance variations in other benefits.
- g) The Department should seek to standardise approaches in districts to reviewing long-term Incapacity Benefit claims. Their "Keeping in Touch" initiative, currently in pilot form, may provide valuable information through contact with these customers to inform the review process.



- h) Workloads at local benefit offices are volatile and difficult to predict. The Department should avoid situations where high priority cases coming up for review in certain district offices are deferred through lack of funds. Ways of achieving this might include keeping back a proportion of funding for medical assessment work centrally.

On customer care

- i) The Department should seek to build performance measures linked to financial incentives on customer care into their contract for medical services. This should be part of any negotiations to extend the contract duration to 7 years, and might include measures to:
 - reduce the incidence of customers being turned away from examination appointments unseen;
 - ensure the waiting time targets of 10 and 30 minutes for customers attending an appointment are met or improved on;
 - provide a doctor of the same gender or an interpreter for all customers who request it when arranging the appointment, subject to the customer being willing to travel to an alternative centre.
- j) The Department should consider, with SEMA Group, ways of eliminating the problem of turning away customers who have been asked to come for examination without seeing them by:
 - implementing nationally the successful pilots where scheduling of appointments is done locally, and local knowledge of customers and geography can help plan sessions more accurately;
 - reconsidering the way fee-paid doctors are remunerated, the scope to let them examine at their own practice premises, and the incentives on them to complete all scheduled examinations; and
 - better training and retention of SEMA Group staff doing scheduling so that they can more effectively judge the length of different types of examinations.
- k) The Department and SEMA Group should continue to look at ways of further improving the surveys of Benefits Agency staff and customers so that they meet generally accepted market research industry standards. The Department should periodically exercise their right to validate these surveys and ensure they provide a representative picture of the views of all customers.
- l) The Department should obtain robust information, from either improved customer surveys, or more directly targeted research methods, to determine the effect of SEMA Group's activities on different customer groups, by ethnicity and gender, in line with the new provisions of the Race Relations (Amendment) Act 2000. Where there are different outcomes for different groups, they should consider setting targets for improvement.
- m) The Department should work with the Commission for Racial Equality to ensure that SEMA Group, as well as their other contractors, put in place race-equality programmes to ensure compliance with the requirements of the Race Relations (Amendment) Act 2000 which introduces a new positive duty on public bodies to promote race-equality. These programmes should be in line with the codes of practice to be issued by the Commission early in 2001.

- n) The Department require better assurance that complaints received by SEMA Group have been properly handled. This might include:
- more detailed categorisation, by type, of complaints about the conduct of doctors at examinations;
 - focusing their monitoring effort on serious complaints and on multiple complaints against the same doctor, to ensure that SEMA Group have taken corrective action;
 - a firm definition of what constitutes a serious complaint; (eg. a matter likely to have influenced the benefit decision, or which inflicts pain or hardship on the customer or relates to improper conduct by SEMA Group staff);
 - negotiating with SEMA Group or a subsequent supplier to build financial remedies into the contract for failures to act in response to such complaints within set timescales.

Recommendations to all Departments on outsourcing

- o) Objectives should be explicitly prioritised and minimum standards set for each so that Ministers and officials are aware of the likely outcomes. In this case the Department pursued several objectives that tended to conflict: to improve the quality of reports, quicken throughput, maintain service to customers, lever in investment, and reduce costs. Although qualitative criteria were weighted, overall the objectives were not prioritised, and the resulting contract focused on reducing the cost of the service whilst speeding up throughput.
- p) Where Departments intend outsourcing to bring significant capital investment they should consider whether the proposed length of contract gives the supplier an adequate period to recover worthwhile investment. There is the risk that this contract will suffer from partial "investment blight" for much of its minimum five-year duration.
- q) Where Departments are unable to define service quality to contractually enforceable standards they should consider other approaches to incentivising suppliers. In this case, options include direct payments for outputs conducive to quality, such as the achievement of targets for numbers of medical staff attaining additional professional qualifications.
- r) Where Departments embark on innovative outsourcing of specialist services they should consider longer shortlists, to offset the increased risk that companies will withdraw without bidding. In this case the Department prudently shortlisted five companies, and therefore managed to maintain competition for two of the three contracts and the illusion of competition for the other.

Part 1

The Department outsourced the medical assessment of benefits to improve the performance and value for money of this vital service

1.1 Medical assessment is key to the award of disability and incapacity benefits costing over £19 billion a year. Paragraphs 1.2 to 1.13 explain that the Department outsourced their medical service because they wanted to improve performance and reduce running costs and saw an opportunity to achieve this through increased private sector involvement. Paragraphs 1.14 to 1.28 show that the procurement yielded substantial price reductions and proposals for improving service quality. But service quality improvements have not been implemented to the extent and timetable promised.

Medical assessment is central to the Department's decision-making on customers' eligibility for disability and incapacity benefits

1.2 The Department's objective in supporting disabled people is to provide them with the support and financial security they need to lead a fulfilling life with dignity. Disability and incapacity benefits and pensions are paid to some of the most vulnerable members of society. It is important that their eligibility is assessed fairly and efficiently, and in a way that causes them minimum anxiety and inconvenience. It is also essential to protecting the public purse that such substantial expenditure is incurred only in payments to those who are genuinely entitled to them.

1 The Department spends over £19 billion on disability and incapacity benefits and pensions each year

Incapacity Benefit and Disability Living Allowance/Attendance Allowance account for the majority of medical assessments

Benefit or pension	Expenditure in 1999/2000 £ million	Estimated number of recipients at mid 1999/2000 (thousands)	Number of cases subject to medical assessment in 1999/2000 (thousands)
Incapacity Benefit	7,075 (note 1)	2,259	892
Disability Living Allowance	5,746	2,126	301
Attendance Allowance	2,866	1,290	- (note 2)
Severe Disablement Allowance	1,045	412	- (note 3)
Industrial Injuries Pensions and Scheme Benefits	802	435	92
War pensions	1,241	301	18
Disabled Person's Tax Credit	43	14	- (note 4)
TOTAL	18,818 (note 5)		1,303

- Notes:
1. Recipients of Incapacity Benefit include those who have not made sufficient contributions to receive the benefit directly, but who receive Income Support instead on the grounds of their incapacity.
 2. Medical assessment of these benefits is included in Disability Living Allowance above because these benefits are assessed together.
 3. Medical assessment of these benefits is included in Incapacity Benefit because the benefits are assessed together.
 4. The number of these cases requiring medical assessment is less than 1,000 a year.
 5. Many of these customers are also eligible to receive other benefits, such as Income Support, Housing Benefit and Council Tax Benefit. The Department estimates total support for the long-term sick and disabled to be £24.5 billion, or a quarter of total benefit expenditure.

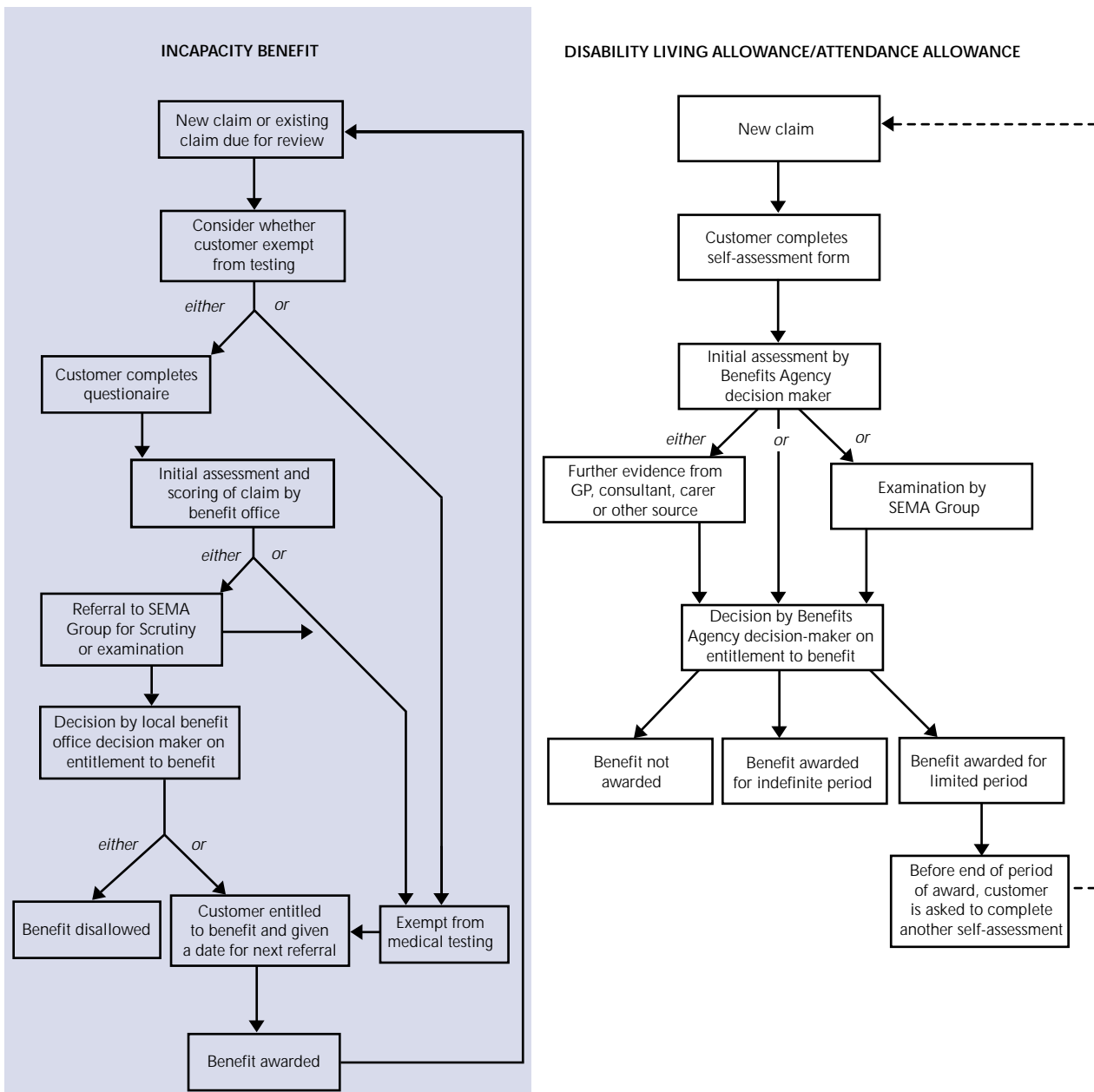
Source: Department of Social Security

1.3 Decisions on whether to award disability and incapacity benefits are made by administrative staff in the Benefits Agency, but they are usually based on medical evidence. Some evidence is provided by claimants and their general practitioners, but often a report is provided by an independent doctor acting on behalf of the Agency. Some 1.3 million independent medical reports are completed each year. How well this medical reporting is done can affect the speed of decision-making, the well-being of claimants, and the level of disability benefit expenditure. The vast majority of medical reports are for Incapacity Benefit and Disability Living Allowance/Attendance Allowance. **Figure 2**

shows how medical assessment fits into the overall management of claims for Incapacity Benefit and Disability Living Allowance/Attendance Allowance.

1.4 Incapacity Benefit is the main contributory benefit for those unable to work because of illness or disability. It was introduced in April 1995 against a background of rapidly growing spending on its predecessors, Invalidity Benefit and Sickness Benefit. **Figure 3** shows that spending fell by an average of 5.9 per cent a year in real terms over the five-year period up to 1999/2000, owing to the removal of entitlement for people over pension

2 Medical assessment of Incapacity and Disability Benefit claims



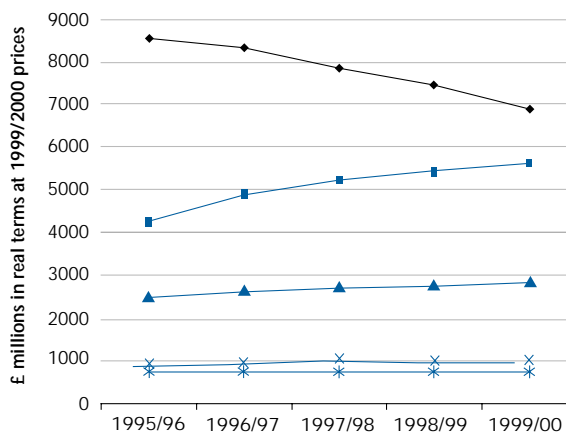
Note: A more detailed process diagram of Incapacity Benefit is included at Appendix 2.

Source: National Audit Office

age as well as the introduction of an "All Work Test", later replaced by the Personal Capability Assessment.

- 1.5 Disability Living Allowance is a tax-free, non-contributory benefit paid to customers under age 65 who because of an illness or disability need help with personal care, getting around, or both. The period of entitlement and the rate of benefit depend on the extent of the customer's care and mobility requirements. Spending has grown on average by 9.3 per cent a year in real terms since 1994/95, due mostly to increasing take-up. Attendance Allowance is a similar benefit for people over the age of 65.
- 1.6 Disability Living Allowance and Attendance Allowance are not paid until sufficient evidence has been provided to show that the customer meets the criteria. So a timely assessment is necessary to avoid undue delays in customers receiving their benefits. In contrast, Incapacity Benefit customers who provide basic medical evidence are paid benefit before receiving an independent medical assessment, and those subsequently found to be capable of work do not have their benefit payments recovered. So for this benefit a timely medical assessment is essential to protect the public purse.

3 Trends in incapacity and disability benefit expenditure



Key

- ◆ Incapacity Benefit
- Disability Living Allowance
- ▲ Attendance Allowance
- × Severe Disablement Allowance
- * Industrial Injuries Disablement benefits

Note: Since the introduction of Incapacity Benefit and the All Work Test (now replaced by the Personal Capability Assessment) in 1995, expenditure on this benefit has reduced in real terms. Expenditure on Disability Living Allowance/ Attendance Allowance has increased over the same period, though the rate of growth has slowed.

Source: Department of Social Security

1.7 Some 40 per cent of medical reports for Incapacity Benefit, and slightly fewer Disability Living Allowance/ Attendance Allowance cases, are completed without the doctor seeing the customer, but by consideration of self-assessment forms and of supporting evidence usually from the customer's general practitioner. In other cases which require a medical examination, this is conducted by a doctor at one of some 200 medical examination centres around the country for Incapacity Benefit, or at the customer's home in the case of Disability Living Allowance/ Attendance Allowance. The doctor normally interviews the customer, focusing on their disablement and how this affects them, records what the customer says, conducts a non-invasive examination and completes a report on the prescribed form for the decision-maker in the Agency.

The Department were not satisfied with the existing in-house service

1.8 The Department have been responsible for medical assessment of all incapacity and disability benefit claims since 1993, before which the Department of Health had been responsible for some of the work. By 1995, some 250 full-time doctors and up to 3,000 fee-paid doctors working part time for the Agency provided medical advice and conducted examinations. However, business targets for the cost, speed and quality of casework were not being achieved.

1.9 In July 1992 the service was placed in the Benefits Agency's market testing programme. In 1995 a collaborative study with three private sector companies, Serco, Capita and BMI Health Services, reported that:

- the service was in a fragile state, and the strains and stresses of delivering new benefits had taken a toll;
- there was a need to develop a distinct purchaser/provider relationship between the Agency and the medical service; and

- the organisation was constrained by tensions with its customers in the Agency, and by a lack of change management skills and planned investment to monitor performance and improve efficiency.

1.10 This led, in September 1995, to a recommendation to Ministers to outsource the whole of the medical service to the private sector, excluding medical policy development work. The proposals were developed in the context of the wider Change Programme being developed by the Department at the time, and launched in February 1996. This programme was intended to deliver improved services in all areas of activity at significantly reduced cost; and required the Agency to achieve a 25 per cent reduction in overall running costs over three years.

The Department pursued outsourcing as the best way to improve the service and reduce costs

1.11 The Department considered several options for developing the medical service, (Appendix 4). They elected for outsourcing because it would fully meet the objectives of Ministers for introducing the private sector into the medical service and:

- transfer operational and investment risk to the private sector;
- establish clear accountability and management roles, and a clear purchaser/provider split;
- allow more flexible staffing arrangements; and
- through offering the whole service to the private sector, maximise economies of scale and provide the supplier with a base for expansion into other markets with consequent reductions in cost to the Agency.

1.12 **Figure 4** shows the objectives of the outsourcing, together with a brief summary of achievement cross-referred to evidence elsewhere in this report. None of these objectives was given priority, and there was no explicit reference to service to benefit customers in this statement of objectives.

4 Objects of the Outsourcing Project

Objective

Award contracts which require suppliers to take account of, and respond to, future Department of Social Security operational and policy needs.

Gain and maintain significant cost reductions, while supporting efficiency improvements.

Award contracts that provide for the maintenance and monitoring of the required professional medical standards.

Maintain and improve service levels and existing commitments, within the agreed project scope.

Effect a smooth transfer of civil service staff.

Summary of achievement of objectives

Arrangements to respond to the Department's future needs were embodied in the contract. Their experience in obtaining a major change to the service, the addition of a Capability Report, is described in the report (Paragraphs 1.25 to 1.28).

Cost reductions estimated at 10-14 per cent over the life of the contract have been negotiated, though most of these should accrue only over the latter half of the contract. (Paragraph 1.20).

The monitoring arrangements provided have highlighted difficulties in maintaining the required professional medical standards (Paragraphs 3.2 to 3.11).

Service Levels are defined mainly in terms of achieving timescales for the return of medical advice and reports. After a difficult start this aspect of performance has improved and is closer to targets, though with a lower workload than under the previous in-house service. (Paragraphs 2.1 to 2.10).

Some 63 per cent of the 220 employed doctors and 1200 administrative staff were transferred to SEMA Group without major disruption or complaint. Most of the remaining administrative staff were redeployed in the Department. Transfer of fee-paid doctors was less successful. (Paragraphs 3.15-3.16).

Source: National Audit Office

1.13 Ministers approved the decision to outsource in November 1995 and asked officials to achieve an award of contract no later than April 1997. The contract was actually awarded in February 1998. Procurement took longer than expected because:

- a decision in 1996 to extend the scope of the contracted service to include the payment of fee-paid doctors and customer travelling expenses, and the arrangement of examinations for Disability Living Allowance/Attendance Allowance, added substantially to the work to be done;
- the shortlisted bidders required more time than originally expected to undertake "due diligence" checks on the service they would have to provide and the business they would take over;
- in May 1997 officials had to put work on hold and seek guidance from incoming Ministers, who gave their consent in July 1997 to proceed to invite tenders; and
- the Department were not satisfied with the initial tenders received, reopened negotiations with bidders to identify scope for further price reductions, and in November 1997 invited the three remaining bidders to retender.

There was sufficient, though limited competition

1.14 In June 1996 the Department invited potential suppliers to express interest. Though the service requirement was a unique one in terms of its specialism and size, 33 parties expressed an interest and 14 supplied information on their financial standing and technical competence. The Department produced a shortlist of five companies or consortia, largely by eliminating those of insufficient strength to take on contracts of this size. During the procurement two of the five shortlisted companies pulled out, leaving three bidders (**Figure 5**):

- in April 1997 EDS Ltd withdrew because they had identified legal uncertainties in their plan to transfer staff to their sub-contractor under protected terms and conditions of employment and were also concerned that legislative constraints on the way the medical service is delivered would limit the scope for cost efficiencies.
- in September 1997, Andersen Consulting (now known as Accenture) did not bid because they still had difficulties with clauses in the Department's draft contract and, like EDS, with their potential exposure to liabilities if staff had to be made redundant. Andersen's withdrawal was not known to the other bidders until after the Department had made their selection.

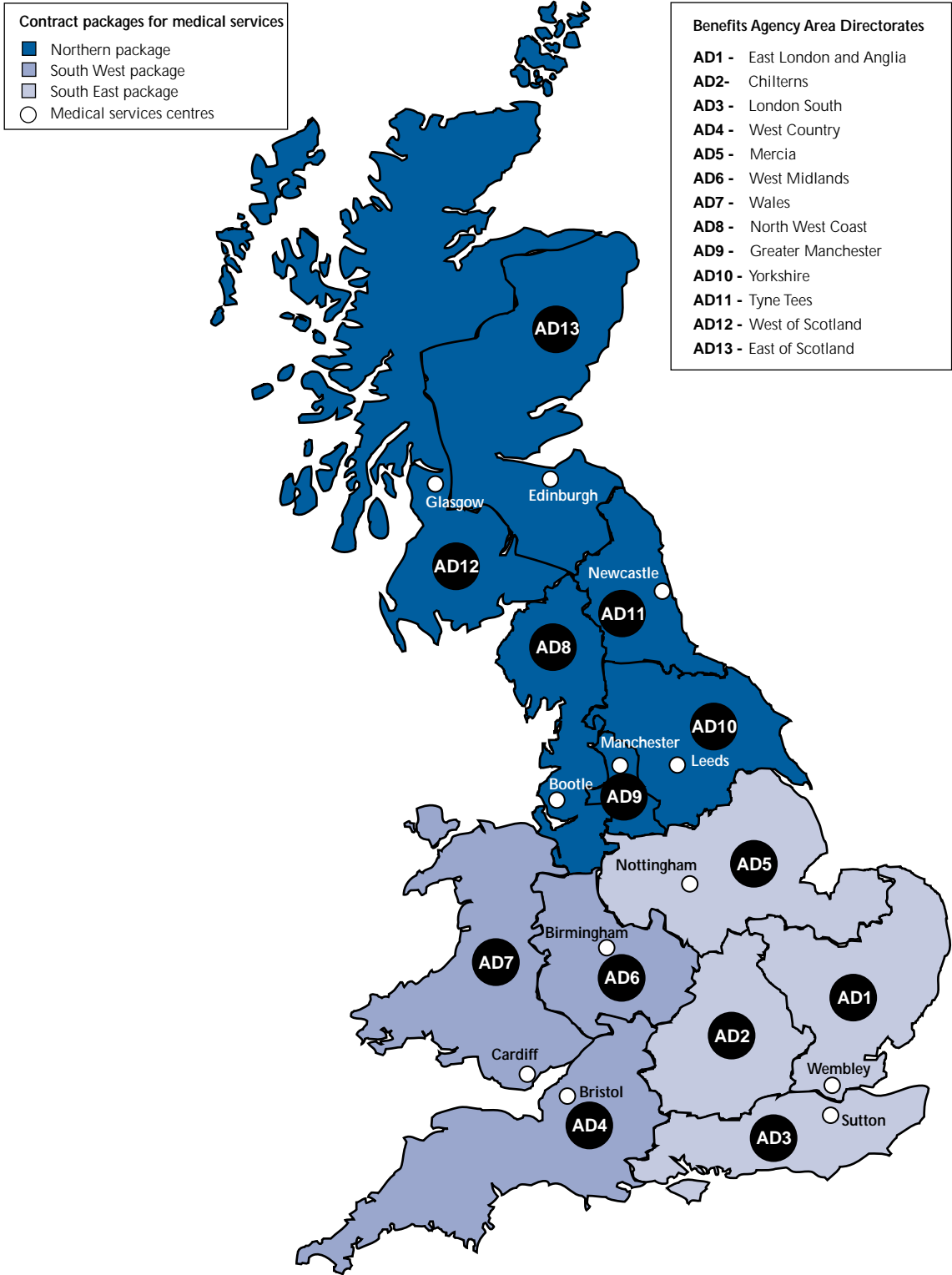
1.15 The large scale of the contract meant that if it had been let as a whole, there would have been too few bidders to provide adequate competition. Therefore, the Department broke the service down into three separate regions (**Figure 6**). The Department agreed that Capita could bid for two of the three contract regions, on the understanding that they would be awarded no more than one. And BMI Health Services were shortlisted for all three regions, but decided to bid for only the South East and South West. Therefore SEMA Group, which bid for all three regions, had no competition at all for the largest Northern region. SEMA Group told us that they had believed that BMI Health Services would bid for all three contract packages. Since the company applied similar prices to this region as it did to its successful bid for work in the South West, the evidence suggests that it did not abuse this potentially powerful position.

5 The companies bidding for the work

Company	Nature of business	Outcome
BMI Health Services	A group providing acute and preventative healthcare and healthcare management in the UK. Provide a number of health testing, screening and support services to National Health Service Trusts and to government departments.	Third placed bidder on cost and quality. Awarded no work.
Capita	An organisation providing a range of business services particularly experienced in managing outsourced administrative, financial and IT functions, many from local and central government.	Second placed bidder on cost and quality. Awarded no work.
SEMA Group	Part of a leading European services and IT company specialising in consultancy, outsourcing, systems integration and business recovery. Formed links initially with PPP Healthcare, then Nestor Healthcare Group as sub-contractor, to strengthen the medical aspects of their bid.	First placed bidder on cost and quality. Awarded all three regional contracts.

Source: Department of Social Security

6 Benefits Agency and SEMA Group regional divisions



Source: Benefits Agency

7 The Department's assessment of the retendered bids in December 1997

The lowest cost options each involved awarding all three contract areas to SEMA Group. Longer contract durations were cheaper and all SEMA Group's prices were significantly lower than continuing public sector management.

If the Northern Region was awarded to ...	and the South West was awarded to ...	and the South East was awarded to ...	for a contract duration of ... (years)	the annual cost of the service in all three regions would be ... £ million (note 1)	which compared to continued public sector management would save each year £ million
SEMA	SEMA	SEMA	10	74	6
SEMA	SEMA	SEMA	7	75	5
SEMA	SEMA	SEMA	5	77	3.5 (note 3)
SEMA	SEMA	CAPITA	10	77	3 (note 4)
SEMA	BMI	SEMA	7	85	- 5 (note 5)

- Notes:
1. Annual costs are discounted at 6 per cent and include the Department's own contract management costs at some £2 million a year. The costs shown for the options ranked 1, 2, and 3 with all work awarded to SEMA Group reflect changes from applying or not applying a four per cent real annual reduction in prices.
 2. This shows the difference between the private sector bids and the estimated costs in the Department's public sector comparator. The comparator was designed to show the cost of continuing the service in-house and assumed that some cost savings would be achieved. It was compiled by the Department's Finance Group. We examined the approach used and found no errors that would have materially affected the decision.
 3. The Department adopted option 3, but in further negotiation with SEMA Group obtained the lower prices of the seven-year bid in return for an option to extend to seven years at the Department's discretion.
 4. The cheapest combination of bids including a supplier other than SEMA Group.
 5. The cheapest combination of bids involving the third bidder, BMI Health Services. This would have cost more than public sector management.

Source: Department of Social Security

SEMA Group offered the lowest prices from the start and the Department obtained further reductions during rebidding

1.16 The Department's evaluation of the first round of bidding in September 1997 showed that SEMA Group were already clearly the lowest cost supplier and below the estimated costs of continued public sector management (the public sector comparator). After a further clarification phase all bidders submitted lower, revised tenders. Also in October 1997 the project steering group decided to reopen negotiations with all bidders to identify possible changes in the contract which could secure further price reductions. None emerged.

1.17 The Department's evaluation of the quality of bids did not change as a result of the clarification and retendering. However, SEMA Group's prices reduced by seven per cent on average compared to their original bid. SEMA Group explained that the changes were very complex and they could not point to specific factors that had contributed to these reductions. A second retendering in December 1997 did not result in further price cuts, but before awarding the contract the Department obtained a further significant concession from SEMA Group - that a five year contract extendable to seven years would attract the lower rates the company had offered for a fixed seven year contract.

1.18 The financial evaluation was complex because in the second round the Department invited bids for five, seven or ten year contract durations, and other variables, to see which permutations would offer the best value for money. However, in all these permutations SEMA Group offered the lowest price (Figure 7).

1.19 The evaluation team recommended awarding all three contracts to SEMA Group for ten years. Although there was a degree of risk, they considered that the benefits in price and potential for further savings were sufficiently large to justify this. But the project steering group and the Benefits Agency's Management Team took the view that a ten-year contract duration was too long, because of the likelihood that major policy changes might impact on the contract. They therefore approved the contract for five years, extendable to seven. The contract allows SEMA Group to receive at the end of their term a fair market value for any assets, such as IT systems, that they have created and that are still required by the service.

1.20 At the Department's request the pricing arrangements provide for an annual reduction in fees to match their targets for savings in running costs. Real prices in the fifth year will be some 19 per cent below those in year one. This is a substantial cost reduction in a service in which over 70 per cent of the cost base comprises doctors' fees and salaries and claimants' expenses, and will require SEMA Group to improve business efficiency if quality is not to suffer.

SEMA Group also offered the highest quality bid and the most innovation

1.21 In terms of quality the Department assessed SEMA Group's proposals as the best of the three bidders in all areas except personnel management and arrangements to ensure medical quality (**Figure 8**). The qualitative evaluation was performed by a team including staff experienced in procurement and medical representatives. The attractive aspects of SEMA Group's proposals highlighted in the evaluation were:

- the reorganisation of medical evidence centres, to be located as near as possible to the benefit offices which refer cases to them, reducing the movement of paper files and enabling more flexible working. Earlier proposals from SEMA Group, to provide electronic links between medical centres and benefit offices, did not feature in their bid given uncertainty about the future for the Agency's own IT;
- cases would be delivered as part of an end-to-end process in which key ratios, such as reducing the proportion of cases being examined, would be "improved";
- SEMA Group would use IT networks across all their centres to support the operation, manage workloads and provide comprehensive and timely management information;
- there would be a higher proportion of full-time medical staff than at present, to raise the quality of work, and SEMA Group would pilot the use of nurses to offer further economies; and
- this localised service would provide quicker processing, reductions in the rates of customers who fail to attend examinations or who attend and are not seen, and greater team working.

To secure improvements in quality the Department negotiated a service improvement plan with SEMA Group, but this has changed in scope and has not yet been completed

1.22 During transition the Department required SEMA Group to draw up a Service Improvement Plan to be implemented in the first two years of the contract. This was intended to demonstrate commitment and show how the innovative ideas in SEMA Group's bid would be taken forward. The Plan is described in Appendix 6. However, the Department lack specific sanctions if parts of the plan are delayed. They could exhort SEMA Group to implement it, which has been done through monthly progress meetings, but they could not enforce this to a specific timetable.

1.23 The Service Improvement Plan has not made fully satisfactory progress, in part because SEMA Group's efforts and management attention focused for the first year on meeting its service level targets for processing its caseload. Some elements of the plan have been implemented, particularly those which enable SEMA Group to process cases more quickly and efficiently. Others, notably to do with improving medical quality, are still in progress. Elements of the plan are dependent on other factors such as:

- the consent and co-operation of the Department, for example for the use of paramedics rather than doctors;
- flexibility to vacate, acquire or remodel accommodation through the Department's contract with their accommodation provider Trillium; and

8 The Department's ranking of the quality of bidders' proposals

The Department assessed SEMA Group's proposals as clearly the best of those of the three bidders in all areas except personnel management and arrangements to ensure medical quality.

Criteria of assessment of bidders' proposals	Scores (Highest)		
	SEMA Group	Capita	BMI Health Services
Service Quality (including organisation, accommodation, customer service, service levels and track record)	520	488	352
Medical Quality (recruitment & training of doctors, systems, quality assurance, monitoring and track record)	396	451	363
Transition, contract management and track record	279	189	135
Personnel (personnel policies, legislation and training)	156	176	96
Change (flexibility, innovation and change management)	160	156	124
Confidentiality and security (general security, IT and data)	180	140	124
Assets and Information Technology	63	54	54
TOTAL out of 2,140 points maximum	1,754 - 82%	1,654 - 73%	1,248 - 58%

Source: Department of Social Security

- increased financial resources to invest in IT, which can be difficult for SEMA Group to justify in the context of the short remaining length of the contract. Whilst the original bid included some funds for investment in IT, the company told us that the contract duration has often made it harder to sustain a case for investment in service development because they have little time to recover any investment with a payback longer than three years.

1.24 One of the key elements of SEMA Group's proposal was for the complete reorganisation of medical evidence centres. Under the in-house service benefit offices sent their work to one of 12 centralised points, which then arranged for the work to take place at each of the 200 examination centres. Devolving much more work to each centre would enable each centre to work closely with "their" local benefit offices, reduce the movement of paper files, capture the benefits of greater local knowledge and enable more flexible working. SEMA Group ran three pilots in late 1998 and early 1999. But they found that full reorganisation was not practicable in all locations, mainly because:

- it would require benefit offices to sort cases for separate dispatch to each centre; and
- it would not be economic to staff medical centres handling few cases to do all the administration work.

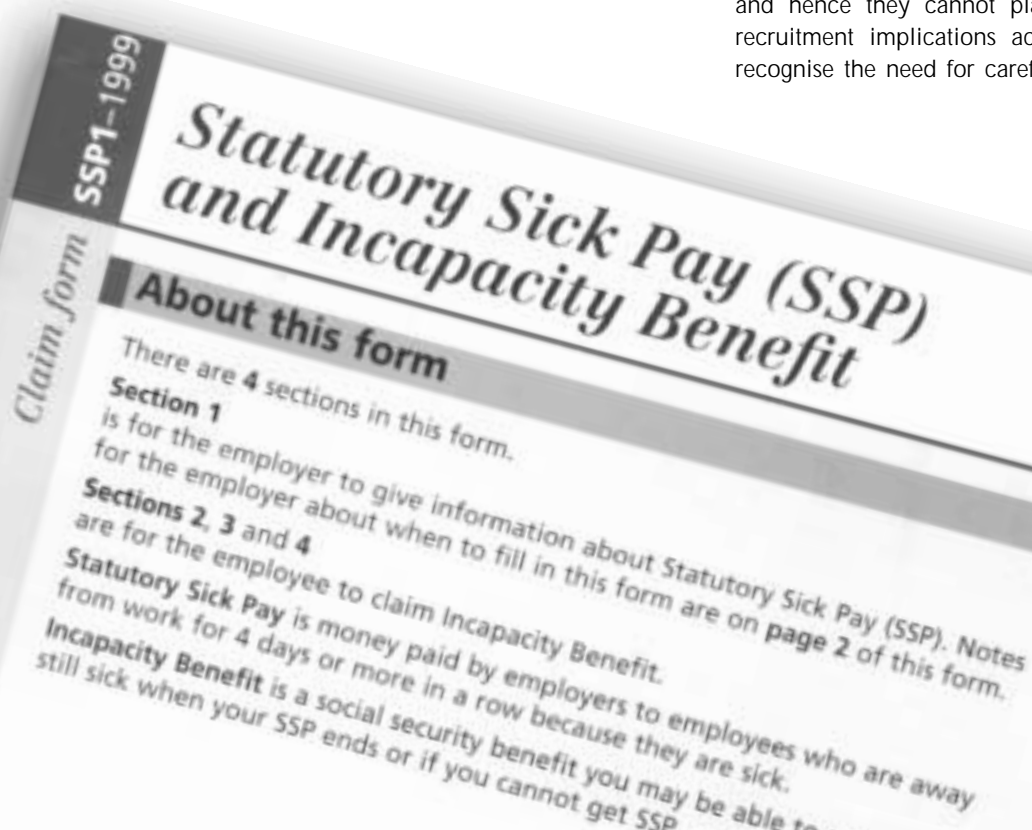
Therefore, services have been reorganised in only a small number of locations. Instead, SEMA Group have begun to implement a new IT infrastructure which they expect to deliver the same benefits as the original proposal.

The contract has so far coped satisfactorily with a major change in the Department's needs

1.25 One of the Department's objectives in outsourcing the service was to require suppliers to respond to future operational and policy needs. The most significant change has been to require Capability Reports as part of the Personal Capability Assessment process, as well as advice to the benefit decision-maker. The new reports provide information on what the customer can do despite his or her medical condition and what help could be provided to aid a return to work. They are being used as part of projects (the "ONE" project and the New Deal for Disabled People) which provide Personal Advisers for people receiving incapacity benefits, currently in the pilot stage.

1.26 The terms on which SEMA Group would provide this additional product were agreed using the formal change control arrangements written into the original contract. Since the price is based on the hourly rates that apply to other work, the Department's negotiations with SEMA Group focused on how long on average it should take doctors to research and complete the 10-page Capability Report. SEMA Group is paid on the basis that this will take 30 minutes in addition to the 47 minutes for the main report on the customer's incapacity.

1.27 Capability Reports have so far been introduced on a partial basis across about one fifth of the country. Initial experience has been favourable: doctors say the assessment is a more positive experience for them and customers recognise that it is designed to help rather than remove their benefit. At this stage it is not yet clear what the resource implications will be if it is rolled out nationally. SEMA Group told us that they had been given no firm indication of the likely volume of work and hence they cannot plan the cost, training and recruitment implications accurately. The Department recognise the need for careful planning of the phased

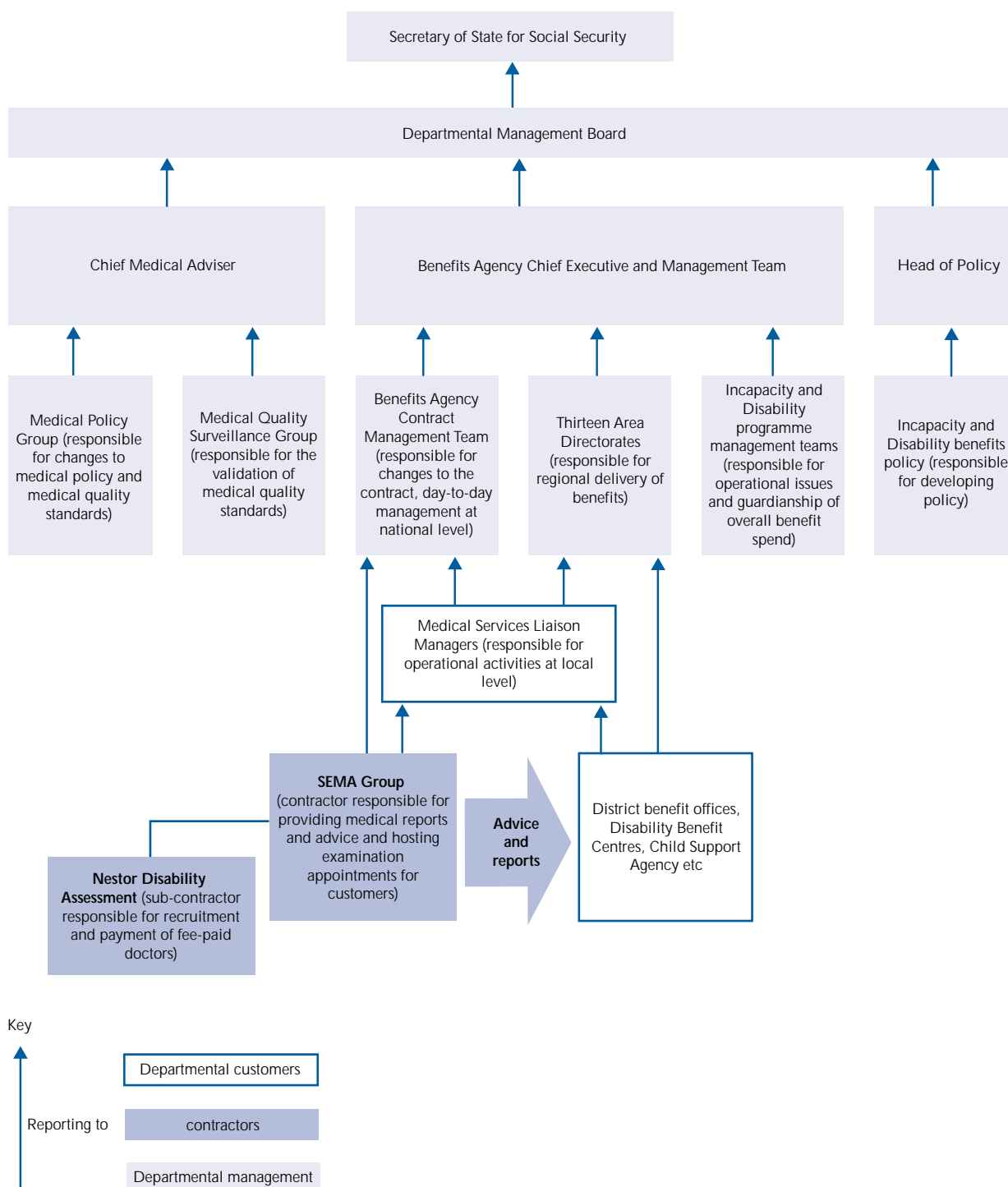


rollout to balance with peaks and troughs of work on other benefits and are looking at this as part of the pilot project evaluations.

- 1.28 Agreement of such changes, and day-to-day management of the contract, is the responsibility of a dedicated team of some 50 Benefits Agency staff based in Preston and Warrington. This team consults as

necessary with policy officials and specialist medical advisers in the Department, and with the users of medical reports within the Department and elsewhere. They monitor activity against contractual obligations, validate invoices received from SEMA Group and manage any changes to the contract through a formal change control process. The management arrangements for the service are shown in **Figure 9**.

9 Stakeholders in the medical services contract



Note: The diagram shows the structures in place during roughly the first two years of the contract (to September 2000). During late 2000 and early 2001, the Department of Social Security was undergoing a number of structural changes which are due to be finalised by June 2001.

Part 2

Since outsourcing, the efficiency and speed of medical assessment have improved but savings could be made by reducing delays in Benefits Agency processes

- 2.1 Carrying out the work of medical assessment quickly and efficiently, and consistently across all regions, is important to prevent financial loss to both customers and the public purse. This part of the report shows that SEMA Group have improved the efficiency of their part of the medical assessment process since being awarded the contract, but that there are still delays and inconsistency in the system.

Before outsourcing performance was highly variable, and backlogs of work had built up

- 2.2 Before outsourcing there were considerable variations in performance between the 12 regional medical services centres and target turnaround times were not being met (**Figure 10**). Moreover, the performance monitoring regime in place did not create incentives for medical services centres to complete a case once it had exceeded the target clearance time, and substantial backlogs of older cases had built up (**Figure 11**).

Most of the Department's payments to SEMA Group are for delivering, within specified timescales, reports that decision-makers find usable

- 2.3 The Department considered that commercial incentives would improve efficiency and speed up the turnaround of medical reports and advice. They revised the performance measurement regime by including in the monthly figures any cases left outstanding from the previous month, to encourage the outsourced service to avoid backlogs of work. Any work outstanding at the end of each month is counted against performance in the following month, so there is now a stronger incentive to clear all cases within the target time. Apart

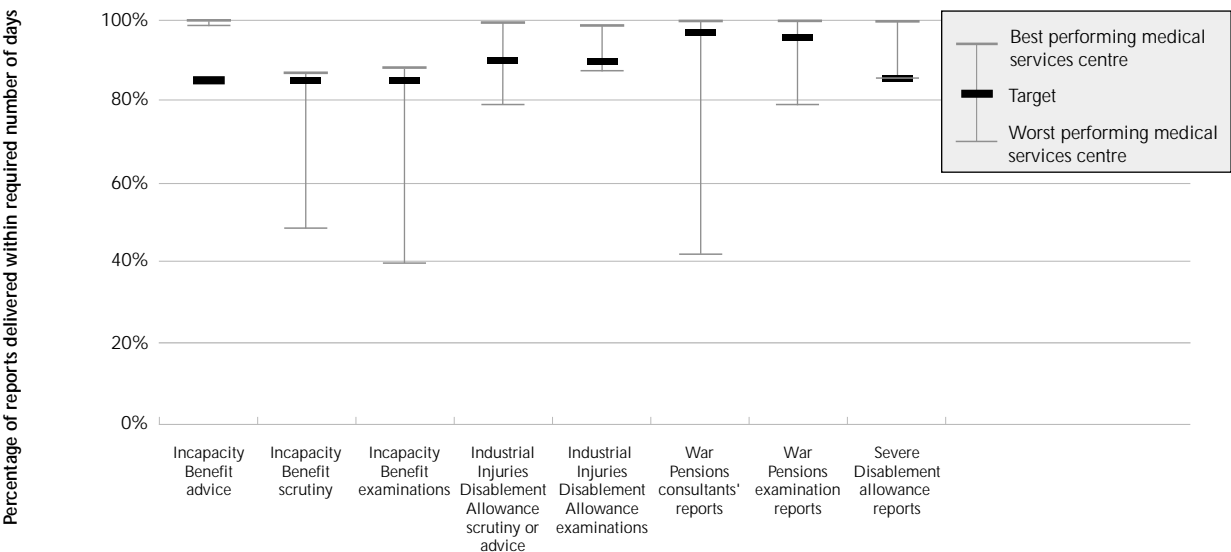
from £14.4 million paid each year to meet the fixed costs of the service (mainly management, capital investment and accommodation), the Department pay SEMA Group mainly through an agreed unit price for each report or other product that decision-makers consider usable. The fee for Incapacity Benefit is approximately £50 per report, whether or not an examination is required. If the company provides a report late, this failure is logged and used to calculate service credits which could, if there are enough failures, result in deductions from their monthly payments. The Service Level targets mainly relate to timeliness of assessments (**Figure 12**). They are listed in full at Appendix 5.

There was a dip in performance for several months after SEMA Group took over

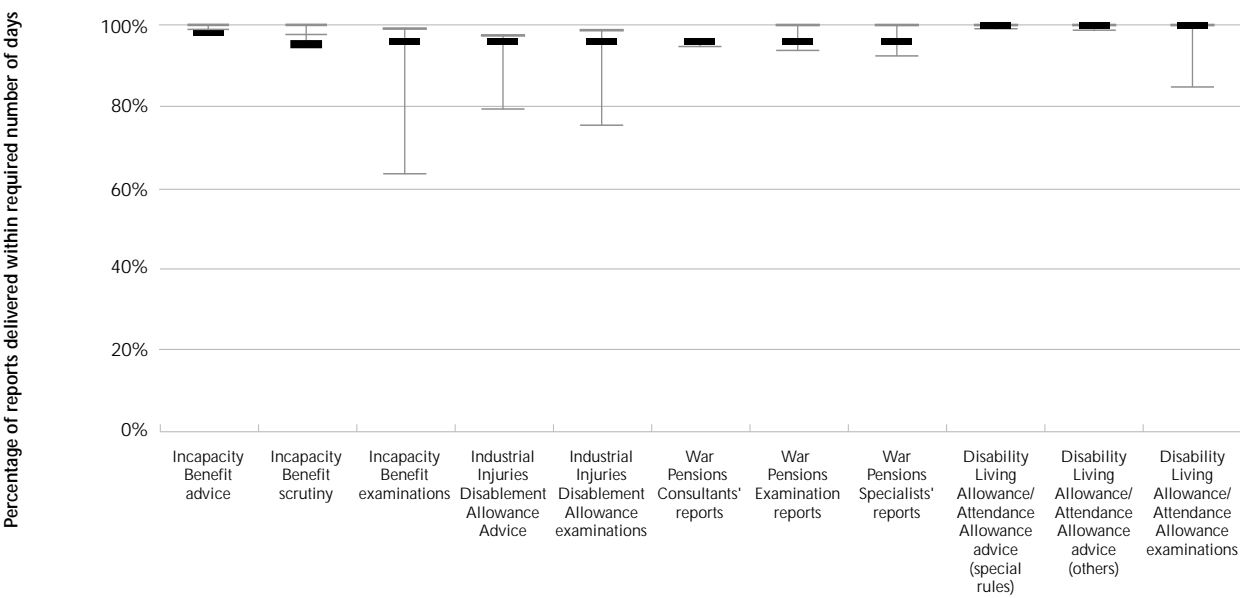
- 2.4 When the Department awarded SEMA Group the contract they recognised that such a large, complex and vital service could not be safely transferred to new management immediately. During a six-month transition period starting in March 1998, they undertook a review process to satisfy themselves that the contractor would be capable of delivering the service in accordance with the requirement. Despite this problems still arose in the first few months after transfer owing to the supplier's failure to transmit data effectively to enable effective scheduling of doctors. This caused late or erroneous payment of doctors' fees and travelling expenses. In October 1998 SEMA Group brought the scheduling of examinations back into their organisation to ensure they would meet their contract obligations. In the following six to nine months these problems were addressed, and the adverse effect on SEMA Group's processing of work was removed.

10 Regional variations in performance of medical services centres before and after outsourcing

(a) Before outsourcing there were significant variations in performance, particularly in Incapacity Benefit and War Pensions work



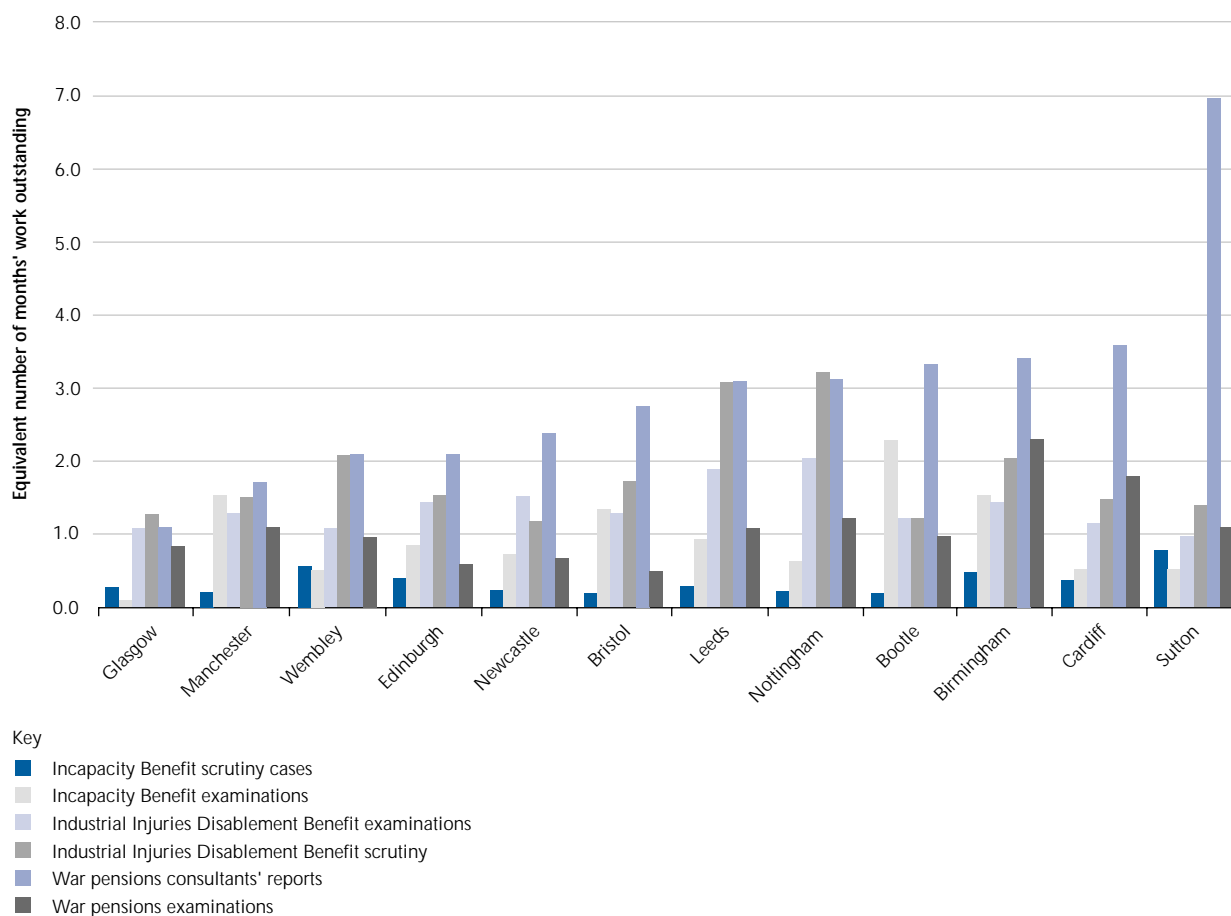
(b) After an initial dip in overall performance, variations have been reduced, but performance is still below target at several medical services centres



- Notes:
1. The graph in (a) shows the average for the year to March 1998, except for War Pensions work, where data was available for the month of March 1998 only; the graph (b) shows average performance for the year to September 2000.
 2. The number of days within which the report is required varies according to type of report. The details of these service level targets are listed in full at Appendix 5, and a selection are shown in Figure 12.
 3. Before outsourcing, the delivery of Disability Living Allowance and Attendance Allowance reports was not measured on the same basis as the other outputs and the Department were not able to provide corresponding data. Severe Disablement Allowance cases are included, since outsourcing, within Incapacity Benefit work.

Source: National Audit Office analysis of Benefits Agency Data

11 Backlogs of work awaiting completion at the 12 medical services centres prior to outsourcing



Notes: 1. The data are taken from the end of the last full year of in-house service: March 1998.

2. For examination cases, three weeks' worth of work is generally considered an appropriate level, whilst for scrutiny cases, the level would be expected to be much lower.

Source: National Audit Office analysis of Benefits Agency data

12 Service Level Targets for two of the main medically assessed benefits

Business Area		Target response times
Incapacity Benefit	Referrals cleared by SEMA Group on the basis of scrutiny of documentary evidence	85 per cent in ten days 95 per cent in 25 days
	Referrals requiring an examination	95 per cent in 50 days
Disability Living Allowance/ Attendance Allowance	Examinations	95 per cent in 20 days 100 per cent in 30 days
	Advice to the decision-maker, other than "special rules" cases (eg terminal illness)	95 per cent in 3 days 100 per cent in 5 days
All Reports	Rework of unacceptable reports (not to exceed 1 per cent in any month)	100 per cent in 5 days for paper scrutiny, or 15 days if examination is required

Note: A full list of service level targets is included at Appendix 5

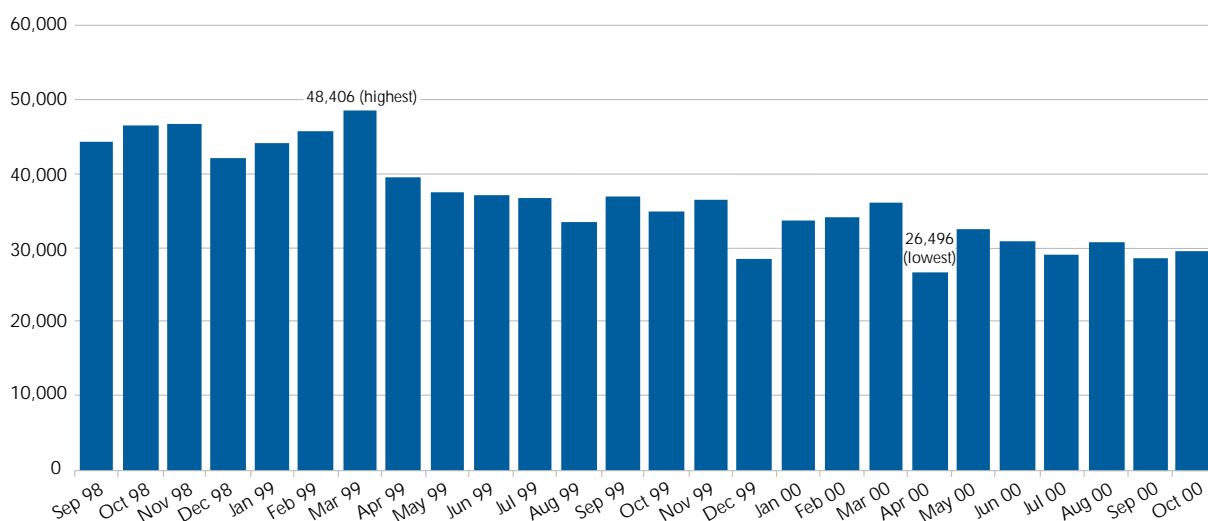
Source: Department of Social Security

The time taken by SEMA Group to provide reports and advice has reduced, against a background of reducing workloads, but there is still room for improvement

- 2.5 By June 1999 performance had stabilised. The new emphasis on delivery had also led to less variation in performance between the 12 medical services centres. In addition, Benefits Agency users of the service confirmed that file management by SEMA Group had significantly improved compared with the in-house service. To further improve file management, in November 1999 SEMA Group introduced bar-coding for all files and electronic recording of their receipt and dispatch.
- 2.6 SEMA Group have also increased the average number of examinations completed in each half-day session from 3.8 in September 1998 to 4.4 to improve efficiency. Part of this improvement has come from overbooking which was also practised by the in-house service (ie deliberately inviting more customers for examination than there are slots, to allow for non-attendance), and by substituting at short notice replacement customers who live nearby. While this can help to speed up the process it needs to be managed carefully to avoid inconvenience to customers. Appointment management and its effect on customers are discussed in Part 4.
- 2.7 These improvements in delivery need to be seen against the background of the reducing volumes of work and in particular of Incapacity Benefit examinations (the largest element of the workload), because of fewer claims, and a reduction in the rate of cases being sent for examination (Figure 13).

- 2.8 In about 20 per cent of all Incapacity Benefit referrals to SEMA Group, Benefits Agency staff specifically request an examination of the customer. But in the majority of cases, they refer the papers to SEMA Group for scrutiny, and SEMA Group doctors consider whether an examination is required, or whether a review of the papers will suffice. Before outsourcing, some 60 per cent of cases referred for scrutiny resulted in an examination. Around a third of those customers examined were found to be ineligible. Following outsourcing, the proportion of scrutiny referrals examined initially fell to around 35 per cent. Instead, more were cleared after a review of the papers by a SEMA Group doctor. With no need for a local examination centre, or a fee-paid doctor, a paper review is faster and less demanding of doctors' time: on average two and a half minutes, compared with some 47 minutes for an examination.
- 2.9 Despite across the board improvements in service delivery, SEMA Group have not yet met their performance targets in all areas (Figure 10b on page 20). There remain significant variations between medical services centres in the delivery of all types of examinations, because of shortfalls in the number of trained doctors available to carry out the work. Performance in delivering Industrial Injuries Scheme Benefits advice is also below target, partly because of difficulties in obtaining relevant medical evidence from customers' hospitals and consultants.
- 2.10 Under the contract, SEMA Group are required to respond to all variations in demand, unless these reach 25 per cent or more, when a contract variation will be triggered. But with continuing shortages of doctors in some areas, they have had difficulty in responding to

13 The number of Incapacity Benefit examinations has reduced by more than one third since outsourcing



Source: Benefits Agency

sharp increases in local workloads. After September 1999, the Department began to deduct service credits from fees paid to SEMA Group in respect of the failure to meet all targets for delivery of medical reports and advice. They also deducted service credits for late receipt of management information. In total, they have deducted some £526,000 between September 1999 and October 2000 from total contract payments since contractorisation of £163 million. They could have deducted an additional £1.6 million and did not, mainly where they were satisfied that the company were taking sufficient steps to improve performance and achieve targets.

Improving speed and consistency in the Department's overall medical assessment processes could bring financial benefits to both the customer and the public purse

2.11 Whilst the provision of medical evidence from SEMA Group is crucial in determining eligibility for benefit, it is only part of a wider assessment process. Delays in the overall processes can cause both delays to customers getting their benefits, and also continued payments to those not eligible. And regional variations in the time it takes to process claims and make decisions can mean that there is inequality of treatment for customers in different parts of the country. We looked at what could be done to reduce variations and the overall time taken to process incapacity and disability benefits.

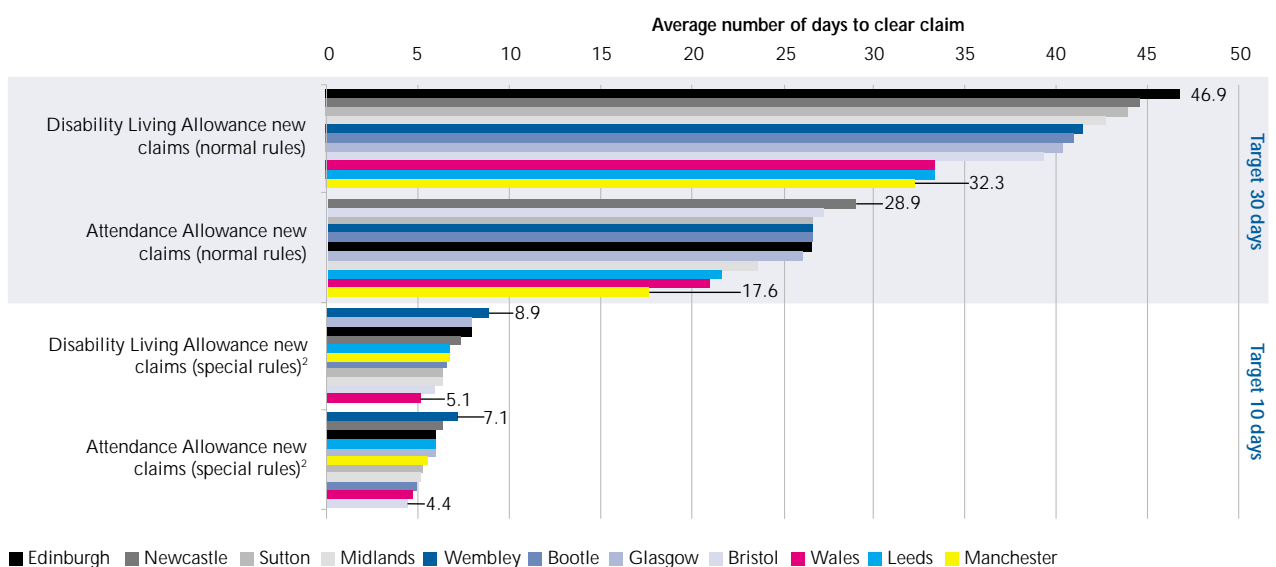
Disability allowances

2.12 For most disability benefits other than Incapacity Benefit (e.g. Disability Living Allowance, Attendance Allowance), no payment is made until the decision-maker is satisfied as to the customer's entitlement. This may involve obtaining statements from the customer's carer, the general practitioner or hospital consultant or seeking independent medical evidence from SEMA Group. Therefore, the Agency's performance in clearing cases within the target time is important for customers' obtaining benefit promptly. **Figure 14** shows that the Agency are generally clearing in a timely way Disability Living Allowance and Attendance Allowance special rules cases, involving people who are terminally ill. However, there is considerable variation in the time taken to clear the other cases.

2.13 The time taken by SEMA Group to deliver medical reports and advice, where these are used, is a significant part of the overall process (most "normal rules" cases referred to SEMA Group for advice should be returned within 3 days, and examination cases within 20 days). But the delays and degree of variation between medical services centres has reduced since outsourcing. However, the remaining time taken within the Benefits Agency varies more. From our visits and discussions with Benefits Agency staff we noted that:

- less experienced decision-makers may seek more detailed medical evidence and take longer to interpret it;

14 Variations in the time taken to clear Disability Living Allowance and Attendance Allowance claims



Notes: 1. The data are taken from the annual average as at November 2000.

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

Source: National Audit Office analysis of Benefits Agency data

- decision-makers have discretion over how long they wait for further medical evidence from sources other than SEMA Group (e.g. the customer's consultant or general practitioner). Some told us they will generally wait two to three weeks before seeking alternative evidence, and others that they will only seek an alternative if the first choice evidence has not been provided within five to six weeks.

Incapacity Benefit

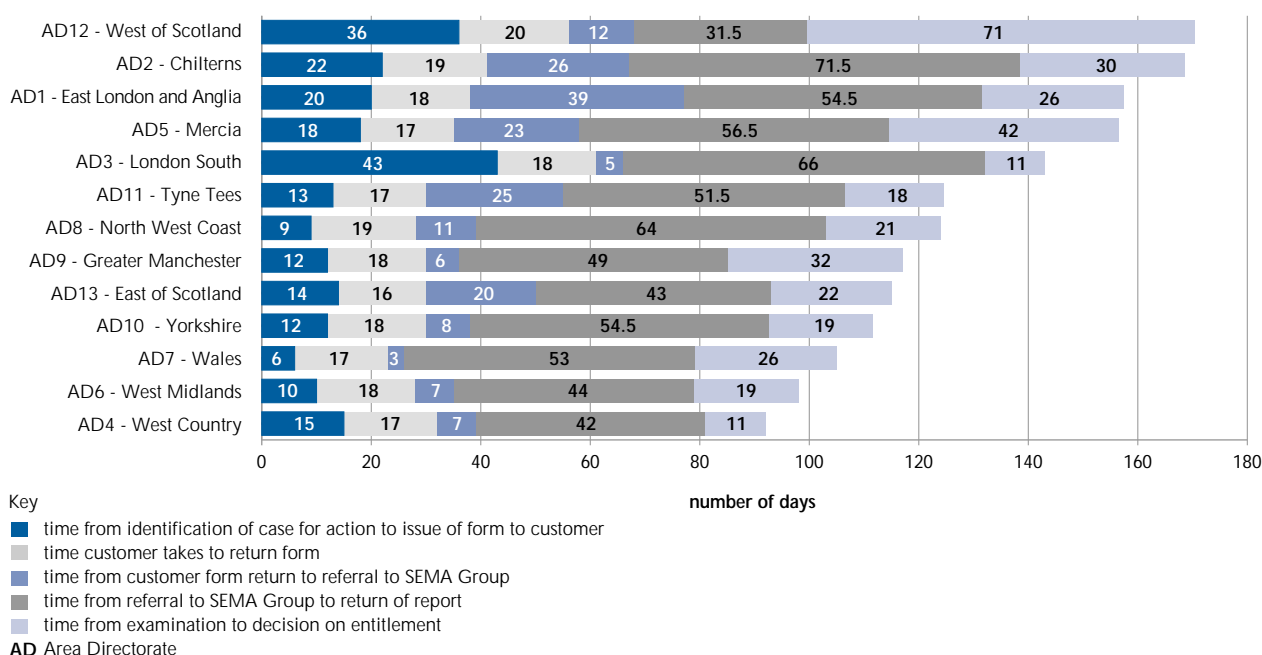
2.14 In recent years, the Benefits Agency have successfully achieved published targets for clearing decisions on the majority of new claims for Incapacity Benefit within 30 days. These decisions are generally made on the basis of certificates provided by the customer's general practitioner. But decisions on whether customers should continue on benefit when cases fall due for review take much longer. The average time taken at this stage varies between about 90 and 170 days, according to a statistical sample of data collected by the Department (**Figure 15**). Part of that process (on average 52 days) takes place within SEMA Group, including arranging a medical examination. Though the time taken for this varies, greater regional variations exist in those stages of the process which take place within the Agency itself:

- the time between identification of the case as requiring action to the issue of the relevant form to the customer varies from 6 to 43 days;
- the time between receipt of the information from the customer to the referral of the case to SEMA Group varies from 3 to 39 days; and

- the time between receipt of the advice from SEMA Group and the decision on whether to allow or disallow benefit varies from 11 to 71 days.

2.15 These variations are costly. An analysis in 2000 by the Benefits Agency showed that the seven-week reduction since 1996 in the national average processing time for Incapacity Benefit saved some £85 million in annual Incapacity Benefit costs. This represents payments which would otherwise have been made to customers who were no longer eligible for benefit. Every week by which the average processing time is reduced would save some £12 million in unnecessary Incapacity Benefit payments. While the Department are concerned about the risk that faster clearance times might result in higher levels of error in benefit payments, this does not appear to be the case. For Incapacity Benefit and other short term benefits, there is no correlation between the clearance time in Area Directorates and the accuracy of the benefit payments, all Area Directorates having accuracy ratings within two per cent of the average. So if the Agency could reduce the processing time in Incapacity Benefit to the levels achieved by the three top-performing Area Directorates they could achieve estimated savings of around £60 million a year in payments of Incapacity Benefit. It is likely, however, that some customers would go on to claim other benefits instead and this could reduce the savings to between £30 million and £40 million. Bringing performance up to the level of the middle performer, which the Department consider more achievable in the medium-term, could achieve net savings of around £20 million.

15 Variations in the time it takes the Benefits Agency and SEMA Group to process Incapacity Benefit medical assessments



Note: The figures used are taken from the Department's sample-based review which was carried out in July 2000 but used 1999 data.

Source: National Audit Office analysis of Benefits Agency data

2.16 There are also variations in performance before cases are actioned. Backlogs of existing cases awaiting review have built up in offices across all Benefits Agency Area Directorates because priority, and limited resources, are given to processing new claims where the customer is not yet receiving payment. Whilst some offices have reached "steady state" and review every case at the time recommended by the medical adviser, most are unable to carry out all their reviews at the recommended time and instead "defer" a proportion of them for one or more months. **Figure 16** shows that the number of "deferred" cases considerably exceed one month's work in most Area Directorates. Whilst many cases require no change on review, a proportion of customers will be found ineligible. We estimate that if the Department could eliminate the backlog of deferrals, this could achieve one-off savings on Incapacity Benefit of around £40 million, which could be reduced to between £20 million and £30 million because customers might claim other benefits instead. Further savings could be achieved by eliminating or reducing the ongoing level of deferrals. But this would require a significant commitment of resources from both the Benefits Agency and SEMA Group and a change in the priority given to Incapacity Benefit in local benefit offices.

2.17 We looked at whether changes to procedures within the Incapacity Benefit process could improve workload management, and hence reduce backlogs. Our work involved holding a cognitive mapping workshop with staff involved in Incapacity Benefit work, mapping the process itself through visits to six district benefit offices, each from a different Area Directorate, and simulation modelling of selected parts of the process. We were assisted by consultants from Strathclyde University and

Visual Thinking International Limited. The results are summarised in Appendix 2. Particular aspects of case management that the Department could address are:

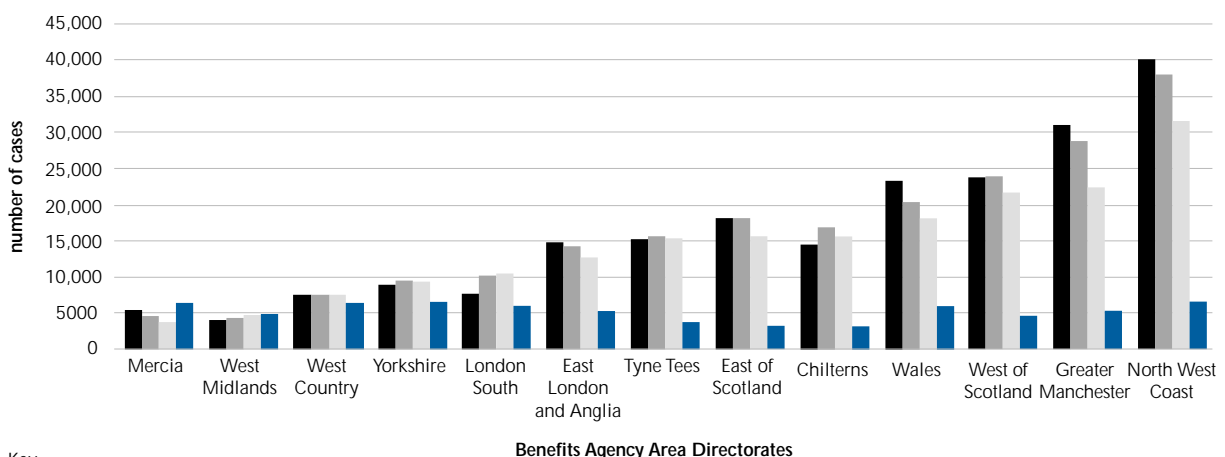
- variable approaches in district offices to setting case review dates;
- variable approaches to reviewing long-term Incapacity Benefit cases for changes in entitlement;
- failures by decision makers to deal appropriately with cases of repeated non-attendance without good cause, given evidence from SEMA Group that they have administered scheduling properly;
- smoothing the flow of work between benefit offices and SEMA Group to avoid surges impacting on the achievement of targets; and
- maximising usage of SEMA Group resources given fluctuating demand from individual district offices, by directing scrutiny work more flexibly around the country.

2.18 The Department have begun to focus on improving performance and reducing variations in the time it takes to process claims and make decisions through the Performance Improvement Programme, which was launched in February 2000. The Programme has so far focused on Income Support and Jobseeker's Allowance, two large and complex benefits, but the Department now intend to apply a similar approach to Incapacity Benefit. This will involve:

- identifying, sharing and implementing good practices from the best performing Areas;

16 Backlogs of Incapacity Benefit cases where review action has been deferred beyond the recommended time

The figure shows that the number of Incapacity Benefit case reviews deferred is reducing slightly but still remains high, particularly in some areas. The total number of reviews deferred in November 2000 was some 185,000



Key

- Deferred cases September 2000
- Deferred cases October 2000
- Deferred cases November 2000
- average number of cases actioned in a month

Source: National Audit Office analysis of Benefits Agency data

- improving management information to track performance;
- training and changes in procedure to improve workflow management; and
- support from Performance Improvement Action Teams for those offices with particular difficulties.

Better matching of Incapacity Benefit funding to workloads in the Benefits Agency could help reduce inconsistency

2.19 Regional variations in the backlogs of Incapacity Benefit cases awaiting attention, and the speed with which they then pass through the system, are due in part to the way this work is organised and funded. The Benefits Agency's 13 Area Directorates administer Incapacity Benefit and other "short-term" benefits such as Income Support and Jobseeker's Allowance. They have autonomy to manage their human and financial resources and prioritise work, within the Agency's overall objectives. The Department allocate funding to Directorates for administration of benefits according to expected workloads. Directorates then allocate this to districts and by benefit, also balancing resources so as to deal with new cases and review a proportion of existing ones. When districts have insufficient funds they defer some case reviews to a later date. Some districts have sufficient funds to clear even low priority Incapacity Benefit cases whilst others defer all but the highest priority cases.

2.20 There are two main reasons why districts vary in the extent to which they defer cases that are due for review:

- different Area Directorates have different workload profiles and different priorities between benefits, and funding for Incapacity Benefit is not ring-fenced. Our workshop of departmental staff indicated that Public Service Agreement targets to reduce losses from error and fraud in Income Support and Jobseeker's Allowance had led Directorates to accord lower priority and staff resources to reviewing existing Incapacity Benefit cases.
- the Department have a computer-based model designed to predict the volumes of Incapacity Benefit work which they updated for the financial year 2000-01 to provide more accurate information at Area Directorate level. But it does not produce statistically accurate forecasts at District Office level. Depending on the arrangements in each Area Directorate, some offices may receive more funds to pay SEMA Group for medical assessments than they need, while others receive too little, leading to deferrals.

Part 3

Improvements in the quality of assessments have yet to be fully delivered

3.1 This part of our report looks at the quality and appropriateness of the medical evidence obtained by the Benefits Agency from SEMA Group and other sources. It shows that:

- the Department are now focusing on improving the quality of the medical evidence provided by SEMA Group. But their ability to enforce quality improvements is restricted by the lack of effective contractual remedies;
- shortages of doctors to do the work of SEMA Group are having a significant impact on the business and are set to worsen; and
- the Benefits Agency and SEMA Group do not always obtain the most appropriate or sufficient medical evidence to support the award of benefits.

Achieving consistently good quality medical assessments has continued to prove difficult since outsourcing, but the Department are now focusing on this

3.2 Prior to outsourcing the Department had put in place a sample-based quality monitoring system which raised concerns about quality (**Figure 17(a)**). And reporting by the President of Appeals Tribunals has indicated that insufficient or poor quality medical evidence is one of several key factors affecting the quality of decisions.

3.3 However, before outsourcing there was no agreed definition of what constituted a quality medical report from the in-house medical services. During transition the Department developed a framework for defining acceptable quality, or "fitness for purpose" which requires reports and other written advice from its medical advisers to be:

- legible;
- complete - all disabilities and relevant facts must be covered and documented;

- logical, internally consistent and based on evidence - the conclusions of the report or advice must be consistent with the evidence obtained from medical records or examination;
- inclusive of details of relevant clinical findings (e.g. symptoms) to help support the opinion given;
- based on up-to-date and generally accepted medical opinion; and
- free from inappropriate material, so that they can be read by anyone without risk of offence.

3.4 The Department saw the opportunity through outsourcing to improve the quality of medical reports and put in place a system which could monitor these standards effectively, and SEMA Group have therefore developed a new quality monitoring system. Based on similar principles to the previous system, it is more rigorous and applied more consistently across the contract locations by full-time medical advisers trained in a revised audit technique. The results in 2000 (**Figure 17(b)**) appear to indicate a slight improvement in the quality of reports although comparison of the two sets of data is difficult because of changes in the sampling and marking approaches. But up to 10 per cent of work still remains unacceptable, most notably for examinations conducted in customers' homes, which are almost exclusively for Disability Living and Attendance Allowances.

3.5 The President of Appeals Tribunals told the Social Security Select Committee in April 2000 that he saw no evidence of an improvement in quality and decision-makers we spoke to agreed. Moreover, complaints from customers still indicate concerns about the completeness and length of examinations (customer complaints are discussed in more detail in paragraphs 4.6-4.10).

3.6 The position on quality is confused because although the percentage of reports sent back by decision-makers is low, they told us that they avoid sending back reports even where they are unhappy with the quality because:

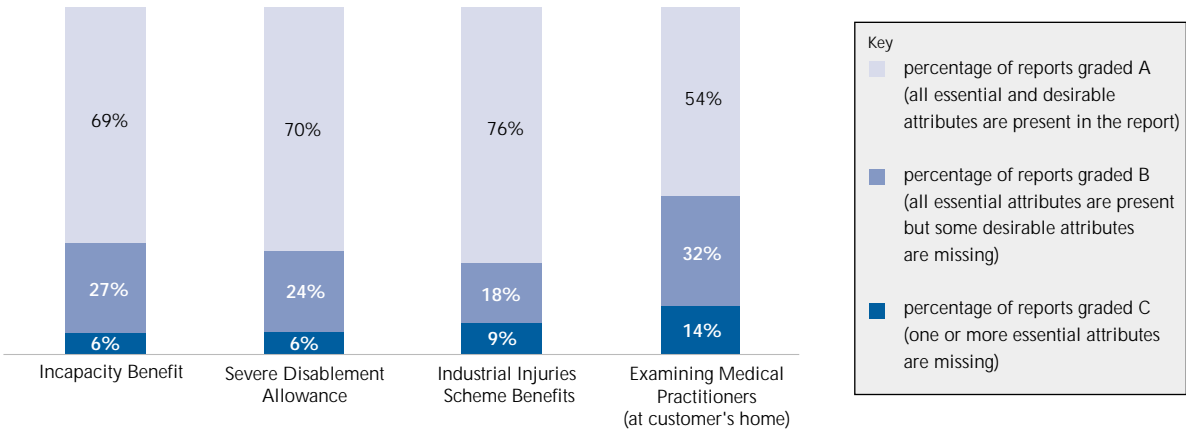
- it takes too long to get revised reports and this prevents them clearing cases quickly;
- when they do return reports for rework, the revised version is often little better than the original;

- they feel they can still use their judgement to make a decision.

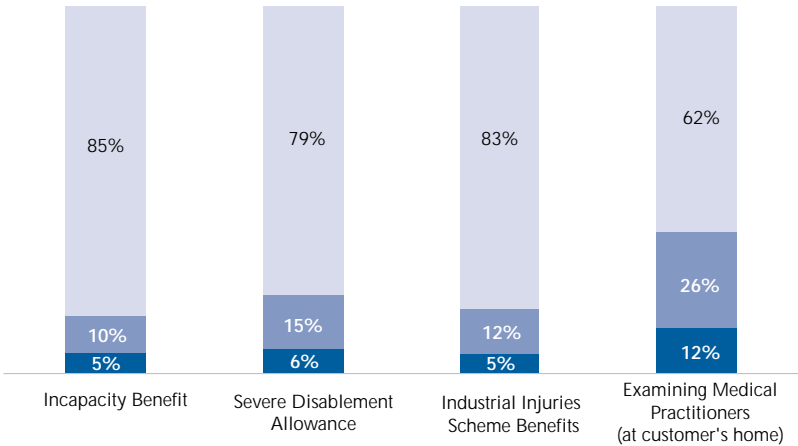
The Benefits Agency have recognised that their staff do not make full use of the rework facility, and have now issued guidance to encourage them to do so.

17 The quality of reports produced by medical services centres

(a) Results prior to outsourcing



(b) Results in 2000



- Notes:
1. The data in (a) covers September 1997. Data were not available for medical services centres at Newcastle and Nottingham.
 2. The data in (b) covers the period February to September 2000.
 3. Care should be taken in comparing these two sets of data because although the same grading system is used, the post-outsourcing system uses larger sample sizes, more robust sampling methods and more stringent definitions of quality.
 4. Examining Medical Practitioners carry out examinations at the customer's home, the majority of which are for Disability Living Allowance/Attendance Allowance.

Source: Benefits Agency data

The Department's ability to enforce change is limited by the lack of effective contractual remedies but they are now focusing on monitoring quality more effectively

3.7 The Department cannot reduce payments to SEMA Group if the quality of the medical reports overall is not fully up to standard. In devising the contract they decided that it was not then possible to define medical quality sufficiently rigorously to be the basis of legally enforceable deductions. As a result their main contractual remedies against poor quality work are:

- for the lay decision-maker to return deficient reports for rework. The Department do not pay again for reworked cases and have the initial charges refunded if any case is not satisfactorily reworked by SEMA Group within the 15 day target time. But as noted above rework is comparatively rare - under one per cent in 1999-00;
- to withdraw the approval of individual doctors to do this work; this has been done on 15 occasions in the first two years of the contract including two occasions at SEMA Group's instigation, during which time some 3,000 doctors have been employed;
- to audit the medical quality of reports, which they began to do in 2000; or
- in the event of severe and persistent quality problems, to terminate one or more of SEMA Group's three contracts.

3.8 The Department and SEMA Group have taken a number of initiatives to improve the quality of medical reports including:

- trialling a survey of users' views seeking specific feedback on the quality of each medical report sampled;
- targets to reduce by 10 per cent the proportion of C grade medical reports by March 2001, and by September 2001 to reduce the proportion of C grade reports across all benefits to less than 5 per cent;
- a departmental audit of doctors' compliance with guidance on when to call Incapacity Benefit customers for examination and when a scrutiny of papers is sufficient (the results of this work to date are discussed in more detail at paragraph 3.24). The Department expect SEMA Group to have reduced the proportion of reports which do not comply with the guidance to less than 5 per cent by June 2001; and
- setting up a Medical Quality Performance Improvement Interface group, with members from the Department's contract management team and SEMA Group, which will discuss and progress medical quality issues monthly.

The Department are seeking to renegotiate the contract so that failure by SEMA Group to achieve the above targets will result in deductions from contract payments.

SEMA Group are now making efforts to improve professional standards

3.9 Doctors must satisfy certain Departmental requirements before being approved to work for SEMA Group. As well as satisfying selectors at interview, and providing appropriate references, doctors must be fully registered with the General Medical Council; **and** have at least 3 years' post-registration experience including one year in general practice and at least six months in either psychiatry, rheumatology, rehabilitation or occupational medicine, **or** have at least five years' post-registration experience in general practice. Before beginning to carry out assessments a new doctor must attend benefit-specific training, as well as training in professional standards provided by SEMA Group, and be formally approved by the Department's Chief Medical Adviser.

3.10 Doctors working for SEMA Group are also subject to continuing random audits of the quality of their work. If the results, or other aspects of the doctor's performance such as complaints from customers, are unacceptable, SEMA Group will provide feedback and remedial training. If the doctor's performance does not improve SEMA Group may recommend to the Department removal of the approval of the doctor to carry out assessments.

3.11 Through outsourcing, the Department set out to improve professional standards among SEMA Group's doctors. Some progress has been made in:

- **Continuous training.** SEMA Group are required to ensure that doctors attend five days of relevant training each year, the content of which is quality assured by the Department. Previously, training other than induction had been voluntary and not part of a planned programme. The Social Security Select Committee noted in April 2000 that the new training requirement had not been delivered for 1998-99 or 1999-2000. By October 2000, 80 per cent of SEMA Group doctors had attended the appropriate trainer-led course for 1999-2000, and 65 per cent had completed distance-learning packages. SEMA Group also undertook to provide the 2000-01 training programme in full by August 2001. However, some 146 doctors had left the service by October 2000, citing the compulsory unpaid training course as the reason, and a further 116 were still refusing to attend it. The Department and SEMA Group are renegotiating this part of the contract, and SEMA Group in association with their subcontractor, Nestor, announced arrangements from November 2000 to pay doctors to attend training courses in future;

- **Professional training.** The Department has worked with SEMA Group, and the Faculty of Occupational Medicine and Royal Medical Colleges to develop a new Diploma in Disability Assessment Medicine which was launched in March 2000. Training for the Diploma equips doctors with the knowledge and skills to do a range of assessments, and will count towards their continuing professional development. The Department told the Social Security Select Committee that they would set targets for a substantial proportion of SEMA Group doctors to have completed the Diploma within five years. By November 2000, 11 SEMA Group doctors had been awarded the Diploma, and a further 15 were working towards it;
- **Safeguarding against unacceptable medical standards.** Until January 2000, it had been difficult for SEMA Group to compile an effective record of a doctor's overall standard of work. But since then the training completed by each doctor, the results of monitoring each doctor's work, complaints received from customers, and any action taken or remedial training given, are now recorded. This Medical Skills Database has the potential, if it is kept up-to-date, to make the monitoring and enforcement of professional standards more effective.

The Department and SEMA Group need to address urgently the shortages of suitably qualified doctors doing this work

The shortages of doctors within SEMA Group mirror the wider shortages in the UK as a whole, and are not improving

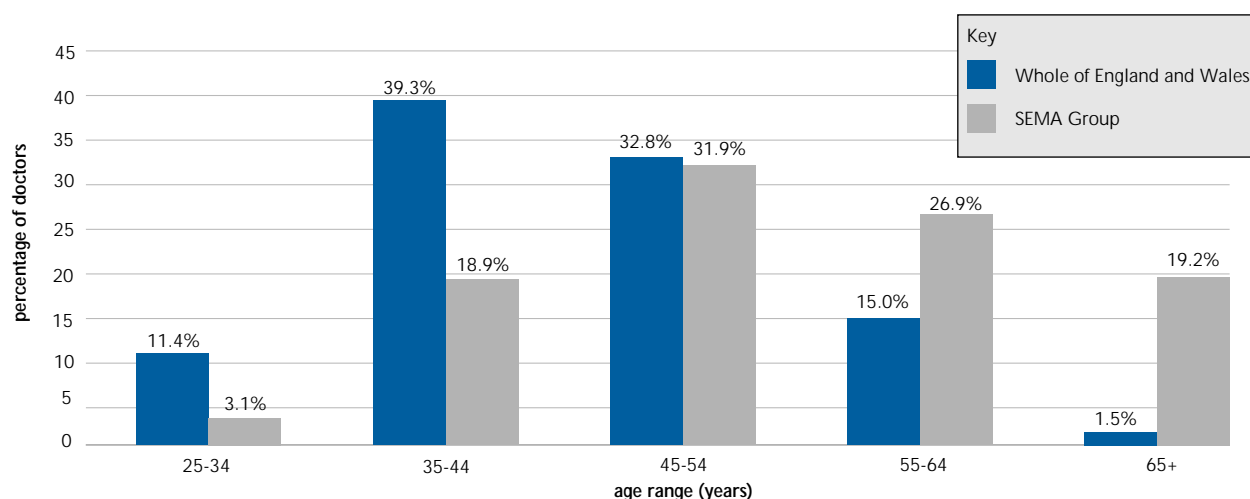
3.12 To achieve continuous improvement in the quality of medical reports, the Department and SEMA Group

require a pool of experienced doctors who have undergone training. Full-time doctors carry out the majority of scrutiny work, and since outsourcing, SEMA Group have increased the number of full-time doctors they employ. But nearly all examinations are carried out by doctors qualified as general practitioners, either retired or still in practice, who work several hours each week for SEMA on a fee-paid basis. In addition to the general pool of doctors, the service also requires a number of practitioners specially skilled in respiratory diseases and mental health, and to meet customers' reasonable requirements a balance of both male and female doctors.

3.13 In recent years the Department and SEMA Group have experienced problems recruiting sufficient doctors with the level of experience they need. The supply of general practitioners is set to worsen before it improves. The August 2000 National Health Service National Plan shows that in a fifth of health authorities, more than 4 per cent of general practitioners are due to retire by 2005, and the supply of younger doctors to take their places does not yet match the demand. The National Plan aims to increase the supply of general practitioners by 2,000 by 2004 with faster growth after then. At the same time, new revalidation rules to be introduced by the General Medical Council mean that all doctors wishing to continue practising will be required to satisfy stricter training and monitoring requirements designed to keep them up-to-date. The Department require that all doctors working on their behalf must be revalidated and SEMA Group are taking this forward.

3.14 The SEMA Group doctor workforce has a higher proportion of older doctors than the UK medical profession as a whole - historically the work has always attracted older doctors. **Figure 18** shows that some 46 per cent of all SEMA Group's fee-paid doctors are aged 55 or over and could therefore decide to retire in the next five years. Whilst the increasing number of doctors

18 Age profile of SEMA Group's fee-paid doctors compared with those in England and Wales as a whole



Note: England and Wales data as at October 1999; SEMA Group data as at April 2000

Source: SEMA Group and NHS Executive

expected to retire from general practice could actually add to the pool of doctors from which SEMA Group can recruit, such reliance on an ageing workforce carries certain risks. Subject to the Department's requirement that they satisfy the new revalidation requirements, SEMA Group are able to employ doctors of any age, although they normally look to retire doctors by age 70. But because of shortages a number of doctors over 70 are still carrying out examinations. Although these older doctors may be highly experienced, there is a risk that their medical knowledge may be less up-to-date than that of more recently qualified doctors who are still full-time practitioners.

3.15 Over and above the general shortage of general practitioners available to work part-time on benefits-related work, many fee-paid doctors have left the service since 1995 when Incapacity Benefit was introduced and new training was required. Since then, according to a survey conducted by the British Medical Association, at least 750 more fee-paid doctors have withdrawn their services, many at the time of outsourcing. SEMA Group told us that in October 2000 they required additional fee-paid doctors sufficient to complete some 4,000 more examination sessions, and over 7,000 more home visits every month. There were particular shortages in the North West of England and the Midlands, which had already affected the contractor's ability to deliver against service level targets.

3.16 The main reason cited by the British Medical Association for members ceasing to work for SEMA Group is the level of pay. In 1992, the Department decided to depart from the rate of pay agreed by other government departments for doctors carrying out government work, and to negotiate their own rate. Between 1992 and September 2000, when a 3 per cent across the board increase was introduced, there had been no increase in the rate paid for examination centre work or home visits. **Figure 19** indicates that the rate now paid by SEMA Group has not kept pace with the rates for similar work. This has led to a continuing dispute with the British Medical Association, who have advised doctors against taking up the work. At the time of outsourcing, a British Medical Association members' survey showed that 51 per cent of fee-paid doctors

responding had not then agreed to sign a contract with SEMA Group's subcontractor Nestor, and could therefore have withdrawn their services without notice.

3.17 The Department and SEMA Group are considering several different approaches to alleviating the shortages of doctors but there is more they can do:

- SEMA Group have introduced, from June 2000, special additional payments to doctors whose visits to customers' homes involve an above average travelling time in certain remote areas. Some 151 doctors made 1,973 claims for these £13 special payments between June and October 2000. And in September 2000 a 3 per cent pay increase was introduced for all fee-paid doctor work. However, no agreement has been reached over pay with the British Medical Association. Other users of medical advice we surveyed in the insurance industry told us that they held annual negotiations with the British Medical Association to agree the rates they would pay doctors providing them with reports;
- SEMA Group and the Department are considering the possibility of carrying out more examinations during evenings and weekends, to make it easier for fee-paid doctors to fit the work around their other commitments. Doctors' representatives told us that allowing doctors in some cases to carry out the work in their own surgeries could also improve availability, although not all surgeries would be able to support this additional activity; and
- SEMA Group have proposed the use of other healthcare professionals to carry out medical assessments. However, plans have not yet moved forward. One problem is that the relevant social security legislation requires some parts of the work to be done by doctors and would have to be changed, although there are other areas of assessment where there is no such requirement. Shortages in these other healthcare professions might prove an obstacle.

19 Comparative rates of pay for general practitioners working outside surgeries

	SEMA Group rate for fee-paid doctors, as from September 2000	British Medical Association agreed rate for locum work in a general practitioner surgery	Rate agreed by other government departments with the British Medical Association ¹
Per hour	£31.62	£34.00 - £40.00	£44.00
Per 3 ½ hour session	£110.67	£120.00 - £140.00	£154.00
Per 7 hour day	£221.35	£240.00 - £280.00	£308.00

Note: 1. This rate, used by a number of government departments, is approved by the British Medical Association, the doctors' representative body, and is increased annually in line with the recommendations of the Doctors' and Dentists' Review Body.

Source: Department of Social Security, British Medical Association

The Department can do more to ensure that the right kind of evidence is used to make accurate decisions

The most appropriate form of medical evidence is often not available to decision-makers

3.18 In his 1999 report on the overall standards of all types of Benefits Agency decisions going to appeal, the Chief Adjudication Officer said, "Where standards fell the main culprit was yet again lack of evidence to support the decision". We looked at what factors affect the Benefits Agency's ability to obtain sufficient evidence to support decisions in the main medically assessed benefits. The main sources of evidence are described in Appendix 7.

Inaccurate or incomplete evidence from general practitioners and customers results in unnecessary examinations on Incapacity Benefit

3.19 Factual evidence provided by the customer's general practitioner is an important component in the Incapacity Benefit medical assessment. It is used by SEMA Group doctors to reach decisions on scrutiny cases, and also by decision-makers when applying the Personal Capability Assessment (Figure 20).

20 Medical evidence requested from general practitioners for Incapacity Benefit

A medical certificate giving a diagnosis of the disorder causing absence from work, provides the evidence to support the customer's initial claim for Incapacity Benefit. A further certificate may be required showing the customer's main condition and any others from which he or she is suffering, along with other comments on the disabling effects of the condition. If the certificates do not give complete and accurate details of all conditions, these may not be fully taken into account in the decision-making process.

If the initial evidence indicates that the customer may be exempt from medical testing (e.g. if he or she is mentally ill, has a terminal illness, or has one of a number of other exempt conditions) the Benefits Agency sends a **3-page medical report** form to the General Practitioner requesting information required to establish whether this is in fact the case. The form is returned direct to a SEMA Group medical adviser.

SEMA Group can request **further information** on a case by contacting the customer's General Practitioner direct.

3.20 But the Department often experience difficulty in obtaining accurate and up-to-date medical evidence from customers' general practitioners, and this can lead to unnecessary examinations by SEMA Group, where a customer ought actually to be exempted from testing. In 2000, around eight per cent of customers who attended for examinations were found to be exempt. This amounts to some 25,000-30,000 people who need not have been called for examination had sufficient evidence been provided by their general practitioners. And although the Department do not collect data on it, a further group of

cases cleared by SEMA Group on scrutiny are also found to be exempt. In all these cases, the Department are charged a fee under the contract. SEMA Group are currently reviewing their procedures for following up forms not returned by general practitioners with the aim of reducing the number of exempt cases which are referred for scrutiny or examination.

3.21 Even when the general practitioner returns the form, the information provided is sometimes not sufficient for the SEMA doctor to advise whether the customer is exempt from testing. General Practitioners are expected to be able usually to provide the information required by the SEMA doctor, which includes the nature of the condition and its effect on the patient, the current treatment and the prognosis. But the British Medical Association told us that, because the information is kept for clinical and not social security purposes, this can be difficult for doctors. Moreover, our discussions with our workshop group and Benefits Agency decision-makers revealed that:

- the general practitioner may not always be aware of the full clinical impact of disease on work ability or activities of daily living, particularly where the customer has a mental health problem. In such cases the Benefits Agency may not be alerted to the involvement of another healthcare practitioner such as a Community Psychiatric Nurse until the customer has been sent a questionnaire to complete. Disability rights groups have pointed out that accurate completion of these forms may be too difficult and stressful for some customers with a mental illness; and
- although the written consent of the customer is always obtained by the Benefits Agency before they contact the customer's general practitioner, as part of the forms the customer fills in, some general practitioners are unwilling to provide the information requested. This is the case even where the form is to be returned directly to a SEMA Group doctor. Some general practitioners express concern for their doctor/patient relationship as a result of their involvement in the benefit system as they feel patients perceive them to be part of the decision-making process.

3.22 The provision of information to the Benefits Agency on Incapacity Benefit customers by general practitioners forms part of their work and remuneration under the standard National Health Service contract. A doctor who has issued a statement of incapacity to a patient is legally obliged to provide on request a report on the patient to a medical officer working on behalf of the Department of Social Security - an obligation underlined in updated guidance from both the General Medical Council and the Department in 2000 - although there is no separate payment for completion of these reports. However, some other reports commonly requested by the Department do attract a separate fee. General practitioners are also increasingly asked to provide patients' insurance companies with certificates and written reports, for a fee, and the British Medical Association told us that the demands on general practitioners for written information on their patients are placing practices under considerable strain. The Regulatory Impact Unit of the Cabinet Office is currently studying ways of better managing this work, including improved targeting of the information required and the application of information technology.

The award of Incapacity Benefit is sometimes based on insufficient evidence of incapacity

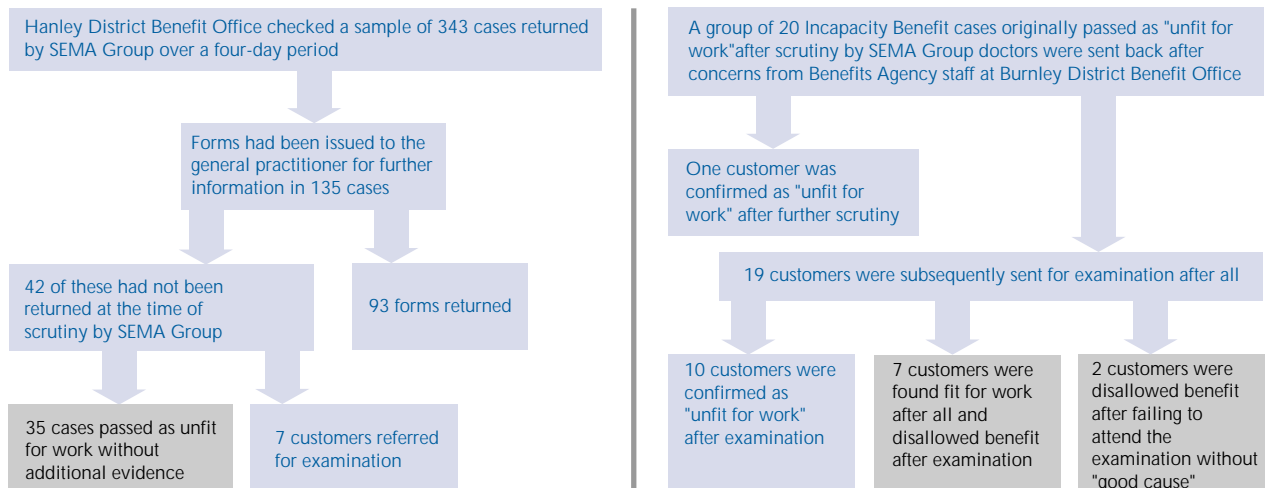
3.23 When outsourcing the medical services, the Department considered that there was scope for better targeting of those Incapacity Benefit cases where examinations were really necessary, to avoid the risks of both under and over-examination. Whilst the Benefits Agency can specifically ask for a customer to be examined, the decision on whether or not to examine is often made by SEMA Group advisers using their professional judgement and the evidence available. The fee payable by the Department is the same in either case. To guard against the greater profitability of scrutiny work leading to a reduction in examinations, the Department stipulated in the contract that the overall percentage of scrutiny referrals resulting in examinations should not fall below 20 per cent. And where an acceptable reduction on examination rates did result in greater profitability, the

Department were entitled to recover a proportion through the annual contract renegotiation process.

3.24 During 1999, concerns arose within the Benefits Agency that some claimants were being passed as "unfit for work" without sufficient evidence of incapacity. Following reviews at individual benefit offices (Figure 21), the Department in June 2000 carried out a formal audit of 400 randomly selected cases which had been passed as unfit for work on the basis of scrutiny. The results showed that in 20 per cent of cases the doctor had not complied with the guidance and in a further 10 per cent there was doubt over the doctor's interpretation. Consequently some customers who might well have been found ineligible for benefit were not examined. As a result, SEMA Group will retrain all doctors who undertake this work and the Department have redrafted the guidelines to doctors to clarify the policy on when to request an examination.

3.25 The Department deliberately designed the contract to try to cut down unnecessary Incapacity Benefit examinations, but in doing so they created a risk that the drive to increase efficiency and profit margins would cause the contractor to reduce the rate of examination too much, with attendant risks to the accuracy of benefit payments. We found no evidence that there has been a deliberate attempt by SEMA Group to do this. But we consider that the Department's and SEMA Group's focus on reducing turnaround time for medical referrals, in the first two years of the contract, may have inadvertently led to lapses in the standard of evidence gathering. The Department are now renegotiating the contract so that the company will make a broadly similar rate of return from examinations as from scrutinies.

21 Reviews at individual benefit offices led to concerns about the number of Incapacity Benefit cases passed as "unfit for work"



Difficulties in obtaining evidence from consultants and specialists also lead to unnecessary examinations for disability allowances

3.26 In assessing the eligibility of Disability Living Allowance or Attendance Allowance customers, the Department generally consider whether other forms of evidence can support an accurate decision before requesting a medical examination by a SEMA Group doctor. If too many unnecessary examinations are requested this will cause unnecessary stress and inconvenience to customers and also increase the costs of medical referrals to the Department. But in many cases decision-makers are unable to obtain evidence from consultants or specialists treating the customer, even after a number of weeks. An examination is then required. Benefits Agency staff told us that before the outsourcing there was an informal limit on the number of requests for examination - only 20 per cent of all cases could be examined and in other cases written reports had to be chased up repeatedly. There is no longer such a limit, and one Disability Benefit Centre we visited had increased its requests for examinations by a factor of four in one year. A monitoring exercise at Newcastle Disability Benefit Centre showed that in 25 per cent of examinations a more appropriate source of evidence than examination could have been chosen.

Better training and feedback for decision-making staff could improve the use of medical evidence

3.27 To make accurate decisions on benefit entitlement, the Benefits Agency need also to interpret accurately the medical evidence they obtain. The results of a sample of 435 appeals cases surveyed by the new Appeals Service in October 1999 indicated that in some 25 per cent of those decisions they changed, the interpretation of the medical evidence, whether from SEMA Group or the customer's doctor, was an important factor. Although this sample was not statistically representative, it included a large proportion of disability-related benefits.

3.28 Our visits to benefit offices highlighted that, to make the right decisions consistently, decision makers needed:

- a comprehensive knowledge of the benefit rules and experience in their interpretation;
- initial training which covers the administrative and medical aspects of the work;
- access to advice from medical advisers as and when required; and
- support and feedback on the outcome of their decisions and any relevant medical advancements.

3.29 SEMA Group are required to provide an on-demand local medical advice service for decision-makers, and performance in dealing with enquiries is one of the service levels against which they are measured. An

August 2000 survey of decision-makers conducted by the Disability and Carer Benefits Directorate concluded that overall staff were not satisfied with the service provided locally and that it was not being used to its full potential. And during our study decision-makers at six District Benefit Offices and two Disability Benefit Centres told us that:

- decision-makers at District Benefit Offices rarely used the advice service, preferring to consult their own colleagues;
- decision-makers at Disability Benefit Centres felt discouraged from using the service because some doctors behaved in an unhelpful and unapproachable way;
- at both District Offices and Disability Benefit Centres, staff felt reluctant to consult medical advisers because of the pressure of work and the additional time it would add.

3.30 Although Benefits Agency staff prepare some 150,000 submissions for appeals tribunals every year for disability and incapacity benefits, at only two of the six District Benefit Offices we visited did those writing the appeals attend the tribunal or receive feedback from tribunals on the results of appeals. Decision-makers told us they would find information on the outcome and causes of appeals useful in doing their work, but they felt that in many cases it would not have helped them make a better decision. They believed the main reasons for successful appeals against disallowance of benefit were:

- new evidence was produced at the tribunal that had not been available to the decision-maker;
- the customer's attendance at the tribunal caused the customer's evidence to be treated more sympathetically;
- the customer's condition had changed by the time the tribunal took place; or
- the tribunal "just took a different view".

3.31 These findings reflect the view of our workshop group, which concluded that building a better relationship with the Appeals Service was crucial to improving the delivery of correct decisions in disability benefits. The group noted that at present a failure of communication and understanding between the Benefits Agency and appeals tribunals produces a culture where decision-makers believe there is nothing they can do to avoid decisions being overturned on appeal. The Department have now begun to look at ways in which the results and main messages from appeals tribunals can be fed back to improve the quality of initial decision-making.

Part 4

The Department, working through SEMA Group, need to improve service to customers

4.1 A key aim of the "Modernising Government" White Paper is to make sure that public service users, not providers, are the focus, by matching services more closely to people's lives. The Department are expected to provide services that are responsive to customers' needs and treat them fairly. An underlying level of dissatisfaction and complaint is perhaps inevitable in view of the sensitive nature of medical assessment, the need for judgements to be made and the likelihood that some customers may have their benefit reduced or taken away as a result. The previous in-house service experienced mixed customer satisfaction ratings. This part of our report shows that the outsourced service has not yet achieved a significant change.

There are concerns that service to customers is not yet adequate

The Department have limited leverage to oblige SEMA Group to raise standards

4.2 The Department's contract requires SEMA Group, as a minimum, to meet the Department's current service standards, including the Benefits Agency's Customer Charter. The standards specified in the contract are broadly similar to those in the Customer Charter. They cover, for example, the time a customer can expect to wait before being seen, the availability of information, equality of treatment for all customers, and the help to be provided for people with special needs. The contract also covers dealing with enquiries and complaints within set timescales, customers' travel arrangements and travel expenses, and the cancellation of examinations and alternative appointments. The contract does not, however, link payments to the achievement of the standards set.

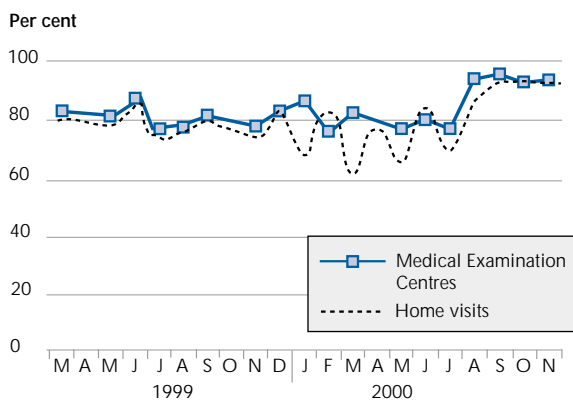
4.3 The main ways in which the Department gain feedback on the quality of services is from monthly reports by SEMA Group on the results of customer satisfaction surveys, and regular analyses of complaints. The Department see individually only those complaints about SEMA Group which are routed through them, and these represent a small proportion of the total. They recognise that there is a need for some form of independent validation to satisfy themselves and customers that every complaint is being recorded and is being taken seriously, and that all necessary corrective action is being taken.

4.4 The Department can compare survey results across the contract packages, and in July 2000 they sought a more detailed analysis of complaints for each Medical Examination Centre. Further analyses of this type could help to show where problems are arising, the underlying causes and possible areas of good practice.

SEMA Group's surveys suggest that most customers are satisfied overall with the service

4.5 While the contract does not specify a target customer satisfaction level, SEMA Group surveys suggest that between 75 per cent and 85 per cent of customers are generally satisfied with the service provided, both at examination centres and at customers' homes, although the survey methods used limit the reliability of these results (**Figure 22**). They also indicate that most customers are content with the conduct of examinations.

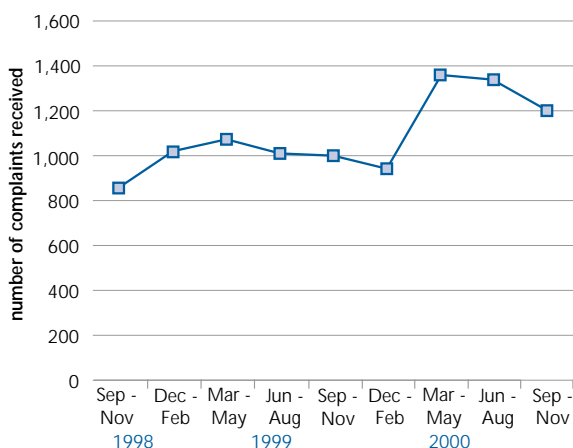
22 Overall customer satisfaction with services at Medical Examination Centres



- Notes:
1. The surveys were designed within the Department and SEMA Group without external professional advice, and the process by which the results were gathered was not independently validated. The contract does not specify how surveys are to be done and to what standard. The number of customer responses varied greatly from month to month because different benefits were sampled each month. The unusually high satisfaction rate for home visits in January 2000 was based on only 15 responses, while the February 2000 survey of examination centres, which had an overall satisfaction rate of 76 per cent, was based on some 1184 responses. In August 2000, following advice from the National Audit Office's consultants from NOP Research Group Ltd, SEMA Group began to sample across the benefits each month to provide more continuous assessment.
 2. Response rates for Incapacity Benefit and Disability Living Allowance/Attendance Allowance averaged about 70 per cent, with lower response rates from the smaller benefits.
 3. April and October 1999 and April 2000 surveys covered Disability Living Allowance and Attendance Allowance examinations only, both of which are carried out in home visits. Therefore there are no data on examination centres for these months.

Source: Surveys by SEMA Group

23 Complaints received about SEMA Group from September 1998 to August 2000



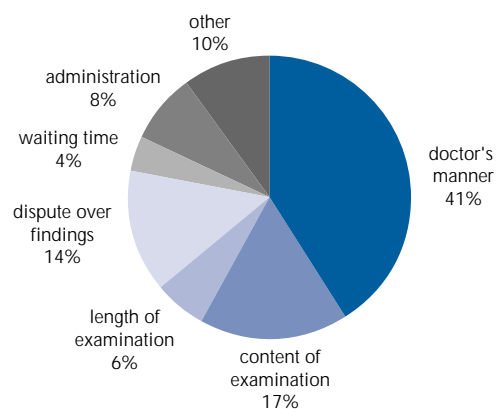
Source: Department of Social Security

The number of recorded complaints about SEMA Group's performance is increasing

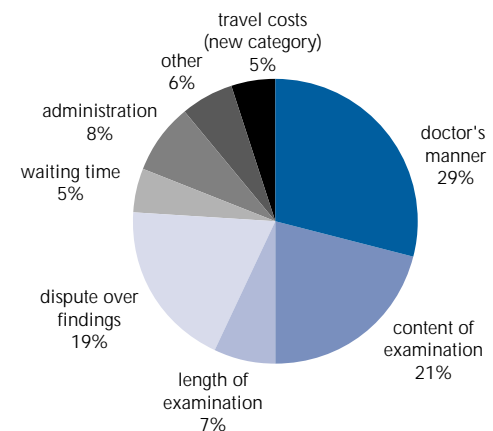
4.6 In the first 2 years of the contract, SEMA Group received about 4,000 recorded complaints a year about its services. The number of complaints is increasing to an annual average of approximately 5,000 (Figure 23). This may be due partly to improved complaints recording. The problems experienced in scheduling appointments and in recruiting doctors (paragraphs 2.4 and 3.15), together with more recent publicity associated with the Social Security Select Committee's report in April 2000 may also have prompted more customers to complain. However, disability rights groups advising benefit customers told us that some customers who are dissatisfied with the treatment they have received are nevertheless dissuaded from making a complaint either because they fear it may affect their benefit, or because they are not clear about how to complain.

24 Analysis of complaints received before and after outsourcing

Before outsourcing, most customer complaints were about how doctors conducted examinations



In the period June to August 2000 most complaints were still about the conduct of examinations



- Notes:
1. The data used in the upper chart relate to the nine months immediately prior to outsourcing. The lower chart relates to the quarter ended August 2000.
 2. The complaints category "travel costs" appears only in the lower chart as it was introduced after outsourcing.

Source: Department of Social Security

Most complaints received are about doctors' attitudes and the conduct of examinations, but the organisation of examinations is also significant

4.7 Before outsourcing, most customer complaints (64 per cent) were about what went on in the medical examination. Some 41 per cent were about doctors' attitudes; the way doctors conducted examinations was the subject of fewer complaints (17 per cent), as shown in **Figure 24**.

4.8 Since outsourcing some 57 per cent of customer complaints still relate to what goes on in medical examinations although fewer are about the doctor's manner (Figure 24). Voluntary and disability rights groups suggested to the Social Security Select Committee that some doctors were discourteous, asked inappropriate questions or behaved in an inconsiderate manner.

4.9 The level and nature of complaints differ both across the 12 Medical Service Centres (**Figure 25**) and depending on whether the customer is examined at home (almost all Disability Living Allowance and Attendance Allowance customers), or attends an examination centre (almost all Incapacity Benefit customers). **Figure 26** overleaf shows that for both home visits and examinations at a centre, the conduct of the examination itself, including the doctor's manner, is important. But for those customers attending an examination centre, appointment arrangements and

waiting times are also very important, whereas, perhaps understandably, these are less important for customers who are waiting at home for the doctor.

4.10 The remainder of this part of the report looks at the causes of customer dissatisfaction with the conduct of examinations; management of appointments and waiting times; how the service handles the different needs of women and ethnic minorities, a particular area of concern in the Social Security Select Committee report. It also considers the action being taken by the Department and SEMA Group in response to the recommendations of the Social Security Select Committee.

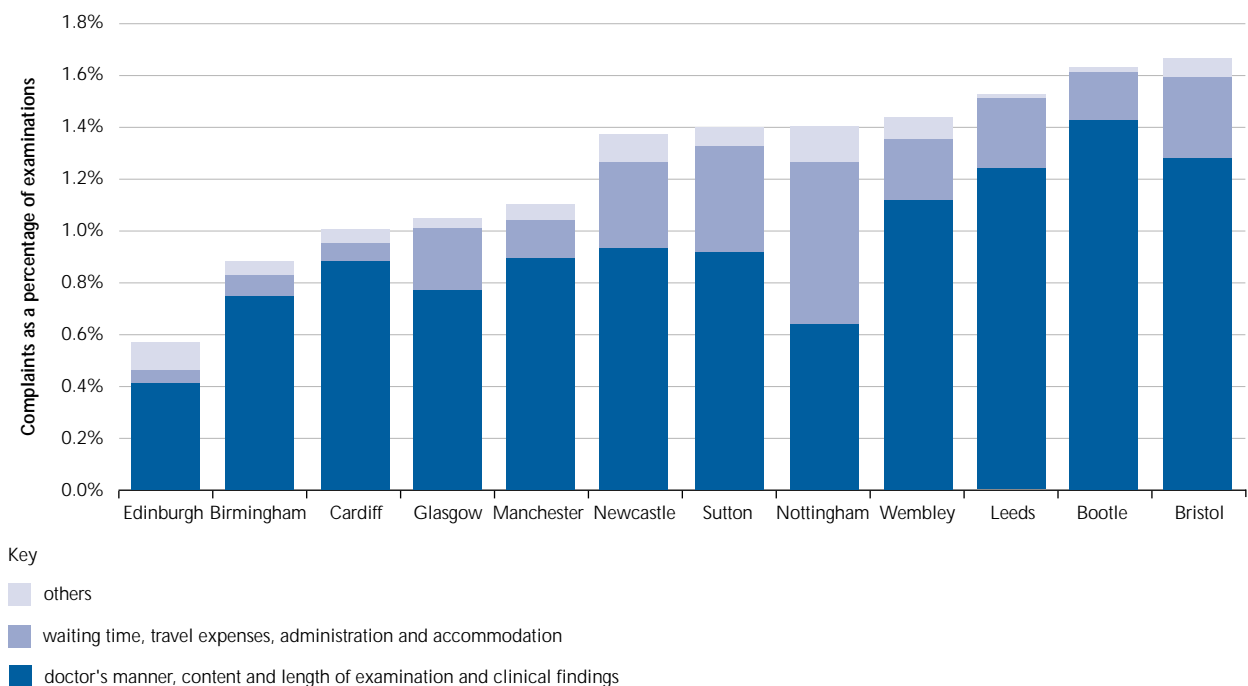
The way examinations are conducted and the explanations given to customers can affect both customer care and the quality of the medical report

4.11 The contract requires that at all medical examinations, SEMA Group doctors shall:

- allow customers sufficient time to give their relevant medical history;
- maintain a non-adversarial manner;
- explain the purpose of the examination and what it entails;

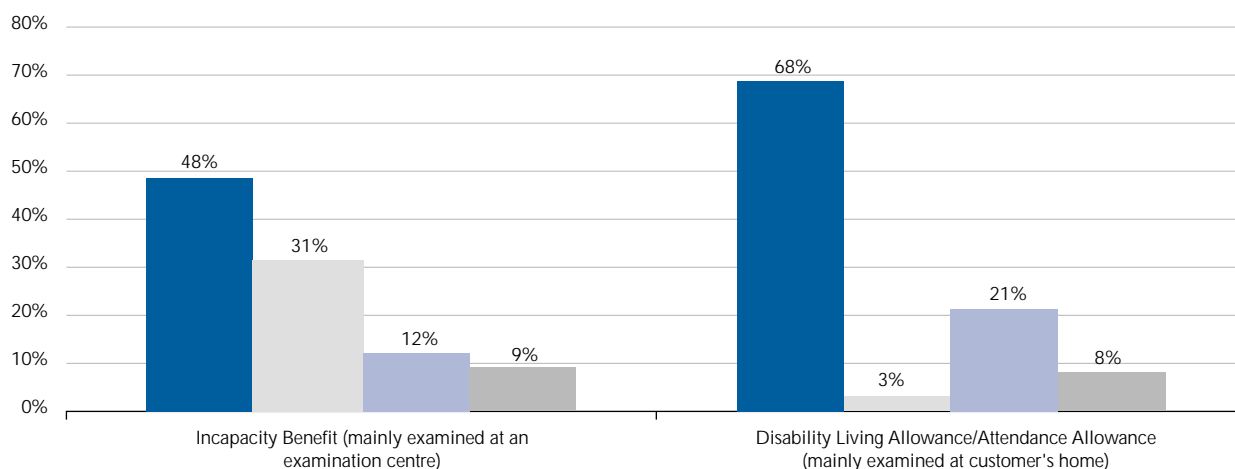
25 Customer complaints, analysed by Medical Services Centre

The level and nature of complaints differ across the 12 Medical Services Centres



Note: The data used relate to the quarter to August 2000, and show the number of complaints received as a percentage of examinations by each centre.

Source: Department of Social Security

26 Analysis of customer complaints categories by the two main benefit groups**Key**

- issues relating to the examination itself
- issues relating to the administration and waiting time
- Clinical findings
- Others

Note: The data used relate to the quarter ended August 2000. The total number of complaints received in the period was 1,353.

Source: Department of Social Security

- perform the examination in a manner that avoids unnecessary discomfort to the customer; and
- answer any appropriate relevant medical questions posed by the customer without giving an opinion on the outcome of the claim or medical condition.

4.12 The conduct of examinations not only affects customer care but can also influence the quality of the medical report. For instance, if the doctor does not put the customer at ease, they may not disclose important information about their condition which is relevant to the report. But it is inherently difficult for anyone not present at the examination to verify whether the doctor acted appropriately, so compliance with these requirements is not linked to payments under the contract.

4.13 The Department consider that the higher level of complaints arising on home visits about the conduct of examinations may be due to customers' expectations that the examination will be like a visit from their general practitioner, which may well lead to disappointment. The SEMA Group doctor will not be seeking to alleviate a customer's medical condition or prescribe medicine, and the purpose of the examination may be only to confirm one aspect of the customer's condition. If the examinations are not explained and conducted in a sensitive way, the doctor could appear brusque and uncaring. Better preparation of customers in advance, to ensure that they know what doctors are going to do and why, could reduce levels of complaint, as well as helping to improve the quality of the resultant reports. Improved training of doctors in customer care

now being provided should increase awareness of the need for greater sensitivity in examining customers at home.

The scheduling of examinations of customers at SEMA Group premises remains an area of particular difficulty

4.14 A continuing cause of concern is that customers are being turned away unseen from scheduled examinations. In principle, a fully effective system for scheduling the examination of customers would ensure that doctors always have customers to see during their examination sessions and that all customers who attend are seen. In practice, this has proven difficult to achieve both before and after outsourcing because a significant minority of customers either do not accept the appointments available, or accept but do not attend.

4.15 In March 1998, before outsourcing, 20 per cent of Incapacity Benefit customers invited for examination advised that they were unable to attend, and a further 20 per cent of those with an appointment did not attend. (The action taken if customers do not attend is determined by decision-makers, and is discussed in more detail in Appendix 2). Though the Department could in some cases make late substitutions, the net "drop-out" rate was 35 per cent. The Department hoped that outsourcing would help to address this waste of resources.

27 Comparison of the numbers of Incapacity Benefit customers who had their appointments cancelled before and after outsourcing¹

Reason for customers not being seen	Customers sent home unseen		Appointments cancelled by telephone	
	Before outsourcing November 1997 - March 1998 monthly average	December 1999 August 2000 monthly average	Before outsourcing November 1997 - March 1998 monthly average	December 1999 August 2000 monthly/average
TOTAL sent home unseen	1,612	1,421	598	299
(Percentage of examination appointments)³	(2.1%)	(2.9%)	(0.8%)	(0.6%)
Broken down as follows:				
Doctor unable to see customers due to overbooking	40%	44%	6%	14%
Doctor productivity lower than expected (including difficult cases)	14%	12%	5%	7%
Doctor cancelled the session	10%	10%	83%	69%
Customer would not wait to be seen (more than 30 minutes)	13%	11%	Less than 0.5%	Less than 0.5%
Other reasons ²	23%	23%	6%	10%

Notes: 1. Figures are for March 1998, the last month prior to beginning of transition of the service to SEMA Group.

2. Other reasons include clients unfit to be seen, accommodation problems, or administrative errors.

3. The average number of appointments between November 1997 and March 1998 was 75,399; the average for December 1999 to August 2000 was 49,807.

Source: Department of Social Security

4.16 Because SEMA Group are paid for each completed report, they have a strong incentive to ensure that as many customers as possible attend and that their staff are fully employed on productive work. However, since outsourcing the average proportion of customers who fail to attend their appointments has not reduced. Between December 1999 and May 2000 it rose to 23 per cent. In such cases SEMA Group incur costs but receive no income. There is also a risk that some customers not examined will continue to receive benefits to which they are not entitled.

4.17 To allow for customers not attending, the in-house service practised overbooking. This has been continued by SEMA Group. More customers are invited to attend than there are appointment "slots". However the numbers who do not attend is volatile and if overbooking does not match the rate of non-attendance it can result in large numbers of customers being turned away unseen. Before outsourcing on average around three per cent of customers a month were turned away or had their appointments cancelled by telephone. Results to date suggest that the situation has deteriorated slightly since outsourcing, and the number has risen to 3.5 per cent (Figure 27). The level of cancellations varies significantly between areas, exceeding 7 per cent in Bootle (Figure 28). The results of simulation modelling of the overbooking problem are at Appendix 2 and show that to avoid turning away customers, the rate of overbooking needs to be matched accurately to the actual rate of non-attendance.

4.18 The main single reason for customers being turned away unseen continues to be excess attendance due to overbooking. Other reasons include:

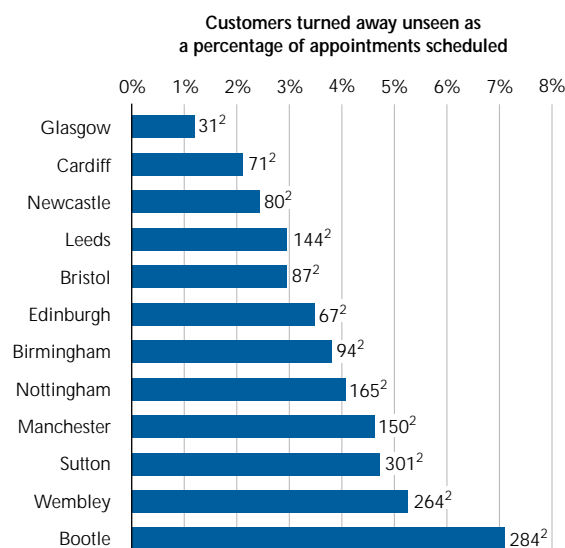
- doctors taking longer than expected to complete examinations;
- customers unwilling to wait longer than the maximum expected time of 30 minutes;
- doctors cancelling sessions too late to inform customers.

Although there may be some exceptional cases where late cancellation of appointments by SEMA Group is unavoidable, all of the above factors can to some extent be managed. Turning away customers causes them inconvenience and unnecessary distress as they will be required to attend again for a further appointment. The Department have repeatedly expressed their concern to SEMA Group about the number of customers turned away, but there is no direct monetary incentive on the company to moderate overbooking.

4.19 Unfilled examination slots and travel expenses paid a second time to customers turned away are costly for SEMA Group. Unnecessary travel expenses alone are likely to cost £75,000 a year. If the number of customers failing to attend and the number of customers turned away unseen could be reduced, more examinations could be completed within the resources available. Part of the solution lies in taking active measures to reduce the proportion of customers who do not attend

28 Incapacity Benefit customers turned away from appointments without being seen in each medical examination area¹

The diagram shows that the percentage of customers with an appointment who are being turned away without being seen varies from one medical services centre to another



- Notes: 1. The diagram covers the period November 1999 to August 2000.
2. The figure to the right of each bar indicates the actual average number of customers sent home unseen in the period, while the height of the bar indicates the number sent home as a percentage of the scheduled appointments in the same period.

Source: Department of Social Security data

examinations, and the need for overbooking. There is also scope for further analysis of the reasons why customers fail to attend, and whether there are different attendance patterns associated with different groups of customers, and with different geographical areas.

4.20 The Department and SEMA Group have piloted improved procedures since 1998, though these have not yet been introduced nationally, and there is also scope to learn from good practice in other sectors such as the Health Service and private medical insurers (Appendix 8). The key lessons are that:

- appointments should be booked at times that are mutually convenient to customers and staff rather than being imposed; and
- customers should be given the option to attend appointments in the late afternoon or evening. The possibility of some examinations being carried out at General Practice surgeries rather than examination centres could be considered as a way of helping to match this work with doctors' other commitments, although customers should of course not be examined by their own general practitioner, or another in the same practice. Exploring the possible use of other health professionals such as nurses may provide greater flexibility in appointment times.



There is so far only limited evidence on how well the service handles the different needs of women and ethnic minorities

4.21 Under the contract, SEMA Group are required to "comply with any reasonable requests to accommodate claimants who have special needs". Provision for special needs might include, for example, a female examining doctor where a customer requests it, or interpreting facilities for customers whose first language is not English. However, there are no performance measures or payment incentives linked to these requirements.

4.22 Interest groups who advise benefit customers have raised with the Department concerns about what they see as poor customer service to ethnic minority groups; specifically failure to provide interpreters and female doctors, and general cultural insensitivity. And the Social Security Select Committee were concerned that information provided to customers and training for SEMA Group medical staff were inadequate in these areas. Moreover, the Parekh Report on The Future of Multi-Ethnic Britain¹ (published in 2000) stressed that issues of potential racial discrimination and gender discrimination are often inter-linked and ought to be considered together. We looked at what evidence the Department and SEMA Group have that they are providing an acceptable standard of care to all customers, in the light of the Race Relations (Amendment) Act 2000², which comes into force in April 2001. This Act places a new positive duty on public authorities to promote race equality in all their activities.

4.23 The number of actual complaints about racial or gender discrimination or cultural insensitivity in the treatment of customers by SEMA Group is small, but interest groups point out that some customers may be dissuaded from complaining. And prior to December 2000, the Department and SEMA Group did not record complaints about cultural insensitivity as a separate category. They have now begun to do so.

4.24 Prior to August 2000, SEMA Group did not collect as part of their surveys information about customers' gender, age, ethnic origin or special needs to allow them to evaluate how well they respond to those needs. They are now beginning to address this and their surveys now identify the views of customers within these broad groupings. Although the results are too early to be conclusive, the first three months' data show a slightly lower rate of satisfaction with home visits among women, as compared with men. This is one area the Department and SEMA Group could monitor with a view to assessing the need for changes in the training they provide to visiting doctors.

¹ *Report of the Commission on the Future of Multi-Ethnic Britain, established by the Runnymede Trust*

² *The Race Relations (Amendment) Act received Royal Assent on 30 November 2000. Its main provisions are expected to come into force in April 2001.*

4.25 It is difficult to draw any further conclusions from these new surveys as the numbers of people from ethnic minorities responding are too small to be statistically valid. However, the low numbers could in themselves be a cause for concern. It is possible that the method of surveying used by SEMA Group could be failing to reach sufficient numbers of people from ethnic minorities, so that the number of responses received from these groups is disproportionately small. However, the Department do not collect data on the overall profile of customers claiming benefits, in terms of their ethnic origin, and so they cannot currently determine whether or not the survey results are representative. The Parekh Report stated that "it is vitally important that proper monitoring by ethnicity should take place throughout the health and welfare systems". The Race Relations (Amendment) Act will also require organisations to identify through monitoring where there are different outcomes for different ethnic groups so that they can take action to promote greater equality.

4.26 SEMA Group acknowledge that shortages of female doctors among their workforce, especially in some inner city areas, mean that they cannot always provide a female doctor when a customer requests one, although under the contract they are required to make reasonable endeavours to do so. Of 216 full-time doctors, one third are female, and around one sixth of the 3,000 fee-paid doctors who carry out most of the examinations are female. On the provision of help to those whose first language is not English, there is no evidence that SEMA Group have failed to respond to direct requests for interpretation services, but there is equally no information on the number of occasions on which they have responded.

In response to the Social Security Select Committee report, the Department and SEMA Group are taking steps to improve customer satisfaction

4.27 In April 2000 the Social Security Select Committee in their report on Medical Services (HC 183 1999-2000) concluded that outsourcing had not improved services to the public. They recommended improvements in the overall treatment of customers and of specific groups, the handling of complaints from customers and the system of customer feedback.

4.28 The Government's response to the Select Committee in June 2000 gave a strong commitment to improving the standards of service to customers. Key actions included updated training for doctors in all aspects of customer care, reviews of communications with customers and complaints procedures and the development by SEMA Group of a database on individual doctors' medical skills and performance, including their customer care.

4.29 The Government also announced new targets for SEMA Group which have been accepted by them, including:

- within one year to train all doctors in the assessment of people with mental health problems; behaviours, attitudes and sensitivities for dealing with people with disabilities; and distress-avoiding techniques for the examination of people with musculo-skeletal conditions; and
- within two years to improve customer satisfaction to at least 90 per cent.

4.30 In addition, the Department and SEMA Group are:

- changing all appointment and related letters, to explain more clearly what will happen during the examination, highlight the availability of an interpreter service, or a same-gender doctor, on request, and describe the complaints procedure;
- issuing revised guidance including additional material on customer care and appropriate behaviour for doctors who carry out assessments on claims for Disability Living Allowance or Attendance Allowance; and
- identifying ways to facilitate meetings between SEMA Group and interest groups.

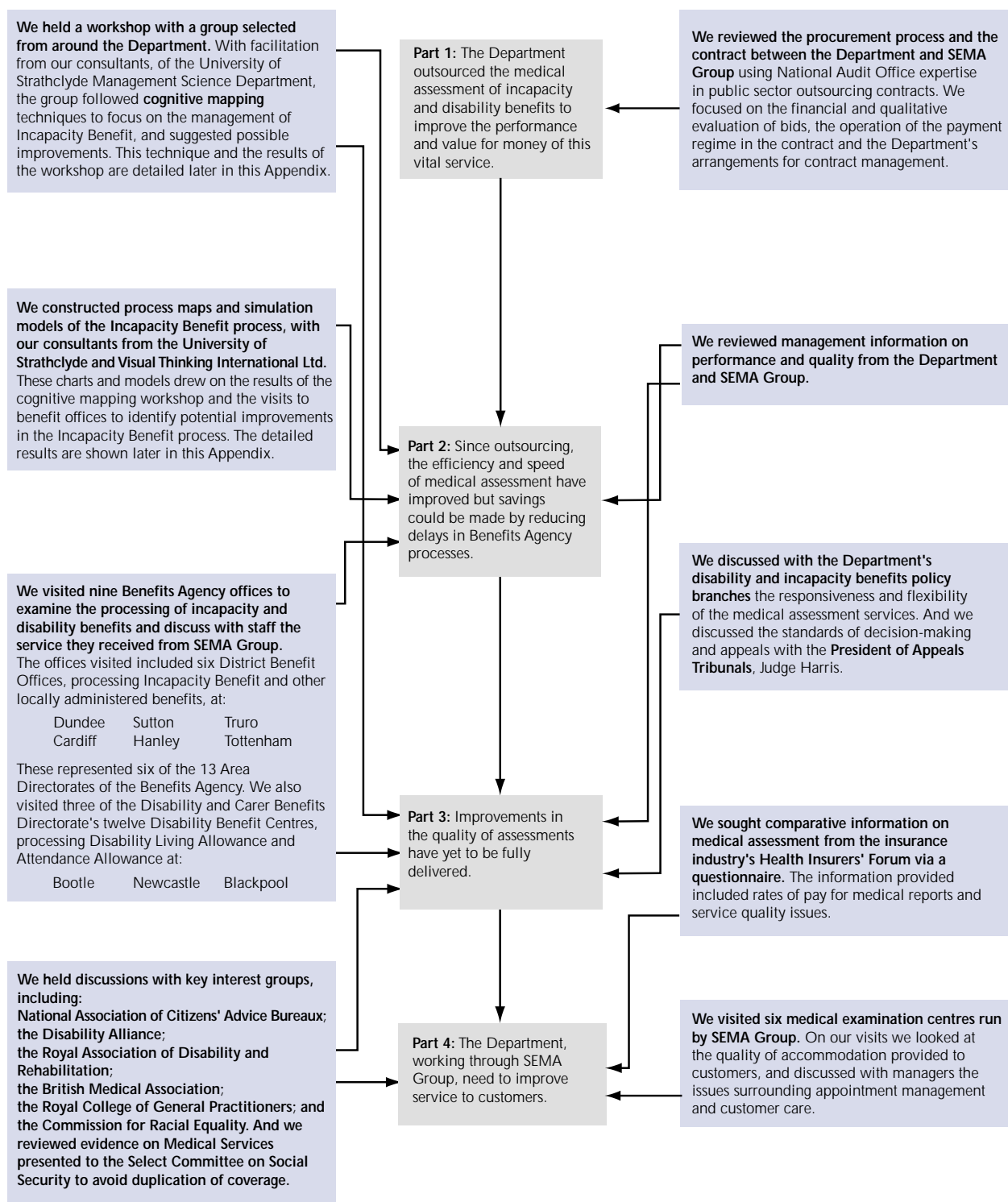
Appendix 1

Chronology of events

Date	Event
Early 1990s	A surge in Invalidity Benefit applications occurred, compounding a steady rise in the caseload over the previous decade.
1992	The Department decided to depart from the centrally agreed fee rate paid to doctors for independent medical examinations and negotiate their own rate.
1992	Disability Living Allowance was introduced, with a move from mainly medical examination to more self-assessment by disabled customers.
July 1992	The Department decided to place the medical service within the market testing programme.
April 1995	Incapacity Benefit was introduced.
1995	A collaborative study was completed with the commercial sector to look at options for outsourcing.
September 1995	Departmental officials recommended to Ministers that outsourcing should take place.
November 1995	The recommendation to outsource was approved by Ministers.
February 1996	The Department's wider Change Programme, to deliver improved services across the board at 25 per cent lower costs over three years, was introduced.
15th June 1996	The Department advertised in the Official Journal of the European Communities for the supply of medical services.
July 1996	The Department issued questionnaires to potential providers, including SEMA Group, who responded with information.
August 1996	The Department issued their operational requirements.
November 1996	The Department issued their more detailed statement of service requirements.
January 1997	Potential suppliers commenced "due diligence" exercises and audits of the Department's relevant properties and assets to ensure they could meet their obligations.
April 1997	EDS withdrew from the competition.
April 1997	The original Ministerial deadline for contract signing passed.
May 1997	Incoming Ministers were briefed on the outsourcing so far. Ministers considered whether to go ahead. Bidders submitted their proposals.
May to August 1997	The Department discussed proposals and requirements with the four remaining shortlisted bidders.
July 1997	New Ministers gave their final approval to go ahead with outsourcing.
4th August 1997	The Department invited the bidders to submit their best and final offers, with the Invitation to Tender.
1st September 1997	Andersen Consulting withdrew from the competition without bidding. Remaining bidders submitted their offers. The Department evaluated the bids received.
18th September 1997	The Department issued a revised Invitation to Tender document.
5th November 1997	The Department invited bidders to submit retenders.
13th November 1997	Bidders submitted their retenders.
20th February 1998	The contract was awarded to SEMA Group.
16th March 1998	Transition of the medical services to SEMA Group began.
1 September 1998	Full "cutover" or transfer of the service to SEMA Group took place.
October 1998	SEMA Group took back the work of scheduling appointments which had been carried out by their subcontractor Nestor, and had run into difficulties.
Spring 1999	Concerns were raised by Benefits Agency users over the number of Incapacity Benefit cases passed on scrutiny.
October 1999	Deduction of service credits for failure to meet service level targets from SEMA Group by the Benefits Agency began.
12 April 2000	The Social Security Select Committee reported on Medical Services.
June 2000	The Government responded to the Select Committee's report.
September 2000	SEMA Group and Nestor introduced a 3 per cent pay rise for fee-paid doctors.
November 2000	SEMA Group and Nestor announced that doctors would in future be paid for attending training courses.

Appendix 2

The National Audit Office's methodology



Results of cognitive mapping, process mapping and simulation modelling

During our work on the management of Incapacity Benefit, we used three techniques described below: cognitive mapping, process mapping and simulation modelling. This allowed us to identify an issue with one technique and check or elaborate on it with another, or "triangulate". Key findings, in terms of areas the Department can address, are described in the final section below.

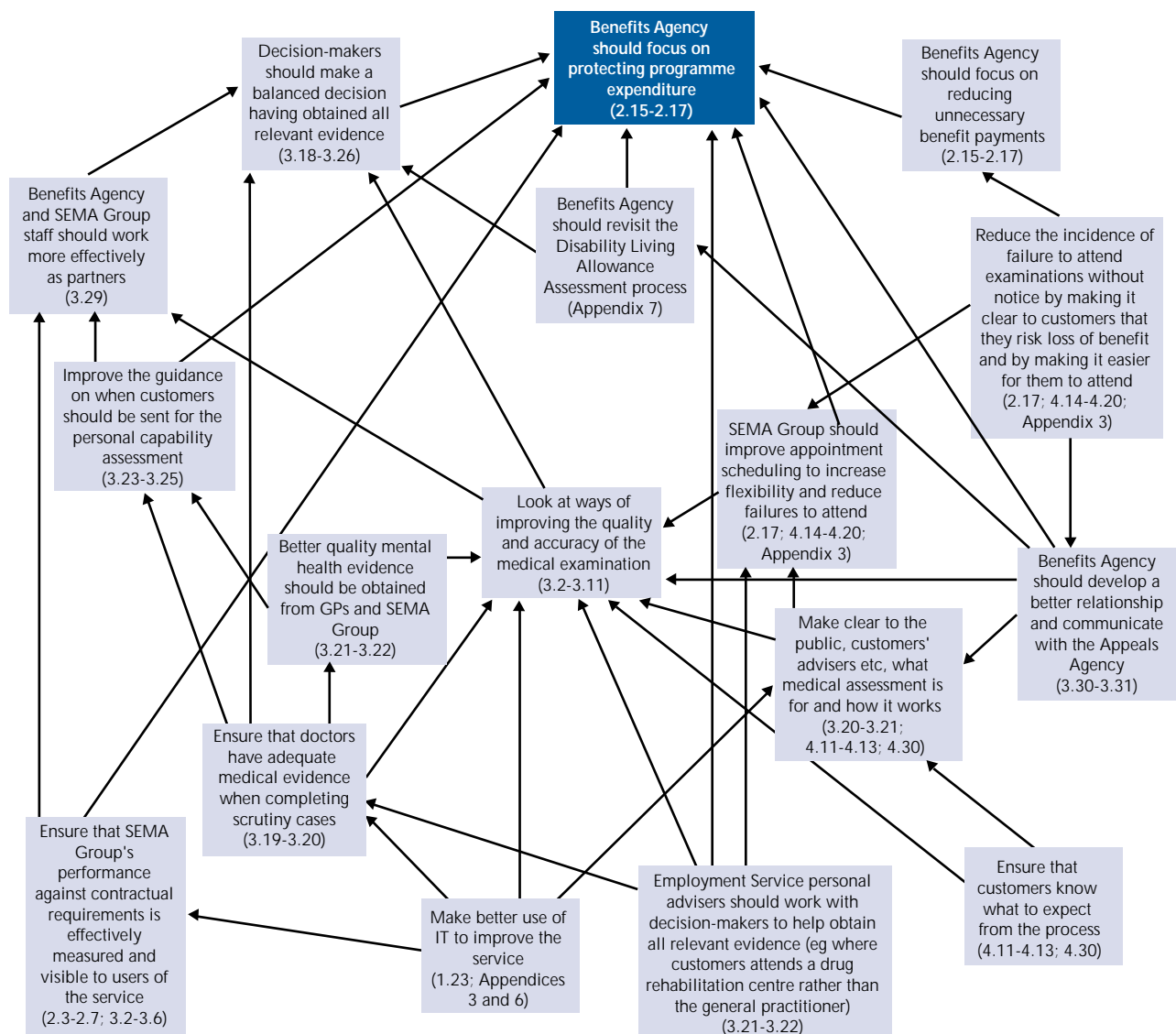
Cognitive mapping

Cognitive mapping is an approach used to generate a shared understanding of a complex issue, system or process by building a picture or "map" from information generated through discussion with those involved in the issue, system or process. It can be used to assist organisations in decision-making or strategy development

or, as was the case here, to understand how decisions are made and to explore the factors that help or hinder the organisation in achieving its objectives.

With consultants from the University of Strathclyde School of Management Science, we held a workshop for staff from the Department and SEMA Group involved in the management of Incapacity Benefit at a range of levels. With facilitation from our consultants, the group produced a set of "maps" which identified issues affecting the efficient and effective management of the benefit, and the linkages between them. The highest level map, below, shows the overall aim the group identified, and the 16 key issues they saw as important in achieving it. The workshop, held at the beginning of our study, helped focus our efforts on the key issues, and all 16 issues are reflected in the report as shown below.

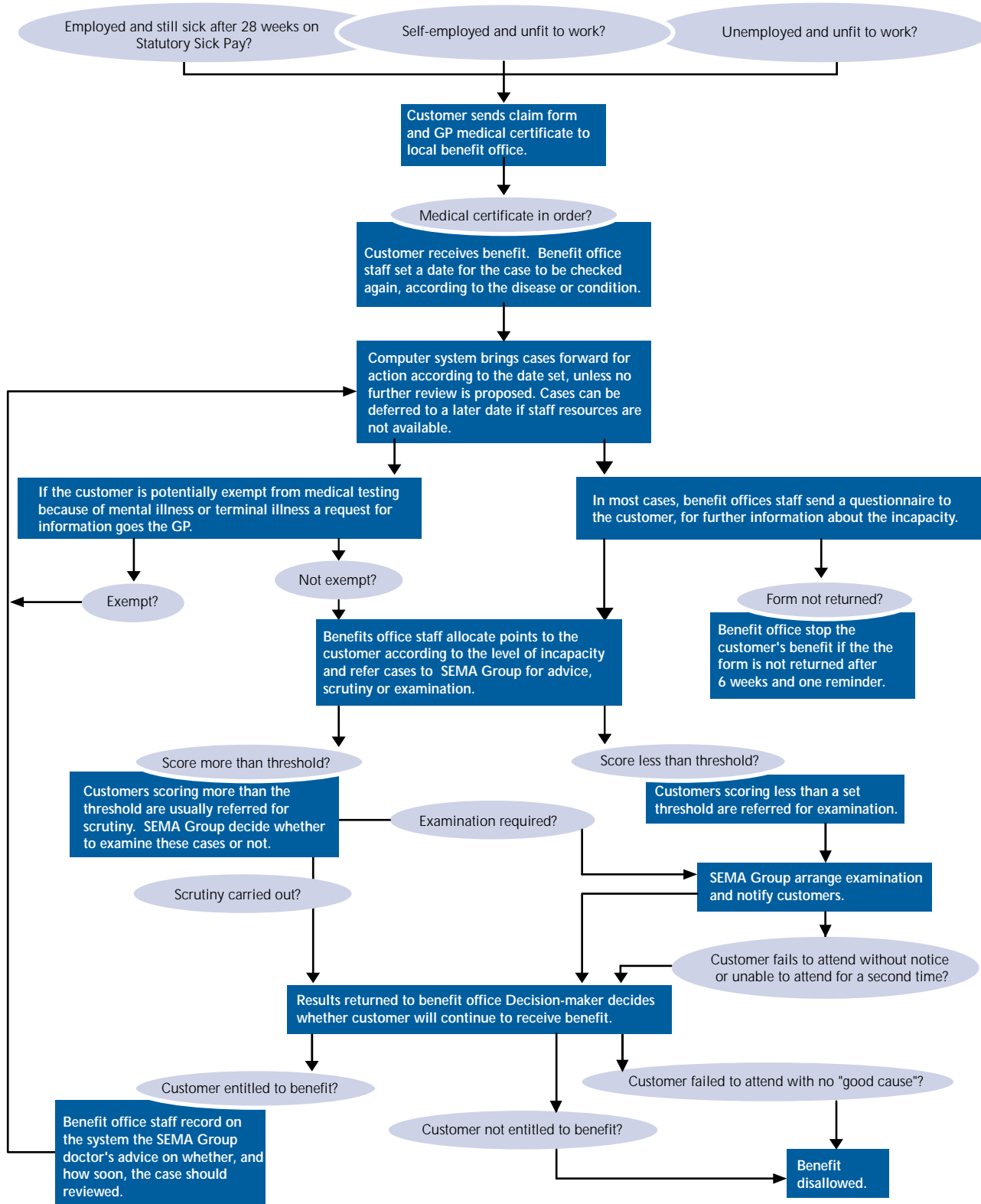
Overall aim and key issues identified by staff at our workshop on Incapacity Benefit



Note: References in brackets indicate where these issues are covered in the main body of the report.

Process mapping

Following the workshop, we examined the processing of Incapacity Benefit at six district benefit offices in different Benefits Agency Area Directorates. This involved observation and interviews with staff working on claims at each stage of the process, and examination of case examples. The following process map of the system resulted from this work.



Simulation modelling

Using the key issues and process map above, we worked with consultants from the University of Strathclyde and Visual Thinking International Limited to produce dynamic simulations of specific parts of the process. Using a proprietary computer-based simulation tool, our consultants produced models to show:

- i) the effect of the decision-maker's action following a customer's failure to attend for examination on effective management of workloads;
- ii) what effect variations in the profile of cases referred to SEMA Group by district benefit offices have on the achievement of service level targets by the company;
- iii) the effect on efficient resource usage of the arrangements by which district benefit offices direct work to SEMA Group medical services centres.

The simulations represent what happens to items passing through the process, replicating the decisions made, and the resources available to process Incapacity Benefit claims. When a flow of claims similar to that found in the real system is fed in for a set time e.g. a "year", performance data can be collected, such as: the number of cases awaiting action; or the efficiency of resource utilisation. By changing values, the effect of changes in the real system can be tested. With highly accurate data, highly accurate results can be produced. In this case, we used simulation to model the broad effects on the system of the key factors identified earlier during mapping.

Main findings from process mapping and simulation

- i) **Variable approaches to setting case review dates.** Where SEMA Group doctors provide scrutiny advice or examinations for Incapacity Benefit, they also indicate when the case should next be reviewed. This is usually after 3 months, 6 months, 12 months, or 18 months. Alternatively, the doctor can advise that no change in the customer's condition is expected. Our workshop group identified the decision on when and how often customers should be examined as a key issue. During process mapping at 6 district offices, we found that at four offices, staff followed the doctor's recommendation, and where no change was expected, they did not set any review date. In one district, the practice was to set a maximum period of 2 years between reviews, whilst another used five years as the deadline. This not only results in variable treatment of customers, but also affects the rate at which cases fall due for review and hence the ability of districts to reduce backlogs (recommendation (g)).

- ii) **Variable approaches to long-term Incapacity Benefit cases.** All district offices we visited during process mapping had some long-term cases on their books which had not been reviewed for several years. At some, customers first assessed under the pre-1995 Invalidity Benefit rules were still on the books. At 3 offices staff were specifically reviewing these cases to check that customers' circumstances were still the same, but at the other three, no special action was proposed, so some of these long-term customers could remain on benefit without review until retirement age (recommendation (g)).
- iii) **Uneven workflows between district benefit offices and SEMA Group.** Staff in both the Benefits Agency and SEMA Group told us that peaks and troughs in the number of cases referred to them by the other party (e.g. a peak at the end of every month) put pressure on them and made it more difficult for them to meet work-related targets. Simulation of this part of the process demonstrated the likely detrimental effect of referring large batches of cases at the end of every month, on the recipient's ability to deliver casework against targets (recommendation (f)).
- iv) **Inconsistency in decision-making where customers fail to attend examinations.** Guidance to decision-makers on Incapacity Benefit states that if a customer *fails* to attend for examination without "good cause", benefit should normally be stopped. If the customer contacts officials to advise that he or she is *unable* to attend, a second opportunity should be offered. If the customer again states he or she is unable to attend, without "good cause", benefit should then be stopped. But some decision-makers told us they frequently allowed customers to continue receiving benefit after failing to attend more than once. Reasons why they felt it necessary to do this included:
 - lack of confidence that appointment letters sent by SEMA Group had actually reached customers, some of whom changed address frequently;
 - the knowledge that, if they stopped benefit, the customer would re-apply, which they felt was a waste of resources;
 - an understanding that attending examinations is stressful, particularly for customers with mental health problems, and that stopping benefit would cause these customers real hardship.

Simulation of this part of the process showed that if customers fail to attend appointments and are fed back into the system repeatedly, this begins to have a significant effect on the ability of the district office to get through work. Our simple simulation was unable to reduce backlogs at all once customers failing to attend were given more than two further appointments (supplementary recommendation on the efficient management of medical assessment - see Appendix 3).

- v) **Overbooking of appointments by SEMA Group.**
SEMA Group have continued the policy of overbooking examination slots started by the in-house medical service, as a means of filling doctor time where customers fail to attend. Part 4 of the report (paragraphs 4.14-4.20) discussed the effect of this policy on customers. Simulation of this part of the process demonstrated that for a given rate of non-attendance, overbooking improves the efficiency of doctors, by reducing the proportion of their time not spent examining customers. But it also showed that there is a roughly exponential increase in the number of customers turned away, as the extent of overbooking exceeds the rate of non-attendance. So matching the overbooking rate accurately to the actual attendance rate is crucial if customers are not to be turned away without being seen (recommendations (i) and (j)).
- vi) **Maximising usage of SEMA Group resources.**
Under current arrangements, district benefit offices direct requests for Incapacity Benefit medical work to the nearest of the 12 medical services centres according to agreed monthly quotas. Medical Services Liaison Managers monitor the level of work being directed to SEMA Group and can flex

district-level quotas to take account of fluctuations in demand within the Area Directorate. But the difficulty of accurately predicting demand even at Area Directorate level, and problems with doctor shortages in some regions, means that the resources of SEMA Group are not always matched with demand. Simulation showed that if the resources of SEMA Group could be shared between an optimum number of district offices, this could maximise usage of these resources, by smoothing fluctuations in demand from one benefit office with those of another. This would also help address overall backlogs in the Benefits Agency, by reducing the instances where districts have to defer cases. Though examination work usually requires a locally-based doctor, there may be scope to direct scrutiny work more freely around the country, as electronic links within the medical service are improved (supplementary recommendation on the efficient management of medical assessment - see Appendix 3).

Appendix 3

Detailed recommendations

To the Department: on the quality of medical assessment and preserving their medical assessment capability

- a) The Department should focus more of their management effort on the quality of medical reports. Stronger oversight of SEMA Group's internal quality assurance arrangements is required from the Department's Corporate Medical Group of specialists and this may require a review of resources.
- b) Unusable reports should always be sent back to SEMA Group for rework, to secure continuous improvement in standards. The definition of a usable report should include the requirement that it provides evidence to back up the opinions given. The Department also requires legible reports which do not include inappropriate or offensive comments, especially since customers or a tribunal may need to read them at a later date.
- c) The Department and SEMA Group should continue to work closely with the new Appeals Agency to further develop the new arrangements for feedback from independent tribunals on the standards of medical evidence they expect to see. This should involve piloting ways of ensuring that:
 - decision-makers receive regular feedback on the findings of appeals tribunals and the implications for their work;
 - SEMA Group doctors also receive feedback on relevant findings; and
 - the Department's case is properly represented at appeal tribunals where benefit decisions are being examined. This may involve a review of the cost-effectiveness of sending staff to attend tribunals.
- d) In view of the worsening shortages of doctors available to carry out medical assessment work, the Department and SEMA Group should look further at the proposals set out in the contractor's original bid, to make use of other healthcare practitioners such as nurses to carry out appropriate parts of the work.

- e) The Department should obtain as soon as possible a projection of the demographic and skills mix and location of the full-time and fee-paid workforce at the end of the contract in 2003 to ensure that a viable service can be delivered beyond the end of the existing contract, and to identify any need for corrective action. This may involve looking again at the mix of full-time and fee-paid doctors.

Supplementary recommendation on the quality of medical assessment and preserving their medical assessment capability

The Department should consider how differentials between current levels of fee-paid doctors' pay on this service and remuneration on other government medical contracts will affect the quantity and quality of the medical workforce up to and beyond the end of the current contract

To the Department: on the efficient management of medical assessment

- f) The Department should, as part of their focus on reducing variations in performance, look to speed up processing times in Incapacity Benefit and reduce the size of backlogs of cases awaiting medical referral, across all regions. This will involve addressing the exact causes of backlogs and processing delays, building on the analysis in this report and on the expertise from the Benefits Agency's own work on performance variations in other benefits.
- g) The Department should seek to standardise approaches in districts to reviewing long-term Incapacity Benefit claims. Their "Keeping in Touch" initiative, currently in pilot form, may provide valuable information through contact with these customers to inform the review process.
- h) Workloads at local benefit offices are volatile and difficult to predict. The Department should avoid situations where high priority cases coming up for review in certain district offices are deferred through lack of funds. Ways of achieving this might include keeping back a proportion of funding for medical assessment work centrally.

Supplementary recommendations on the efficient management of medical assessment

The Department and SEMA Group should consider the scope for better matching of SEMA Group's resources with demand from districts for Incapacity Benefit work. This could involve districts directing paper-based scrutiny work more widely around medical services centres.

The Department should work with SEMA Group to ensure that decision-makers can be confident that customers have received appointment letters by strengthening systems for passing on customer changes of address. This should allow decision-makers to make more objective decisions on whether to stop benefit.

SEMA Group and the Department should examine the practicality of holding some medical examination sessions for Incapacity Benefit in the surgery of the examining doctor, rather than at a SEMA Group examination centre, subject to the surgery's ability to support the required standard of service to customers. This could help ease shortages in supply by allowing some doctors who otherwise could not do fee-paid work to do so. And in some cases it could result in savings in travelling time and accommodation costs, although there may be additional charges for the use of National Health Service properties.

The Department should work with the Cabinet Office Regulatory Impact Unit, the Department of Health and the British Medical Association, to review arrangements for remunerating general practitioners for the various forms of medical certificate or report they are asked to provide on behalf of their patients. Current arrangements are piecemeal and inconsistent and may contribute to delays in the system. They also do not reflect the variable disability benefit related workload of general practitioners.

To the Department: on customer care

- i) The Department should seek to build performance measures linked to financial incentives on customer care into their contract for medical services. This should be part of any negotiations to extend the contract duration to 7 years, and might include measures to:
 - reduce the incidence of customers being turned away from examination appointments unseen;
 - ensure the waiting time targets of 10 and 30 minutes for customers attending an appointment are met or improved on;

- provide a doctor of the same gender or an interpreter for all customers who request it when arranging the appointment, subject to the claimant being willing to travel to an alternative centre.
- j) The Department should consider, with SEMA Group, ways of eliminating the problem of turning away customers who have been asked to come for examination without seeing them by:
 - implementing nationally the successful pilots where scheduling of appointments is done locally, and local knowledge of customers and geography can help plan sessions more accurately;
 - reconsidering the way fee-paid doctors are remunerated, the scope to let them examine at their own practice premises, and the incentives on them to complete all scheduled examinations; and
 - better training and retention of SEMA Group staff doing scheduling so that they can more effectively judge the length of different types of examinations.
 - k) The Department and SEMA Group should continue to look at ways of further improving the surveys of Benefits Agency staff and customers so that they meet generally accepted market research industry standards. The Department should periodically exercise their right to validate these surveys and ensure they provide a representative picture of the views of all customers.
 - l) The Department should obtain robust information, from either improved customer surveys, or more directly targeted research methods, to determine the effect of SEMA Group's activities on different customer groups, by ethnicity and gender, in line with the new provisions of the Race Relations (Amendment) Act 2000. Where there are different outcomes for different groups, they should consider setting targets for improvement.
 - m) The Department should work with the Commission for Racial Equality to ensure that SEMA Group, as well as their other contractors, put in place race-equality programmes to ensure compliance with the requirements of the Race Relations (Amendment) Act 2000 which introduces a new positive duty on public bodies to promote race-equality. These programmes should be in line with the codes of practice to be issued by the Commission early in 2001.

- n) The Department require better assurance that complaints received by SEMA Group have been properly handled. This might include:
- more detailed categorisation, by type, of complaints about the conduct of doctors at examinations;
 - focusing their monitoring effort on serious complaints and on multiple complaints against the same doctor, to ensure that SEMA Group have taken corrective action;
 - a firm definition of what constitutes a serious complaint (eg. a matter likely to have influenced the benefit decision, or which inflicts pain or hardship on the customer or relates to improper conduct by SEMA Group staff);
 - negotiating with SEMA Group or a subsequent supplier to build financial remedies into the contract for failures to act in response to such complaints within set timescales.

Supplementary recommendations on customer care

The Department and SEMA Group should look at ways of ensuring that customers are aware of the nature and likely length of the medical examination, of the options to request a doctor of the same gender or an interpreter, and of the complaints procedures. This could involve changes to the literature given to customers or to the training of fee-paid doctors.

The Department and SEMA Group should look to good practice in the Health Service and insurance industry on appointment scheduling, and seek to reduce the incidence of customers failing to attend examinations by scheduling these to suit the customer in the first place.

To all Departments: on outsourcing

- o) Objectives should be explicitly prioritised and minimum standards set for each so that Ministers and officials are aware of the likely outcomes. In this case the Department pursued several objectives that tended to conflict: to improve the quality of reports, quicken throughput, maintain service to customers, lever in investment, and reduce costs. Although qualitative criteria were weighted, overall the objectives were not prioritised, and the resulting contract focused on reducing the cost of the service whilst speeding up throughput.
- p) Where Departments intend outsourcing to bring significant capital investment they should consider whether the proposed length of contract gives the supplier an adequate period to recover worthwhile investment. There is the risk that this contract will suffer from partial "investment blight" for much of its minimum five-year duration.
- q) Where Departments are unable to define service quality to contractually enforceable standards they should consider other approaches to incentivising suppliers. In this case, options include direct payments for outputs conducive to quality, such as the achievement of targets for numbers of medical staff attaining additional professional qualifications.
- r) Where Departments embark on innovative outsourcing of specialist services they should consider longer shortlists, to offset the increased risk that companies will withdraw without bidding. In this case the Department prudently shortlisted five companies, and therefore managed to maintain competition for two of the three contracts and the illusion of competition for the other.

Appendix 4

Alternatives to outsourcing considered by the Department

The Department considered the following options and decided that:

- **Doing nothing** would achieve no transfer of risk to the private sector, fail to secure major investment resulting in a major risk to service delivery, and would fail to tap into private sector innovation and efficiency gains;
- **Privatisation**, the transfer of all responsibilities to the private sector, was not viable because Government had to retain further interest as purchaser of the medical service;
- **Private Sector management consultancy** would be expensive, leave all risk with the Department, have no guaranteed outcome, and perpetuate uncertainty, in turn affecting the workforce;
- **Piloting private sector involvement in a limited geographical area** before proceeding nationally, would need two to three years to conduct, would delay savings and again perpetuate uncertainty for staff;
- **Giving private sector managers responsibility for part of the service**, such as appointment bookings, would retain risks within the Agency, complicate management, and the private sector would still be constrained by civil service conditions and practices; and
- **A buy-out by management or employees** would, even if viable, raise propriety issues because existing management had been evaluating private sector proposals.

Appendix 5

Service levels for medical reports

Benefits Agency work	Primary Target for return of medical evidence by SEMA Group	Secondary Target for return of medical evidence by SEMA Group
Incapacity Benefits (including Severe Disablement Allowance and Statutory Sick/Statutory Maternity Pay except as indicated below)	Advice - 90 per cent in 2 working days Scrutiny referrals cleared on the basis of documentary evidence - 85 per cent in 10 working days Examinations - 95 per cent in 50 working days	Advice - 98 per cent in 5 working days Scrutiny - 95 per cent in 25 working days
Disability Living Allowance/ Attendance Allowance (including Disabled Passenger Scheme and Medical Appeal Tribunals)	Advice - Special Rules: 98 per cent in 1 working day Advice - Others: 95 per cent in 3 working days Examinations - 95 per cent in 20 working days Periodic enquiries special handling cases - 95 per cent in 15 working days	Advice - Special Rules: 100 per cent in 2 working days Advice - Others: 100 per cent in 5 working days Examinations - 100 per cent in 30 working days
Industrial Injuries Scheme Benefits	Advice - 85 per cent in 10 working days Examinations - 60 per cent in 33 working days	Advice - 95 per cent in 25 working days Examinations - 95 per cent in 50 working days
Work analogous to Industrial Injuries	Advice only - 98 per cent in 15 working days Examinations - 90 per cent in 70 working days	
Statutory Sick and Maternity Pay	Advice - 90 per cent in 5 working days Examinations - 100 per cent in 25 working days	Advice - 100 per cent in 10 working days
Age Determination	Advice - 85 per cent in 10 working days Examinations - 95 per cent in 50 working days	Advice - 95 per cent in 25 working days
Debt Recovery Group	100 per cent in 28 working days	
Pensions and Overseas Directorate (Incapacity Benefits, Pro Rata Benefits, and examinations carried out in the UK in respect of UK and non UK legislation)	Advice - 90 per cent in 2 working days Scrutiny referrals cleared on the basis of documentary evidence - 85 per cent in 10 working days Examinations - 85 per cent in 50 working days	Advice - 98 per cent in 5 working days Scrutiny referrals cleared on the basis of documentary evidence - 95 per cent in 25 working days Examinations - 95 per cent in 70 working days
Pensions and Overseas Benefits Directorate (Jamaica/Barbados cases)	Scrutiny referrals cleared on the basis of documentary evidence - 85 per cent in 50 working days	Scrutiny referrals cleared on the basis of documentary evidence - 95 per cent in 70 working days
Pensions and Overseas Benefits Directorate (Industrial Injuries Benefits)	Advice only - 85 per cent in 10 working days Examinations - 95 per cent in 50 working days	Advice only - 95 per cent in 25 working days
Vaccine Damage Payments Scheme	Advice cases - 85 per cent in 5 working days Examinations - 100 per cent in 25 working days	Advice cases - 100 per cent in 25 working days
Work for other agencies		
Child Support Agency	Advice only - 60 per cent in 5 working days	Advice only - 100 per cent in 10 working days
Compensation Recovery Unit	100 per cent in 15 working days	
Disabled persons tax credit	Renewal and review claims - 100 per cent in 2 working days Examinations - 65 per cent in 30 working days	Examinations - 95 per cent in 50 working days
Job Seeker's Allowance	100 per cent on the day of receipt or next day where referral received after 5pm	
Appeals Service	Examinations (home visits) - 95 per cent in 20 working days HCNs - 95 per cent in 20 working days	Examinations (home visits) - 100 per cent in 30 working days HCNs - 100 per cent in 30 working days
War Pensions Agency	Examinations - 80 per cent in 30 working days Specialist reports - 80 per cent in 50 working days Regional Consultant reports - 80 per cent in 50 working days	Examinations - 95 per cent in 50 working days Specialist reports - 95 per cent in 80 working days Regional Consultant reports - 95 per cent in 80 working days
All Business Areas		
	Rework accuracy:	Not more than 1 per cent of reports cleared in any month returned for Rework
	Rework response times:	Advice only required: 100 per cent in 5 working days or normal period if shorter Examination required: 100 per cent in 15 working days or normal period if shorter

Appendix 6

The service improvement plan put in place at the start of the contract

Aspect of Service	Main improvements proposed at start of contract	Planned actions and any progress made
Medical Quality	Introduction of a uniform assessment for recruitment. Development and delivery of a modular training programme. Development of monitoring arrangements based on peer review, including standards, reporting systems and remedial action plans. Development of medical protocols, linked to training. Development of an accreditation and quality management system.	When raised in August 1998 the Medical Quality plan was scheduled for completion by September 2000. As at that date, the modular training programme had been developed although not all doctors had been trained. A medical skills database to monitor doctors' skills and the quality of their work was operational from January 2000, as was a new Integrated Quality Audit System.
Incapacity Benefit casework	The scrutiny of case papers was to be improved by the production of new guidelines piloted initially at two sites.	Scheduled for completion by December 1999. The scrutiny guidelines have been redrafted and clarified twice. The latest clarification was in November 2000. SEMA Group had completed a pilot on electronic completion of medical assessment forms by doctors.
Information Technology / Services	To comprise enhancements to existing medical service systems, and development of a long-term strategy and roll-out plan for new IT.	Enhancements were due for completion by January 1999 and the production of a long-term strategy by June 1999. Bar coding technology was introduced in November 1999. By November 2000, consolidation of the local computer systems into one national system was underway.
Quality Management	Implementation of quality management systems to recognised standards.	ISO9001 accreditation was planned by March 2003. It was achieved in August 2000.
Business Procedures	Achievement of "quick wins" by gathering information on local initiatives and rolling the best of these out nationally. Improvements in scheduling of examinations through short and long term measures including an agreed policy to manage overbooking, deployment of "sweeper" doctors, examination of rewards to doctors and of forecasting of customer failures to attend.	"Quick wins" to be implemented by December 1998. Scheduling improvements to be completed by September 1999. As at November 2000 SEMA Group and the Department were discussing the findings of pilot schemes relating to failure to attend. Pilots testing a new payment structure for doctors were still running.
Medical Evidence Centres	To draw up detailed plans to implement the organisational model proposed by SEMA Group in their bid, (paragraph 1.24), starting with pilots at three sites.	Plans for national roll-out by April 1999. After pilot work SEMA Group decided that establishing a full centre in each site is not the most efficient or cost effective solution; and each site has to be taken on its merits.
Medical staff	Refine and pilot SEMA Group's bid proposals for the use of paramedical staff.	Plans for national roll-out by November 1999. This issue has not moved forward because of legislative and policy constraints.
Customer and DSS staff satisfaction	Surveys of benefit customers and DSS staff.	Surveys to be implemented by December 1998. This was achieved.
Electronic data interchange	System modifications to allow SEMA Group to exchange casework with the fee-paid doctor allocation systems of its sub-contractor Nestor.	To be rolled out to all sites by October 1998. The system was abandoned.

Appendix 7

Sources of medical evidence

Not all decisions on benefit eligibility require an examination by a SEMA Group doctor. Unnecessary physical examinations can cause stress and inconvenience to sick and disabled people and the Department are concerned to examine customers only where appropriate evidence cannot be obtained from another source.

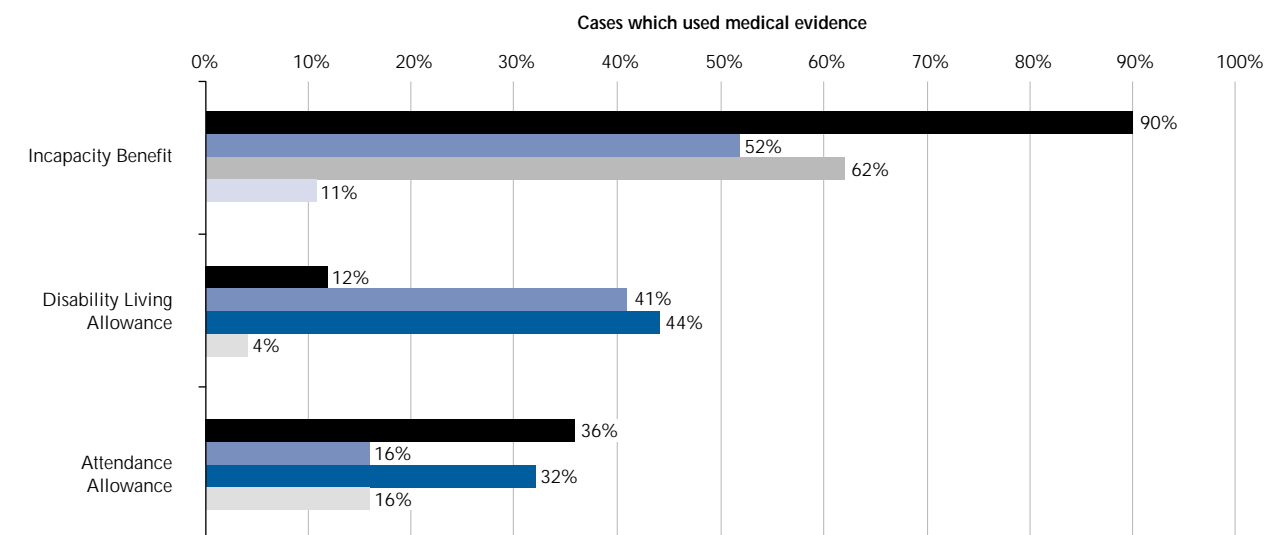
Disability Benefits

Assessment of Disability Living Allowance and Attendance Allowance is based on the principle of self-reporting. This means that the initial evidence is normally the customer's statement on the effects of his or her disabilities on everyday life. Decision-makers can make decisions on the basis of this statement. Where necessary, they can also request one or more of a range of different types of further evidence before making a final decision. One possible source is advice and/or an examination carried out by SEMA Group. The focus of evidence gathering is on the needs arising from the disability, rather than the nature and extent of the disability.

The rules for deciding entitlement to these benefits are based on a range of subjective tests that require the decision-maker to reach conclusions based on the evidence available. There is therefore scope for different interpretations in apparently similar cases. For example, the needs of blind people may depend on how well they have adapted to the loss of sight. The high proportion of awards which are made for the customer's lifetime means that if errors do occur in decision-making they can lead to significant over- or under-payments if not identified early. The Department have recognised these problems with the process, and in 1998 initiated a Disability Modernisation Programme which has made changes to :

- ensure the collection of sufficient evidence to fully support decisions on entitlement;
- improve explanations to customers of how decisions have been made and changes in circumstances which must be reported to the Agency; and
- carry out periodic checks on long-term awards to make sure entitlement is still correct.

The different types of medical evidence used in making benefit decisions



Key

- questionnaire or statement from customer
- examination by SEMA Group doctor
- written report from specialist or hospital
- scrutiny by SEMA Group doctor
- information from customer's consultant or specialist
- GP's report

Source: Department of Social Security

Incapacity Benefit

Entitlement to Incapacity Benefit is initially based on medical evidence from the customer's general practitioner. For the first 28 weeks, eligibility is based on the customer's ability to conduct their normal occupation if they have one. After 28 weeks (or a shorter period if the customer was not recently employed) further medical evidence is required to assess the level of incapacity. This evidence comes from a combination of a questionnaire completed by the customer or the customer's general practitioner and evidence from SEMA Group, which may involve a physical examination. Under this "Personal Capability Assessment" process, the customer scores 'points' according to their capacity (or incapacity) to carry out various tasks associated with work (e.g. sitting in a chair comfortably for a certain period, walking a certain distance unaided).

Whilst Benefits Agency staff can specifically request an examination in certain cases where the level of incapacity is in doubt, in the majority of cases SEMA Group's doctors use their professional judgement as to whether an examination is necessary. Before the outsourcing of the medical services, the Department were concerned that too many Incapacity Benefit customers (some 60 per cent) were undergoing examinations and drew up revised guidelines for SEMA Group's doctors defining the circumstances in which an examination was required. Also, the Department deliberately set a single contractual price for all Incapacity Benefit reports, to remove any incentive to carry out unnecessary examinations.

The Department are also looking at ways of helping customers claiming Incapacity Benefit return to work where this is possible. Currently, although most cases are reviewed at intervals, there are a number of cases where no further review action is proposed. The Department are considering the possibility of contacting these as well as all other customers at regular intervals. Trials of the Keeping in Touch initiative, in which a small number of Incapacity Benefit customers were contacted by personal advisers, took place in 2000, and the Department expect to roll out the initiative across the whole of the United Kingdom.

Appendix 8

Improvements to attendance scheduling

The Department and SEMA Group have piloted improved procedures since 1998 but these have not been introduced nationally

The Department and SEMA Group have piloted in many areas improved procedures for more efficient scheduling of appointments. Some of these pilots have been ongoing since 1998, but have not been introduced nationally. One such pilot involves a number of SEMA Group's examination centres managing their appointment scheduling locally, using scheduling software on dedicated personal computers, as opposed to the normal practice of appointment schedules being produced centrally by regional Medical Services Centres, and faxed to examination centres. Staff in examination centres used local knowledge of transport arrangements to bring in substitutes for cancelled appointments.

The pilot has been successful in reducing the number of lost examination slots, but has not been introduced nationally. It would require the provision of personal computers to all examination centres. The Springboard Project, which will enable Medical Services Centres to communicate electronically and to redistribute peaks and troughs in appointments is currently being introduced, and it may obviate the need for some local initiatives.

Research carried out at Bootle Medical Services Centre in conjunction with the Benefits Agency district office suggests that one reason why customers fail to attend is due to appointment letters being sent to incorrect addresses. This can arise if the district office fails to notify SEMA Group of a change of address, or if SEMA Group fail to record such changes when notified by the district office. Some district offices are now delivering some appointment letters to customers by hand, or informing customers of appointments when they visit the district office to collect order books.

Sutton Examination Centre operates a "front loading" overbooking policy, which invites all extra customers to attend at the start of the morning or afternoon session, rather than at regular intervals throughout the day. This has proved successful in enabling empty slots to be filled immediately, thus reducing the number of customers turned away. Not all examination centres can operate this policy, however, as the size of waiting rooms is a limiting factor, and many customers arrive accompanied by a relative or friend. There is also a risk that if more customers attend than expected, this could badly affect waiting times.

More flexible deployment of doctors can also help. When examination centres are located in the same building as full-time doctors carrying out other work the latter can assist if more customers attend for examination than expected. This "sweeper system" depends on the willingness of full-time doctors to undertake this work, however, and we saw indications that this is not always given. SEMA Group have also piloted a scheme which encourages fee-paid doctors to stay on after their session for an additional fee in order that more customers can be seen on the day of their appointment. This has met with limited success, as many fee-paid doctors have their own prearranged surgeries to attend and are unable to stay late.

SEMA Group have found that the use of an extra doctor at some centres has assisted in reducing the numbers of claimants turned away unseen. SEMA Group are sharing details of such successes across all their centres, and targeting inner city areas where the problem is worse, owing to the larger proportion of the population being transient or mentally unwell, with more unpredictable attendance patterns.

There is scope to learn from good practice in other sectors

There is still scope to learn from good practice in attendance scheduling in other areas. At present the first that customers know about a forthcoming medical examination is when a letter arrives from SEMA Group, stating that they have been booked to attend at a particular date, often with just one week's notice. (The contract specifies at least seven days' notice for all but a few smaller benefits, which require at least ten days' notice, periods which are currently required by legislation). Asking customers to contact Medical Services Centres, by telephone where possible, to agree mutually convenient dates for appointments may result in fewer cases of non-attendance.

The National Health Service are developing a new on-line appointments booking system in which general practitioners may book outpatient appointments from their surgeries while patients are present, taking account of their patients' availability and preferences. Patients are now being asked to bring their diaries to general practitioners' surgeries and to hospital consultations. The Health Service have also piloted a partial booking system for outpatients in which the general practitioner referral letter is acknowledged to the patient by the consultant, indicating the likely waiting time. About four weeks before appointments, the hospital writes to

patients asking them to telephone the hospital to agree a mutually convenient date for their consultation. Use of the partial booking systems has reduced waiting times by up to 40 per cent, and reduced the non-attendance rate from the national average of 11 per cent to between four and six per cent.

Alternative approaches to scheduling appointments should be considered

Our survey of health insurance companies supported the key message that customers should be consulted about the time of their appointments. Customer attendance is less reliable in the early morning than in the afternoon. Since fee-paid doctors are in their own surgeries towards the end of the afternoon, their availability at times customers would like to see them is limited. Doctors' representatives we spoke to have suggested that customers should be given the option to attend the general practice surgeries of fee-paid doctors for examinations. This would provide more convenient times for many customers, reduce accommodation constraints, and offer a wider choice of locations potentially nearer to customers' homes. The use of other health care professionals such as nurses could also extend the options for customers to attend examinations later in the day.

Appendix 9

The Social Security Select Committee's report on Medical Services¹

Recommendations and conclusions of the Committee (HC 183 published 12 April 2000)

Time spent with claimants

- (a) We recommend that no reduction in average times spent examining claimants should be allowed to occur, unless hard proof can be deployed to show that there has been a genuine increase in claimant satisfaction. We are sceptical that the two can occur simultaneously. We also recommend the present duration of examinations be monitored by the Medical Quality Surveillance Group to ensure that they are sufficient to enable the doctors to produce accurate reports without being under pressure of time.

Inaccurate or distorted recording of information

- (b) We recommend that Medical Services design and implement a system of recruitment, training and monitoring that ensures that its doctors can perform the fundamental task of information recording to an accurate standard. Action should be taken to dismiss those doctors who consistently fail to attain the necessary standard.

Legibility of reports

- (c) We agree [with those who raised the matter in their evidence] that illegible reports are unacceptable.

Training in customer care

- (d) We recommend that Medical Services has a dedicated training course in customer care for all new doctors, and that customer care issues also run as a 'golden thread' through all other training. There should be regular refresher training in customer care issues, delivered on an annual basis as a minimum, and such training should be assessed to ensure its effectiveness.

Dealing with poor performance

- (e) We recommend that Medical Services review their procedures for identifying and dealing with underperforming doctors and report back to the Chief Medical Adviser on these procedures.

Treatment of claimants: overall conclusion

- (f) We recommend that Medical Services and the Benefits Agency take urgent steps to achieve better treatment of claimants: present performance is not acceptable.

Claimants with mental health problems

- (g) We support the recommendation of Mind, that there be better training on [mental health] issues for all Examining Medical Practitioners [EMPs] and that there should be some specialist resource within Medical Services, which could help provide such training, and also see claimants in cases which were particularly complex.
- (h) We recommend that the Chief Medical Adviser instigates a review of Medical Services' treatment of claimants with mental health problems, covering time spent with claimants, doctors' expertise, the ability of the system to assess accurately the nature of mental health problems, to assess how the system could be improved and, in particular, what scope there is for reducing distress caused to claimants. We would expect to see the outcome of such a review in due course.

Claimants from ethnic minority groups: interpretation services

- (i) It is of the utmost importance that claimants whose first language is not English are able to communicate effectively with EMPs. All claimants must be told clearly in their first correspondence from Medical Services that they have the right to request the presence of an interpreter if they so wish. Such correspondence should include a multi-lingual notice inviting claimants to contact the centre if they cannot read the letter. We look forward to speedy action in this area.

Claimants from ethnic minority groups: cultural insensitivity

- (j) We recommend that doctors who demonstrate cultural insensitivity should receive immediate remedial training and have their subsequent performance monitored. Those doctors failing to improve their performance after such action has been taken should be dismissed.
- (k) We believe that Medical Services could be laying itself open to the charge of institutional racism in two ways: in failing to train adequately doctors in issues of cultural awareness; and in failing to make claimants aware that they may request the service of an interpreter. We expect it to address both issues as a matter of priority. We recommend two further steps: that Medical Services monitor the service received by claimants from ethnic minority groups through targeted surveys and other means; and that the Commission for Racial Equality be invited to review the work of Medical Services in relation to its treatment of claimants from ethnic minority groups.

¹ The name "Medical Services" as used in this Appendix is equivalent to "SEMA Group" as used in the rest of the report

- (l) It is unfortunate that doctors have made inappropriate references to claimants' ethnic origins in reports, and it is clear why this has given offence. What is perhaps more worrying, is the suggestion that, despite undertakings having been made, effective guidelines and training on this issue had not been given. We appreciate that the undertakings were given at the time that the Benefits Agency had responsibility for the service. Now that Medical Services is SEMA-run, we expect robust guidelines to be followed by all doctors, and the necessary training to be provided to help them do so.

Female claimants

- (m) We recommend that the availability of an examination by a female doctor should be spelt out clearly in the initial letters sent by Medical Services to claimants.

Complaints

- (n) We are concerned that, because of the perceived failure of the complaints system, many claimants are choosing to appeal, rather than to complain. We note that SEMA have recognised a problem with their complaints procedures and are conducting a review, which we welcome. We would expect to see the results of the review and we expect the Department to monitor performance in this area and push very hard for improvements to be made. At the very least we expect that details of how to complain should be drawn to the attention of each individual undergoing an examination, wherever the examination takes place.

Customer satisfaction surveys

- (o) We recommend that a proportion of customer surveys are conducted with claimants after they have seen the EMPs' reports.

Complaints and customer satisfaction: overall conclusion

- (p) Changes to the system [of complaints and monitoring customer satisfaction] are required; allied to those more minor ones we recommend in relation to customer surveys, an improved system of customer feedback will give Medical Services indispensable information which they must use to help draw up the improvements we hope to see in their service.

Appeals

- (q) We note that the Chief Medical Adviser and Dr Carol Hudson of Medical Services intend to hold regular meetings with the Appeals Service to discuss issues coming through on Appeal. We welcome this.

Appeals: EMPs' access to other medical evidence

- (r) We appreciate that allowing EMPs greater access to other medical information relating to claimants would have resource implications. However, we think it would also help raise the quality of reports produced and lower the number of successful appeals. We therefore

recommend that Medical Services and the Benefits Agency explore ways in which such records can more frequently and readily be made available to EMPs. One alternative might be for EMPs to be able to request medical records in DLA/AA cases. This might provide more accurate case histories and could also prove to be more cost-effective.

Appeals: use of feedback

- (s) We think that as a matter of quality control, SEMA should be made aware if a significant proportion of successful appeals can be related to cases where particular doctors have provided the medical report.
- (t) We recommend that individual Medical Services doctors should be informed of the outcome of appeals where the Tribunal has chosen not to endorse that doctor's findings. Furthermore, we recommend that Medical Services monitor this feedback and take appropriate action where individual doctors have a higher than average proportion of such cases.

Sessional doctors sitting on Tribunals

- (u) It seems surprising that legal advice has not been taken on the potential incompatibility of the present practice of sessional doctors sitting on Tribunals with the European Convention on Human Rights. We recommend that such advice be taken.

Cases determined by scrutiny and by examination

- (v) We welcome the fact that the Department has now acknowledged that the Committee's concerns regarding the falling number of medical examinations being carried out were justified. However, we remain concerned that there may be structural reasons, relating to the nature of the contract with SEMA Group, why this problem is occurring.
- (w) We recommend that the contract be renegotiated in such a way as to ensure that there can be no question of profits being increased as a result of a policy which could cost the taxpayer millions of pounds through the payment of benefits which should not be made. We further recommend that the Committee of Public Accounts considers inquiring into this matter.

Pressure to see more claimants

- (x) We criticise the approach taken by Medical Services which encourages doctors to produce reports which might be of a lower quality than that which the doctors might want to produce. Interfering with the judgment of medical professionals in this way is not acceptable.
- (y) We recommend that the Benefits Agency and the Department should monitor closely Medical Services' performance in order to ensure that, by increasing claimant numbers per session, profitability is not put before performance.

Financial pressures: conclusions

- (z) As we have noted, the falling number of examinations as compared to cases dealt with by scrutiny, and the increasing numbers of claimants seen per session, lead to the suspicion that standards are coming second to profitability. It would be naive to blame SEMA for trying to make a profit - that is their business. The onus must be on the Benefits Agency and the Department to monitor Medical Services and, if necessary, make contractual renegotiations, in order to ensure that financial pressures do not lead to a lower quality service.

Doctors' pay

- (aa) We recommend that SEMA examines the case for a one-off 'catch-up' increase in payments to doctors to account for the fact that their pay has not increased since 1992. We further recommend that SEMA lays down a timetable for ongoing regular reviews of doctors' pay.

Responsibility for the service

- (bb) We recommend that, in exercising their overall responsibility for the service, Ministers act speedily to remove confusion as to where day-to-day responsibility rests for detailed aspects of the service.

Training

- (cc) As a minimum, we recommend that Medical Services meet their contractual obligations to provide 5 days training to all doctors annually. We deplore the fact that SEMA has failed to meet this contractual obligation to date.

Diploma in Disability Analysis Medicine

- (dd) We recommend that if the Department are serious about achieving a step change in quality in the delivery of Medical Services they should make it a long term objective that all sessional doctors attain it and they should set a timetable in which this will be achieved. There should be a financial incentive available to encourage doctors to undertake the Diploma. The Department should begin to explore funding options to this end.

Performance since contractorisation

- (ee) We recommend that the Benefits Agency explores the reasons why decision makers appear to demand reworked cases so infrequently and makes systemic reforms to ensure that unsatisfactory reports are never accepted.
- (ff) We recommend that the sample of reports audited be larger, especially for IB cases, and that the audit be carried out by an outside body, so as to increase confidence that it is an independent and objective exercise.
- (gg) The Committee has not been convinced that there has been an improvement in the quality of examinations and reports since contractorisation. Some efficiency improvements have been made: the challenge now must be to improve the quality of reports and the treatment of claimants. Given that there is pressure on doctors to see more patients more quickly it is difficult to see how this can be achieved. Ministers should ask themselves whether one of the goals of contractorisation - improved service to the public - has really been achieved. If they conclude, as we do, that it has not, they should take steps to renegotiate the contract, or otherwise influence performance to ensure that this goal is met.

Reply by the Government (Cm 4780 published 27 July 2000)

Introduction

1. The Government is strongly committed to improving the standards of service to benefit claimants. Prior to 1998 it was recognised that the standards of service and medical quality delivered by Benefits Agency Medical Services [BAMS] in many respects fell far short of those expected by the Department of Social Security and by people making claims for social security benefits. National standards in professional performance and medical quality were wanting. Training of doctors was uncoordinated and failed to assure consistent achievement of appropriate examination skills. Fewer service levels had been agreed, and measurement of their achievement was less robust.
2. The Government chose the option of contracting out because it believes that the public is entitled to good quality public services. What matters is what works. The service needed improvement and it was decided to engage SEMA Group UK. As the Committee has pointed out, there have been some significant improvements in service delivery. This is illustrated, for instance, in:
 - IT investment to provide comprehensive monitoring and reporting systems, providing detailed management information about all aspects of service delivery;
 - Improvement in turnaround times for clearing advice and examination cases;
 - The development of protocols to ensure that medical advice is evidence-based.
3. Nevertheless, the Government is determined to see significant improvements in the service. Measures of medical quality have not yet revealed significant improvements in the delivery of Medical Services' and the required quantum of training for Examining Medical Practitioners (EMPs) and other fee paid doctors has not been delivered.
4. Improvements in medical quality should be secured under a contract which also delivers the best value for money and ensures that Medical Services achieve these improvements. The majority of Medical Services' doctors already provide high quality medical assessments, but the Government is concerned that in too many instances this is not the case. Firm action has already been taken to identify bad practice, to provide retraining where possible and to dispense with a doctor's services where there is persistently poor performance.
5. The Government acknowledges the challenges posed in devising and applying valid measures of medical quality, a task which confronts the medical profession in general. Initiatives implemented to address the issues raised by the Committee include improved handling of complaints, and closer monitoring of standards which must be achieved. Details of these, and other initiatives, are described in the responses to the Committee's recommendations.
6. In drawing up rigorous and robust standards the Government insists that the following quality principles must underpin all of Medical Services' work:
 - Professional advice is correct, complete, evidence-based and impartial;
 - Benefit claimants are dealt with fairly and courteously;
 - Systems are in place to continually reduce error; and
 - Errors are dealt with promptly and efficiently and lessons are learned.
7. To assess compliance with these principles the Government has decided to set the following targets by which tangible improvements in service, to achieve contracted medical quality standards, will be judged:
 - Within six months to reduce the proportion of C-grade medical reports which fail to meet the Department's standards by 10%; and within one year to reduce the proportion of C-grade reports across all benefits to less than 5%;
 - Within one year to demonstrate improvement in compliance with the agreed medical scrutiny guidelines for Incapacity Benefit claims so that the proportion of non-compliant reports is less than 5%.
 - Within one year to deliver training to all doctors covering the assessment of people with mental health problems; behaviours, attitudes and sensitivities for dealing with people with disabilities; and distress avoidance techniques for the examination of people with musculo-skeletal conditions;
 - Within two years to improve customer satisfaction rates to at least 90%.

We expect Medical Services to deliver these targets. If not, further action will be taken.

The Government's reply also included detailed responses to the Committee's recommendations.

Glossary of terms

Attendance Allowance	A non-contributory, non-means-tested benefit for people over state retirement age who require frequent attention or continual supervision as a result of mental or physical disability.
Capability Report	A report produced by a SEMA Group doctor for use by the Employment Service, regarding an Incapacity Benefit customer's capacity for work.
Chief Adjudication Officer	Prior to 29 November 1999 this officer headed the Central Adjudication Services, an independent statutory body responsible for reporting on decision-making standards in the Benefits Agency and Employment Service. The role was abolished after this date and responsibility for decision-making standards transferred to Agency Chief Executives.
Chief Medical Adviser	The senior accountable officer to the Department of Social Security on all benefit-related medical issues. He has overall accountability for medical quality standards of doctors working for or on behalf of the Department of Social Security.
Customer	A person claiming, or already in receipt of, a benefit or pension.
Cut-over	The transfer of responsibility for the delivery of medical services from the Benefits Agency to SEMA Group UK, which took place on 1 September 1998.
Decision-maker	A Benefits Agency civil servant who decides on entitlement of customers to a benefit. The decision-maker may make use of medical evidence in making the decision.
Disability Living Allowance	A non-contributory, non-means-tested benefit designed to cover the additional living costs associated with disability, for people under state retirement age. It has two components, covering the extra costs of care, and of mobility. Some customers are entitled to use the mobility component to lease a vehicle from the Motability scheme.
Examining Medical Practitioner	A SEMA Group doctor who usually examines a benefit customer at the customer's home.
Incapacity Benefit	The main benefit for people under state pension age who are not in employment and who meet a threshold of incapacity for work.
Industrial Injuries Scheme Benefits	A range of benefits paid to compensate for inability to work or reduced earnings owing to a personal injury sustained in the course of employment.

Invalidity Benefit	A benefit for those unable to work because of illness. It was abolished on the introduction of Incapacity Benefit in 1995.
New Deal for the Disabled	A joint initiative by the Department of Social Security and the Department for Education and Employment providing training and help for disabled people to find work.
ONE	An initiative bringing together employment and benefit services at a single point of contact for the customer, and providing a personal adviser to help them return to work.
Personal Capability Assessment	An assessment by a SEMA Group doctor of an Incapacity Benefit customer's capacity for work, for use by a Benefits Agency decision-maker. The assessment may involve a review of written evidence by the doctor or an examination of the customer.
Public Sector Comparator	An evaluation of the costs and benefits of managing an activity within the public sector, which can be used for comparison with options for outsourcing or privatisation.
Scrutiny	An assessment by a SEMA doctor of an Incapacity Benefit case on the basis of paperwork only, rather than by physical examination of the customer.
Service credit	A sum payable by the contractor (SEMA Group) for failure to meet contractual performance targets.
Severe Disablement Allowance	A non-contributory benefit for people below state pension age who are incapable of work, and are assessed as suffering from 80 per cent disablement or more.
Transition	The period between 1 March and 31 August 1998, during which new management arrangements were put in place ready for transfer of responsibility to SEMA Group UK in September 1998.
Tribunal	An independent, locally-based panel which hears appeals by customers against decisions on entitlement.
User	A civil servant (usually a decision-maker) in the Benefits Agency or other agency who makes use of a SEMA doctor's report.