The Medical Assessment of Incapacity and Disability Benefits

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL
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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.

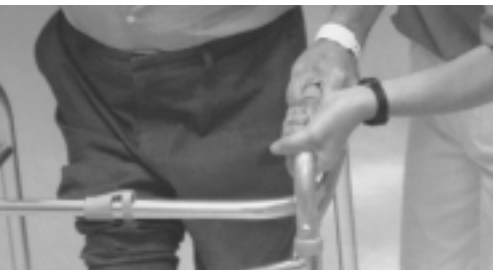
3 Following competition the Department awarded SEMA Group contracts totalling £305 million to deliver the service for at least five years. Though two of the five bidders withdrew there was still competition for two of the three regional contracts, and for the third the lack of competition did not result 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.

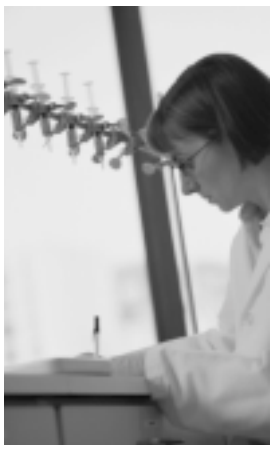
13 When outsourcing, the Department aimed to make medical assessment more efficient and to avoid the risk of over or under examination by better targeting of physical examinations and paper scrutinies of cases. They introduced new guidelines for doctors to reduce unnecessary examinations by more clearly

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 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.