



House of Commons

Committee of Public Accounts

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# **Progress in improving the medical assessment of incapacity and disability benefits**

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**Sixteenth Report of  
Session 2003–04**





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**Sixteenth Report of  
Session 2003–04**

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

*Ordered by The House of Commons  
to be printed 15 March 2004*

**HC 120**

Published on 1 April 2004  
by authority of the House of Commons  
London: The Stationery Office Limited  
£0.00

## The Committee of Public Accounts

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The following was also a member of the Committee during the period of this inquiry.

Mr Nick Gibb MP (*Conservative, Bognor Regis and Littlehampton*)

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Powers of the Committee of Public Accounts are set out in House of Commons Standing Orders, principally in SO No 148. These are available on the Internet via [www.parliament.uk](http://www.parliament.uk).

### Publications

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### Committee staff

The current staff of the Committee is Nick Wright (Clerk), Christine Randall (Committee Assistant), Leslie Young (Committee Assistant), and Ronnie Jefferson (Secretary).

### Contacts

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

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## Summary

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Incapacity and disability benefits costing over £18 billion a year are paid to some of the most vulnerable members of society. Part of the test of eligibility for these benefits is a medical assessment. Some of the evidence for these assessments is provided by claimants' own doctors, but over 1 million medical reports a year are provided under contract by Schlumberger Medical Services. In 1998, the Department for Work and Pensions contracted with SEMA Group to provide this service.

In 2001, we took evidence on the service, and found that bottlenecks throughout the system were resulting in delays in paying some benefits and continued payment to people who were no longer eligible, and a highly variable quality of service to claimants. Our subsequent Report<sup>1</sup> (27<sup>th</sup> Report of Session 2001–02) expected improvements in the speed of benefit processing, the quality of medical evidence and the quality of service to the public.

In April 2001, SEMA were subject to an agreed takeover by Schlumberger to form SchlumbergerSema (Schlumberger from 2003). The Department extended the contract from August 2003, when it was due to expire, to 2005, provided Schlumberger could demonstrate service improvements. The Department and Schlumberger introduced new contractual targets. The Department is due to let a new contract in August 2005.

On the basis of a Report by the Comptroller and Auditor General,<sup>2</sup> we took evidence from the Department on the extent to which performance had improved since 2001, and whether the Department and Schlumberger could carry out medical assessments more efficiently. We examined the quality of medical evidence in the light of the continuing high numbers of successful appeals for these benefits, and whether improvements had been made in the standards of customer care.

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1 27<sup>th</sup> Report from the Committee of Public Accounts, *The medical assessment of incapacity and disability benefits* (HC 682, Session 2001–02)

2 C&AG's Report, *Progress in improving the medical assessment of incapacity and disability benefits* (HC 1141, 2002–03)

## Conclusions and recommendations

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1. **Since 2001 performance has improved in many aspects of medical assessment.** The Department has taken action in relation to all of our earlier recommendations. New performance targets have been set and met, or are on track to be met. Schlumberger has halved the number of substandard medical reports and the number of complaints against them has reduced steadily. In some areas, our recommendations have been implemented but have not yet fed through into service improvements.
2. **The Department has improved the time taken to process medically-assessed benefits, but performance in poorer offices needs to be brought up to the standard of the best.** For Incapacity Benefit, the backlog of examinations, which had reached 368,000 cases in 2001, has almost been eliminated, saving the taxpayer £29 million in payments to those no longer eligible for benefit. For Disability Living Allowance and Attendance Allowance, improved processing times means that in 2002–03 customers received their benefit on average 5–6 days earlier than in 2000–01, but there is still a 25% difference between the best and worst offices.
3. **Pilot Incapacity Benefit reforms have led to further reductions in the time taken to carry out examinations. The Department should make these levels the norm.** Schlumberger have reduced the average time taken to carry out medical examinations from 52 days to 30 days, which has contributed to an annual cost saving of £21 million. On the basis of evidence from Incapacity Benefit reform pilots, the Department consider it is possible to reduce this further to 15 days, which would result in further financial savings as ineligible customers are identified quicker.
4. **The Department should determine the unit cost of processing benefit claims to improve its management of the decision-making process.** The Department cannot allocate and manage resources efficiently without knowing the full cost of assessing medical benefits.
5. **The re-tendering of the medical services contract should be used to seek further service improvements and more innovative ways of delivering medical services.** The Department needs to encourage bidders to make better use of information technology and to gather medical evidence more effectively from a range of sources. Investment in improving IT systems should be a criterion for selecting the winning contractor.
6. **The Department should assess the risk that a significant proportion of decisions are incorrectly overturned at appeal.** If so the Department will need to improve the training of appeals tribunal doctors and provide for more systematic review of their work.
7. **It is difficult to see how doctors and decision-makers can improve their performance if they do not know the outcomes of the cases they examine.** In our report *Getting it right, putting it right: Improving decision-making and appeals in*

*social security benefits*<sup>3</sup> we highlighted the error rate of nearly 50% for Disability Living Allowance decisions. The Department should:

- provide regular feedback on decisions reached and on the results of appeals;
  - speed up implementation of systems to improve the quality of medical evidence; and
  - look again at the standards used to assess the adequacy of medical reports and consider whether they should be raised, or the contractor set a more demanding target.
8. **The calibre of the doctors conducting examinations is crucial and the Department and its contractor should enforce rigorous standards.** The Department should act swiftly to identify and, where necessary, remove those who fail to reach the necessary standards of care.
  9. **The Department must understand better the causes of non-attendance and introduce measures to address them.** The Department has put in place measures to deter non-attendance, but not all non-attenders are deliberately avoiding an examination. The Department and Schlumberger should identify and deal with those who are avoiding examination. But they should also make it easier for others to attend by for example, rethinking where examinations take place and improving the accessibility of medical examination centres.
  10. **Improvements should be made to medical assessments for specific groups, such as those with mental health problems.** There is evidence that people with mental health problems experience greater than average difficulties in attending examinations, being assessed and getting a fair hearing. The contractor's doctors should be trained to recognise and deal with customers with mental health problems.

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3 12<sup>th</sup> Report from the Committee of Public Accounts, *Getting it right, putting it right: improving decision-making and appeals in social security benefits* (HC 406, Session 2003–04)



# 1 Improving the medical assessment process

1. Since 1998 the Department for Work and Pensions has contracted for the supply of medical services. The Committee reported on performance under the contract in 2002.<sup>4</sup> Following the agreed take-over of the then contractor, SEMA Group by Schlumberger in 2001, the Department offered to extend the contract—due to expire in 2003—to 2005 as an incentive to deliver service improvements. The extension amended the contract to introduce new targets for customer service, the throughput and adequacy of medical reports, and the recruitment, retention and skills of the doctors employed. These targets were met by April 2002, and go some way towards meeting the recommendations from our previous report. **Figure 1** summarises progress.<sup>5</sup>

**Figure 1: Summary of progress against the Committee's recommendations**

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

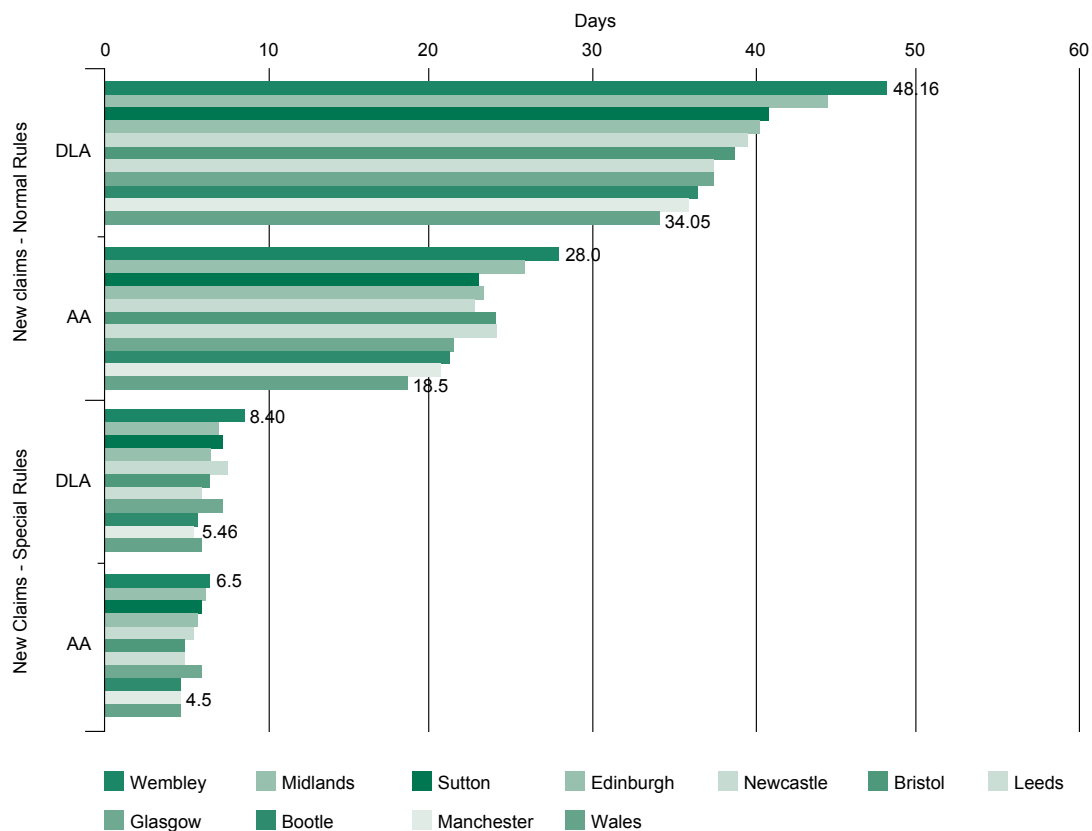
4 27<sup>th</sup> Report from the Committee of Public Accounts, *The medical assessment of incapacity and disability benefits* (HC 683, Session 2001–02)

5 C&AG's Report, paras 1.13–1.14, Figure 3

2. Disability Living Allowance and Attendance Allowance are administered by the Disability and Carers Service from 11 regional centres. Since early 2000, there has been a steady improvement in processing times for these benefits, which meant that in 2002–03 customers under the normal rules of the benefits received cash on average 5–6 days earlier than in 2000–01. The Department consider some further marginal improvement possible without jeopardising quality. It had set and achieved targets for narrowing the gap in average processing times between the best and worst performing offices, but in 2002–03 this still ranged from 34 to 48 days for Disability Living Allowance (**Figure 2**).<sup>6</sup>

**Figure 2: Variation in clearance times between Disability Benefits Centres**

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



Source: C&AG's Report, Figure 6

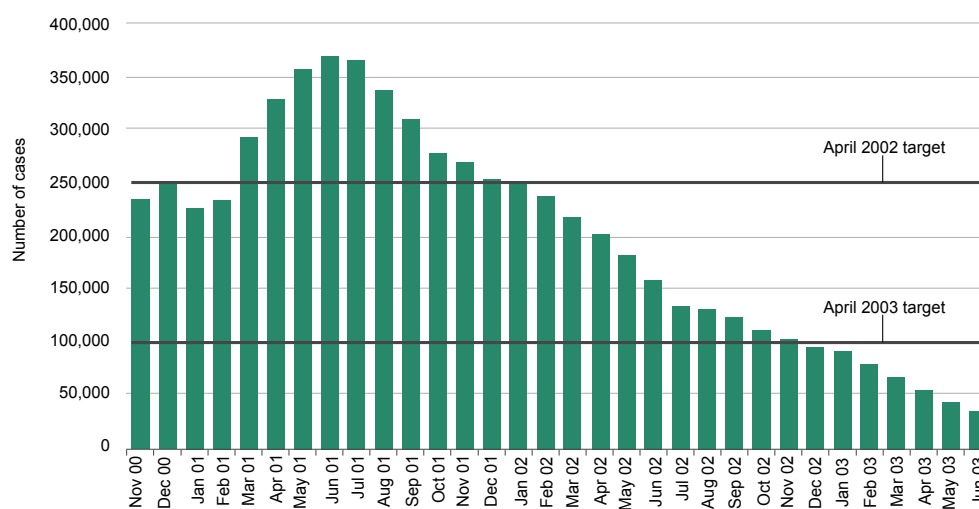
3. Incapacity Benefit customers meeting basic eligibility criteria are paid benefit immediately, but have a medical examination periodically to determine they are still incapable of work. At the time of our previous report, there was a large backlog of such examinations, which grew to 368,000 by June 2001. This has almost been eliminated (**Figure 3**), with a resultant saving to the taxpayer of some £29 million through withdrawing benefit from ineligible customers. The Department and Schlumberger have also substantially reduced the time they take to process these assessments—from 52 to 30 days to complete the examination and from 27 to 15 days to make a decision on entitlement. This has saved a further £21 million a year.<sup>7</sup>

<sup>6</sup> C&AG's Report, paras 2.2, 2.5–2.6; Q 1

<sup>7</sup> C&AG's Report, paras 2.9–2.12

4. Following the Green Paper *Pathways to Work*, from October 2003 the Department began to pilot reforms to the administration of Incapacity Benefit in Bridgend, Renfrewshire and Derbyshire. These are to assist people to return to work more quickly, and involve the completion of a capability report on claimants as well as the current medical assessment. The Department said early results were positive. The revised process also involves an earlier medical examination, and Schlumberger is trialling completion of these in 15 days, compared to the current average of 30 days. For this to become the norm would require changes to the organisation of assessments, but it could realise further substantial savings.<sup>8</sup>

**Figure 3: Progress in reducing the backlog of Incapacity Benefit cases**



Source: C&AG's Report, Figure 8

5. The Department pays Schlumberger about £80 million a year under the Medical Services contract. However, this is not the full cost of administering the £18 billion annual expenditure on incapacity and disability benefits. The costs to the Department, as well as managing the contract, include the costs of decision-making, paying benefits, and checking accuracy, as well as the cost of dealing with 140,000 appeals a year. The Department was unable to tell us the value of this activity because they have no unit costing system. An organisation paying out billions of pounds in routine transactions to millions of people must know the costs of these activities and in the absence of unit costing it is difficult to see how it can judge the efficiency of its operations or make sensible decisions about allocating and deploying resources.<sup>9</sup>

6. The Department is due to let a new contract in August 2005 and intends to put into practice lessons from five years of operating the current contract. As part of the tendering process, bidders are to be asked to make their own suggestions about how service delivery can be improved. The Department is looking for innovation in four areas: better use of information technology especially in developing electronic interfaces with the Department, more flexible use of accommodation, wider use of other healthcare professionals and redesign of existing processes.<sup>10</sup>

8 Qq 8–11, 42–44

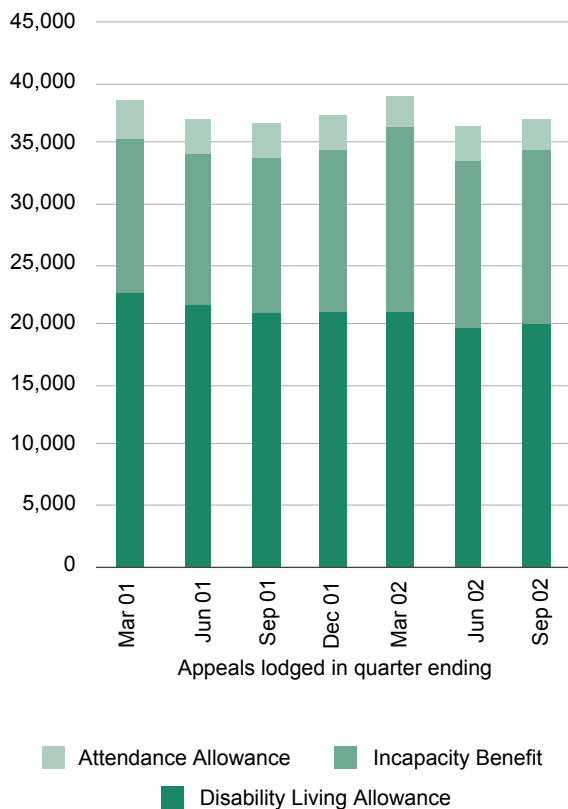
9 Qq 65–66, 126–130

10 Q 131; Ev 17–18

## 2 Improving the appeals process and the quality of medical decisions

7. Medical assessments are a key part of the benefit decision-making process, but there remain cases where poor decisions are made following apparently rushed or inadequate medical examinations. That these are not isolated cases is illustrated by the level of appeals, which for incapacity and disability benefit decisions has not changed significantly since 2001 (**Figure 4**). Of these, the number of successful appeals is still over 40% for each of these benefits. The President of the Appeals Service reported to the Secretary of State that in a sample of about 700 cases, tribunals considered the medical report had underestimated the appellant's disability in a third of cases.<sup>11</sup>

**Figure 4: Number of appeals lodged against incapacity and disability benefit decisions**



Source: C&AG's Report, Figure 10

8. Whilst requiring judgement, it is important that there is consistency in the decision-making process. The Department's Chief Medical Officer told us he had re-examined a sample of cases, and disagreed with the tribunal's assessment in about half. This did not necessarily mean the tribunal's decision was wrong, as tribunals identified other contributory factors in their decisions, and the medical member's opinion might not be decisive. Furthermore, these findings are based on small samples of the total number of appeals.<sup>12</sup>

11 C&AG's Report, para 3.2, Figure 11

12 Qq 20–25, 95–103

9. However, if decisions are being overturned incorrectly at appeal, there could be serious financial implications. For Incapacity Benefit alone, the cost of extra benefit payments could be some £1.5 to £2 million a year if the Chief Medical Officer's figures were representative of all cases. The Department pointed out that Schlumberger doctors have more experience dealing with disability benefit cases and receive more training than the doctors who serve on tribunals. If the Department is losing money through incorrect tribunal decisions, there is a case for more investment in the selection and training of tribunal doctors, and for more systematic review of their work.<sup>13</sup>

10. The number of substandard reports has halved since 2000 as measured by the Department's quality control processes. Based on a sample of cases, the number of reports graded at 'C' fell to below 2% in May 2002, but has subsequently risen slightly. The improvement has been achieved by the Department setting more stringent targets and by more active monitoring by Schlumberger of doctors' performance. There has nevertheless been no impact on the quality of decisions as indicated by the number of successful appeals against them, which suggests that the standard against which they are assessed may be too low, or that the target should be tightened.<sup>14</sup>

11. The Department told us doctors received feedback if their reports were below standard, but there was no process for feeding the results of decisions back to doctors, or the results of appeals to decision-makers or doctors. It would require major systems development for this to happen routinely. The Department is organising meetings between regional appeals chairmen, medical representatives and decision-makers to identify trends, but the results need to reach those making assessments much more frequently to have an impact on quality.<sup>15</sup>

12. Some improvements to medical evidence are still to be implemented, including in response to our previous recommendations. These were being piloted at the time of the Comptroller and Auditor General's Report. The Department told us that their evidence based medicine system would not be rolled out until June 2004, and they were only now revising claim forms to make it clearer to customers what medical evidence is needed. Improved processes for recruiting and monitoring the performance of doctors have only recently started to have an effect—for instance, most cases of doctors being removed from the register are recent. It is too soon for these developments to have resulted in improved decisions as measured by the proportion of decisions overturned on appeal.<sup>16</sup>

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13 Qq 23, 95–99; Ev 16

14 Qq 29–34; Ev 15–16

15 Qq 2–4, 94

16 C&AG's Report, paras 3.14–3.21; Qq 5, 51–56, 104–105

### 3 Ensuring high standards of customer care

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13. One area where the Department have made little improvement in performance since our last report is in sending customers away from appointments unseen. In 2002–03 this was still happening to over 3% of customers called for examination—some 15,000 a year. This can be a distressing experience. The most common reason is overbooking of appointments to cover the appointment time wasted when customers fail to attend. Measures to improve the efficiency of appointment booking have not made much impact on non-attendance, and some 20% to 25% of those asked to attend Incapacity Benefit examinations fail to do so. One Medical Examination Centre told the NAO that they over-booked by 21% to allow for non-attenders.<sup>17</sup>

14. The Department's procedures may not work well either in treating fairly those who genuinely cannot attend appointments, or in dealing with those who deliberately do not turn up. People may not be able to attend for a number of reasons. Clearly some claimants do not attend because they think their benefit will be withdrawn. The Department and Schlumberger explained the procedure by which appointments are made and those who do not attend are followed up. But they recognised that people who wished to take advantage of the system could probably give a reasonable explanation for non-attendance. On the other hand, there have been instances where benefits were withdrawn despite people giving notification.<sup>18</sup>

15. The level of complaints against Schlumberger has fallen steadily since our last report, and the Department reports that customer satisfaction levels are high. Schlumberger agreed that doctors' attitude toward the customer were important, and not just their medical knowledge. Recruiting doctors of sufficient calibre was a challenge, and although Schlumberger had appointed 100 new full-time doctors since 2001, there were still shortages in the North-West of England, North Wales and West Yorkshire.<sup>19</sup>

16. The Department and Schlumberger assured us that they now had rigorous processes for selecting and training doctors and for monitoring the quality of their work. These took into account the number of substandard reports, the number of reports returned by the Department for rework, complaints, and training attended. If remedial action, such as training and closer supervision, did not work, the Department would revoke its approval for doctors to carry out examinations. This had been done in 80 cases since 2000, of which 52 were in the last year. The Department would also pursue serious cases through the General Medical Council, although in fact only one doctor had been reported to the Council because of alleged conduct in the course of Medical Services work.<sup>20</sup>

17. A particular issue is the treatment of people with mental health problems, who are more likely to have difficulties attending examinations. Conclusions may be drawn which are not supported by examination evidence, and problems may not be fully understood by, or discussed with, the doctor. Schlumberger told us that new protocols developed under the

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17 C&AG's Report, paras 4.5–4.10

18 Qq 6–7, 46–48

19 C&AG's Report, paras 2.14, 4.19, Figure 18; Qq 12–16

20 Qq 19, 26, 35–39, 49–60, 83–87; C&AG's Report, para 3.14; Ev 14–15

Evidence Based Medicine system and improved training would help doctors to understand the impact of these conditions on people's lives. They were looking at ways of communicating more effectively with this group and were seeking advice from disability organisations about improving their training techniques.<sup>21</sup>

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21 C&AG's Report, paras 4.12, 4.15; Q 45

## Formal minutes

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**Monday 15 March 2004**

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon  
Mr Frank Field

Mr Brian Jenkins  
Jon Trickett

The Committee deliberated.

Draft Report (Progress in improving the medical assessment of incapacity and disability benefits), proposed by the Chairman, brought up and read.

*Ordered*, That the Chairman's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 17 read and agreed to.

Conclusions and recommendations read and agreed to.

Summary read and agreed to.

*Resolved*, That the Report be the Sixteenth Report of the Committee to the House.

*Ordered*, That the Chairman do make the Report to the House.

*Ordered*, That the provisions of Standing Order No. 134 (Select Committees (Reports)) be applied to the Report.

Adjourned until Wednesday 17 March at 3.30 pm

## Witnesses

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**Wednesday 10 December 2003**

*Page*

**Mr David Anderson, Professor Mansel Aylward CB, Mr John Sumner,**  
Department for Work and Pensions, and **Mr Simon Chipperfield,**  
SchlumbergerSema

Ev 1

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Jobcentre Plus

Ev 14

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Twelfth Report	Getting it right, putting it right: Improving decision-making and appeals in social security benefits	HC 406
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Fifteenth Report	Procurement of vaccines by the Department of Health	HC 429
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The reference number of the Treasury Minute to each Report will be printed in brackets after the HC printing number