Northern Ireland Assembly

Committee for Social Development

OFFICIAL REPORT (Hansard)

Medical Assessments — Benefit Eligibility: DSD Briefing

9 May 2013

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Alex Maskey (Chairperson)
Mr Mickey Brady (Deputy Chairperson)
Ms Pam Brown
Mrs Judith Cochrane
Mr Michael Copeland
Mr Sammy Douglas
Mr Mark Durkan
Mr Fra McCann

Witnesses:

Ms Margaret Boyle	Department for Social Development
Mr Paddy Rooney	Department for Social Development

The Chairperson: I welcome Margaret Boyle and Paddy Rooney. You are very welcome. Papers are in members' information packs. I will hand over to Margaret and Paddy to brief the Committee.

Ms Margaret Boyle (Department for Social Development): Mr Chairman and members, thank you for the invitation to brief the Committee on the quality assurance framework, which is in place in the Social Security Agency to maintain the quality of service and support and to promote quality improvement of medical assessments. With me is Paddy Rooney, manager of the employment and support allowance (ESA) centre.

My areas of work include responsibility for the health assessment adviser work programme. As the Committee is aware, Atos Origin Healthcare was appointed in June 2011 to provide medical expertise to support the Social Security Agency in making benefit eligibility decisions on claims for disability living allowance (DLA), employment and support allowance, incapacity benefit and assessment, and industrial injuries disablement benefit. This is the first briefing that the Committee has received on the agency's quality assurance framework, and it provides an opportunity to further develop your understanding of, and confidence in, the independent assurance processes that are in place to ensure that a high standard of quality is achieved in medical assessments. I will start by briefly outlining the role of the health assessment adviser and the development of the quality assurance framework. I will then outline the main components of the framework and the outcomes to date.

The heath assessment adviser is a medical health professional, whose role is to provide independent assurance of the quality of the medical processes and outcomes undertaken by the healthcare professionals employed by Atos. A quality assurance framework has been developed and is in place to support that work. The framework has a number of processes that complement one another and

ensure that the medical services provided by Atos are of a high standard and continue to meet the needs of the agency.

At the core of the framework are the audit processes, which consider the expected quality standards laid down in the contract and the work capability assessment guidance. The main components of the framework are quarterly audits of scrutiny: a paper-based process that allows Atos healthcare professionals to advise agency decision-makers whether there is enough evidence to place a customer into benefit without a face-to-face assessment. A sample of face-to-face medical assessment outcomes and formal/informal written advice are provided by the healthcare professionals to decision-makers in the disability living allowance branch.

The quality assurance framework also includes a monthly validation of Atos' s internal audit processes to ensure the standardisation of audit outputs and outcomes, the management and monitoring of medical-based complaints, the review of medical handbooks and guidance, and the ongoing approval of the healthcare professionals employed by Atos. The health assessment adviser is also responsible for assisting in the implementation of medical-based recommendations as part of the work capability assessment review. An example of that was the recommendation to put mental health champions in place.

The quality assurance framework has been in place for the past 12 months and has been reported to the agency's management board on four occasions. In the past 12 months, the health assessment adviser has audited 223 scrutiny cases, 222 face-to-face assessments and 221 formal/informal advice cases. To date, the audits have indicated a high level of compliance with the agreed processes and a high quality of medical assessment. Any issues that have been identified have been of a minor nature and none has been serious enough to affect the outcomes from scrutiny or examinations. Seven monthly validation audits have also been undertaken, which have not identified any inconsistencies with Atos's internal audit processes.

To date, 99 medical-based complaints have been received in the agency; every complaint is thoroughly investigated by the agency and Atos. Examples of issues identified in complaints include queries on the accuracy of the content of the medical report or the approach taken by the examining healthcare professional.

The approval process undertaken by the health assessment adviser ensures that all healthcare professionals receive appropriate training and meet satisfactory standards to enable them to carry out their duties effectively. To date, the health assessment adviser has made 248 approvals, of which 180 were for doctors and 68 for nurses.

The medical process outcome standards that ensure the consistency of medical assessments across all healthcare professionals were agreed with Atos in October 2012. The clinical manager of Atos reports against those as part of the monthly medical equality report. To date, there have been no issues.

The health assessment adviser is responsible for reviewing changes to a range of medical guidance documents provided by Atos to its healthcare professionals. These are aimed at ensuring a consistent standard of assessment and assisting healthcare professionals to maintain their knowledge of medical advances. The health assessment adviser is also responsible for reviewing healthcare professionals' continual professional development and training packages to ensure that they meet business needs. The implementation of the quality assurance framework ensures that standards are maintained and that any medical issues are identified and addressed promptly. Where a problem is identified, it is brought directly to the attention of the medical manager of Atos, who addresses it with the healthcare professional involved, and, if necessary, may provide training or undertake further audits of their medical reports over an agreed period to ensure the quality of the healthcare professional outputs.

In summary, to date, the medical assessments undertaken by Atos Origin Healthcare, on behalf of the Social Security Agency, are considered to be of a good standard. Where an issue arises, there is a robust process to manage it. This has been effective, as there is no evidence of the same issues recurring once they have been addressed. Thank you for your time. Paddy and I are happy to answer any questions that you may have.

The Chairperson: OK, Margaret. Thanks very much for that. Some members have indicated that they wish to speak.

Mr Brady: Thanks very much for the presentation. You said that standards have been agreed. I can give you one example of a case that highlights the problems. A young fella of 19 with Down's syndrome was being migrated across and was sent for an assessment. His mother went instead because he might not have been that capable. You know that the form is a tick-box exercise by the "healthcare professional". The first question that the nurse asked was how long he had the condition. The second question was when she thought he might get better. When it was pointed out that he had Down's syndrome, the lady was told that they were there to ask the questions on the form not to discuss the particulars of his case. That is just one example.

I had another case where a fella broke his foot. I am just highlighting the inconsistencies.

Ms Margaret Boyle: Yes, I understand.

Mr Brady: He broke a number of bones in his foot and attended Musgrave Park Hospital. He was given what is commonly known as a moon boot, which provides compression for the foot and allows you to put your foot on the ground and relieves the pain. When he went for the assessment, he was asked what it was. When he explained it, the nurse in question said that she had never heard of it. She went on to say that a friend of hers had the same injury and was back playing football, which was not necessarily relevant to the particular case. Those are just a couple of examples.

In respect of the healthcare professionals, how many doctors have been contracted by Atos in the North?

Ms Margaret Boyle: How many have been approved?

Mr Brady: How many doctors and nurses have been contracted? The majority in my constituency seem to be —

Ms Margaret Boyle: One hundred and eighty doctors and 68 nurses have been approved to date; that is a total of 248. Within that, there are regular revocations because doctors or nurses may leave or move on to something else. The health assessment adviser also looks at that aspect. In answer to your question, 180 doctors have been contracted to date.

Mr Brady: Professor Harrington is mentioned in your report, and he never got this far.

Ms Margaret Boyle: I can update you on that: Dr Litchfield has taken over that post. Just last week, Paddy and I had a teleconference with him, and we are arranging for him to come across. He has given us dates, and one of the things that he would like to do is meet the Committee as part of his visit.

Mr Brady: He started fairly recently; I think that he was with BT before.

Ms Margaret Boyle: He started just after Easter. In respect of the two cases that you mentioned, the health assessment adviser and Atos look at any cases that are raised with us. I can take a further look at the two cases that you raised. I understand the point that you are making about inconsistencies.

Mr Brady: Those were two stark examples, but there is a trend, and in my experience, having been involved in this area of work for a long time, it seems that, rather than improving, the standard of assessment has got worse. That is borne out by the number of people who have gone through the assessment and have come to our constituency office to raise issues about it without necessarily making a formal complaint. It seems to be an ongoing issue.

Ms Margaret Boyle: The agency wants to know about such cases so that we can look at them. I have explained the audit process that we have gone through — the healthcare professional audit — and no particular issue was raised that we have not dealt with in a particular way. Any complaint is looked at very thoroughly, and there is continual dialogue with Atos on any issues raised.

I appreciate what you said about issues not always being raised as a complaint, but we will look at any issues that are raised.

Mr Brady: I have one or two more points to make. There are paper exercises where decisions are made based on written evidence about a person's condition. Can those be challenged by the decision-maker?

In my experience, having talked to people whose cases I have come across — as have others — the medical evidence that is produced at the assessment is ignored in many instances and is only addressed when a person appeals. The decision-maker, who ultimately makes the decision, cannot make an informed decision based on medical evidence that was available to the assessor. That needs to be addressed.

Mr Paddy Rooney (Department for Social Development): I will pick up on that, Mickey, and explain what we have been doing since the employment and support allowance was introduced in October 2008.

We have been trying to embed a culture among decision-makers of taking all available evidence into account in making a decision; the medical report that we get from Atos is just one aspect of that decision. We will seek further medical evidence from the customer to ensure that we make an informed decision.

Within the past 12 months, we have introduced a pre-disallowance call for people who find themselves in a disallowance position. We will contact customers to tell them about the evidence that we have and what the medical report tells us, and we will ask customers whether they can provide any additional evidence that would allow us to review that decision.

It is a difficult call to make for everyone, because people think that they have sent all the medical evidence in. However, we have seen some success in that, and we have been able to allow cases when we have received the further medical evidence. Recent figures show that, in the past three months, 215 people have sent further medical evidence as a result of the pre-disallowance call, and 55% of those cases ended up with the case being allowed. That was because of medical evidence that we did not have at the outset and which, perhaps, would prevent an appeal.

Mr Brady: The perception, rightly or wrongly, is that the decision-maker bases the decision on the tick-box form. I have had to deal with cases where people brought medical evidence to appeals but were not even questioned because the medical evidence was of such a quality that it immediately prompted the doctor. The doctor is there is to assess the medical evidence that is available without having to continue with the appeal.

That is a big issue that needs to be addressed because there is a huge gap between the person being assessed and the decision-maker. It sometimes seems that the medical evidence is almost left in limbo.

Mr Rooney: I agree with you, Mickey. We have worked hard with customer representative groups such as Citizens Advice and Advice NI, which represent customers at appeals, to encourage them to get medical evidence to us at the very earliest stage. If we have all the medical evidence at the outset of a claim, it is much easier for us to make an informed decision.

Over the past number of years, we have found that there are a number of representatives and advisers who will, reluctantly, provide medical evidence and who will wait until the appeal to provide medical evidence that we have not had an opportunity to review. We are encouraging them to give us the evidence beforehand, because none of us wants to put anyone through the frustration and anxiety of an appeal if they have medical evidence that would allow us to make a decision.

Mr Brady: I think that the primacy of medical evidence is important.

The Chairperson: Before I bring Michael in, I want to raise a couple of points that flow from that. You mention in the paper that the four healthcare professional guides have been gone through. You refer to doctors and nurses, but are there any other professionals, for example, mental health professionals, involved in that?

Fifty-five per cent of decisions being, if not reversed, at least changed seems an extraordinarily high figure.

Mr Rooney: I can give you an update on appeal outcomes for work capability assessments: 65% of decisions are upheld.

The Chairperson: Sorry; you mentioned pre-disallowance calls and the fact that 55% of decisions that were about to be taken were then changed.

Mr Rooney: Absolutely; because we got the medical evidence.

The Chairperson: That is a very high figure; that is the point. The key thing for me to find out is whether, as a result of the auditing process, any specific themes have emerged to explain what caused that, or was it just that you did not have the medical evidence?

Mr Rooney: I mentioned that to highlight the importance of getting medical evidence to us at the earliest stage of the process, as it allows an informed decision to be made.

The Chairperson: You will appreciate that, from day one, that has been the recurring argument, and yet, it still seems to be happening. That is my point. Thank you for elaborating on that.

Mr Copeland: Thank you for your presentation. I will begin by asking you to pass on my most sincere thanks to Denise Fox in the customer services team, without whom, I would have, on occasion, been battering my head off a brick wall.

I want to go through this process step by step, highlighting the things that, in my personal experience, are wrong.

First, is there any marrying of the stated conditions on which the customer is assessed and the medical professional assesses them? Quite often, there is a balance, particularly in employment and support allowance but not so much in disability living allowance, between physical difficulties and mental health difficulties. I know of one particular case involving a survivor of an incident during the Troubles who was in the military and who subsequently lost his wife or partner to suicide. The first thing that was said to him upon entering the assessment was, "By the way, we will not be talking about the person who died because I am not qualified to do that". That did not exactly instil confidence in the process at that stage.

Mickey referred to the tick-box exercise, and I have witnessed that at first hand. I have been to dozens of ESA and DLA appeals, but I had never been to an ESA medical assessment. It was a torturous experience for the individual concerned, whose difficulties were real and apparent, and it was equally torturous for the healthcare professional. The thing that struck me at the start was that — she knew who I was, and I knew who she was — she did not indicate whether she was a nurse or a doctor, what her particular specialities were or whether her areas of expertise could be applied to that female. It was apparent to me that if she had carried out any examination of the medical facts surrounding the case, she would have known that, in the three months since the previous assessment, that individual could not and would not have improved to the degree where there would be a reasonable expectation of a change. To be frank, the process, in my opinion, actually caused her harm; it was distressing. As Mickey said, the healthcare professional essentially asked a quivering, crying, shaking wreck of a human being whether she could do x, y and z. That was distressing for me and the healthcare professional. The result came out OK in the end — fair and dandy — but, in my opinion, the process, in that case, was unnecessary.

We then get to the differential between a support group and a work-related activities group. About a fortnight ago, I took another client who was awarded benefit on the basis of, I think, mental health indicator 15 — the inability to cope with change — and another one about not being able to go out. He was then sent a letter saying that he was required to do work-related activities, which is totally at variance with the nature of the award in the first place. I just do not understand how a logical decision is taken to say that someone who has trouble going out and coping with new situations has to go to the dole every couple of weeks and present himself for work. One overrules the other.

I am also curious to know whether you automatically track the number of decisions found against customers by specific healthcare professionals and the ratio of those won on appeal. There are some people, and forgive me for using the word of the streets, who feel that certain healthcare professionals would find a corpse fit for work. I wonder whether you track to ensure that the thing is being applied fairly.

Ms Margaret Boyle: No; we do not track individuals against outcomes.

Mr Copeland: I suggest that a relatively small number of individuals apply much harsher criteria and perhaps a social judgement. I have seen forms, on which the appeals are based, coming through recently on which the healthcare professional has stated that the customer has said x, y and z, and that, effectively, they do not believe them. That is imparting opinion to a form that is supposed to be a statement of fact, and in my view, that directed the appeal before the case was even heard. I have serious doubts about imparting opinion in a document that is so harshly constricted to be factual.

I have one example, with your indulgence, that happened in an appeal case for DLA. The guy had the closest thing to shell-shock that I have seen in any human being since watching films of the First World War, again due to a terrorist-related incident. Prior to the appeal being heard, I went into the room next door where there was a departmental official. I would normally go and say hello and find out what their take on the situation is, and it was patently obvious to me that whoever had taken the decision to disallow this benefit either had not accessed all the relevant information or had access to it and discounted it. In among the papers was a report from my constituent's GP, which vindicated and substantiated everything that my constituent's claim form said, everything that I said and everything that he said. For some reason, it had not been seen by the decision-maker even though the form was contemporaneous to the date the decision was taken. The appeal lasted, I think, 39 seconds, and the constituent won the claim, so, again, the primacy or even importance of medical evidence from the GP appears to be being downgraded. Decisions are being taken that defy justice, never mind logic. I am sorry for the rant.

Ms Margaret Boyle: The tracking of individuals does not take place at the minute. If there are complaints against an individual healthcare professional, we will look at them.

Mr Copeland: Would that include not just complaints against the healthcare professional, but complaints against the decisions in which a healthcare professional was involved? The two things are slightly different.

Ms Margaret Boyle: Yes. I understand the difference, but there is no monitoring of that. We have just agreed with our agency management board to look at the framework that we have in place, so we could consider that. We will also look into the monitoring of appeals. As I explained, we do scrutiny and advice cases, but we do not do appeals cases, although we will look at how we might do that.

You mentioned the expertise of the healthcare professionals with regards someone with mental health problems. We have mental health champions to whom healthcare professionals can refer and from whom they can get advice and information.

Mr Copeland: They can or they must?

Ms Margaret Boyle: They can if they need to. My understanding is that there is not a total requirement to do that. I will check that for you.

Mr Copeland: Yes, because one of the reasons why we have a much higher instance of disability living allowance, for example, is that we have 88,000 people with mental health problems, most of which are directly attributed to the Troubles. I know people who have serious mental health issues, but for eight hours a day, six days a week, you would not think there was a thing wrong with them. However, if you were to dig down below, you would see just how serious the problems and difficulties are. We take very great risks with people, particularly those with mental health problems.

I am sorry to go on, but the female whom I referred to at the start of the session, who had been the victim of abuse, self-harm, suicide attempts and a whole raft of stuff, was found fit for work due to the original ESA decision to disallow benefit. She concluded that she was cured and stopped taking her medication. She then tried to kill herself. The ESA said that she was not getting the benefit, and, ipso facto, she concluded that she was cured and did not need to take the medicine.

So, we walk a very fine tightrope. The problem is that it is not the medical professionals or anybody in this room who falls off that tightrope; it is the person who needs to be treated very carefully.

Ms Margaret Boyle: I understand that. The audit process that we have in place aims to provide assurance on the outcomes of the health assessments for all benefits. I appreciate the individual

cases that you raised. The complaints process, the monitoring and the issues that are being raised are opportunities for us to learn and understand.

Mr Copeland: I do not doubt that, nine times out of 10 — in fact, 10 times out of 10 — the process ultimately arrives at the right decision. The issue is the damage that is done to the individual while that process is in train. There must be traffic lights, indicators or operating points along the road that save people from having to go through that.

For example, if you get someone who has a stated condition of agoraphobia, it means that they cannot go out of the house. Not attending a medical assessment in Royston House because you have agoraphobia is fairly understandable, but, in my view, it is not grounds for benefit to be cut off immediately.

Mr Rooney: It should not be, Michael.

Mr Copeland: It has happened on a number of occasions.

Mr Rooney: There are safeguards in place to avoid our stopping anyone's benefit where a mental health condition is known to us. If they do not attend a medical assessment or do not even return the medical questionnaire, we can take steps to have a visit to the home. We do that regularly.

Mr Copeland: I have a number of cases that I could discuss. Again, Chair, the results were ultimately all satisfactory, but the issue is the damage that is done during the process. I drew a number of cases to the Minister's attention. It would be interesting to see the total number of cases that you have and the number that I have been involved in. I have received apologies. The apology is nice for the people who are further damaged by the process, but it does not count for much, especially when, three months later, you are called for another medical on exactly the same basis.

Mr Rooney: I do not think that anyone underestimates the complexity of the work, Michael. That is why, when the ESA was introduced, the legislation required an annual review of the work capability assessment. Professor Harrington did that, and although he could not travel to Northern Ireland, he was very much involved with us.

Dr Paul Litchfield has just been appointed. One of his areas of expertise is mental health illnesses and their impact on work. We hope that that will bring much greater focus to the work capability assessment to address some of the issues that you raised.

Mr Copeland: Lastly, and with the Chair's indulgence, could you explain how someone is assigned to a support group or a work-related activity group? If an ESA appeal or award indicates that a person has trouble going out or coping with situations, it strikes me that attending a work-related interview means having to go out and cope with a new situation. There is something intrinsically wrong with that. Who decides which group they are in and the mechanism by which that decision is arrived at?

Mr Rooney: The decision to assign anyone to a work-related activity group or support group is based on all the evidence that we have in front of us. There will be —

Mr Copeland: At the time of award?

Mr Rooney: At the time of award.

Mr Copeland: At the time of appeal, if the appeal overturns the original decision, can they indicate?

Mr Rooney: Do you mean appealing the work-related activity status if they were in the work-related activity group and going into the support group?

Mr Copeland: Yes.

Mr Rooney: If they appeal that and win, they will go into the support group. That will be backdated to when they were put into the work-related activity group.

The decision is determined by the person's condition, the medical evidence that is available to the decision-makers and the impact of the person's illness on their ability to work. There is an assessment, which is why the ESA was introduced. The aim is to try to understand what we need to do for people who have some capability for work and how we can help them into work or programmes. They do attend, and it is mandatory for those people in work-related activity groups to go into the work-focused interviews with the Department for Employment and Learning. Where attending or not attending that work-focused interview is concerned, the Department for Employment and Learning writes to the claimant to say, "This is my name; I am your personal adviser. This is how you contact me." There can be a discussion with the customer to help them to understand the permutations of their leaving the house or being able to attend a work-focused interview. So, there are mechanisms in place to help to support people through that process.

Mr Campbell: Towards the end of your presentation, you said that there was a robust process to manage any issue that arises. You also said that the process:

"has been effective as there is no evidence of these issues recurring".

A casual glance at that sentiment would appear to suggest that there have not been any issues. Is that a correct analysis?

Ms Margaret Boyle: There have been a number of issues, but they have not been significant. Issues have been raised where, perhaps, the health assessment adviser has looked at the case and felt that there was a query about why a customer was placed in the red, amber and green (RAG) group, as opposed to anything else. Or there may have been a view that a case should be referred back to the decision-maker for further medical evidence. In any event, the issues that have been raised have not significantly impacted on the award of benefit.

Mr Campbell: So, does that mean that it is not accurate to say that there is no evidence? It is rather that there is no significant evidence.

Ms Margaret Boyle: There is no significant evidence; that is more accurate. I would also like to explain that although the health assessment adviser auditing programme is in place, there are a number of meetings each month with operational colleagues, one of which I chair. At those meetings, we look at Atos referrals and any issues that we might have. There is also a monthly meeting with the contract team, Atos and myself. At that meeting, we look at any aspects on volumes, issues raised, and so forth. So, there is an ongoing discussion.

Mr Campbell: My only other question is for Paddy. In response to the Chairman, you said that the figure for appeals being upheld was 65%. Is that right?

Mr Rooney: Yes; 65% are upheld.

Mr Campbell: Given that we are coming towards the end of the second year, has that figure been consistent, or has it gone up or down?

Mr Rooney: It has been fairly consistent since ESA was introduced in October 2008. It has been 65:35, with 35% upheld in the customer's favour. In the past, that 35% has been viewed as a bad thing from an ESA decision-making perspective, but I would like to say a couple of things about that. The ESA decision-making accuracy, which is externally reviewed, is currently sitting at 99%. In the appeals service, the most recent report that the president of the appeals produced acknowledged that 87% of the 35% that were upheld in the customer's favour were because of evidence that was not previously available to the Department being produced or considered on the day of the appeal. He described that as ocular, oral and written evidence. One of those three, or a combination of all three, will have allowed the panel to make a different decision. What he did say, which was comforting from an ESA perspective, was that the decisions that the appeals panel upheld for the customer were not necessarily because the ESA centre got it wrong; it was because the legally qualified members arrived at a different opinion, which was arrived at due to the availability of evidence that was not available to the Department beforehand.

Mr Campbell: I did not intend to ask another question, but, given what you just said, if the vast bulk of the 35% is because of belated or new information or evidence that was brought on the day of the appal — you said 87% of the 35% is in that category — what is the agency and Atos, through the

agency, trying to do to ensure that that is weeded out at an early stage? If that information comes in at the application stage, would your 35% figure not obviously fall to single figures?

Mr Rooney: Absolutely, and since year one, we have been trying to achieve that through the introduction of the pre-disallowance call. It reminds the customer to give us all the medical evidence that they have, from whatever healthcare professional is looking after, treating and helping them with their illness. They should get that evidence to us before we make any decision, because we want to prevent people from going to appeal.

We have also introduced another telephone call at the appeal stage. So, we have gone through the pre-disallowance stage, where the customer either has not provided medical evidence or has provided medical evidence that does not affect the overall outcome. Whenever we receive an appeal, we make another telephone call to discuss the case. Again, we reiterate the message about further medical evidence. We introduced that within the past six or eight months. To date, we have been able to overturn another 16% of cases that have come to appeal. Ordinarily, they would have just gone to appeal, but we have been able to get further medical evidence that has allowed us to overturn those decisions

Mr Campbell: Is that without the need to go to appeal?

Mr Rooney: Yes. I have to say that we have worked really hard with the customer representative groups — Citizens Advice, Advice NI and the many organisations under that umbrella — to encourage them, whenever people approach them, to go to appeal, to provide the medical evidence up front and to get as much such evidence as possible to us to allow us to review the decisions.

Ms Margaret Boyle: We have in place a customer advice and support team for incapacity benefit reassessment customers. That team contacts the customer after the assessment to let them know the outcome and to talk to them about their options. Those include whether they want to appeal and what they might do, further medical evidence or any specialist report that they might have. It is all focused on trying to explain and help the customer to understand their position, what they might best do next and what their options are.

The Chairperson: It is a constant source of frustration that, since 2008, 35% of appeals are still upheld in favour of the claimant. That figure is high. I am not putting the responsibility for that on any individual, but, five years on, the process still seems to be fundamentally flawed. It cannot be right that we have had 35% of appeals upheld consistently for five years. That is despite the fact that 55% of the previous decisions — or, near enough decisions — were changed at an earlier point.

It seems that the system is overly bureaucratic and difficult. We are not dealing with the fundamental flaw, which appears to be the system. We constantly hear about it. I have been in this position for two years, and I heard on day one of this Committee that if the medical evidence is obtained on time, the problem will be properly addressed. For the life of me, I do not know why that is not done on day one; I really do not. That is why people are making the argument. I am not blaming you; you are dealing with a process. When I came into this role, I spoke to the head of the agency, and I was assured that the Atos contract had additional clauses that deal with this region. That is because of the inherent problems that people such as Professor Harrington pointed out, even though he never came here. It seems very frustrating that we still have a high level of cases being dealt with and upheld. So, there has to be something fundamentally wrong with the system. That is not to second-guess any individual, and I am not accusing any individual. However, from that point of view and certainly to me, the process appears to be seriously flawed.

I also hear that mental health professionals are almost a secondary consideration in all this. I am not getting any assurance that they are being treated on the same basis as other health professionals. I do not want to misrepresent you, Margaret, but such professionals are available if needed.

Ms Margaret Boyle: Yes.

The Chairperson: We are told that there is a very high incidence here of mental health issues in people with disabilities. The professionals are available.

Ms Margaret Boyle: My understanding, Chair, is that there is considerable reference to them, but I will check for you about the mandatory reference to assure you and provide information on that.

Certainly, those professionals are contacted on a regular basis, but I will check the frequency and consistency of that.

Mr F McCann: I will try to be brief, because I think that a lot of the questions have been answered.

The Chairperson: Avoid the scenic routes to the question.

Mr F McCann: Thank you very much, Chair.

Are figures available for how many people who formerly had enough points to quality for benefit now receive zero points when they go through the process? People are coming into day centres saying that they cannot understand how different aspects of their illness did not even accrue any type of point.

The other issue is that 66,000 people have had face-to-face interviews. What were the decisions on those 66,000? What does the 35% whose appeal was overturned mean in numbers?

Mr Rooney: Just to pick up on the zero points, there are people who, when they claimed employment and support allowance pre-March 2011, will have been assessed under different descriptors, particularly for mobility. There were changes to the mobility descriptors in March 2008, which made it more difficult for those people to get back on to ESA. So, we have had instances where people have come in and claimed ESA pre-2011. They have been awarded and have gone into the RAG group, but when they have come back for an assessment, they have scored zero points because there were changes to the legislation on mobility within those descriptors.

Mr F McCann: Just on that point, I know that all of us around the Table have spoken to people who have had difficulties with the assessment. For the life of me, I cannot understand how a person who walks with difficulty can go in for an assessment and is then stopped because the assessor realises the difficulty. However, an assessment is then made that they can walk 100 yards or 200 yards. I cannot understand how that can be done on the basis of someone taking two steps.

Mr Rooney: I am not a healthcare professional, but —

Mr F McCann: I am just saying —

Mr Rooney: That is part of the process; yes.

To go back to what I was saying about the zero points; there are a number of people with zero points, but it might be interesting to give you some figures about the disallowance rates over the past number of years as a result of work capability assessments. We have seen that, in 2010, 60% of people who went through the work capability assessment were disallowed. At that stage, that was 8,000-odd customers. In 2011, 49% were disallowed, and, in 2012, 38% were disallowed. So, the majority of people who go through the work capability assessment are allowed.

Somewhere in the region of over 113,000 people have gone through the work capability assessment process. I am not trying to belittle complaints or issues, but we have relatively few complaints in comparison with those figures. We are trying to have annual reviews of the work capability assessment, which Professor Harrington had been carrying out. He said that there was nothing fundamentally wrong with the structure, but he acknowledged that there are processes in that work capability assessment that need to be improved. I am hoping that Dr Litchfield and his particular expertise in mental health will bring a different aspect to that review. We have a call for evidence every year for the annual review of the work capability assessment. So, those are the issues that we need to get into the call for evidence, as they will allow us and Dr Litchfield to take these matters forward.

Where face-to-face interviews are concerned, I said that about 34% of ESA customers in the past 12 months have been disallowed, 28% went into the support group and 38% went into the work-related activity group. For the incapacity benefit reassessment journey, 34% were disallowed, 33% went into the work-related activity group and 33% went into the support group.

Mr F McCann: If 35% have been disallowed, what does that mean so far as numbers of people are concerned? It is OK going into a work-related group, whatever it is, but what happens at the end of that? Do they get their benefit back?

Mr Rooney: When you go into a work-related activity group, you get a higher rate of employment and support allowance, and you also get the support and help from the Department for Employment and Learning. That aims to help you into employment, but you stay on employment and support allowance and get a higher rate.

Mr F McCann: For what length of time?

Mr Rooney: That would depend on your condition and on a recommendation from the healthcare professional to say that you should be reviewed in three months, six months, 12 months or 18 months. The most common period is probably 12 months.

Mr F McCann: What does 35% of people being turned down at appeal mean in numbers?

Mr Rooney: Last year, between incapacity benefit reassessment and employment and support allowance, we received 19,000 appeals. So, that would be on the back of 19,000 disallowances.

Mr Durkan: Thank you for the presentation, Margaret and Paddy. I do not for a second doubt the amount of hard work that you have done to improve the situation. You referred to that, Paddy. I think that the point that the Chair was making in a more diplomatic fashion was that you cannot make a silk purse out of sow's ear.

A lot of the questions that I wanted to ask have been asked, and, in fairness to you, they have been answered. So, I will just ask a couple of wee questions about the evidence that you gave us today. How do you derive statistical validity for a sample? How many cases, or what percentage, has to be audited? It seems that quite a small proportion of scrutiny and face-to-face cases were looked at.

Ms Margaret Boyle: When deciding on the numbers to audit, we sought advice from our statistician colleagues. Some of the numbers that were audited to date have not been considered statistically valid, and we are working towards ensuring that that is the case. The number for informal/formal advice cases for DLA is statistically valid, and the numbers that we are completing are considered to give a confidence level of 90%, with a confidence interval of 10%.

The process has been in place for about a year now, and I explained that we are reviewing the framework. The numbers of audits are not high in comparison with the numbers of assessments. Paddy just mentioned that there were 113,000 assessments, and we have completed over 1,000 audits to date. So, it is a small amount. We are still working with statistician colleagues to further validate the numbers. Does that help? Does it cover your question?

Mr Durkan: Yes; I think so.

Your paper states that the:

> *"Training Needs Analysis... is undertaken by Atos...and is reviewed by the Health Assessment Advisor in collaboration with the relevant business areas."*

I hate the use of the word "business"; I think that it shows what the problem is with Atos.

Ms Margaret Boyle: What we mean by "business areas" are the branches: Paddy's unit of the employment and support allowance centre; the incapacity benefit reassessment; and DLA. In that process, Atos sets out what training it is providing. In recent months, our health assessment advisers attended some of the training sessions, and they have done so on a continual basis. The business areas then look at that and give some views about the training aspects that they consider relevant. That all goes into the training needs analysis.

Mr Durkan: Going by your paper, it gives them:

> *"the opportunity to consider what additional training is required".*

Does it give the Department the opportunity to insist that additional training is provided?

Ms Margaret Boyle: Yes. We are very proactive in providing requirements. The agency also signs off the training needs analysis with Atos. It is not something that Atos presents to us as a fait accompli that we have no input into; we certainly have that input.

Mr Durkan: You are selling yourself short with the language that is used in the paper.

My final question is on audit activity and outcomes. In the scrutiny cases, five "minor" issues were identified. I do not know what is deemed as "minor" or whatever, but, in the face-to-face or examination cases, four "issues" were identified. Were those issues not minor?

Ms Margaret Boyle: None of them was significant. I suppose that that is just the wording that is used in the paper. There were issues such as questions about what group individuals should be placed in. There was further consultation on many of those issues, but none was of any significance. Other issues were raised, including further medical evidence where a specialist report may be required or considered to be required. There is a consultation on that so that we can further understand it. A customer may have had a number of incapacities, and there may have been a query on whether all of them were taken into account. However, those issues were resolved through discussion and consideration with Atos.

There have been a small number of occasions when the health assessment adviser has looked at a complaint, for example, and, through discussions with Atos, the customer has been invited to have another examination but has not taken that up. We will look at that and at the report to see what went on. We will also have the health assessment adviser's medical opinion, together with the opinion of a clinical manager and the healthcare professional's report. So, all that would be taken into account.

I assure you that none of the issues has been significant. Perhaps the use of the word "minor" is the issue.

Mr Brady: I just want to make a couple of points. Your answer to Gregory and the Chairperson about medical evidence reinforces the argument about how important it is in many cases, if not all, that it has primacy.

The public perception is that Atos is paid on results. In other words, the more people it fails, the more money it gets. It is my understanding that, under its contract, Atos is paid partly on the basis of the numbers that it puts through. I know that, in my constituency, going back a year or so, it was oversubscribing to the centres on the day. That meant that people were getting phone calls to say that their appointments were cancelled because too many had been booked.

My other question is important. Does Atos have targets for the numbers of people who go into different groups? There is a very strong public perception that it has.

Mr Rooney: I agree with you, Mickey. I am often told that a majority of people who go through the work capability assessment are disallowed. The figures that I quoted show that there has been a decline over the past three years in the total number of people who have been disallowed. We have gone from 60% in 2010 to 38% in 2012, and so far this year, it is 30%. So, we have seen a decline in disallowances.

As the operational manager, I do not have access to the contract that we have with Atos Origin Healthcare, but I am not aware of any targets to which Atos works that are to do with disallowing people. Those figures suggest that, given the decline that we have had over the past four years pre- and post-Atos, that is not the case.

Mr Brady: Is it possible to get access to the contract? Sometimes perception is everything. I could go back 20 years to when people were saying that, when they went to the doctor, payment was made on results, and the more people the doctors failed, the more money they got. I would not have accepted that necessarily; maybe in some cases I would, but that is an individual matter. This issue is so important that that contract should be in the public domain.

Ms Margaret Boyle: I will check out the availability of the contract.

Mr Brady: We are constantly told that the Department has targets. I worked in the Civil Service 30 years ago, and the Social Security Agency had them.

Mr Rooney: We certainly have targets for clearance times and such things, Mickey, but I am not aware of Atos having any targets for assessments. The figures suggest that it does not.

Ms Margaret Boyle: Or that Atos is paid on results.

I want to address the issue that you raised about people being sent away from medical assessment centres. I mentioned the monthly meeting that I chair that looks at some activities. One of the things that we look at is the management information that we get, which includes the numbers of customers that are sent home unseen, for example.

There are occasions when there have been a small number of additional appointments; there is always some non-attendance. However, we look at that closely, and it is not a particular issue for us. I am not saying that it does not happen, but when and where it does, we look at it in detail.

Mr Brady: These are people who were actually contacted by the centre and told not to come today because they were oversubscribed.

Ms Margaret Boyle: Sometimes that happens because of, for example, the unavailability of healthcare professionals on a particular day after they have said that they were going to be there. That can happen, but we look at it very closely.

The Chairperson: Michael, you wanted in there, but you were out for 10 minutes, so I am very reluctant to call you back. Is it something that is really pressing?

Mr Copeland: No, I will get them in the corridor. *[Laughter.]*

The Chairperson: Are you sure about that? Thank you. We still have another presentation. No other members have indicated that they wish to speak, so thank you for being here, Margaret and Paddy. I think you have probably got this brief at relatively short notice this morning.

Ms Margaret Boyle: Not particularly, for me, because I am responsible for this area of work. Brian was going to be here, but his father died this morning.

The Chairperson: I am sorry to hear about that. Thank you for your very professional handling of the session this morning. I also hear that Tommy O'Reilly's mother died.

Ms Margaret Boyle: Yes, yesterday.

The Chairperson: We send our commiserations to both Brian and Tommy.

Mr Durkan: I share that sentiment, of course, Chair, but I have one last question. Were the numbers audited in a particular area, or was it right across the North?

Ms Margaret Boyle: It was right across. For example, DLA is the only area that has informal and formal advice, but the other areas included the incapacity benefit and income support reassessments and ESA cases. They are the benefits that were included. Does that answer your question?

Mr Durkan: Yes.

The Chairperson: If you do not mind, Margaret and Paddy, we will pick up on some of these issues and probably write to you for more information.

Mr Rooney: Chair, I extend an invite to the ESA centre for any member who would like to come along to see what we do and perhaps talk about some more of the issues that are brought to your door.

Ms P Bradley: You might live to regret that.

The Chairperson: I am being advised in stereo that we have a visit scheduled already for 27 June.

Ms Margaret Boyle: That trip is to the medical assessment centre, as I understand, to see an assessment.

Mr Rooney: That is at Royston House. I am talking about the ESA centre at James House.

The Chairperson: We will send Michael down there. Do not rush to send him back. *[Laughter.]* Thanks very much.