The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

WELFARE REFORM COMMITTEE

Tuesday 23 June 2015

Session 4

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WELFARE REFORM COMMITTEE

13th Meeting 2015, Session 4

CONVENER

*Michael McMahon (Uddingston and Bellshill) (Lab)

DEPUTY CONVENER

*Clare Adamson (Central Scotland) (SNP)

COMMITTEE MEMBERS

*Annabel Goldie (West Scotland) (Con)
*Joan McAlpine (South Scotland) (SNP)
*Margaret McDougall (West Scotland) (Lab)
*Christina McKelvie (Hamilton, Larkhall and Stonehouse) (SNP)
*Kevin Stewart (Aberdeen Central) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

David Haley (Atos Healthcare)
Mark Kennedy (NHS Lanarkshire)
Dr Barrie McKillop (Atos Healthcare)
Kenneth Small (NHS Lanarkshire)

CLERK TO THE COMMITTEE

Simon Watkins

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Welfare Reform Committee

Tuesday 23 June 2015

[The Convener opened the meeting at 10:30]

Atos Healthcare and Salus

The Convener (Michael McMahon): Good morning, everyone, and welcome to the 13th meeting in 2015 of the Welfare Reform Committee. I hope that it is not unlucky for anyone. I ask everyone to make sure that their mobile phones and electronic devices are in silent mode.

Agenda item 1 is evidence from representatives of Atos Healthcare and Salus. I welcome to the committee David Haley, who is client executive for personal independence payments at Atos Healthcare; Dr Barrie McKillop, who is the clinical director at Atos Healthcare; Mark Kennedy, who is the general manager of Salus; and Kenneth Small, who is director of human resources at NHS Lanarkshire.

Mr Haley will make an opening statement.

David Haley (Atos Healthcare): Thank you, convener, and good morning.

I am the Atos client executive responsible for delivery of the personal independence payment—or PIP, as I will refer to it from now on—contract. I joined Atos in March 2014 exclusively to manage the end-to-end PIP contract.

I am pleased to have been invited to today’s Welfare Reform Committee to talk about the important role that Atos plays in PIP in Scotland. It is also good to have this opportunity to explain how we work with our partners on PIP, and the role of the Department of Work and Pensions.

Atos has no involvement in policy setting. We are responsible solely for evidence gathering on behalf of the DWP via the assessment process, so that reports are delivered to the department for decisions to be made. Atos uses a blended model of local supply-chain partners as well as our own clinicians, and we provide all the back-office support functions for Scotland and the rest of the United Kingdom.

PIP was introduced as a brand new benefit, and all parties involved in PIP have had a difficult start—lessons and improvements needed to be worked on very quickly. People had to wait longer than we would have expected and we have been very clear that those delays were unacceptable.

I am pleased therefore to have the opportunity to provide members of the committee with an update on the progress that we have made in Scotland, which includes a four-times increase in our head count of health professionals, which has ensured that the time that is taken to move through the process is now approximately four weeks—or four to five weeks where a home consultation is required.

With our partners, we now have 65 assessment rooms available throughout Scotland. We have also ensured that anyone who lives in an outlying area or in a geographically challenging part of the country where public transport availability is difficult will receive a home consultation as part of the assessment process.

I am very aware of the difficulties of the past and the concerns that surround the process, which is why I am constantly looking at ways to improve the part of the process for which Atos is responsible. Everyone involved in the PIP process at Atos is doing all that they can to make sure that the experience that people have of coming for an assessment to us or to one of our partners is as positive as it can be.

I was therefore pleased that the committee convener and colleagues were able to visit both the Salus and Atos assessment centres in Glasgow and Edinburgh to see at first hand the level of professionalism and care that is afforded to people who visit for an assessment.

Once again, I thank you for the invitation to attend today’s meeting.

The Convener: Thank you. Does anyone from Salus want to comment, or was that opening statement on behalf of you all?

Kenneth Small (NHS Lanarkshire): I would like to say briefly that, despite the fact that this is the 13th meeting of the committee, this is only our third visit—we do not come along to every meeting.

Mark Kennedy and I are very pleased to be here in support of colleagues with whom we have worked very closely in partnership throughout the two years or so that the PIP contract has been running in Scotland.

Salus’s contribution has been to concentrate on what we believe we are good at, which is working with our colleagues in Atos and the DWP to deliver mainly for the west of Scotland and Edinburgh city. The 31,000 or so assessments that we have conducted have met the aspirations that we had in the initial stages, when we first came to the committee and articulated why a national health service organisation would become involved in such a matter. I stress that Salus is fully an NHS organisation and that the income that is generated from our involvement in delivering the PIP assessments is reinvested exclusively and totally in NHS Lanarkshire.

We believe that the quality of our assessments has justified our involvement, and that the public experience of the assessments that Salus has delivered has been positive. As I said, we have conducted 31,000 assessments so far; we have received only 57 complaints against those 31,000 assessments, 42 of which were received after the decision about benefits. Those decisions are not Salus's or Atos's, but the DWP's, so I would not count them as genuine complaints against Salus's involvement. That leaves 15 complaints out of 31,000 assessments, which I think is a pretty good standard.

The Convener: I start by thanking both Salus and Atos for giving us the opportunity to come out and see the facilities from which you operate. Although a mock assessment is not ideal, it certainly gave us a feel for what could happen and it allowed us to speak to people who are involved in the process, which was helpful, even if it was not identical to the reality of going through an assessment. I certainly found it informative and helpful to do that.

I would like some clarity around the impressions and perceptions that have been created about the process; I will not go so far as to call it mythology. When Atos announced that it was entering a partnership with Salus, the members of the committee were under the impression, based on our discussions with Salus, that Salus was going to conduct the assessments throughout Scotland. Maybe that was the intention at the outset, but the reality is that it is not the case. There are some parts of Scotland where the assessments are being carried out by Salus, some where they are being carried out directly by Atos itself, and I believe that there is a third partner, Premex Services, which is doing assessments in central and north Scotland, so there are three different organisations carrying out assessments, all of them under Atos.

We were told that there would be a difference in delivery of the service because of Salus's involvement: it would be done with a public sector ethos that would be beneficial to the process and would be better than the private sector ethos, but we have both. How have we come to be in a situation in which we have three different delivery bodies—two in the private sector and one in the public sector? How do you maintain across the whole of Scotland the standard that Salus believed it was bringing to the table, when two areas are being covered by the private sector?

David Haley: The contractual arrangement is that we deliver the service across our two lot areas. Lot 1 is Scotland, the north-east of England and north-west of England. Lot 3 is the south-east and south-west of England and London. We deliver that through a blended model using local supply-chain partners to ensure that there is a level of familiarity and an ability to provide services locally. That is the model that we have adopted across our whole areas. In Scotland, we deliver directly ourselves and with two supply-chain partners that operate through our infrastructure to ensure that they are able to deliver services in exactly the same way. We hope that you will have seen, having visited both of our centres, that there is a lot of similarity in the surroundings and environment and how the services and assessments are delivered.

Dr McKillop will talk about the training that we use to ensure that the public sector healthcare provision is provided in exactly the same way by supply-chain partners and Atos.

Dr Barrie McKillop (Atos Healthcare): Good morning, everybody. One of the most important things from my perspective, with my responsibility for the clinical performance of the health professionals who deliver PIP assessments, is that we have consistent quality of service. We do that by working closely with supply-chain providers to ensure that the training and support that are available to health professionals, whichever organisation they deliver services under, are exactly the same. We work very closely in partnership. We provide the same training, the same level of support and the same level of on-going continuing professional development training and engagement with all health professionals, irrespective of their organisation. It is important that that is understood.

The Convener: The key thing that you said there was that you provide the training. That indicates to me that it is Atos that trains the staff who conduct the assessments. That is done not just for Atos, but for Salus as well.

Dr McKillop: I will expand on that. The training that we provide for PIP is fundamentally based on the DWP's PIP assessment guide, which sets out to all providers how PIP assessments are to be carried out and the standards that the department expects in the reports that we provide to it.

The training material that we have devised for PIP is, essentially, to illuminate that PIP assessment guide and to make it clear for providers and health professionals how the assessments are to be carried out. We use that training material if we are working with our colleagues in Salus: we will train Salus's own trainers, and its trainers will then deliver that training to health professionals who will be working on PIP assessments for Salus.

The Convener: You are trying to ensure that there is the same standard across Scotland. Salus has told us that it has done in excess of 30,000 assessments, from which there have been 57 complaints, 42 of which were against the DWP. What are Atos's figures?

David Haley: Since the beginning of the contract we have delivered just over 92,000 assessments in Scotland. That, of course, includes assessments by our supply-chain partners. The number of registered complaints is 276 across the whole of Scotland.

The Convener: So, doing a quick calculation, Salus has had just short of 60 complaints, and you have had more than 200 in total, so there were about 140 complaints against Atos across the whole of Scotland. The standard appears to be the same, regardless of whether the assessments are being conducted by the private sector or by the public sector. Do you believe that the standard is the same?

David Haley: Yes. The figures bear that out.

Clare Adamson (Central Scotland) (SNP): Have I got the figures right? You are responsible for 61,000 assessments, if we take out the Salus figure. That is about twice the number of assessments that Salus has done, so you would expect to have had about 120 complaints, but you say that you have had 276. That indicates to me that there are far more complaints arising from assessments that are conducted outwith Salus. Is that the case?

David Haley: The remaining 60,000 assessments have been delivered by us and the other supply-chain partner, which is Premex. Atos accounts for about 36 per cent of the assessments that are delivered and the supply-chain partners deliver 44 per cent. Those are face-to-face assessments, however the important thing to mention is that Atos is solely responsible for all the paper-based reviews, which, this time last year, were running at about 3 per cent of the total amount of assessments, but are currently sitting at about 22 per cent.

The complaint statistics are broken down according to whether the complaint is about health professionals' manner and conduct, about travelling and the assessment centre, about procedure or about expenses. The breakdown is that the majority of complaints are about the procedural side, which involves people feeding back about the process that they have been through.

Clare Adamson: You do not think that there is a significant difference between the performance of the other providers and Salus, which appears to have a very good—

David Haley: I do not. The number includes paper-based reviews as well, which tends to skew the statistic.

10:45

Clare Adamson: Salus has not done paper-based reviews.

David Haley: That is correct. None of our supply-chain partners does paper-based reviews.

I think that the percentage of complaints out of the overall number of assessments is tolerable, although obviously we are always looking to improve the service.

Kevin Stewart (Aberdeen Central) (SNP): I thank Atos for coming to committee today. It is a pity that you did not come here before to discuss work capability assessments when that matter was on the go, because that would have been beneficial—not only for us, but for you.

You said in your opening statement, Mr Haley, that Atos and your subcontractors have no responsibility for policy decisions. Do you think that the general public understand that?

David Haley: It is important that we have had the opportunity to come here today to discuss the part that we play in the process. It is important that we are able to talk about the bit that we are responsible for, which, as I said, is not policy, but delivery of assessments.

On your direct question on whether I think the public know that, it is important that we have events such as this to ensure that it is understood exactly what Atos does in the end-to-end process, which is deliver the actual assessment.

Kevin Stewart: Do you think that the DWP is passing the buck for policy decisions to guys like you, who have taken up the contracts?

David Haley: A number of operational assumptions were made at the time when PIP went live; we know that they have not been borne out. It is important that the part of the process that we look after, which is scheduling and delivery of assessments, continues to improve.

We obviously work very closely with the DWP, from both a medical perspective and a process perspective, to ensure that we are always improving the process. Clearly, policy setting is in the department's domain. We are always looking continuously to improve the assessment process.

Kevin Stewart: The former chair of the House of Commons Public Accounts Committee said:

> "The implementation of Personal Independence Payment has been nothing short of a fiasco."

Do you think it has been "a fiasco"?

David Haley: As I said before, I think that the beginning of the PIP contract was very unacceptable for everyone involved, but we have been very much focused on ensuring that people who absolutely need our service and who need to come through the process are seen as quickly as possible, with the least amount of discomfort and as conveniently as possible. I believe that we are delivering that.

Kevin Stewart: In research that the committee commissioned from Sheffield Hallam University, in the report "The Cumulative Impact of Welfare Reform on Households in Scotland", there was an estimate that 120,000 people in Scotland would lose money as a result of the change from disability living allowance to PIP. The annual loss per individual was estimated to be £2,600, which is obviously a concern to many. We have heard first hand from folk who have spoken to the committee about their fears about that, but there is a huge backlog in dealing with assessments, which adds to their woes and worries. How are you and your partners trying to allay folks' fears and how are you coping with the backlog?

David Haley: I restate that we have said clearly that the backlog situation was unacceptable. Since I took over the contract, I have with colleagues—not just at Salus, but internally, too—been very focused on ensuring that we deliver assessments as quickly as possible by increasing the number of health professionals to four times the number that we had last year and by increasing the amount of facilities that we have for people to access their assessment, while also ensuring that we can deliver home consultations to the people who are struggling to get into our assessment centres or who would normally have had too far to travel. Our key focus has been to ensure that people are able to get through the process as quickly as possible.

Kevin Stewart: It is difficult for folk on islands and in many rural parts of the country to get to assessment centres. I recently visited Stornoway.

Some folk are put off by home assessments—they will be in their own environment, where they are often better than they would be elsewhere. Do you take that into consideration when folk are being assessed at home?

David Haley: We take that very much into consideration. We try to ensure that we deliver the assessment as comfortably as possible for every person who needs to go through the process. There are geographical challenges and it is difficult for people to travel long distances.

That said, for people who are uncomfortable about being assessed in their home, we have in some situations worked with the disability representative groups in our partnerships to lever in their available estate in outlying areas in order to enable people to get from their home to an assessment centre, if that is their preference. We always take into consideration where the person would like to be assessed. If we can deliver the assessment in their home comfortably for the individual, that is where we will deliver it.

Kevin Stewart: We have spoken about the fear that folks have that they will lose money that they see as being vital to their wellbeing. Do you think that people would gain confidence from hearing you talk in managementspeak about things like a "blended model" and a "supply chain" in relation to these matters?

David Haley: That is a good point. It is important that the public understand that it can be very difficult for people to go through the process, so we must ensure that we deliver the services locally. You are right that it is a blended model and that that may not make sense to people, but we work with partners to ensure that they have familiar assessment centres and rooms available in high streets—typically rooms that have ease of access. That is important and it is key to what we have been delivering, which is to ensure that people find the assessment centre as accessible as possible. Delivering through partners is definitely a model that works.

Kevin Stewart: I do not understand what a blended model is, convener, so I think that the term would confuse people. It is galling enough that folk know that profit is being made out of the assessments, so to add managementspeak just adds fuel to the fire.

I understand that you have taken on the contracts for commercial reasons. Do you think that it is commercially wise in the long run for your company and other companies who are taking part in the process—you carry out the wishes of the DWP, but have no influence whatever over its policies—to take part in the assessments, which obviously hold great fear for a number of folk?

David Haley: Our part in the process is to deliver the assessment. I believe that we—not just Atos, but our partners, too—deliver high-quality assessments. The contract is specifically about delivery of assessments. The only targets that we work to are to ensure that people get into our assessment centres as quickly as possible—or have an assessment as quickly as possible—and that a high-quality report is delivered to the DWP so that it can make its decision. Do I believe that it is right for an organisation such as ours to be involved in that process? We take the role very seriously and I think that we deliver very high-quality assessments as part of the process.

Kevin Stewart: Do you think that you are being paid to be the fall guys?

David Haley: I think that it is important that we focus here on the part that we play. As you said, we are not involved in policy or in wider welfare reform; we are responsible for delivering the assessments. We have to stay focused on making sure that people who require an assessment are able to get one as quickly as possible. You have heard us talk about it taking approximately four weeks to get through that part of the process. It needs to be as comfortable as possible for people to go through the process.

The Convener: Before we go on to Joan McAlpine, I will ask a follow-up question. Kevin Stewart started by asking about the backlog in the early phase of the introduction of PIP that we have been made aware of. You explained how you have overcome that backlog. Can you tell us why the backlog happened in the first place? What went wrong that created the problem?

David Haley: A number of operational assumptions were made at the time about audit, how long the assessment would take end to end, and the availability of health professionals and staff in the department to deal with the amount of cases. A lot of evidence proves that those operational assumptions were not borne out, and as a consequence, quite early in the process we became aware that a number of people were starting to wait for too long. Our immediate response was to increase the number of people doing assessments, and to create as many assessment rooms as possible to meet demand. The backlog was due to operational assumptions, and for everyone involved in that part of the process it was unacceptable. However, we quickly focused on trying to clear the backlog and get on top of the work, which we did by increasing the number of people we had to deliver assessments.

Joan McAlpine (South Scotland) (SNP): The committee has taken evidence from people who have been declared fit for work but were not. That evidence is echoed in the media and by disability groups. There seems to be a recurring pattern. For example, David Waite of Dalry was declared fit for work even though he could not hold a pen after having a major stroke. There was the dreadful case of Jacqueline Harris, a retired nurse from Gloucester, who sadly killed herself after a two-minute assessment said that she was fit for work. Her family were clear that she did that because of that decision. You must feel that there is something wrong with the criteria under which you assess people when such cases keep coming up.

Dr McKillop: These cases are always difficult for us to hear about. Clearly, the assessment for PIP does not concern fitness for work or otherwise—its purpose is to recognise people's additional costs when living with a disability. Our key role in the process is to allow the individual who comes to us for an assessment the time to explain the difficulties that they experience in their everyday lives because of their medical problems. We ensure that our report to the DWP contains the level of detail that is required to paint a picture of that person and their difficulties, and how those difficulties vary from day to day or week to week. That is our part of the process.

Joan McAlpine: I hear what you are saying, but a number of people are distressed that their medical condition does not seem to be taken into account by the PIP assessors.

Dr McKillop: Rather than looking at someone's diagnosis, medical condition or the treatment that they receive, PIP assessors focus on the effects of those medical conditions on people's everyday lives and on what someone is able, or unable, to do. It is not our role as PIP assessors to question someone's diagnosis or to ignore their medical condition. Our role is simply to consider how that individual is affected. Many people who have the same medical condition on paper have very different day-to-day stories, and we recognise that people are individuals in that respect. PIP practitioners are trained to make that assessment, consider all the conditions that an individual has, and write a report on their day-to-day function.

Joan McAlpine: My colleague Kevin Stewart asked about people being assessed at home. In all assessments, people have self-respect and pride and are trying to do their best. When they go for an assessment, they often have to make huge efforts to get to the assessment, and that could count against them in the process. It is not a normal day for them. People could make themselves ill by having to make the effort to drag themselves to the assessment.

Dr McKillop: For PIP, I do not believe that is the case. The PIP assessment is not a snapshot—that is one area that people have been concerned about. It is not a snapshot of how an individual is on one particular day, be it the day of the assessment or any other day.

11:00

When we are constructing a report for the DWP, we need to be clear that we do not just look at how someone is on a particularly good day, or even on the day of the assessment. We have to look at what we call variability. People's conditions are not the same day to day. They might be able to do something on one day, but can they carry out that task most of the time? Can they do it reliably, safely and to an acceptable standard?

You also mentioned the other key point, which is about someone making an effort for the assessment. We have to be careful to ensure that people do not underplay the effects of their condition on their day-to-day lives. That is probably a part of our role that people do not recognise as much as they might. We need to ensure that we write a report that does not disadvantage people who have a very positive attitude to their condition, and that we look at their needs in relation to the assessment criteria.

Joan McAlpine: I am struggling to understand how you do that. I and other members of the committee have had the experience of sitting in on interviews at which citizens advice bureau advisers help people to fill out forms, and my experience from the interview that I attended was that the lady continually underplayed her condition. It was only because the adviser had expertise that meant that he asked the additional questions on the 35-page form so that it adequately reflected the severity of her condition. That was before she even got to the assessment. There are some serious concerns here. How are you addressing them?

Dr McKillop: One of the key aspects of the face-to-face assessment is that our health professionals are able to have a conversation with the individual who comes for assessment. Rather than just asking a series of questions—for example, “How do you carry out this task? How do you cope with this?”—we look at variability in every area. We ask every individual, “Does your condition vary from day to day? Do you have good days and bad days?” and we say, “Tell me about what is different between the days.” That is drawn out through the assessment. Having a face-to-face conversation is very helpful in that regard.

Joan McAlpine: Okay.

I go back to my point about the dreadful cases of people suffering because their applications have been rejected. You suggest that things are better with PIP, but we all know that, under PIP, we will see a 20 per cent reduction in disability benefits. How can it be better, as you suggest, when you are working to reduce those benefits by 20 per cent?

Dr McKillop: I want to make it clear that we, as assessment providers, do not have any targets relating to the outcome of an individual case or cases as a whole. We do not even know the outcome of any individual case that we assess. We send the report back to the DWP and we do not receive feedback on the outcome or the decision that is made. Our role is to ensure that we provide a fair assessment that contains all the information that the decision maker will need to come to their decision on the individual case.

Joan McAlpine: Would you suggest that the DWP might be coming to decisions that do not reflect the advice that you give it?

Dr McKillop: I could not possibly comment, because that is not part of our role.

Joan McAlpine: Okay. Thank you.

Margaret McDougall (West Scotland) (Lab): I will continue the line of questioning that Joan McAlpine started.

What sort of feedback do you get on assessments from the DWP? You said that you do not know the outcome of particular assessments. What feedback and information do you get? How do you ensure that you are asking the right questions and that your assessors are teasing out all the information that they need?

Dr McKillop: We submit our report to the DWP and a decision maker in the department reads it. I explain to individuals that we are the clinical team who understand medical conditions, but that the people in the DWP are the ones who know about benefits legislation and the criteria, and that that is their area of expertise. If a decision maker looks at a report and wants to clarify something about an aspect of the case or is not quite sure how a particular piece of medical information should be interpreted, they can telephone us and discuss it with one of our health professionals. They can also send a report back with some questions for us to review, and we are happy to look at the case and give any additional information that they require on it.

Margaret McDougall: Are the people in the DWP not medical professionals?

Dr McKillop: My understanding is that decision makers are non-clinical individuals. They have a background and training in benefits and in the legislation itself. It is our health professionals who have the medical training and can write a report in plain English to explain the effects of an individual’s medical condition on their daily life.

Margaret McDougall: We have heard from witnesses that they felt that the assessor did not seem to be aware of what they had written in the 35-page form, because of the questions that the assessor asked. Some people had also provided consultants’ reports, but no mention was made of those reports at their assessments. Where is that information taken into account?

Dr McKillop: As you say, there is a questionnaire that the individual can fill out as part of the application process, and people often send in further evidence, such as a consultant’s letter or information from other people who know their situation. Our health professionals always look at that information when they review the case and consider it when they write their report at the end.

Margaret McDougall: So they take that into account.

Dr McKillop: Yes, they do.

Margaret McDougall: What happens if someone turns up late? We have heard evidence that some people have had to travel quite a distance. For example, we have heard of someone from Fife having to go to Edinburgh, or someone from Edinburgh having to go to Dundee—which did not seem practical to any of us—and we have heard that if people are late for their appointment they are told, “Sorry, you’ve missed your appointment,” and that is it.

David Haley: The travel distance issue was a challenge last year. Building extra assessment rooms and making assessments more widely available with extra health professionals has certainly helped. We do not expect people to travel unduly long distances.

I am not aware that we have turned anybody away from an appointment because they were late. Our assessors and our reception staff are highly trained and are experts in dealing with the people who attend for their assessments, and if people are distressed or concerned about lateness—or if the opposite is the case, and they arrive very early—we always ensure that that is managed locally at every centre. I am not aware of people being turned away because they were late, but if you know of anyone to whom that has happened I would be happy to look into their case.

Margaret McDougall: We read evidence of one case in which a lady could not get parked—she had to go round and round looking for a place to park—and as a result she was late for her appointment.

David Haley: Typically, our assessment centres are based in high streets and locations that are easy to get to by public transport. We conducted some satisfaction surveys to capture information about how people got to the assessment centre, what their travel time was and what mode of transport they used, and we have become increasingly aware that the vast majority of people tend to use their own transport or get dropped off. Town or city centres or high streets are always difficult for parking, so when we send the appointment letter out we always send maps showing local parking or detailing relationships that we have with local facilities where people can park. We always try to ensure that there are drop-off facilities outside our assessment centres, so that that is as easy as possible.

We will continue to work on our estate to make sure that, wherever possible, we are able to provide parking facilities, given that we now know that considerably more people use their own transport than use public transport to get to our facilities. We will always try to help where we can, and we always make clear on the maps where local parking, or the nearest parking, is.

Margaret McDougall: One person who gave evidence to us felt that the PIP assessment is geared more towards mental health issues than physical health problems. What do you do about that?

Dr McKillop: Most people who come to see us have several medical conditions. Often, they have a combination of physical problems, mental health conditions and conditions that affect their sensory functions. All those are taken into account in the assessment. We recognise that everyone is an individual, and for every individual who has a combination of medical conditions we look at how that affects their day-to-day situation. It is about letting the individual tell their own story. In the assessment, physical and mental health aspects are taken into account in all areas. We are careful to look at every angle of a case in that respect.

Margaret McDougall: One of the questions is about whether the person can walk 20 feet or yards. Do you think that that is a practical assessment? Often, they have to walk that distance to get to the assessment.

Dr McKillop: In terms of the criteria, PIP has a set of what we call descriptors of the activity, which describe someone’s ability to walk, and 20m is one of the distances that are measured—the range is from 200m down to 1m, which is as far as some people can walk. A person’s ability to walk a range of different distances is assessed.

We do not set the policy; the assessment is provided to us. However, someone who was limited to a distance of 20m would have a significant problem with their ability to walk, and the assessment would recognise that.

Margaret McDougall: We have heard of a recent high-profile case in which a young girl who was a Paralympian lost her PIP because the assessors said that she could walk. I think that she could manage to walk 20m, although with great difficulty. What recourse do you have in such cases? You say that your assessors ask questions to highlight how a person’s life is affected by their disability or health problems. When you see such stories in the press or on TV, what recourse do you have to say, “Reassess that person. I would have thought she requires the assistance and financial aid that she’s applied for”? Do you have any discussion with the DWP about such things, or is it purely down to the DWP to make the decision?

Dr McKillop: A key aspect of any of the PIP criteria—we are talking about mobility in particular—is reliability. When someone is able to walk 20m on one occasion or occasionally, but cannot do that reliably, safely or in a reasonable time, that must be taken into account. We have to look at how somebody is most of the time. My understanding is that, even if an individual can walk more than 20m on some occasions, if they cannot do that reliably and safely, taking all the variable factors into account, that will be reflected in our report.

Margaret McDougall: Are any spot checks done? Does your service check a certain number of your assessments?

11:15

Dr McKillop: Our health professionals come to us with at least two years of previous experience in clinical roles, but many of them have much more than that. They are trained in disability assessment medicine, which is the role that we carry out. Once they have gone through an approval process to demonstrate that they are able to perform assessments to a high standard, we will continue to monitor and support them, and we check reports on a random basis to ensure that the required standards are maintained. There is also a continuous professional development programme for all our health professionals, as well as a support service, mental function champions and an advice line if anyone needs to discuss a particular case or receive further support on their practice.

Margaret McDougall: If someone with a disability or a condition that is not going to get any better was previously provided with a lifetime award of disability living allowance, will they be treated any differently? Do they get a different assessment? Is their condition taken into account? Obviously, it will not get any better. Will they be called back in five years' time? I think that the policy is to do that, but why is that happening?

Dr McKillop: Our assessors absolutely recognise that some people have chronic medical conditions that will either stay the same or perhaps progress over time. Such people go through the same assessment, which can be a paper-based review where we look at the information that has been provided to us—as I mentioned, we have the claim form that the individual has completed and any other information that they have sent along with their claim. We might have enough information to be able to give advice without seeing an individual face to face. If we do not have enough information, or if we feel that we could get a better picture of the individual by doing a face-to-face assessment, such an assessment will be carried out. Following the assessment, our health professional offers an opinion on how a person's condition might change over time. Some people might have a condition that we would expect to change over a very short period of time, but with others, we will advise that their condition will stay the same over a longer period. That advice is given to the DWP and it will make a decision on the length of award and any review period after that.

Margaret McDougall: Okay. Thank you.

Christina McKelvie (Hamilton, Larkhall and Stonehouse) (SNP): I thank the witnesses for the written evidence that they provided to the committee, which has been very helpful. However, your evidence suggests that the average waiting time is four weeks. I am sorry to say that I do not have anyone coming through my door who has waited for only four weeks. Certainly, when they come to me, they have generally waited for much longer than that. A recent Citizens Advice Scotland report stated that its advisers were saying that the average waiting time was six months but some people were waiting for 13, 14 or 15 months. We have heard evidence about that at this committee. Can you give me some idea of how many cases are delayed? I know that you have said that you have made progress on that but, for the life of me, I cannot remember meeting anyone who has waited only four weeks for an assessment and a decision. I am therefore baffled as to how you can make that claim. Please enlighten us.

David Haley: Obviously, I am disappointed to hear that you are meeting people who are having to wait an excessive time. What I would say is that the statistics that we have from measuring on a daily basis confirm the statistics that show that going through the process is taking approximately four weeks, or four to five weeks if a home consultation is required. I am aware that there have been previous statistics that showed that we were having difficulties last year and that backlogs were being worked through. The DWP statistics that were issued last Wednesday morning are the latest set of statistics and go up to the end of March, and they bear out what our statistics show, which is that nationally it is taking between five and six weeks to go through the process.

As far as people who have come to see you who have waited extensive periods are concerned, I cannot comment on individual cases, but I would be happy to look into the case of anyone who feels that they have had to wait for an excessive length of time, because we have to manage the case load with our partners to make sure that we are getting people through the process as quickly as possible. In Scotland, that process definitely takes about four weeks, or four to five weeks when a home consultation is required.

Christina McKelvie: Just a few weeks ago, *Third Force News* published a report that suggested that 3,200 people in Scotland were waiting for more than a year. That was in April.

David Haley: I am not aware of the report; I would have to review it.

Christina McKelvie: In your submission, you provided the statistic that

> “To date, we have delivered 92,901 assessments for people living in Scotland.”

How many of those assessments were overturned on appeal?

David Haley: I am not aware of that information.

Christina McKelvie: Last year, 43 per cent of work capability assessments were overturned on appeal. Are we talking about a figure similar to that? You must know who comes back for reassessment on appeal.

David Haley: Once the assessment report has been completed and passed to the department for the decision makers to make the decision, we have no involvement in the process. You are obviously referring to the statistical information that comes out, but we are not aware of whose cases get overturned at appeal.

Christina McKelvie: So no one comes back to you for reassessment if they appeal.

Dr McKillop: The appeals process is carried out by the appeals tribunal service; our health professionals are not involved in it.

Christina McKelvie: Some of my colleagues picked up on the issue of full disclosure of the information that people need. Are assessments and score sheets sent to people who have been through the assessment process as a matter of course?

Dr McKillop: If an individual wants to see their assessment report, they can request that from the DWP.

Christina McKelvie: Are people told that?

Dr McKillop: I am not aware of what communications—

Christina McKelvie: In my experience, they are not told that.

Do you know how many errors turn up in score sheets when people get their hands on them?

Dr McKillop: I am not aware of that statistic.

Christina McKelvie: Are you aware that there are errors on score sheets that mark people down? When those score sheets are challenged, people’s marks go up, with the result that the decision is overturned.

Dr McKillop: Score sheets are not part of our process. We do not use such things in our part of the process. We write a report and send that back to DWP.

Christina McKelvie: You might call it a report; other people call it a score sheet or an assessment form. Are you aware of the number of errors that people have highlighted in those reports?

Dr McKillop: If there is an area in a report that someone has disagreed with or that they feel is not correct, a decision maker can send that information back to us to review. They can telephone us and can send the report back to us to review.

Christina McKelvie: How quickly do you return that information to people once they have asked for it?

Dr McKillop: If a decision maker sends back a report and wants further information, we return that within two days.

Christina McKelvie: How long do people have to appeal?

Dr McKillop: I am not aware of the appeals process.

Christina McKelvie: I am going to take advantage of the fact that you are a doctor and ask whether you agree that motor neurone disease is a terminal illness.

Dr McKillop: Motor neurone disease is a serious progressive condition.

Christina McKelvie: People with it do not get better.

Dr McKillop: They do not.

Christina McKelvie: And they die very quickly—14 months is the usual period following diagnosis.

Dr McKillop: I believe that that is the case in most situations.

Christina McKelvie: Do you think that it is fair for anyone who is suffering from a life-limiting illness such as motor neurone disease to be continually assessed because it has to be determined that they will die within six months before they will be considered unfit for work or considered for PIP?

Dr McKillop: In relation to PIP, it is very important that we look at the individual claimant’s situation, whether it is the one that you have just described or any other. Clearly, if someone is diagnosed with a serious condition such as motor neurone disease, that is a very important piece of information for us, and our health professionals would take it into account. We also have to consider the individual’s situation at the time they make the claim and ensure that the information is passed on to the DWP in a report. We absolutely recognise the need to consider the diagnosis, consider the situation that the individual is in at the time and write a report that reflects that.

Christina McKelvie: That is the point that I want to get to. In that report, would you say to the DWP that the person has a life-limiting illness, will not get better, will only get progressively worse and, therefore, should not be reassessed but should be given the full entitlement?

Dr McKillop: We would not write a report that mentioned entitlement. We would give clinical advice on the situation, which would normally be based on the information that the individual gave us in their claim and the information that we were able to get from their general practitioner or someone else who is involved in their treatment and care and knows their condition well. Our role is to pass that information on to the department in the form so that the person who makes the decision on the outcome of the claim and on any review period is aware of the circumstances of the individual case.

Christina McKelvie: Would you not give the assessment that the very short time that the person might have left to spend with their family should not be spent fighting the system just to get the additional money that the person needs to live every day as it comes?

Dr McKillop: Our role is to ensure that, if someone is in a serious situation such as you describe and has a condition that will probably progress rapidly over time, our report reflects that so that a non-medical person can understand the difficult situation that the individual is in. However, any decision about the award that is made, how long it should be for or when any review should take place is out of our hands.

Christina McKelvie: Are you aware that MND Scotland has a litany of, and a campaign running against, some of the worst ravages of the system, especially work capability and PIP assessments? Are you aware of the case studies that it has produced and the challenges that people with such a condition have faced?

Dr McKillop: We work closely with a range of disability representative groups locally and nationally. That continuing engagement with those groups is very worth while. Whether it concerns more general situations or individual cases in which people have difficulties, we use all the information that we get from those discussions to try to make our service fit the needs of the people who use it.

Christina McKelvie: Do you agree with Lord Freud that people with motor neurone disease should perhaps get a part-time job or take a lodger, as he said when I wrote to him last year and asked him about the bedroom tax and other assessments?

Dr McKillop: I could not possibly comment.

Christina McKelvie: Thanks very much.

Annabel Goldie (West Scotland) (Con): Good morning. I will explore three areas.

The assessment application form is challenging for individuals. It is a physically large document. Is that template permanent, or are the witnesses able to feed in from their experience of meetings with applicants whether improvements could be made to it? Is there any proposal to revise it?

Dr McKillop: The form that you are talking about, which we call the PIP part 2—the questionnaire—is the DWP's form, as are all the forms that we use. We have worked with the DWP on the forms that we use for our assessments—the PA4 or the PIP assessment form—to ensure that they fit as well as they can with the way in which our health professionals conduct the assessments. Some of the improvements that we have made to them with the DWP have helped considerably with the way in which the health professionals carry out the assessments. We do not have any input into how the questionnaire is designed.

11:30

Annabel Goldie: The committee has heard experiences from people living in remoter parts of Scotland, as some of my colleagues on the committee have indicated. I am interested in your efforts to improve the ease of communication with those people and the facility for face-to-face meetings. You said, for example, that you are trialling the use of video technology. In this digital age, there already are digital exchanges by which people can have face-to-face meetings—it can be done on social media or whatever. Could those initiatives not be used to assist people with the face-to-face element of assessments without them having to travel extensive mileage, which many of them find challenging because of their condition?

David Haley: We have run a very successful trial to help us to understand the behaviours not just of the health professionals who conduct the assessments but of the people coming in to be assessed. Because the PIP assessment is a functional assessment, we are finding that in some cases—quite a lot of them in fact—it is difficult to conduct the assessment using video links. However, where there is a requirement for a face-to-face meeting or a conversation that could take place to form the basis of the assessment, there is no reason why video would not work. Indeed, the trial has been a great success. It is one of the areas that we are looking at in order to reach people in outlying areas, and we are looking at the numbers of people who would be able to make use of that facility.

Annabel Goldie: Is there a timescale for that?

David Haley: The trial is under way. We have received feedback and have given that to the DWP; we have been able to crunch the statistics and report back. It comes down to the availability of broadband, availability of devices in the home and so on. That is the next phase that we are looking at. Can we leverage things using iPads or home computers? That is the next part of the trial.

Annabel Goldie: When you say that that is the next part, does it require proactive engagement by you with the claimant, or does the DWP have to improve its information provision to the claimants for those who go to the DWP office? Who is giving the claimant the information that this improved communication facility may be available?

David Haley: The trial is a proactive one that we and some of our partners have been working on, looking at what the capabilities are and what the flexibility would be in relation to delivering the assessment out. When we submit the findings of the full trial, we will obviously discuss with the DWP the decision about whether the approach should become part of the policy and requirement for how we deliver PIP assessments.

The trial is on-going. The next phase will look at the ability to leverage the approach through use of iPads, the availability of broadband connectivity and the security of the networks. If the assessments are going to be delivered digitally, the system will have to be very secure.

Annabel Goldie: If we look at the pre-assessment support part of the process, some people have the IT already and may have access to broadband, wi-fi or whatever it is. Could they use that as a communication medium just now?

David Haley: I am happy to go away and see where the report of the trial is and feed that back to the committee. We have had to go through the stages of looking at the technology and security first, followed by a limited trial in the assessment centres. The next trial has looked at home use and the ability to deliver out the assessment. I can get an update on that, if it is ready. If the approach has been proven within the trial, I see no reason why it could not be made available.

When the approach has been proven as a viable form of delivering the assessment, I would imagine that it will be made public through websites and also the disability representative groups. As Dr McKillop has mentioned, we work very closely with those groups. Citizens Advice Scotland has been very supportive in helping to deliver assessments out in outreach areas. We would work with partners to make sure that communications are understood and that people are aware, when the time is right to do that.

Annabel Goldie: Thank you. Convener, the committee would find it helpful to be given an update on how the trial is going and on the proposed roll-out from that, depending on what the trial finds.

The final area that I am interested in, which my colleague Christina McKelvie was also asking questions on, concerns evidence that we have heard from witnesses who are suffering from degenerative diseases. The diseases will not improve and the witnesses were very anxious about the prospect of reassessments, in whatever period of time that may be.

This is perhaps a question for you, Dr McKillop. If the health professional, in assessing an individual in that situation, is clear that the individual has very restricted physical ability and mobility and would find it very challenging to be doing anything, whether at work or in the home, and if the report reflects all that, it is presumably not a good use of your time to have to reassess that person two years later, because they will not have got better. One witness put it eloquently, saying that, unless she could be given “a new skeleton”, she would be worse than she was at her assessment at any future time.

I cannot quite reconcile the common sense of it. If a health professional has met the individual and has made the assessment, and if the DWP is satisfied and gives a payment—indeed, the higher payment—is there no mechanism in such situations to avoid the inconvenience and stress of a further review?

Dr McKillop: In the situation that you have described, we would always give the advice that the individual’s condition was likely to stay the same or perhaps progress over time. That would be the advice of our health professional in such cases. If we were referred that case back again for a review at some future point, my hope would be that the information given in the case would allow us to do a paper-based review, without having to see that individual again face to face, because our health professionals would understand the conditions that the individual had and would understand that things were likely to have stayed the same or got worse since the previous assessment. They would be able to give advice without having to see the individual at a face-to-face assessment a second time.

Margaret McDougall: You are talking about health professionals. Do they specialise in any particular condition? If someone has a mental health condition, is there a particular assessor, or half-dozen assessors, who would be best placed to assess that person, or are the roles purely generic?

Dr McKillop: All our health professionals come to us with at least two years' clinical experience, and many of them have much more than that. We have practitioners who have worked as community psychiatric nurses and we have registered learning disability nurses. We have general nurses. We have occupational therapists, physiotherapists and paramedics working for us. In their clinical experience before coming to work on PIP, they will have met a wide range of clinical conditions.

Margaret McDougall: They will not be experts in all those fields.

Dr McKillop: We recognise that, when they come to PIP, a lot of the people who come to see us have several conditions, not just a physical condition or a mental health condition but a combination of several conditions. All our assessors are trained to assess somebody's function and how their day-to-day life is affected by all their conditions together.

On your point about people who specialise, we have a specialist team of what we call mental function champions. They are health professionals who have a background and who are experts in a mental health or learning disability field. They have at least two years' worth of experience in that specialist field. They are always available to provide support and to offer advice to any health professional who is carrying out an assessment, before, during or after. They also work with our health professionals on developing and delivering training, so that the benefit of their experience is passed on to the rest of our health professionals.

Our challenge is that people come to us with a variety of medical conditions. We have to ensure that we do not just focus on one area but look at the whole individual.

Clare Adamson: Thank you for coming today and for the opportunity to visit the centre, which was helpful. We have taken evidence on work capability assessments from people with mental health issues who felt that the process had damaged their mental health. In the mock assessment that we saw in the centre in Glasgow, the actor who was presenting with mental health problems was asked how low they had been and whether they had considered committing suicide. If someone was suffering from post-traumatic stress disorder, perhaps because of sexual abuse, or was undergoing cognitive behavioural therapy, that process could damage their mental health. Do you have a mechanism for coping with that?

Dr McKillop: We try to make what we recognise can be a difficult experience for people as easy as we possibly can. That clearly includes people who have mental health problems. It is important that our assessors recognise the impact that mental health can have on an individual's life and that they are sensitive to that.

Our role is to focus not so much on the diagnosis and what someone's history is—their background or their mental health condition—as on the here and now and the difficulties that someone has day to day. We make the assessment as up to date and reflective of the person's current situation as possible, rather than going into the details of their background.

Clare Adamson: Margaret McDougall touched on a concern that I have about the range of health professionals involved. Forgive me if I have picked this up wrong, but I understood Dr McKillop to say that you give the DWP an opinion on whether a person's medical condition is likely to progress. Someone who presents with MND, multiple sclerosis or something rarer, such as complex regional pain syndrome, could be faced with a mental health professional who has no clinical experience of dealing with those conditions.

Dr McKillop: We make sure that all our health professionals have access to the information that they need, as in clinical practice. Everyone who works in a clinical setting will have a range of specialist knowledge but also general background training.

Not every health professional can have personal knowledge of every condition at all times. We ensure that people have access to support lines, training, guidance and handbooks to answer the questions that they have on a particular case. We always encourage a health professional to telephone for support or guidance or to review the handbooks in individual situations.

Clare Adamson: I understand what you are saying, but a health professional in any other role in the NHS would not be asked to comment on an area that they were not professionally trained in, did not have experience of or were not working in. A mental health nurse in a hospital would not be asked for an opinion on MND. Physiotherapists would have virtually no medical training on some of the conditions that are presented. Does that not place a huge onus on the health professional to educate themselves and decide whether they are clinically competent and sufficiently confident to provide an opinion on someone?

Dr McKillop: The key is that all our health professionals are registered with their individual licensing body and it is therefore their responsibility to make sure that they work within the appropriate body's guidelines and regulations. They have a duty to make sure that the advice that they give is reasonable and that they are working to a level of competency that they are comfortable with.

The training that we provide for our health professionals focuses on their role. They are not diagnosing or treating individuals with any of the conditions referred to. They are offering a report that looks at someone’s day-to-day function. That is not the same as getting involved in the clinical treatment or diagnosis of an individual.

On review periods, an individual health professional gives their advice on a clinical review of the case but is not looking at the clinical condition so much as how the person’s function is likely to change over time.

11:45

Clare Adamson: Are the health professionals giving the DWP an opinion on the progression of the disease? Can that happen?

Dr McKillop: In the report, they tell the DWP when they feel that the individual’s function may change; that change may be a worsening, or the individual’s condition may improve with treatment or following upcoming surgery. That view is based on what the individual told them about their medical condition at that time and the health professional’s knowledge of the condition.

Clare Adamson: If someone fails to look up the guides that you provide, fails to investigate and makes an error of judgment, and it is left to them—there is no check on whether the assessment is valid by someone who is clinically or medically qualified to give that opinion—how is that process ethical?

David Haley: We talked earlier about working closely with the disability representative groups because we are aware that many different conditions can be presented during an assessment. One of the things that we have found that works really well is a condition insight report. To produce that, we work with the various bodies in the representative groups to help us capture and understand particular conditions, which may be more rare.

That is part of the delivery to the health professionals to make sure that they have an understanding and a training capability. There are regular quarterly sessions where we deliver continuing professional development to the health professionals. There has just been refresher training on the latest modules, which capture some of the condition insight reports. There is a continual loop to make sure that the health professionals are aware of all the conditions, without being experts in particular conditions, and have an understanding—particularly from the perspective of the disability representative groups—of how best to handle an individual with a particular condition.

Clare Adamson: We are going through the devolution of further powers to Scotland and PIP is due to come under the Scottish Parliament’s competency. The Scottish Government has made representations to delay PIP’s introduction. Certainly, devolution should have happened before the 20 per cent cut that is coming from the UK Government. Do you have any opinion as to whether it would have been sensible, given that the Scottish Government may change PIP, to delay PIP’s introduction until after the power was devolved?

David Haley: It is important that we reflect on the reason why we are here today: we have been invited to talk about the part of the process for which we are responsible, which is delivering the assessment. Our contract is with the Department for Work and Pensions and will continue until it ends. We remain focused on that to ensure that the people who require the assessment get seen as quickly as possible. Of course, we would be delighted to have a conversation with the Scottish Government about where welfare may go, but our focus is on making sure that we deliver the assessments, as part of the end-to-end process in contract with partners, to the DWP.

Christina McKelvie: I have a quick supplementary question. My colleague Clare Adamson asked about cases where there is a serious misjudgment and a failure in an assessment. We have seen that happen—we have heard lots of examples of that. Has your company ever had a claim for compensation made against it by someone who was a victim of a misjudgment in an assessment?

David Haley: I am not aware of any such case. I am happy to do some research to find out whether there has been any such case. PIP has been running for two years and I can comment only on that contract. I am happy to do some research and bring that information back to the committee.

Christina McKelvie: It would be appreciated if you did that. Constituents have asked me where their recourse is in all this. Such a claim is one method of recourse, especially if someone has used up the last precious days of their life fighting a system that does not want to help them.

Kevin Stewart: Atos has stated that, at the moment, it is contracted by the DWP to carry out the PIP assessments. Can you indicate how much profit Atos is likely to get from that contract?

David Haley: I go back to my earlier point about the backlogs that we had to tackle last year. We did that by increasing the number of health professionals that we had available and the amount of additional estate across all our contractual areas.

With any contract of this size, a long-term view has to be taken of the return and the profitability that is expected. We are focused on delivering the assessments as quickly as possible with the required number of health professionals.

Over the duration of the contract, we would expect to return a profit. I am not in a position to talk about what the figure is, given that we are currently investing in health professionals and additional assessment rooms to ensure that we do not run into the backlogs again and to ensure that we can deliver our service as quickly as possible.

Kevin Stewart: Is the profit that you will make over the long term likely to be in the millions of pounds?

David Haley: If you require a more detailed response, I am happy to go away and see what I can share with the committee, then send that information on.

Kevin Stewart: We would be grateful if we could get an idea of how much you are likely to make in profit over the course of the contract. I realise that Atos was unwilling to give figures for the work capability assessment contract, but you gave out documentation that showed that, over the piece, in Scotland and the north of England, you were likely to make £40 million. It would be good for us to get an indication of how much you are likely to make on the contract, to see whether you are being well paid for being the fall guys.

David Haley: We are certainly not unwilling to provide that information. As I said, I am happy to take the question away and find out what I can share. If it is appropriate, I will certainly send on the information.

The Convener: That would be helpful.

I have a couple of questions to finish off. Mention was made of people not receiving a benefit on the basis of a very short assessment. Can you give us an idea of the average time of an assessment in normal circumstances?

David Haley: Our current average assessment duration, which is the time that it takes to go through the process, is about an hour and a half.

The Convener: So the process takes an hour and a half.

David Haley: Yes.

The Convener: We are hearing from people who believe that they were rejected on the basis of an assessment that took one or two minutes. How does that square with what you say?

David Haley: I do not recognise one or two minutes as an assessment duration. The most important thing that we deliver is the face-to-face assessment. We have always prided ourselves on the fact that it takes as long as it takes to capture all the information that Dr McKillop mentioned. On average, that will take about 90 minutes, but every individual is different and therefore they will require the amount of time that they need to go through the assessment in order to ensure that all the information has been captured.

The Convener: When we visited the Atos assessment centre to discuss the work capability assessment, we learned about the importance of further medical evidence. We also discovered that GPs were returning evidence for only about 50 per cent of FME requests; we have written to those concerned to see whether that situation has improved.

How important is FME to the PIP process? Do you have the same authority to obtain FME from GPs as was the case with the work capability assessment?

Dr McKillop: As we have said, further evidence is key to the PIP assessment process. One of the differences is that individuals who have some evidence, whether that is a letter or any other information about their health condition, are encouraged to send it in as early as possible in the process, along with their claim.

It is important to recognise that that evidence does not have to be medical. It does not have to come from the person’s GP or from a consultant. We tend to refer to further evidence in relation to PIP rather than further medical evidence, in recognition of the fact that there are often other people who know a bit more about an individual’s day-to-day situation than their GP might. Any information that is sent in along with the case, whoever it is from, will be considered as part of the claim.

The Convener: Are GPs contractually obliged to provide further evidence for the PIP process, as they are in relation to the work capability assessment?

Dr McKillop: We write to GPs for further evidence, when we think that that will be helpful, before we decide whether an individual can have a paper-based review or will be invited in for a face-to-face assessment. I am not aware of the contractual arrangements that we have with GPs to provide that. Much depends on the individual’s conditions, the information that they have provided and the day-to-day difficulties that they have.

The Convener: Kevin Stewart rightly raised the issue of the value of the contract, which you have said that you will help us with. Given that Salus is part of NHS Lanarkshire, will the profits that it makes from the process be in the health board’s accounts, which would be made available to the public?

Kenneth Small: My recollection is that the figures are on the public record. We have previously discussed the matter in the committee and have said that, over the contract's full term, NHS Lanarkshire expects through Salus to bring in income of between £1 million and £2 million, which will be further invested in our core business. That would feature as part of annual accounts.

The Convener: That is what I suspected. What is the contract's duration? When is it scheduled to be completed? I should make it clear that I am talking about the current contract.

Mark Kennedy (NHS Lanarkshire): The first break in the contract is July 2017. The contract comes with the option of extending it for one or two years after that. Salus plays no part in the negotiation of the contract—that would be between the Department for Work and Pensions and Atos.

The Convener: The contract that you have with Atos was approved by the Scottish Government before it was signed.

Mark Kennedy: We sought approval from the Scottish Government prior to signing.

The Convener: Mention was made of requests for a moratorium or for the ending of the roll-out of PIP. If Salus stopped doing the assessments, that would represent a cost to NHS Lanarkshire. Does the health board factor in the projections on profit? If there were to be a moratorium, would that form a loss in the projected income of NHS Lanarkshire?

Kenneth Small: In our initial consideration of involvement in the contract, due consideration was given to risk assessment, and that continues to be the case. NHS Lanarkshire's financial exposure from the continued contractual relationship in relation to PIP largely involves the staff we employ. Some terms of leasing of properties are associated with that, but the main exposure concerns the 50 staff we currently employ in relation to the contract.

NHS Lanarkshire employs 12,000 staff. We have an on-going and efficient process for staff redeployment from organisational change. Our assessment of the risk is that the figure of 50 staff is not something that we are unduly concerned about.

The Convener: What percentage of Salus's overall work commitment is taken up by the PIP assessments?

Mark Kennedy: Salus delivers core services for NHS Lanarkshire around occupational health and safety, which is protected and entirely separate from any commercial activity that we are involved in. PIP takes up perhaps 40 per cent of our overall commercial activity.

The Convener: Mention was made of the fact that, at some point, PIP will be the responsibility of this Parliament and the Scottish Government. I know that you have made it clear that you are not responsible for the policy that drives PIP, but do you have any recommendations for the Scottish Government on changes to the PIP policy?

David Haley: I think that, at some stage, there will be a wider discussion that will involve the DWP and the Scottish Government about the move of responsibility for welfare to Scotland. We would need to be part of that discussion, given our experience, along with that of Salus and Premex, of delivering PIP and given the continuous improvement of the service that has taken place over the two years and which we would hope continues to take place.

We welcome involvement in any conversation that involves the on-going improvement of PIP as a service. However, until we are invited into those discussions—if they are planned—we will have to wait and see what our position will be.

The Convener: I will leave it at that. Thanks for coming before us. Again, I thank you for opening up your facilities to allow us to see how the system operates on the ground, albeit in a mock capacity. It was certainly advantageous to speak to the health professionals who are involved and to see the facilities that people visit when they go in for assessments.

We will continue to monitor the development of PIP, so you might find that you are invited back to speak to us. I thank you again for the information that you have provided, and we look forward to receiving the information that you have given a commitment to provide in writing.

We have another item on the agenda, but that was only there in case we did not manage to sign off our report on women and social security. As we managed to do that by correspondence, we do not need to discuss anything under item 2, so I can close the meeting by pointing out that our next meeting will be in September, when we will start our inquiry into the practical implementation of social security schemes, as outlined in the Smith agreement.

Meeting closed at 12:01.

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