HARRINGTON RECORDING PILOT

Pilot Evaluation Report

PREPARED FOR: **Department of Work and Pensions**

04/06/2011 FINAL

Atos Healthcare

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1. Management Summary

Prior to the publication of the Harrington report Atos Healthcare (AH) was receiving an increasing number of requests from clients to undertake recording of assessments and work had already been undertaken to look at how this might be undertaken.

The Harrington report recommended that recording should be piloted to see if the approach was helpful for clients and improved quality. The main focus of this pilot was therefore to look at the up take of recording by clients, the client's view of how helpful they found this and the impact on medical quality and feedback from the health care professional (HCPs). The pilot did not aim to assess any technical solution that might be used should routine recording be rolled out nationally.

1.1 Pilot summary

The pilot was conducted in Newcastle assessment centre using 10 volunteer Health Care Practitioners (HCPs) during March – May 2011. Participation by the clients was voluntary and 500 offers of recording were made by telephone in advance of the client's attendance at the assessment centre. Initially 68% of clients accepted the offer but as a result of clients who subsequently did not attend the assessment and those who withdrew on the day, this only resulted in 46% of the 500 offers completing a recording.

Qualitative and quantitative evaluation of the clients' view of recording and also their overall satisfaction was obtained by independent telephone survey. The HCPs were given the opportunity to provide feedback of the pilot from their perspective and additional medical audit of the assessments was undertaken to see if the recording appeared to make any difference to the quality of the reports.

1.2 Overview of Results

Client Acceptability

- 68% of customers agreed to the recording when contacted by telephone prior to the appointment although this reduced to 46% of the pilot original sample due to clients deciding not to participate in the recording on the day and others failing to attend their appointment
- 9% of those attending changed their mind at the MEC.
- < 1% of customers requested a copy of the recording.

Feedback from clients

- Majority of the surveyed customers thought recording was a good idea with **85%** of those consenting saying yes with only **36%** of those not consenting saying yes.
- However when asked whether they would find it beneficial only **47%** of the surveyed customers said yes.

Profile of HCPs taking part

- 2 doctors, 1 physio and 7 nurses.
- All were experienced practitioners

Feedback from HCPs on the experience

- Overall the HCPs felt the experience had been positive.
- They all felt the recording would support them in potentially difficult interactions with customers and in the resolution of subsequent complaints.

Impact on average assessment time

- For the pilot cases there was a small reduction in the time to complete cases although it is likely that the clients that chose to participate in the pilot were those with simpler cases and less likely to have multiple physical or mental health conditions which would tend to make the assessment times longer. This is an area that would need more evaluation if recording was rolled out nationally.

Acceptability of compulsory recording on HCPs

- The HCPs who took part felt they had become used to the recording fairly quickly. Most felt it would be appropriate for all HCPs to be required to undertake recordings if the recording were to be rolled out to all customers.
- However, it was accepted that not all HCPs would be able to accept the change and it could lead to increased stress in the workplace or an increase in attrition.

Medical quality

- IQAS audit on a sample of assessments did not change the audit grade or outcome of any reports, but the auditors felt that there may be some enhancement to the soft skills of the HCPs but this was difficult to quantify.

1.3 Next steps

The results of the pilot indicate that there are a significant proportion of clients who would welcome the opportunity to have their assessment recorded although only a small number actually require a copy of the recording.

There seemed to be no impact on the grading of the audit of the medical reports when the audio recording was used as part of the audit but it is accepted that the use of recording as part of a training programme for HCPs or for mentoring / feedback in cases where HCPs receive complaints regarding their manner.

There is increasing demand for recording of assessments and currently there is no easy process to offer this and we estimate AH receives around 1-2 requests / day. Therefore is a need to make recordings more readily available on request.

The solution for delivery of this would need to take into account data security and a manageable IT solution. The scale of the solution would depend on whether or not recording was made available routinely to all clients or only to those who specifically requested it.

Our recommendation would be that recording should be become routine as it is in a call centre or for example – NHS direct.

There is therefore an urgent need to decide how the issue of recording of assessment is progressed and AH is keen to work closely with the Department to develop a measured and cost effective way of implementing this.

2. Background and Scope

2.1 Background

Before the publication of the Harrington report the Department had asked Atos Healthcare to respond to an RFP to the consider options for conducting audio recordings of medical assessments for various possible scenarios. The Harrington report was subsequently published and accepted by the Minister. One of the recommendations of which was that a pilot is conducted of recording of medical assessments.

The recommendation is as follows:

'that Atos pilot the audio recording of assessments to determine whether such an approach is helpful for clients and improves the quality of assessments.'

Whilst audio recording of calls made to call centres is now common place and video recording of medical assessments is used for training purposes, the concept of recording all medical assessments is un-chartered and therefore it is difficult to know what impact this may have on client and HCP behaviour and consultation length.

2.2 Scope and Inclusions

The scope of this report only covers the evaluation of the initial pilot of audio recording of medical assessments from the perspective and impact on

- the client
- the Health Care Practitioner (HCP)
- the quality of the assessment
- the duration of the assessment
- administrative processes for the pilot

This report does not set out to evaluate the recording solution that would be used on national roll out. A national solution would require significant IT infrastructure to enable secure central storage together with a process to allow restricted access to JCP users or the appeals service.

3. Pilot Details

3.1 Pilot Summary

The pilot commenced on 21st March in the Newcastle MEC in the Regent's Centre, Gosforth. The first recorded assessments were undertaken on the 24th March. The pilot completed on the 9th May 2011. The table below contains a summary of the key statistics from the pilot.

Description	Count	Percentage
Offers Made	500	100%
Accepted	344	68%
Declined	156	32%
Attended (Yes Only)	266	53%
Withdrawals at MEC	25	
Not Completed (Total)	11	
Arrived Late no HCP Available	2	
No HCP Available	4	
Arrived Early no HCP Available	2	
IT Issue	1	
Recording Failure	1	
Customer Sent Home Unseen	1	
Completed Successfully	230	46%
CD Copies Issued to Customer	4	1.7%

3.2 Client Consent

Clients were able to choose whether they wish to be included in the pilot. Client's were initially contacted by telephone prior to their assessment and asked whether they wanted to participate. Only ESA clients were contacted. If they indicated they wished to participate. This was noted on the contact log. Similarly if they indicated they did not wish to participate this was also recorded on the log.

Those clients who had indicated they wished to participate were asked again on attendance at the assessment centre whether they still wished to participate. If they indicated they still wished to participate they were handed an information sheet to read whilst waiting for their appointment. For a small number of cases, when some additional slots were available for recording other than those pre-booked by telephone, clients were asked randomly on arrival at the MEC whether they would like to participate and they were recorded on the log.

Signed client and third party consent (if the client was accompanied into the assessment) was obtained by the HCP prior to commencing the recording of the assessment.

Those clients which indicated they had changed their mind were sent to see an HCP not participating in the pilot.

3.3 HCP Consent

HCPs were asked to volunteer to be included in the pilot. 10 HCPs volunteered and signed consent forms prior to starting their first assessment recording session.

3.4 External Consent

AH believes that full roll out of recording would require would require discussion from the medical statutory bodies:

- Nursing and Midwifery Council (NMC)
- Health Professions Council (HPC)
- Medical Protection Society

For the pilot our approach to these bodies resulted in their agreement to a small pilot of a recording solution based on HCPs volunteering to participate in this and the necessary consents and disclaimers being in place.

3.5 Assessment Process

The recording can not be a full record of the content of the assessment and evidence gathered therein. The evidence collected during an assessment includes observed behaviour and establishing rapport during the period when the HCP greets the client and travels from the waiting room to the exam room and on the return journey. The assessment recording commences in the examination room and continues during any physical examination carried out at an examination couch.

4. Evaluation Criteria

The Harrington recommendation is:

'that Atos pilot the audio recording of assessments to determine whether such an approach is helpful for clients and improves the quality of assessments.'

Therefore the objectives and evaluation areas are set out below:

a) Acceptability / Benefits to customers

b) Qualitative evaluation of recording on HCPs and reception staff on attitudes. It is important to obtain a view on potential impact on morale, and staff attrition should the pilot be rolled out to inform how this approached.

c) Impact of recording medical assessments on business processes to include areas such as MST, administrative functions

d) Medical quality

4.1 Customers Criteria

	Data	**Evaluation**
1a	**% of customers agreeing to the recording** was **68.9%.** However **23%** of those saying yes did not attend leaving only **53%** of the pilot original sample actually attending and **9%** of those attending changed their mind at the MEC.	**Inconclusive**
1b	**% of customers subsequently requesting a copy of the recording**. At the time of this report only 2 customers have requested a copy which is **less than 1%**	**Low - negative**
1c	**feedback from customers on benefits of recording** A majority of the surveyed customers thought it was a good idea with **85%** of those consenting saying yes with only **36%** of those not consenting saying yes. However when asked whether they would find it beneficial only **47%** of the surveyed customers said yes.	**Inconclusive**
1d	**reasons for requesting a copy**. **23%** of those recorded said they would request a copy but at the date of this report only **4** requests had been made	**Inconclusive**

4.2 HCPs Criteria

Feedback from the HCPs was obtained through informal discussion following the completion of the pilot.

	Data	Evaluation
2a	**% of HCPs agreeing to participate compared when asked** For the purposes of the pilot HCPs were chosen who regularly worked in Newcastle assessment centre. To control the cost of the pilot we only used 10 recording units and this again limited the number of HCPs who could be involved. Although the participation was voluntary HCPs who were approached were actively encouraged to take part. There was initially some reticence and concerns regarding the pilot but in order to get 10 participants required a pool of 16 HCPs were approached.	**Inconclusive**
2b	**Analysis of reasons why not taking part** HCPs who did not wish to take part cited: *Concern about protection of their own data and identity and inappropriate use of the recording by customers.* *Concern about the impact on the time taken to do the assessment.* *Concern that audio recording is only one part of the evidence available to the HCP and that it may mislead customers who feel that proof of having said something should equate to a certain outcome.* *Concern that this misconception may lead to an increase in complaints.* *Unwillingness to pilot another change to the assessment whilst taking on board current changes to WCA.*	**Valid** **Most objections were associated with the practical implications of the recording rather than a general distrust of the recording itself.**
2c	**Profile of HCPs taking part (Dr/Nurse/experience etc)** 2 doctors, 1 physio and 7 nurses. All were experienced practitioners	**linked to attrition rates**

2d	**Feedback from HCPs on the experience** *HCPs who had taken part said they felt:* *…Comfortable with the concept of recording* *…The rapport did not suffer unduly although it was made more formal by the recording.* *...The recording of assessments may encourage calmer behaviour from some customers* *…The existence of an audio recording would support them in many cases of customer complaints and/or appeals.* *…They took more notice of their personal interaction with the customer* However they also said: *They felt the introduction at the beginning of the assessment was cumbersome and added significant time to the duration.* *They felt they often became overly detailed in their capture of information, focusing on things that were not necessarily relevant because of the pressure to make no mistakes.* *They continued to feel concern that their personal data would not be protected.* *Feedback from the admin staff involved was:* *That it took as many as 4 calls to make contact with one customer* *That some customers were angry / agitated at being asked to take part in the recording whilst others felt it would be intimidating to take part.* *That those customers who did agree to take part had no significant questions to ask in the MEC.*	**Positive** **Overall the HCPs felt the experience had been positive.** **They all felt the recording would support them in potentially difficult interactions with customers and in the resolution of subsequent complaints.**
2e	**Impact on average assessment time** This is covered in more detail in section 5.5.2. It is felt that the group of clients who agreed to participate in the recording pilot were not typical of the normal client profile. It is thought that those clients with simpler non mental health problems were more likely to agree to take part in the pilot. The impact of this would be that the average completion time for cases in the pilot dropped.	**Inconclusive**

2f	**Evaluation of potential impact on HCP morale / attrition rates if participation compulsory if rolled out nationally** The HCPs who took part felt they had become used to the recording fairly quickly. Most felt it would be appropriate for all HCPs to be required to undertake recordings if the recording were to be rolled out to all customers. However, it was accepted that not all HCPs would be able to accept the change and it could lead to increased stress in the workplace or an increase in attrition.	**Given the originally small numbers of people volunteering, we expect to need substantial engagement with HCPs prior to any national roll out. Our expectation is that many would accept the change given the right support. However a proportion of HCPs are likely to be unable to accept the change.**

4.3 Impact of recording equipment

	Data	**Evaluation**
3a	**Ease of use in assessment** The handheld digital recorders were found to be easy to use after a short period of familiarisation. Additional MCA resource was required to download the recordings onto the secure PC. This was accomplished using overtime for the pilot. This solution of handheld records is not feasible for a national roll-out due to security considerations	**Positive, however the solution is not viable for national roll-out due to security considerations**
3b	**Ease of producing a CD for customer** Production of the CD, labelling it, packing it and posting it via recorded delivery was performed by an MCA. After a short demonstration this was easy to perform but required additional MCA time.	**Positive**
3c	**Potential solution for full rollout** The recording solution used in the pilot is not suitable for national roll-out due to security considerations and therefore the data from the pilot does not inform this	**Neutral**

3d	**Destruction of data and CDs** The secure PC will be securely wiped at the end of 14 months from the finish of the pilot. Any CDs produced and subsequently not required will be physically shredded. There would be a cost for this in a national roll-out	**Positive**

4.4 Medical quality of assessments

	Data	**Evaluation**
4a	**IQAS audit on a sample of assessments to compare contents of the report with the recording.** The recording did not change the audit grade or outcome of any reports, but seemed to improve the soft skills of the HCPs	**Positive**
4b	**Feedback from Atos on benefits of using assessment recordings to investigate customer complaints.** At the time of this report no recordings have been used to investigate customer complaints	**Inconclusive**

See section 5.2 for summary findings and a copy of the audit spreadsheet.

5. Clinical

5.1 Objectives

The medical purpose of the pilot was to evaluate whether the quality of the assessments would be improved with recording.

This can be measured in 2 areas:-

1. the quality of the report
2. the quality of the assessment (interview)

The existing IQAS audit in isolation would not be able to evaluate how closely the report mirrored the actual assessment or the questioning style of the HCP.

The approach adopted was:

- the report was be audited using existing IQAS criteria
- the interview was subsequently assessed by listening to the audio recording using newly developed IQAS criteria to see the additional information had an impact on the audit outcome.

5.2 Audit Methodology & Results

In a pilot of this size it was not possible to produce evidence that is statistically significant in view of the relatively small sample size and the lack of baseline data to compare against.

It has therefore been agreed in conjunction with HWWD that for each practitioner involved in the pilot that 5 cases will randomly selected for audit.

Ten HCPs were involved making a total sample size of 46 cases (one HCP only did 2 recordings).

The approach taken for audit was as follows:

1. Complete IQAS audit of a random selection of 5 cases included in the pilot in the traditional paper based way

2. Listen to the recording of the assessment using the recording audit criteria

3. Evaluate the content of the report in light of the recording and consider whether the original audit would be changed in any way as a result of having listened to the recording.

5.3 Additional IQAS attributes

As the recording provided additional information to the auditor that would not normally be available some additional IQAS attributes were agreed with HWWD.

	Audio recording IQAS attributes
1.	Introduces oneself appropriately
2.	Explains the process appropriately
3.	Deals courteously and appropriately with accompanying person/ carer
4.	Manner empathic
5.	Uses predominantly open questions
6.	Demonstrates active listening techniques
7.	Deals appropriately with any FME introduced on the day
8.	Seeks appropriately detailed consent to carry out examination
9.	Explains what examination entails
10.	Deals appropriately with clients questions
11.	Explains what will happen next
12.	Offers no opinion on outcome of claim
13.	Gives client sufficient time to provide history / typical day
14.	Questions sufficiently probing when necessary
15.	Deals with requests for special need requests appropriately (interpreter etc)
16.	Decide whether the typical day and diagnosis history was an accurate reflection of what was discussed

5.4 Audit Constraints

There were several constraints inherent in the design of the pilot which impact on the value of the data derived from it.

1. There is no baseline to compare the pilot cases with, making it difficult to draw definitive conclusions
2. All the HCPs were volunteers. This could introduce a bias in that it could be argued that only HCPs who felt highly confident in their competencies volunteered for the pilot. Those who had had recent complaints might have felt less inclined to volunteer.
3. As involvement with the pilot was optional for the clients. We cannot predict whether the customers who agreed to take part are more or less likely to complain. This could, in theory, introduce bias. Currently only one complaint has been received and this was a complaint based on the decision not the recording itself
4. The audio recording made in the examination room will not capture the full interaction in that the important meeting in the waiting room will be missed. Important visual and body language details will also be omitted.
5. Traditionally pilots undertaken by the DWP have had sample sizes in excess of 500. Any results coming out of this pilot, even if the above constraints could be addressed will not have statistical significance.

5.5 Outcome of audit

Time taken to perform an audit increased considerably due to the need to listen to the recording this would be a factor in a national roll-out.

Listening to the recordings did not change the audit grade or outcome of the report in any of the 46 audits done.

It was felt that the written reports were an accurate picture of what was discussed. There were a couple of cases early in the pilot were LiMA approximations were used that did not fully explain the situation but this would not have changed the outcome of the report. Deficiencies could be picked up looking at the paper report.

Overall the auditors felts that the recording provided a good vehicle for the identification of soft skill issues with HCPs. The amount of free text increased and soft skills improved during the pilot.

5.6 Clinical Considerations

5.6.1 Style of assessments

The style, content and approach to the clinical assessment was altered with a longer time required for introductions, confirmation of understanding and consent to recording and managing expectations of the status of the recording as part of the assessment as well as explanation that the written report will not be a word for word transcript of what is discussed and recorded. There is evidence from the customer satisfaction survey that HCP and client behaviours were altered with some quoting positive aspects and others saying they felt inhibited. The formality of the assessment was increased with a perception that everything needed to be recorded on tape, which is one of the factors in a longer MST.

5.6.2 Medical Standard Time

The impact of recording of assessments was expected to increase the MST due to change in behaviour by the client and HCP as well as an increased time in between cases initiating the recording and covering any consent issues.

Data was obtained from LiMA to look at the average time taken to complete WCA cases for the 10 HCPs included in the pilot for the 3 month period immediately preceding the pilot.

The average time to complete a case for these practitioners in the 3 months prior to the pilot was 66 minutes.

For the pilot cases the average time taken / case was 50 minutes with a range between 20 minutes and 2 hours.

The reduction in the average time to complete the cases is thought to be due an atypical group of clients agreeing to participate in the pilot. Out of 500 offers originally made only 46% of these progressed to a complete recording. It is thought that those clients that had a single physical disability may have been more likely to agree to participate in the pilot compared to those with multiple chronic conditions or mental health conditions.

The concerns that the impact of recording would increase the length of the assessments remains and this would be an area that would need to be considered carefully when planning a national roll out.

6. Client

In order to ensure an effective evaluation of the client experience we consulted Wyman Dillon (Independent Market Research Company) in order to obtain the best advice about how to gauge customer satisfaction in respect of the recording of medical assessments pilot. Wyman Dillon currently undertake the customer satisfaction surveys for AH.

6.1 Interview method

Interviews were conducted by telephone. Contact details were provided overnight in a timely manner, and the client call made within 2 or 3 days of the assessment, when the experience was still fresh. Call-backs were made at convenient times if necessary, and included evenings and/or weekends if requested. The interviews were the same as if it were face-to-face at the MEC, collecting views and satisfaction levels.

6.2 Survey content

The survey content was agreed with CMMS.

6.3 Survey Results

A total of 100 interviews were completed, 75 with customers whose assessment was recorded and 25 that weren't.

6.3.1 Headline Result

The general consensus of those surveyed was that recording assessments was a good idea, although relatively few said that they would be requesting a copy of the recording.

The behaviour of the health care professionals who conducted the assessments in the trial was judged to be at least as good as previous standards and largely outscored both the national average and the pre-pilot scores achieved by the Newcastle Assessment Centre. The only exception to this was with regard to explaining the purpose of the assessment where the standard achieved during the pilot fell slightly behind the previous Newcastle score.

Below are some of the results from the Customer Survey. Care should be taken when comparing the results as the different methodologies may influence responses (e.g. customer may feel more positively inclined if Atos

have gone to the trouble of telephoning them). The full satisfaction survey is embedded at the bottom of this section.

6.3.2 Summary of Report

Thinking about the beginning of your assessment, did the health care professional … (those saying yes as percentage of all remembering)

	March 2011 Postal Survey		**April 2011 Recording Pilot**	
	National	Newcastle	Recorded	Not Recorded
tell you their name?	95%	92%	100%	100%
wear a name badge?	79%	81%	97%	94%
put you at ease?	81%	74%	100%	82%
explain the purpose of the assessment?	85%	93%	92%	86%
explain how the assessment would be carried out?	82%	77%	93%	85%
give you enough time to describe your symptoms/difficulties?	76%	61%	97%	86%

How would you rate the health care professional for …(those saying very good or quite good as percentage of all remembering)

	March 2011 Postal Survey		**April 2011 Recording Pilot**	
	National	Newcastle	Recorded	Not Recorded
courtesy/politeness?	92%	83%	100%	100%
professionalism?	89%	82%	100%	100%
gentleness of the assessment?	91%	84%	100%	100%
unhurried manner?	85%	78%	99%	90%

In all aspects other than explaining the purpose of the assessment, the performance during the trial period was considered to be at least as good as normal, and in most measures much better.

It would also appear that being recorded had a positive effect on the behaviour of the health care professional during the pilot. These differences, however, should be treated with caution as the differing sample sizes can partly account for the disparity.

Do you think recording medical assessments is a good idea?

	Yes	**No**	**Don't Know**
All respondents	73%	13%	14%
Those consenting to recording	85%	5%	9%
Those not consenting	36%	36%	28%

Would the recording be helpful to you?

	Yes	No	Don't Know
All respondents	47%	42%	11%
Those consenting to recording	48%	45%	7%
Those not consenting	44%	32%	24%

Will you be requesting a copy of the recording?

	Yes	No	Don't Know
Those consenting to recording	23%	75%	3%

Finally respondents were asked whether they had **any other comments**. 79 people had something to say and the responses were diverse, but the general impression was that they were happy with the assessment, the health care professionals and the recording process – with a few exceptions.

7. Operational Impacts and Processes

7.1 Description of the service delivery

The pilot was undertaken in Newcastle MEC, which has 23 rooms; although only 10 digital recorders were available at any one time to manage set up costs.

A solution using individual hand held recorders was used for the purposes of this pilot.

7.2 Practical Operation of Process

During the pilot a total of 10 digital hand-held recorders were used. At the point of installation of the equipment all staff involved in the pilot were trained / familiarised with the operation of the equipment, including limitations and common issues. Medical Centre Administrators (MCAs) undertook ongoing admin input relating to the preparation of the equipment and the management of the completed recordings

Please see the imbedded process flow diagrams below which summarise the processes followed.

7.2.1 Client Flow

This flow describes the process followed to contact and schedule clients into appropriate recording slots.

Resource scheduling administrators initiated the contact with the customer. A log was kept on a shared drive to record the customer's response to whether they were willing to participate in the pilot. This log was also referenced as customers arrived for their assessment and updated if they subsequently did not consent or for some reason did not attend.

The log was used by Wyman Dillon to select customers for the customer satisfaction survey

7.2.2 Assessment Flow

This flow describes the process followed when a customer arrived at the MEC for their assessment.

The customer was given a Customer Fact Sheet to read if they were participating in the pilot whilst they were waiting for their assessment.

Formal signed consent was obtained by the HCP after the customer had been collected from the waiting area.

7.2.3 Recording Device Process Flow

This process describes the flow regarding the use of the handheld recording devices.

The devices were kept in a locked office and cabinet and prepared for use each day by MCA staff who issued a device as required to the HCP. The HCP would sign for the device and after completing a session would return the device to the secure area. The recordings would be transferred to the secure PC and the device formatted to completely erase all recordings on the device. The device was then ready for re-issue or returning to the locked cabinet if not required.

For those assessments selected for audit, the recording was listened to on the secure PC in the locked room.

7.3 Release of recordings

A signed written request was required if the customer requested copy of the recording. These were sent by recorded delivery to their home address and were un-encrypted.

To-date only 2 requests for recordings have been received and actioned.

7.4 Data retention

The advice provided by the Department was for the data to be retained for 14 months. Due the length of time it takes for a case progress through the appeal process it AH will need to maintain a process in place to provide copies of the recordings through out this time.

8. Impact of National Roll out

The impact of recording assessments for a national roll-out will depend on the will require decisions to made regarding whether this was an on demand or compulsory service. This would thereby define the requirements to allow a technical solution to be developed for national roll out.

Answers to all of these questions will impact on the potential one time costs and ongoing costs of a roll-out.

- Would recording of assessments be made compulsory for all clients?
- Would recording be extended to IBR reassessments or only apply to ESA cases?
- A discussion on potential national roll-out technical solutions to further clarify the amount of storage, network requirements and type of devices to be used in a national rollout. (Hand held devices are not an option for national roll-out due to security issues)
- How long would the recordings be required to be held?
- Would there be a requirement for a Disaster Recovery solution for recordings?
- Agreement with DWP to altered targets and/or increases in HCP and estates due to the increase in time needed to gain customer written consent prior to commencing an assessment
- Would listening to recordings be incorporated into standard audit processes?
- Agreement to a process for providing external bodies (JCP, tribunal service) access to recordings or transcripts.

8.1 Technical Considerations

Atos Origin currently has expertise in audio recordings through the contract with the Ministry of Justice. For that contract Atos Origin has installed audio recording solutions in courts across the UK. The solution is scalable and would be an option to be used for a national roll out. This option was not considered viable for the pilot and hand held recorders were used.

There therefore remain several unanswered questions and technical discussions to be had prior to national rollout.

There would be significant impacts on the IT Network as each recording is between 50Mb and 100MB. This traffic on even the internal networks within larger assessment centres would add significantly to the network load.

Depending on the technical solution, this would also impact on both the main network connection into the Andover data centre and also the infrastructure for any Disaster Recovery environment.

The length of time that AH would be required to store recordings would need to be agreed to determine the additional storage required for the recordings. We would also need to implement an archiving process to ensure storage did not grow year on year.

Potential technical delivery solutions are considered at a high level below.

8.1.1 Full DARTs solution

This is the solution that had been deployed within the court system and is also designed to be deployed more widely across Government. This comprises a front end recording system to be deployed in every examination room. The data would be stored on a local PC or server and then uploaded onto a back end system. For the courts service this is provided by a third party, Logica. This system would then allow access to the recordings to DWP as required via a web portal and if necessary a transcription service could be provided.

This would be the most expensive solution and at this stage it is not clear how often the data would be accessed making the remote access and transcription services underused.

8.1.2 DARTs with storage within Atos Healthcare

A cheaper alternative would be to use the same recording equipment in the MEC but the information would be initially stored on a local PC in each exam room and uploaded via an automated process to central Atos Healthcare server overnight.

Alternatively the data could remain stored at the local site on a PC. The disadvantage here would be that there would be no disaster recovery and it would be difficult to provide copies of the recordings quickly on request. They would need to be burnt to CDs or data cards to be transferred which would have a negative impact on data security.

It would not be possible to use the current thin client machines currently in the MEC for this purpose. So a roll-out of alternative equipment would be required.

8.2 Clinical Considerations

8.2.1 Medical Standard Time (MST)

The impact of recording of assessments on the time taken to complete assessments (MST) is inconclusive but it anticipated that if made compulsory for both clients and HCPs this would has increase the MST due to change in behaviour by the client and HCP as well as an increase time in between cases

initiating the recording and covering any consent issues. The nature of the technical solution will determine the extent of this as well and the time required for such things as labelling the output material.

8.2.2 Training

The training of new HCPs will need to be amended and all existing HCPs will need an element of retraining around consultation style and content, managing customer behaviours, managing equipment failures etc

8.2.3 Morale

With only a sample of 10 HCPs we still cannot predict the impact on morale and attrition. Whilst the output form the pilot suggests that the HCPs coped well with the recording and it became fairly unobtrusive it is inevitable that there will be group of HCPs that will find the introduction of recording threatening and this will have an impact on HCP morale, attrition and potentially our ability to attract new recruits.

Recording of all consultations is not normal clinical practice in the wider healthcare environment. Recording is used in clinical environments on limited case volumes for training and audit purposes as is the case in our own induction training. What is being requested is a substantial change from this and likely to cause apprehension amongst less-experienced practitioners in particular and a feeling of a lack of trust in their professionalism and competence.

However some HCPs saw this as a form of protection against spurious complaints.

8.2.4 Audit

The time taken to audit an assessment increased considerably and took approximately 45 to 60 minutes longer than a normal paper audit because of the need to listen to the recording as well as consider the written assessment.

This would obviously add to the cost of performing audits in any national roll-out situation if the requirement form DWP was to utilise the recording in the performance of audits.

The audit of the recording does allow evaluation of the quality of the interaction between the HCP and the client and the questioning styles. IT therefore suggested that the recordings would not be used as part of a standard audit but there may be benefits if this is considered as apart of the post approval audits or where there are complaints about the HCP’s manner.

8.3 Operational Impacts

To a significant extent the operational impact of this change will vary depending on the final solution. However, it is possible to highlight the areas that will be impacted to some extent.

8.3.1 Customer Queries

From the pilot it was proven that whatever communications were done with customers prior to their assessment regarding the recording of medical assessments MEC receptionists received questions relating to it. This was partially mitigated by providing a fact sheet to each customer as they arrived at the MEC. There is still potential for the VCC to need to field such queries. The extent to which this would be the case was not informed by the pilot

8.3.2 Practical Operation of Process

If all examinations are to be recorded the assumption is that all examination rooms would be fitted out with the chosen recording equipment. At the point of installation of the equipment all staff would need to be trained/familiarised with the operation of the equipment, including limitations and common issues. It is expected that the implementation of this change will require ongoing admin input related to the preparation of the equipment and the management of the completed recordings which would increase the need for admin resource. In smaller MECs where admin resource is restricted to one person a solution would be needed to cover for absences.

An area that Atos Healthcare needs more specific requirements on is the contingency process in circumstances where a recording is not possible. This needs to cover both circumstances where it is known before the start of the examination that recording will not be possible in a certain exam room and circumstances where recording stops part way through an examination.

8.4 Impact on Accommodation and Medical Resource

As with other elements ultimately the impact on accommodation depends on any change that occurs to the MST as a result of the introduction of recording.

The impact on MST has already been discussed earlier in this document as being inconclusive.

The impact on HCP capacity and estate capacity would still need to be considered as part of any national roll out and it is suggested that any roll out would need to be staged on a region by region basis to assess this.

9. Conclusions

The aim of this pilot was to obtain a view of

- the feasibility of recording assessments
- whether clients would want to use this service and whether they found it helpful
- the acceptability of recording to the HCPs
- the impact on of recording on the quality of the reports
- the impact on medical standard times

The technical solution used was not suitable for national roll out mainly on the grounds of data security and the recording was not made compulsory therefore the outcome of this pilot can only given a high level view of the potential impacts and help to highlight the areas that would need closer consideration if national roll out was considered.

9.1 Client

Overall clients seem to view the introduction of recording as positive but out of 500 offers made less than half went on to have a recorded assessment. Of those who had a recording only 48% said that they found it helpful when surveyed after the assessment.

The client satisfaction survey conducted by telephone showed an increased level of satisfaction across all groups.

There were no problems encountered during the assessments.

Only 1.7% of clients have requested a copy of the recording to date.

9.2 HCPs

9.2.1 Personal

There was some initial reticence amongst HCPs to volunteer to participate but the feedback form the HCPs after completion of the pilot was generally positive and the concerns regarding the impact of recording on the rapport during the assessment did not materialise.

There remain some general concerns regarding the potential inappropriate use of the recordings by the clients such as posting on web sites.

The presence of the recording may make aggressive clients less likely to be abusive if the assessment is being recorded and may provide the HCP with some protection against malicious complaints.

9.2.2 Quality

The audit with use of the recording did not have any impact on the audit grade awarded but it was felt that the recording could be used as a valuable learning tool as part of a mentoring programme for HCPs with quality or poor customer service or in the early approval stages for new HCPs. It is felt it does not have a role for routine audit use

9.3 Operational Impact

Prior to the pilot the most significant concern was the impact of recording on the medical standard time. For the cases that agree to participate in the pilot these was not adverse impact on the MST although it is felt that the cases included were not typical of the normal ESA / IBR case load and therefore further work would need to be done to evaluate this further should roll out be considered.

Additional time may be required for investigation of complaints but to date only one case included in the pilot had generated a formal complaint.

9.4 DWP

The availability of recordings will have an impact on the JCP decision maker and also the appeals service but this pilot has not sought to assess what the impact may be.

9.5 Next steps

Within the limitations of the pilot the overall position from both the HCP's and client's view is that the introduction of a recording facility into the assessment process has benefits.

Consideration of the technical solution to achieve large numbers of recordings and store these securely as well as having a process whereby these can be made available to the complaints team, the decision maker and the appeals service is still required.

The pilot allowed clients to opt in to recording rather than the recordings being compulsory as they would be when ringing a call centre. This will be a key consideration as part of a national roll out.

If it is decided that compulsory recording should not proceed there remains an urgent need to put an ad hoc recording process in place to satisfy an increasing number of client requests that are being received currently.

Historically Atos Healthcare's policy, in agreement with DWP has been to allow audio recording of assessments when requested but it has required the customer to provide the recording equipment. To ensure that the recording is

fair to both the customer and the HCP, dual recording equipment has been required with professionally calibrated equipment.

Over the past few years the number of requests to record assessments has been small number but more recently it has been accepted in order to comply with the Data Protection Act, we are unable to prevent a customer requesting recording an assessment if they so wish.

In compliant letters and written requests an increasing number of customers are also quoting "Upper Tribunal case CIB/3117/2008" which relates to a customer who was disallowed on the basis that he had not attended a medical assessment because he was not able to record it.

As a result of the publicity surrounding the Harrington recommendations, the Government's acceptance of these recommendations and an increase in activity on welfare rights blogs relating to recording, there has been a significant increase in requests from customers to undertake recordings.

Feedback from the customer relations team indicates that they currently receive 1- 2 enquiries a day regarding recording of assessments and one formal complaint / week where a request has been made and we have indicated that the customer needs to supply their own equipment.

AH's current position has been to maintain the line that we were undertaking a pilot and we would make changes to the process and availability of recording once this was complete – otherwise the existing processes of requiring the customer to provide their own dual tape machine remained in place.

In light of all the publicity surrounding the recording and the commissioners' decisions it is understandable that customers do not feel this is an acceptable position. There is therefore an urgent need to decide how the issue of recording of assessment is progressed and AH is keen to work closely with the Department to develop a measured and cost effective way of implementing this.