Research report

Decision making on Employment and Support Allowance claims

by Lorna Adams, Katie Oldfield and Catherine Riley

DWP Department for Work and Pensions

Department for Work and Pensions

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Abbreviations and glossary of terms

Atos Healthcare	Atos Healthcare, the contractor responsible for conducting the Work Capability Assessment
DM	Decision Maker
DWP	Department for Work and Pensions
ESA	Employment and Support Allowance
ESA50	A questionnaire claimants complete, giving details of how their health condition affects their day-to-day activities
GP	General Practitioner
HCP	Healthcare Professional
IB	Incapacity Benefit
IBR	Incapacity Benefit Reassessment
IS	Income Support
JSA	Jobseeker's Allowance
LCW	Limited Capability for Work
LCWRA	Limited Capability for Work Related Activity
NFD	Non Functional Descriptor – a regulation invoked to allow a claimant ESA in cases where a DM deems a return to work to be a risk to the claimant
Paper scrutiny	Decisions on ESA entitlement which are made without a face-to-face Work Capability Assessment
SDA	Severe Disablement Allowance
WCA	Work Capability Assessment
WFI	Work Focused Interview
WRAG	Work Related Activity Group

Summary

This report covers findings from a small-scale qualitative study commissioned to understand more about how Decision Makers (DMs) make judgements in the minority of Employment and Support Allowance (ESA) cases where they potentially face conflicting evidence, or where it may be debatable which outcome should be awarded. Throughout the report these types of cases will be referred to as 'borderline'. The research involved ten group discussions with DMs across five Benefit Centres and ten depth interviews with Atos Healthcare Professionals (HCPs) responsible for conducting Work Capability Assessments (WCAs), which took place in September and October 2011.

The research explored overall views on the role of the DM, the types of cases that tended to be borderline and the approaches to reaching a decision on these, relationships between Atos and Benefit Centres and the training and guidance available for DMs.

Role of the Decision Maker

All DMs participating in the research were aware of the key recommendations made in the Harrington Year 1 Review of the WCA[1] around improving the fairness and effectiveness of the WCA specifically and empowering and investing in DMs so that they are able to make the correct decision on ESA claims. For the most part they considered this appropriate and welcomed the recommendations.

However, despite initial movement towards greater empowerment of DMs, many felt that by the time of the research, the guidance that they had been given had been revisited in such a way as to give them less control over decision-making. Some felt that they still had some ability to reach their own decision over borderline cases where they disagreed with the Atos advice while others felt limited in this respect. In the latter group were those who felt they had been expressly told that they could not make a decision that ran contrary to the Atos advice without securing Atos agreement to do this (which they had found Atos reluctant to provide).

Generally, DMs needed further clarity on how they should approach decision making.

Borderline cases

None of the Benefit Centres covered by this research had specific procedures for identifying and handling borderline cases. Cases that DMs found more difficult to reach decisions on were not generally limited to those that were on or near the boundary of two ESA outcome categories. Typically, these more complex cases were those that DMs came across in their normal caseload of claimants likely to be disallowed but where they felt that there was reason to question the advice of the HCP who had conducted the WCA.

For most DMs, the WCA report compiled by Atos was considered to be the main piece of evidence when assessing a case and in the majority of these cases, the advice given by Atos in this report was followed. The proportion of cases considered to be borderline where DMs sought clarification or guidance from Atos or acted against the advice of the WCA report was small. DMs struggled to quantify the volume of cases involved but estimates given tended to be around the 1 in 40 mark. DMs who felt that some of their decision making power had recently been revoked stated that in the immediate aftermath of the publication of the Harrington Year 1 Review this volume had been much higher but they had been under pressure to reduce it.

[1] Harrington, M., *An Independent Review of the Work Capability Assessment* (November 2010).

Where DMs felt that there was evidence that ran against the advice in the WCA report they could either choose to raise queries with Atos and ask HCPs to review the case or they could choose to change the points allocated under particular descriptors (statements that best fit how a claimant's condition affects execution of daily tasks or activities) without recourse to Atos (or to apply Non Functional Descriptors (NFDs) to the case). Some felt they had been instructed that only the former option was open to them and that – in cases where Atos did not agree with their suggested amendments – they were forced to 'rubber-stamp' a decision that they were not satisfied with.

This research interviewed relatively senior DMs who in the main dealt with cases where the issue was of disallowance (rather than allocation to the Work Related Activity or Support Group). Most of the evidence collected concerned cases where DMs felt that the WCA advice of disallowance was wrong. While they had some experience of DMs questioning WCA advice to allow ESA, they reported such cases to be rare.

Cases where DMs were more likely to have queries over the HCP's advice were those involving claimants with mental health or fluctuating conditions. This was generally because the descriptors that applied to mental health cases were felt to be more subjective and open to interpretation. This was a view shared by Atos staff. While there was some acknowledgement that this was inevitable, DMs felt that there was scope for greater clarity on the meaning of each of the descriptors and wanted training on how they should be applied.

Other types of borderline or unclear cases were those where there were apparent internal inconsistencies in the Atos medical report, where complications had been caused by claimants completing parts of the ESA50 that were not relevant to their condition or cases which had been assessed by Atos on paper scrutiny alone (i.e. without a face to face assessment). DMs also stated that it sometimes became complicated to reach a decision on a case if evidence was provided by the claimant after the WCA. Sometimes this was because it was difficult to assess whether documentary evidence genuinely added anything new to the case. More commonly the issue was that this evidence was provided verbally over the phone making it difficult to present to Atos.

DMs generally agreed that it was appropriate to consult Atos in cases where their queries about a case related to:

- internal discrepancies within the Atos medical report;
- a DM need for further explanation or clarification on a specific medical condition or term in order to reach a decision;
- if the claimant has provided further 'medical' evidence after attending the WCA.

Action taken on borderline cases varied more when reasons for considering acting against the HCP advice related to:

- the DM perceiving discrepancies between the ESA50 and the WCA report;
- claimants providing additional evidence about the way their condition affects them (rather than strictly medical evidence) after the WCA.

Reaching a decision on borderline cases

Some DMs felt that they could not act against the advice of the WCA report in these sorts of cases without the express agreement of Atos. Some felt that they had to refer these cases to Atos first but could still act against the advice of the WCA if Atos did not agree with their suggested approach. Others felt that they had discretion over whether or not to involve Atos at this point and could choose to act against the advice of the WCA report if they felt the evidence was sufficiently strong.

Generally, Atos HCPs felt that it was reasonable for DMs to act against their advice without involving them if they had sufficient evidence to do so. Atos HCPs viewed the role of DM as an independent assessor of evidence who should have the authority to make a final decision without necessarily seeking Atos' approval. They viewed their own role as one that was subsidiary and advisory.

Until recently, the Benefit Centres participating in this research had a regular scheduled Atos HCP presence within the Benefit Centre. This enabled some discussion of borderline cases. Workload pressures have led to the cessation of these visits which has reduced the amount of informal discussion of borderline cases that takes place (although there is still a helpline resource that DMs can access if they wish to discuss cases). However, DMs generally reported an amicable working relationship with Atos.

Implications for policy and practice

The research has identified some areas of the process that may be worth reviewing. These focus on the role of the DM and, more specifically, how DMs deal with borderline cases. We discuss each of these below. It is worth noting that these are largely based on the interpretation of the findings by the researchers conducting the study rather than direct recommendations from participants.

- Communication of guidance on role of Decision Makers and Atos

The research found considerable variation in DMs' views of their role in the decision-making process, and some felt that the consistency of the communication of guidance about their role could be improved.

- Decision Makers handling of mental health cases

DMs were more likely to query or go against the Atos advice in cases involving mental health issues, compared to those relating to physical impairments. In some cases, DMs felt that the descriptors that could be applied to mental health cases were vaguer and more subjective and that there was scope for more guidance and training on using these descriptors.

- Collection of monitoring information

Evidence from this research suggested considerable variation in the volume of cases returned to Atos from the Benefit Centres for clarification, and the volume of cases where the final decision went against the advice in the Atos WCA report. It may be helpful to get an indication of the variation in DM approaches by collecting information about these aspects of cases.

- Feedback on Decision Maker assessments

Deciding the outcome of ESA claims is a complex process and the original decision can be changed on appeal, leading DMs to feel that they need feedback to judge their own performance and therefore improve their decision making. More effective feedback mechanisms on decisions (including the level of cases that are successfully appealed), and communication with DMs on the factors that lead to successful appeals, could be beneficial.

- Claimant calls from Decision Makers

Not all Benefit Centres had introduced the calls to claimants to inform them of the likely outcome of their claim and to give them the opportunity to provide additional evidence at the time of the research. DMs felt that it would be more in keeping with a move to empower DMs if they had some discretion over which claimants they made calls to. This would enable them to focus their efforts on borderline cases where they felt there was potential for their decision to be influenced by the call.

- Reintroducing site visits from Atos Healthcare Professionals

In all Benefit Centres, regular site visits from a dedicated Atos HCP had been withdrawn as a result of workload pressures. However, the majority of DMs felt that these visits had been very positive in developing working relationships between DMs and Atos and improving the knowledge of DMs about how particular impairments or conditions might affect claimants, and would welcome their return. There was an indication that this regular presence encouraged greater discussion of borderline cases than is currently the case, when DMs only have the ability to call the Atos helpline.

- Training for Decision Makers

Most DMs felt that they had not received training that had been specifically designed for DMs and that what they had received had been adapted from material designed with other operational staff in mind. Some DMs felt they would benefit greatly from talking through case study claims and how they should be interpreted.

Some less experienced DMs felt that they would benefit from a better understanding of the implications of outcomes of ESA claims (i.e. what happens when claimants are disallowed or enter the Work Related Activity Group). They felt this would put them in a better position when explaining the implications of their decisions to claimants and in determining the suitability of particular outcomes for individual claimants.

1 Introduction

This report presents findings from research commissioned to explore 'borderline' Employment and Support Allowance (ESA) claims. A minority of ESA cases are more complex to assess. This can occur, for example, where there is contradictory evidence, or where paperwork is poorly completed. This report focuses intentionally on the types of cases where these complexities arise, how DMs deal with them, and how support for DMs could be improved to result in a better assessment process. In considering these issues, the report focuses on areas of the process where there is scope for improvement.

ESA was introduced in October 2008 to replace Incapacity Benefit (IB), Severe Disablement Allowance (SDA) and Income Support (IS) paid on the grounds of illness or disability. It provides financial support and personalised help for people who are unable to work, because of a health condition, with an emphasis on what people can do, as well as what they are unable to do. Most people claiming ESA will be expected to take steps to prepare themselves for work, including attending a Work Focused Interview (WFI) with a personal adviser. However, those with an illness or disability that severely affects their disability will not be expected to prepare for a return to work, although they can volunteer to do so if they wish.

A typical claim for ESA takes several stages which are:

- the completion of an ESA50 (a medical questionnaire) by the claimant which is then returned to Atos Healthcare;
- a WCA attended by the claimant and conducted by an Atos Healthcare Professional (HCP);
- the gathering and assessing of evidence by the Decision Maker (DM) to decide the outcome of the claim – including the ESA50 and Atos medical report, alongside any other medical evidence the claimant may have supplied;
- a phone call to the claimant by the DM to advise them of their claim outcome and to ask for any other evidence that might support their claim;
- an outcome notification.

To be awarded ESA, a claimant must score a total of fifteen points at their WCA. In their report, Atos HCPs will assign statements or descriptors that best fit how a claimant's condition affects their execution of daily tasks or activities. Activity descriptors are split into physical and mental functionality and are graded in terms of severity – each grade equating to a certain number of points. The DM will then review the Atos medical report alongside the claimant's ESA50 (where available) and any other additional evidence.

If found eligible for ESA, claimants will be placed in one of two groups depending on the severity of their illness or disability. Those claimants displaying Limited Capability for Work (LCW) but able to prepare themselves in some way for a return to work are placed into the Work Related Activity Group (WRAG) which involves them attending a Work Focussed Interview (WFI) with a personal adviser and receiving support to help them prepare for suitable work. This group of claimants receive a payment in addition to the basic ESA allowance, provided they undertake the required work-related activity. Of all new ESA claims received between October 2008 and August 2011 across England, Scotland and Wales, 16 per cent were placed in the WRAG[2].

Those with more severe functional limitations who are found to have Limited Capability for Work Related Activity (LCWRA) are placed in the Support Group (which accounted for eight per cent

[2] http://statistics.dwp.gov.uk/asd/workingage/index.php?page=esa_wca

of those who put in a claim for ESA)[3]. If placed in this group a claimant will receive a support component in addition to the basic ESA allowance. Claimants in this group will not be expected to participate in activities to prepare them for a return to work, however they can so do on a voluntary basis.

If found fit for work (around 37 per cent of all claims for ESA) a claimant will be advised that they are not eligible to receive ESA and that they can apply for Jobseeker's Allowance (JSA)[4]. The remaining 39 per cent of new claimants either closed their claim before completing the WCA process or it was still in progress. [5] Claimants are able to appeal their decision if they are not found eligible for ESA and submit further medical evidence to support their continuing claim. Around 15 per cent of all new claims for ESA in this period resulted in the claimant appealing against an original 'fit for work' outcome.[6]

A DM plays a key role in processing claims for ESA. They are ultimately responsible for deciding whether or not a claimant should be allowed ESA and if so whether or not they are capable of taking steps to prepare themselves for work.

The research was commissioned within the context of the recent Harrington Year 1 Review of the WCA – the first of five independent evaluations of the fairness and effectiveness of the WCA.

One of Professor Harrington's key recommendations of the report was that the Department for Work and Pensions (DWP) should empower DMs and invest in their development so that they are able to make the correct decision on ESA claims. This provided an important background against which DMs discussed the processes they follow when making a decision on an ESA claim.

1.1 Aims and objectives

The overall aim of the research was to understand more about how DMs find the process of making decisions about ESA cases and borderline cases in particular. It was intended to investigate the need for further guidance for DMs in assessing borderline cases.

More specifically, the research aims were to:

- understand the types of cases that can be considered borderline;
- examine how DMs currently deal with these types of cases;
- provide recommendations and guidance to support DMs in reviewing borderline cases.

1.2 Methodology

A qualitative approach was taken, involving a programme of ten group discussions with Jobcentre Plus DMs at five different Benefit Centres and ten depth interviews with Atos HCPs. Each group

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3 Ibid (percentage is of all new ESA claims received between October 2008 and August 2011 across England, Scotland and Wales.)

4 Ibid (percentage is of all new ESA claims received between October 2008 and August 2011 across England, Scotland and Wales.)

5 Ibid (percentage is of all new ESA claims received between October 2008 and August 2011 across England, Scotland and Wales.)

6 Ibid (percentage is of all new ESA claims received between October 2008 and August 2011 across England, Scotland and Wales.)

involved between three and five DMs and were moderated by a member of the project team at IFF, all of whom had previous experience of moderating Jobcentre Plus staff discussions on ESA decision making. The ten group discussions took place across three weeks in September 2011. A more detailed breakdown of who was involved in the group discussions can be found on Table 1.1.
The participating Benefit Centres were selected to provide a mix in terms of:

- the outcome profile of ESA claims processed (i.e. the proportion of claims resulting in Support Group, WRAG or disallowance decisions);
- location (to give coverage across England, Scotland and Wales);
- types of claim processed (new and existing ESA claims or both new ESA claims and Incapacity Benefit Reassessment (IBR) cases).

Within each Benefit Centre, two group discussions were held. Different types of DMs were invited to attend each of the discussions to try to maximise common ground between participants and ensure that staff felt able to contribute their views freely. In some Benefit Centres one discussion was held with more experienced DMs and one with less experienced DMs. In others one was held with those responsible for making decisions on IBR cases and one with those responsible for decisions on new or existing ESA claims. DMs interviewed for this research were more senior and therefore dealt mainly with cases likely to be disallowed. This meant that they only really had experience of cases at the borderline between being allowed and disallowed (and not of the borderline between cases allocated to the WRAG group and those allocated to the Support Group). Some DMs were occasionally involved in advising other less experienced DMs on cases where the Atos advice was that a claimant should be allowed ESA but the DM questioned whether this outcome was correct. Table 1.1 below summarises the group discussions conducted.

Table 1.1 Overview of fieldwork approach

Group	DM experience	Outcome profile of ESA awards	Benefit Centre
1	More experienced IB Reassessment DMs	Higher proportion of Support Group awards than national average	Scotland
2	More experienced DMs on new ESA claims		
3	More experienced DMs on new ESA claims	Higher proportion of WRAG awards than national average	England
4	Less experienced DMs on new ESA claims		
5	More experienced DMs on new ESA claims	Higher proportion of Fit for Work (disallowance) awards than national average	England
6	Less experienced DMs on new ESA claims		
7	More experienced DMs on new ESA claims	Average profile	Wales
8	Less experienced DMs on new ESA claims		
9	More experienced IB Reassessment DMs	Average profile	England
10	More experienced DMs on new ESA claims		

In addition to the group discussions, a short interview was conducted with the Team Leader responsible for managing the DMs participating in the group sessions.

Both the group discussions and the interviews with Team Leaders explored:

- the role of the DM in processing ESA claims;
- types of cases that can be considered to be borderline;
- how decisions are reached on borderline cases;
- additional support or guidance that would assist DMs in performing their role effectively.

Each group discussion typically lasted between 90 minutes and two hours while the depth interviews with Team Leaders lasted around half an hour.

In addition to research among DWP staff, a series of ten in-depth telephone interviews were undertaken with Atos HCPs responsible for producing WCA reports on ESA claims processed at the participating Benefit Centres. As well as producing these reports, some of these staff were also responsible for staffing the Atos helpline that DWP staff can contact with queries about individual ESA cases.

These interviews explored HCP views on the same issues discussed with DMs and lasted around 30 to 40 minutes on average and were conducted by either a member of the research team or one of IFF's qualified in-house qualitative interviewers across five days in the last two weeks of October 2011.

Each group discussion and interview was transcribed.

A coding framework was devised relating to all sets of interviews, but which also reflected the distinctive concerns of particular groups of respondents, such as IBR and ESA DMs or Atos HCPs. The framework was developed by the research team who had been involved with both the group discussions and depth interviews with Atos staff.

The framework made provision for recording of answers to direct questions asked of respondents as well more interpretive data collected through more discursive approaches. Each individual interview/group discussion transcript was coded into broad themes (for example, types of cases that were seen as more complex to deal with or approaches to handling these cases) using a manual approach by members of the core research team. All the information in each theme area was then reviewed and further coded into sub-themes, allowing an assessment of the relative weight/ commonality of issues raised and how views varied by respondent type. Analysis was conducted by all members of the project team.

All topic guides used can be found in Appendix A and B.

1.3 Report structure

The remainder of the report is structured into five chapters of findings and a final conclusions and recommendations chapter. Each chapter covers the views of both DMs and Atos HCPs.

Chapter 2 discusses the perceived role of the DM and recent changes to their working practices. Chapters 3 and 4 explore the types of cases considered to be borderline. Chapter 5 and 6 cover working relationships between DMs and Atos HCPs and training issues. Chapter 7 presents conclusions and recommendations from the research.

2 Role of the Decision Maker in the decision making process

This chapter provides some information on how Decision Makers (DMs) view their role in determining the outcomes of Employment and Support Allowance (ESA) claims. This provides useful context for the rest of the report, which explores how DMs handle borderline cases (such as those where the DM faces potentially conflicting evidence or where it may be debatable whether cases should be in one outcome category or another).

The role of the DM in a claim for ESA is to gather and review a claimant's evidence in support of their claim for ESA and make an informed and, importantly, justifiable decision on whether or not that claimant is eligible to receive ESA, and, if so, which of the two groups (Support or Work Related Activity Group (WRAG)) the claimant should be placed in. Typically, the evidence includes the claimant's ESA50 in which they describe how their condition affects their ability to execute daily tasks, an Atos medical report compiled by the Healthcare Professional (HCP) who conducted the WCA to gauge an individual's capability for work, alongside any other additional evidence submitted by the claimant's General Practitioner (GP), advocate or other support worker. The evidence is scrutinised by the DM and descriptors or points awarded to the claimant based on the perceived severity of the condition or disability.

There has been some scrutiny of the role of DMs in ESA claims recently. In the first of his five independent reviews of the Work Capability Assessment (WCA) (published in November 2010), Professor Harrington outlined key recommendations to improve the fairness and effectiveness of the WCA. One of his recommendations was to empower and invest in DMs so that they are able to make the correct decision on ESA claims. The Government accepted the recommendations made in the first review and rolled out activity to ensure that they were taken on board across all Benefit Centres.

This research took place around ten months after the publication of Professor Harrington's Year 1 Review.

2.1 Extent to which Decision Makers feel empowered

There were wide ranging views among DMs on how they characterised their contribution towards the decision-making process. Some DMs felt that they were at the heart of the decision making process (as the Year 1 Harrington Review recommended) with the ability to use their experience and judgement to weigh up the evidence available to them. Some felt that their role was in effect just to 'rubber stamp' the outcome advised by Atos in the WCA report. Others felt that their role lay somewhere between these two extremes. These overarching views of the role of the DM tended to underpin approaches to handling borderline cases, which are discussed in Chapters 3 and 4.

All DMs were aware of the recommendation in the first Harrington Review that they should be central to the decision-making process and that they should be empowered to make judgements about the correct outcome for each claim through considering the Atos report alongside other available evidence. The majority of DMs supported this recommendation and felt that this was a role that they wanted to fulfil. However, a minority of generally less experienced DMs did not feel that it was right for someone in their position to perform this role and felt that the views of trained HCPs should largely determine the outcomes of ESA claims.

The variation in the degree to which DMs felt that they were genuinely at the heart of the decision-making process largely depended on the direction that they felt that they had received from senior management within their Benefit Centre since the publication of the Year 1 Harrington Review.

Most DMs reported that an initial move towards greater freedom to employ their own judgement in ESA cases took place in around April/May 2011 when staff were encouraged to embrace the recommendations of the Year 1 Harrington report. DMs in some Benefit Centres had not received any alternative guidance since then and continued to feel that they were empowered to take a central role in decision-making. However, a number of DMs felt that they had since received instructions that had reduced the extent to which they felt empowered in their role.

It was relatively common for DMs to talk of a 'u-turn' in the guidance they had been given about how they should reach decisions on ESA cases.

> *'At the outset we felt empowered...but within the last couple of months the Department has definitely steered us away from that empowerment.'*
>
> (More experienced ESA DM)

DMs who no longer felt that they were genuinely at the heart of the decision making process reported that they had been given very specific guidance on how to approach cases where they disagreed with the advice of the Atos report. They stated that they had recently been told that they could not do this without first consulting with Atos (whereas immediately following the publication of the Year 1 Harrington Review, these DMs felt they had been told they could override the Atos advice if they felt that the evidence pointed towards an alternative outcome). Some felt that they had been told even more specifically that they could not override advice unless they had agreement from an Atos HCP that this was the correct route to take.

Those staff who felt they had been instructed not to go against the advice of an HCP report unless they had agreement from Atos that this was appropriate tended to be those who felt least empowered and least central to the decision-making process. In cases where they consulted with HCPs and Atos elected to uphold the initial advice, then some of these DMs felt that they then had to 'rubber stamp' a decision that they were not happy with.

> *'We went from being decision makers to just rubber stamping what's there...the simple fact is I'm your decision maker but if I get further evidence from you as the claimant, I am not the one to make a decision on it – it needs to go through Atos. To me, that makes* [the] *Harrington* [Review] *pointless.'*
>
> (IBR DM)

The DMs that felt they had been instructed to consult with Atos on all cases where they wished to override the advice of the HCP report but felt they still had scope to determine the outcome of a case themselves if they could not reach agreement with Atos described these instructions more as a 'partial u-turn' from the direction they received immediately following the first Harrington Review. These DMs felt that they were neither empowered in the way that they had been previously nor simply rubber stamping Atos advice. Some of these DMs felt that this was an appropriate middle-ground for a DM to occupy.

DMs were not always clear on the reasons why the guidance they had been given on their role in the decision-making process had changed. Generally, it was felt that pressure to reduce the volume of ESA decisions that were appealed underpinned the guidance to involve Atos in any cases where the DM was minded to disagree with the HCP advice. The feeling was that the instructions that they had received were designed to ensure a clearer audit trail in the event of an appeal. Others felt that the

guidance stemmed from concern over a drop of the volume of cases processed since DMs were first instructed to take a more central role in the decision-making process. In either case, DMs felt that management teams with responsibility for different areas of the business were pulling in opposing directions, leading to them receiving conflicting guidance on their role.

2.2 Recent changes in Decision Makers' working practices

Aside from direction about the overall role of the DM in processing ESA claims, there have been three specific changes to DM working procedures since the implementation of the first Harrington Review. All of these were introduced in an effort to simultaneously empower DMs and manage and support the claimant throughout the process. These changes were the introduction of a:

- phone call made by the DM to the claimant to explain their decision on whether or not the claimant has been found eligible for ESA;
- more detailed written justification by the DM to explain the reason(s) for allowing or disallowing a claimant ESA;
- personalised summary statement written by the Atos HCP in their WCA report to justify their choice of descriptor(s).

These changes had some bearing on the evidence available to DMs in processing ESA cases and hence had an impact on the treatment of borderline cases. As such, we briefly discuss DM views on these developments below.

2.3 Phone call to claimant

An additional step has been built into the decision-making process that requires DMs to attempt to speak to claimants on the phone to advise them of the likely outcome for their claim for ESA before the final decision is made. If the claimant is likely to be found disallowed, DMs ask at this point if they have any additional evidence that might further support their claim.

At the time of the research the phone call had only been introduced in some of the Benefit Centres visited. However, those working in Benefit Centres that were not yet making these calls were aware that they would soon be asked to do so.

DMs had mixed views on the value of these phone calls. Overall, the call was felt to be helpful in generating additional evidence only in a small minority of cases.

> *'Every now and again you do pick up some new information and you're very grateful you didn't disallow them in the first place and then get the information after.'*
>
> (ESA DM)

DMs felt that because the call reached claimants 'out of the blue' they were often too shocked to respond to the request for additional information. They felt claimants tended to be unable to respond at all or were simply preoccupied by concerns over when their payments would stop.

Some felt that the call was a waste of resources and could not see any positive value in contacting claimants in this way. Others felt that it had potential to provide better customer service but felt that the call would have more value after claimants had had time to consider whether they had any additional evidence to provide. Their suggestion was that claimants should receive some sort of written summary of the evidence considered and likely outcome prior to receiving the call.

DMs generally felt frustrated that they were expected to attempt to call all claimants and that they were not able to exercise any discretion over which claimants to call. This lack of discretion appeared to DMs to be at odds with an intention to give them greater empowerment in handling cases.

> *'When we make these phone calls there is there is no evidence, you know before you phone that you are not going to get anything different because of the nature of their incapacity, and the claimants are saying "Send me a GL24 form" which is the appeal form...so that phone call isn't achieving anything, it is taking up our time because you know you are not going to get them to claim JSA and why should they, because it is the same rate of benefit as it is on the appeal rate.'*
>
> (More experienced ESA DM)

2.4 The longer Decision Maker's justification

All the DMs interviewed stated that they were now producing longer justification statements to accompany their decisions. They understood the aim of these statements to be largely about ensuring transparency in the event of an appeal. Some also believed that these statements might eventually be sent to claimants.

There was general support among DMs for the underpinning principles of the justification in that it evidenced their role as decision makers. Although a consistent approach was being adopted by all DMs in how it was written at the time of research, there was some variation between DMs in the extent to which they felt that this was a departure from their previous approach. In most cases, DMs felt it did not entail an overhaul of the way in which they reviewed a case and made a decision, but rather marked an intensification of paperwork. However, some did feel that they now scrutinised cases in much more detail so that they were able to fully justify their decision.

> *'We always did do a justification, but we didn't address absolutely every single area that they* [the claimant] *identify themselves, for example if you had somebody with depression, you'd sort of look at their general mental health problem or just talk generally about their mental state but now you've got to say, if they say they can't go out, well why do you say they can go out on their own, why do you say that they can interact with people, why do you say that their behaviour is appropriate for people, you know, all the areas they ticked.'*
>
> (Less experienced ESA DM)

Producing the more detailed justification was regarded by DMs to be very resource intensive. Concerns were expressed about the impact that the time spent producing these statements was having on the volume of cases that they were able to close within a specific time period.

Some DMs were under the impression that the longer justification had been brought about to try and reduce the appeals success rate (by ensuring that there was clear proof that all evidence had been considered) but were sceptical that this would be the case. DMs, generally, had not been provided with any information about the outcomes of appeals and the success or otherwise of other initiatives attempted in this area in the past. This left them with a feeling of operating in the dark and for some reduced their 'buy-in' to new procedures.

2.5 Personalised summary statement

In his first review, Professor Harrington recommended that the HCP should complete a personalised summary of their assessment which would be routinely sent out to the claimant who could subsequently discuss any perceived inaccuracies with a DM.

The main objective of this was to improve claimant understanding of their report, but it was thought it could also improve the overall quality of the report produced.

In line with this, some DMs did feel that the personalised summary statements made them feel more confident that HCPs were referring back and reviewing in detail the claimant's ESA50 which DMs previously feared was not being given enough credence by HCPs. They also felt that such scrutiny of the ESA50 led to a better quality and more detailed justification on the part of the HCP.

Similarly, some DMs found the personalised summary statements helpful to provide an overview of the HCP's opinion on a case, and in some instances felt they made the decision making process slightly easier.

A few DMs were critical of the quality of the personal summary statements that they received. Some felt that the summary was often just a combination of text that appeared elsewhere in the report rather than a true overview or rationale for the HCP's advice.

More widespread was DM criticism of the quality of the report in terms of grammar and punctuation, which meant they felt it was unlikely the reports would ever to be fit to be sent out to claimants.

2.6 The Atos perspective

Atos HCPs were also asked to give their views on the role of the DM in the decision making process.

The majority of HCPs viewed the DMs to be independent assessors of the claimant's evidence and that, ultimately, any decision should be made by a DM.

Atos HCPs tended to regard themselves as advisors to DMs, and on hand to offer further medical knowledge or clarification if a DM was unsure about a condition.

Atos HCPs were also asked to give their opinion on how much weight the DM should attribute to each piece of evidence when coming to make a decision on whether ESA should be awarded to a claimant.

Overall, HCPs felt that DMs should evaluate all evidence presented to them and draw a conclusion looking at everything in combination (the ESA50, the medical report and any other correspondence received in relation to the claimant's condition). They, generally, saw value in this overall assessment being conducted by an individual outside of the medical profession who could review all evidence objectively.

A minority of HCPs felt that DMs assigned too much importance to the ESA50 and this was thought to be problematic, particularly in cases where claimants exaggerated the severity of their illness. They were also concerned that DMs took additional evidence supplied at face value and did not always consider the provenance of this additional information.

Atos HCPs thought that the medical report they produced was an important piece of evidence that should be afforded due consideration by DMs, but not to the neglect of other evidence. HCPs viewed themselves as medical experts and 'disability analysts' and therefore felt that if the report had been compiled correctly then it should be taken to be an accurate measure by which to gauge an individual's capability for work. Similarly, if conducted correctly, HCPs felt the WCA report should cover information the claimant had given in their ESA50, therefore giving a more comprehensive document on which the DMs should base their decision.

Most HCPs felt that given DMs had access to all the evidence, they should be in a position to be able to make a decision and that they should not always have to consult an HCP if they wanted to go against Atos advice – providing they could fully justify their decision. A small number of HCPs, who believed that DMs did not possess the necessary medical knowledge, felt that DMs should always consult an HCP if they wanted to go against Atos advice.

Overall, HCPs were in favour of the ongoing Harrington review, particularly those recommendations relating to empowering and investing in DMs. HCPs felt that DMs should review all evidence and move away from rubber stamping Atos advice, which they felt had become the case with IB claims. Some had previously questioned the validity of the role of the DM if they were not confident enough to contest Atos advice and make their own decisions.

> *'I think it is a good idea. I keep on harping back to IB just because it's been around for longer and I think with IB the DMs were rubber stamping the reports. But I think now we are getting DMs perhaps going through our reports more with a fine toothcomb and picking up areas where we could do better and I think that is very good and I think DMs should be encouraged to disagree with us. They should be encouraged to apply their own descriptors or change the descriptors if they feel the evidence is more weighed on the other side. I think that's a good idea.'*
>
> (Atos HCP)
>
> *'I couldn't see the point in having DMs if they're not going to make decisions. If they're only going to rubber stamp what we said I couldn't see what their role was.'*
>
> (Atos HCP)

HCPs mentioned benefits to their own roles that had stemmed from the first Harrington Review – in particular the review of the descriptors and the employment of medical champions.

> *'The Harrington Review has also brought up the benefits to Atos and to the DMs and to our HCPs in having a mental health champion. For example, somebody who is available all the time, somebody who is always available to assist HCPs in choosing the right descriptors for any mental health issues and to have some discussions with the HCPs before they complete their reports.'*
>
> (Atos HCP)

Where the writing of personalised summary statements was mentioned, HCPs tended to view these negatively. They felt that producing these statements was a waste of their time given the information could already be found in the main body of the report.

3 Defining borderline cases

Generally, Decision Makers (DMs) received several pieces of evidence produced by the claimant, Atos medical professional and sometimes the claimant's General Practitioner (GP), advocate or other support worker at various points along the claim process. These combined to give the DM a full picture of the claimant's condition and form a basis on which to decide whether a claimant should be found eligible for Employment and Support Allowance (ESA).

Evidence received was usually a completed ESA50 questionnaire in which the claimant described how their condition affected their ability to complete everyday tasks; a medical report compiled by an Atos Healthcare Professional (HCP) which recorded and described what the HCP had observed and discussed with the claimant during their face-to-face medical assessment or Work Capability Assessment (WCA); and any other evidence the claimant may have submitted to support their claim for ESA. This additional evidence sometimes took the form of a letter written by the claimant's GP, support worker or advocate. These documents were scrutinised alongside each other by the DM and formed the basis of their decision to allow or disallow ESA.

This chapter discusses the types of cases which prove to be more complex to assess, both from a DM and Atos perspective. It therefore focuses on the challenges that DMs face in assessing this minority of cases. For the purposes of the report, we will refer to these cases as 'borderline'.

3.1 Identifying borderline cases

Each of the Benefit Centres visited had separate DM teams dealing with cases where HCPs advised that ESA should be allowed, or disallowed. More senior DMs handled those cases which Atos had advised should be disallowed ESA, and more junior DMs reviewed the cases which Atos had advised should be allowed ESA.

The DMs interviewed for this research were the more senior DMs handling cases likely to be disallowed. This meant that they only really had experience of cases at the borderline between being allowed and disallowed (and not of the borderline between cases allocated to the WRAG group and those allocated to the Support Group). Some were occasionally involved in advising other DMs on cases where the Atos advice was that a claimant should be allowed ESA but the DM questioned whether this outcome was correct, but this was not a core part of their role.

For the remainder of the report, we will concentrate on the discussion with these higher grade DMs and the borderline between being allowed and disallowed, unless otherwise stated.

None of the Benefit Centres had separate systems or processes in place to initially identify and allocate borderline cases. Generally, cases were allocated to DMs on a date basis and there was no evidence of sifting for more or less complex cases.

Borderline cases for most DMs were those where they felt there was some reason to question the Atos advice. These cases were most commonly:

- simply where the HCP had allocated points against some descriptors but not enough to reach the threshold for being allowed ESA;
- claimants with mental health or variable conditions;
- where there were perceived to be internal inconsistencies in the Atos medical report;
- where the claimant submitted additional evidence to support their claim;
- where the ESA50 was incorrectly filled in by the claimant.

3.2 Cases which do not score enough points

To be awarded ESA, a claimant must score a total of fifteen points at their WCA. In their report, Atos HCPs will assign statements or descriptors that best fit how a claimant's condition affects the execution of daily tasks or activities. Activity descriptors are split into physical and mental functionality and are graded in terms of severity – each grade equating to a certain number of points.

In reviewing the Atos report, alongside the ESA50 and any other evidence the claimant may have provided, the DM will decide whether the descriptors awarded in the first instance are correct or not and so uphold, refer back to Atos and/or adjust the number of points awarded to the claimant.

Some DMs described a borderline case worthy of additional scrutiny as any case where the Atos medical report awarded a descriptor (or combination of descriptors) that equated to more than 0 points or some Limited Capability for Work (LCW). They felt that they had a particular responsibility to thoroughly review these cases where the respondent had come close to meeting the threshold for allowance.

This was in the context that DMs at some Benefit Centres commented that an increasing number of medical reports were coming through to them without any descriptors being awarded and that if some limited capability for work had been identified then the condition must be relatively severe.

3.3 Mental health and fluctuating conditions

DMs sometimes found claimants with mental health or fluctuating conditions to be borderline.

Some DMs felt that this was because the design of the assessment process did not allow for the accurate measurement of the manifestation and severity of these conditions. Some DMs felt that the WCA was not long enough to provide a robust measure of an individual's mental state and others expressed concerns that some Atos HCPs did not treat mental health conditions to be credible and hence tended to under-score claimants with these conditions.

> *'I think the difficult cases for me are people with mental health issues but the assessment doesn't really in my opinion cover some of the major difficulties that these people have.'*
>
> (Less experienced ESA DM)

A particular problem reported by DMs for those cases where the claimant had a mental health condition was that the ESA50 was often incomplete and lacking in detail and in some cases was not provided at all. DMs stated that claimants with a mental health illness were less likely to return an ESA50, which meant that their decision had to be based solely on the Atos medical report. This lack of evidence could prove problematic for DMs who then felt they were lacking the claimant perspective in the evidence available to them.

Others felt that there was inevitability in these cases being more difficult to assess because the related descriptors were more subjective. Mental health descriptors were generally considered by DMs to be vaguer and more difficult to interpret than those relating to physical impairments. Indeed, this sentiment was also shared by the Atos HCPs who found the 'Initiating and completing personal actions' and 'Appropriateness of behaviour with other people' descriptors too subjective in their use of terms such as 'occasionally' and 'familiar' – what might be one person's 'occasionally' might be someone else's 'rarely'. In contrast, the physical descriptors were thought to better quantify someone's (dis)ability by both HCPs and DMs and therefore allow for a more accurate and justifiable outcome.

'For me, the mental health cases are much more difficult. The coping with change descriptor , I don't find it very clear, I think it's quite confusing and I think when you're not trained in mental health I just find I don't know whether I do justice to the claimant, really, some of the time.'

(ESA DM)

3.4 Inconsistencies in the Atos medical report

DMs found that complexities also arise where the medical report compiled by Atos was internally inconsistent – it was reported that usually discrepancies occurred between the HCP's choice of descriptor and their justification in the personal summary statement, typically in mental health cases. Often information provided in the HCP's summary statement or justification would suggest that a higher descriptor should have been awarded earlier in the report.

DMs also criticised the medical report for lacking detail or insight – such examples include HCPs commenting that a claimant's mental health state was 'unremarkable'. Similarly, often no reference was made to any additional evidence the claimant had taken along to and discussed at the WCA, nor was it always clear that issues raised in the ESA50 had been adequately covered in the WCA.

3.5 Submission of additional evidence

DMs stated that it was rare for additional documents to be provided to accompany a claim after the WCA. Where additional information was provided it tended to be letters from the claimant's GP, advocate or community worker. On occasions, DMs found it difficult to assess whether these documents provided any genuinely new information, but they were generally comfortable in determining whether they or not they needed to consult with Atos staff on this additional evidence.

More problematic were the cases where DMs obtained additional verbal information from a claimant. At the time of the research, an outbound phone call to claimants prior to the DM making their final decision had been introduced in some of the Benefit Centres visited (and was planned for the others). The purpose of the call was to notify the claimant that they were likely to be found disallowed for ESA and check whether or not the claimant had any additional evidence they would like to submit that would further support their claim.

This sometimes generated verbal evidence that DMs found difficult to take into account when making their decision. DMs mentioned experiences of claimants giving further information that they were too embarrassed to disclose to the Atos HCP at the WCA. In instances where claimants were able to provide further information over the phone, some DMs felt that they did not possess sufficient medical knowledge to be able to understand the importance or relevance of the information in how an individual's day-to-day capabilities were affected. Some DMs felt unsure of how much weight they could or should give to information given verbally.

3.6 Complexities of the ESA50

Apart from DMs' views that the ESA50 did not fully capture information on mental health conditions, DMs also found that many claimants, regardless of their condition, struggled to complete the form correctly and that this could impact on the straightforwardness of reaching a decision. DMs reported that some claimants failed to include evidence about how their condition affected their everyday lives in the relevant sections of the questionnaire, only to then provide much more in-depth detail on the back page. In this format the information was more difficult to tie to particular descriptors,

sometimes leaving them unsure about how this information was then treated in the WCA and how they themselves should incorporate it into their decision.

Frequently DMs stated how difficult it was to interpret the 'it varies' option on the ESA50. They felt that when this option was selected they were not able to adequately quantify the severity of the condition and therefore unsure how to go about awarding points.

> *'On the ESA50 where they give the claimant the option 'it varies' – how does it vary, how many days of the week does it affect you? It's a bland statement, 'it varies' – it could be anything. It might have been one bad day a month or it could be 30 days a month. It would be helpful if there was something on there where they quantified the variability – make the claimant give us some information. Directly ask them if she says 'it varies' and say if you fill this box in you've got to tell us.'*
>
> (More experienced ESA DM)

The ESA50 comprises two separate sections – one which deals with physical functionality and the other mental, and it is expected that claimants should only complete the section that is relevant to their condition.

DMs felt that the distinction between the two discrete sections in the questionnaire was not clear enough to claimants, so that claimants with only either a mental health condition or a physical health condition tended to fill out both sections of the questionnaire. This made the challenge of interpreting the information more complicated.

For example, DMs reported that in some cases where claimants appeared to have a mental health condition only, they answered questions about physical mobility in terms of how their mental health condition impacted on them being able to get out or make themselves understood. Sometimes this would lead to a situation where the ESA50 would suggest that the DM should award points for physical descriptors even though they were fairly sure that the claimant did not have a physical health condition.

3.7 Paper scrutiny cases

Although the DMs interviewed largely handled cases likely to be disallowed ESA, a few also had responsibility for reviewing allowed cases that less senior DMs were unsure whether to place in the WRAG or Support Group. They mentioned that cases on this borderline were particularly likely to be those that were assessed on paper scrutiny alone (i.e. without a face-to-face assessment)[7].

DMs reported that paper scrutiny cases could prove difficult to assess because they relied only on the information the claimant had provided in the ESA50 and sometimes a very short report from Atos. They felt that these reports were often too short for them to be confident in making a decision. DMs reported occasions where the report had simply stated that the descriptors for the Support Group were not met, without explaining why this was the case (when the DM felt that there was evidence in the ESA50 of a serious condition). In addition, sometimes the ESA50 was only partially completed.

> *'The scrutiny gives us very little information and you have no idea why* [the claimant has been disallowed]. *All it basically says is that the descriptors for the Support Group aren't met, but they have significant disability.'*
>
> (IBR DM)

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[7] Claimants typically assessed on paper scrutiny were those with very severe or debilitating conditions who were not able to travel to a face-to-face assessment.

In these cases, DMs referred back to previous ESA claims where possible and inferred decisions based on these. However, if it was a new claim for ESA, DMs felt obliged to follow the Atos advice.

3.8 Other types of complex cases

Although fewer in number, DMs also mentioned other types of cases that were not necessarily borderline in the sense that DMs were unsure how to handle the case, but difficult for them to explain what appeared to be inconsistencies in the advice given to some claimants.

One particular scenario that DMs found problematic (and felt was likely to result in appeals) was that where claimants were employed but were no longer eligible to receive Statutory Sick Pay and hence had made a claim for ESA. In some cases these claimants had had an assessment by an Occupational Health professional (sometimes employed by Atos) that had found them to be unfit for their current job but then had been found fit for work in their ESA assessment. This was not necessarily inconsistent because the ESA assessment took into account all types of work and DMs were clear that they would need to disallow claimants on this basis. However, DMs felt that this scenario was very difficult to explain to claimants and anticipated that most of these cases will be overturned at appeal stage anyway.

DMs felt that in these cases they were leaving the claimant no other option but to appeal so that they could 'buy time' to carry on engaging with Occupational Health and their employer to negotiate a return to work. This implied that the claimant's preference would be to develop a work-around with their current employer rather than start a new job better suited to their abilities. It was felt that the strength of the claimant's argument on this point (i.e. that there was evidence of them working with a consultant to get back to work in their original job) would result in the outcome being overturned at appeal stage and the claimant being awarded ESA.

Generally Atos HCPs perceived that DMs dealt with more complex cases, or those on the threshold of being allowed, differently to others. Some HCPs felt that DMs could sometimes appear unsure when dealing with them, but mainly they recognised that DMs scrutinised these cases and associated paperwork in more detail and were more likely to come back to Atos for further clarification.

4 Tackling borderline cases

Chapter 3 established the common features of a borderline case; this chapter will now go on to examine how Decision Makers (DMs) go about reaching a final decision for these more complex cases.

In deciding how to handle borderline cases, DMs have three broad options, to:

- accept the original Atos advice;
- request Atos reconsideration;
- overrule the Atos advice without seeking Atos reconsideration.

The course of action typically taken by DMs was driven by their respective views on the scope of the DM role, particularly the extent of decision latitude that DMs had, as discussed earlier in Chapter 2. In some cases, DMs that experienced a greater degree of empowerment would overturn the Atos advice without first consulting Atos. DMs who felt less confident assessing medical evidence typically asked Atos to review their advice or simply took the approach (as they saw it) of 'rubber stamping' that advice.

4.1 Volume of cases sent back to Atos

In the majority of the cases covered by the research, i.e. those likely to be found fit for work and disallowed Employment and Support Allowance (ESA), the original advice given by Atos in their medical report was upheld by the DM. Estimates varied but typically DMs approximated that they changed or challenged the advice made by Atos in around one in forty of these cases – though some said considerably fewer than this (only one or two in the past couple of months and the move away from greater DM empowerment).

4.2 Experience of going back to Atos – Decision Makers' perspective

All of the DMs interviewed as part of the research reported sending back some cases to Atos for clarification. These cases tended to be those where:

- there were discrepancies internally within the Atos medical report – typically these inconsistencies were between the descriptor awarded in the main body of the report and the Healthcare Professional (HCP) justification or personal summary statement;
- DMs required further explanation or clarification on a specific medical condition or term;
- the claimant had provided further 'medical' evidence after attending the Work Capability Assessment (WCA) – such evidence would usually include letters from General Practitioner (GPs) or hospital correspondence using medical terminology detailing the physiological aspect of the condition.

There was some more variation among DMs in sending back cases where:

- there were discrepancies between the ESA50 and the WCA report – some DMs felt more able than others to come down on one side in these cases where they had enough evidence to justify their decision;

- additional evidence was acquired from the claimant about the way the condition affects them. This tended to take the form of anecdotal evidence from the claimant, their support worker, or GP in which the impact of the claimant's condition on everyday life and their capability to work was explained more in laymen's terms.

However, in some Benefit Centres DMs were advised they must always refer back to Atos if they were seeking to go against the initial Atos advice.

> *'If I've got a query I've always sent it back, I've never awarded extra points. I don't think it should be within the DM remit to do that, when there's medical stuff involved.'*
>
> (Less experienced ESA DM)

Although Atos HCPs did not have to change their advice (and it was up to the DM to decide whether to follow it or not, based on the balance of evidence), DMs in those Benefit Centres where they were advised to always refer back to Atos felt frustrated by instances when HCPs were reluctant to alter their views in light of additional evidence submitted by the claimant which was perceived to be substantial by the DM.

> '[Previous experience] *doesn't inspire me to send things back. Some of them* [Atos HCPs] *kind of give the impression that they are slapping your legs like how dare you question that!'*
>
> (More experienced ESA DM)

4.3 Experience of going back to Atos – Healthcare Professionals' perspective

Typically, Atos HCPs were in agreement with DMs that the cases that tended to be 'sent back' to Atos were those where:

- the DM had received further medical evidence from the claimant;
- the DM required further explanation or clarification on a medical condition or term;
- there were internal inconsistencies within the report or where the DM considered the HCP's justification to be lacking;
- mental health cases that were generally considered to be more subjective and open to interpretation at both stages.

HCPs reported a mixed picture in terms of the number of cases sent back by DMs. While some thought that an improvement in the quality of reports written by Atos HCPs had led to a reduction in the number of re-works, others felt that there had been a considerable rise in the number of cases referred back to Atos by DMs.

It was suggested by those who thought there to be an increase that this could be down to the perceived high number of claims being overturned at the appeals stage and DMs trying to mitigate this by challenging the decision with Atos at an earlier stage in the process. Others pinpointed the start of the IBR migration project as the start of a rise in the number of cases referred back to Atos which may suggest a cultural difference in the ways reassessment (IBR) cases were dealt with in comparison to new and existing ESA claims (although there was no evidence of this from the groups discussions held with DMs for the research).

4.4 Awarding additional points/Non Functional Descriptors without going back to Atos

In some Benefit Centres, DMs were less likely to refer back to Atos if they disagreed with the initial advice provided and instead just go against it. This, however, only occurred when DMs felt they could fully justify their decision to award ESA.

> *'You have got a choice – you could send it back for rework or advice, or you can just think well the past history shows that very rarely they* [Atos] *change anything no matter what you say or ask so you could, if you have got enough evidence to support your reasoning, your thought process, give them the points.'*
>
> (More experienced ESA DM)

DMs stated a decision could be overturned and a claimant allowed ESA by either awarding a higher descriptor on by invoking a NFD. NFDs were introduced to the assessment process in acknowledgement that some claimants might not fulfil the criteria to be placed in the Support Group or be awarded the required number of points (15) to be eligible for ESA, but still be considered as having limited capability for work. In those cases where a higher descriptor was awarded, the claimant scored a higher number of points therefore pushing them over the threshold to be entitled to ESA.

Points were awarded in some cases where a claimant had supplied additional evidence during the telephone call when the DM advised the claimant they were likely to be disallowed unless they had any other information to demonstrate their incapacity for work.

DMs also awarded a higher descriptor if they felt that the Atos medical report lacked detail (usually in the summary statement) and the DM felt that on reviewing the case the claimant had met the criteria for a higher descriptor. This was usually based on a comparison with the level of information provided by the claimant in the ESA50 alongside any other medical evidence that the Atos HCP would have been privy to at the time of assessment.

Similarly, if a DM felt that the HCP had not taken all of the evidence into consideration or perhaps under-scored the claimant based on the evidence presented, they would amend the descriptor choice.

In addition to awarding a higher descriptor, some DMs mentioned invoking NFDs – most commonly, Regulation 29. Regulation 29 was invoked specifically in cases where there would be a substantial risk to the mental or physical health of the claimant if they were found not to have limited capability for work. At the time of research, these regulations were being invoked at the discretion of the DM without the need to consult an Atos HCP.

DMs were most likely to invoke Regulation 29 for claimants with conditions such as cancer who were receiving ongoing treatment, those recovering from an operation, those exhibiting signs of severe mental health conditions or, in some cases, addiction (as a result of mental health problems). In some cases, DMs used NFDs if a claimant displayed obvious signs of severe mental or personality disorders when they spoke to them about their claim.

Other examples where DMs had awarded additional points included cases which shared a great deal of commonality but were awarded completely different outcomes (allowance and disallowance).

5 Relationship between Decision Makers and Atos Healthcare Professionals

This chapter will explore the working relationship between Decision Maker (DMs) and Atos Healthcare Professional (HCPs) more broadly and then seek to understand the role of the regular contact between the two in helping a DM to make decision on a case.

On the whole DMs reported having an amicable working relationship with Atos. In particular, this had been supported and developed recently through regular face to face contact at Jobcentre Plus Benefit Centres.

5.1 Atos site visits – the Decision Makers' view

All DMs interviewed as part of the research stated that until a few months prior to the research being conducted, Atos HCPs came into the Benefit Centre in person. During these sessions they would discuss and advise on cases that DMs had delayed making a decision on because they needed further clarification or information from a medical professional. DMs would also use these sessions to talk through any new evidence that the claimant may have submitted after the Work Capability Assessment (WCA) which the HCP would not have seen when writing their initial WCA report.

This was viewed by all DMs as being very positive for relationship building more generally and discussions about borderline cases. DMs felt that these visits were valuable in that they developed their confidence and that they were able to infer from these cases how best to proceed with similar cases in the future.

> *'Other DMs would go and discuss cases* [with ATOS in person] *and then they'd come back and they'd say to us "We're gaining quite a lot of knowledge now, aren't we?"'*
>
> (IBR DM)

In all Benefit Centres visited as part of the research DMs said that these Atos site visits had recently stopped. DMs thought this was due to a response to additional resourcing required by Atos to deal with a backlog of assessments and deliver personal summary statements. They would all welcome these visits being reinstated in the future.

5.2 Atos site visits – the Healthcare Professionals' view

Similarly, Atos HCPs viewed these visits as being helpful in developing the role of the DM. HCPs felt that face-to-face visits could help better convey the subtleties of a more complex case than either a discussion over the phone or a more formal review of a case. Atos HCPs considered the site visits to serve a two-way educational role in that they could explain medical conditions to DMs, and they themselves could gain a better understanding of the DM perspective on a case.

'I liked [face to face meetings] *because I prefer to communicate personally, not on the phone and not via email. It's nice when you have a case and you sit down together and go through everything and discuss this point and that and they can ask anything they want and it's a constructive discussion, I think generally for DMs it's very good.'*

(Atos HCP)

'They usually bring us the file and print out the Employment and Support Allowance (ESA) form and they sit down and talk us through the problems they're having with the case, why they can't come to a decision and ask us specific questions.'

(Atos HCP)

However, a small number of HCPs did not consider site visits as the most efficient use of their time, especially where a great deal of travelling was involved. Some commented that, over time, the number of cases DMs presented to them during these sessions declined to such an extent that it was a better use of time to talk through the cases over the phone.

5.3 Atos helpline – the Decision Makers' view

Some DMs reported having used the Atos helpline available for them to call if they had any queries about Atos advice or would like to discuss further evidence submitted by a claimant.

Most agreed that the speed of response was good. However, the picture was more mixed in terms of the nature of the response given by HCPs, which was heavily dependent on the individual HCP at the other end of the line. Some DMs found the HCPs staffing the helpline to be very reluctant to go against what a fellow HCP had previously advised, as this was seen as undermining another medical professional. On the other hand, some DMs found some Atos staff happy to review and, in some instances, amend their advice.

5.4 Atos helpline – the Healthcare Professionals' view

The vast majority of HCPs interviewed for the research worked on the helpline or customer service desk. Many felt that DMs rarely called the helpline and instead submitted their queries in writing, and that the majority of calls that came into the helpline were in fact from other HCPs seeking advice from more experienced doctors.

Where DMs did call in, HCPs usually found it was because the DM required further clarification on a WCA report, more information on a medical condition or to check the relevance or impact of additional evidence.

'They are typically cases that have gone to examination and now they have further information that they want clarified, or they're considering a descriptor needs to be moved from a lower level to a higher level. So they just want to have a chat about the pros and cons of the evidence of both sides of the debate.'

(Atos HCP)

Generally, HCPs considered the helpline to be useful for DMs but felt there were some limitations in the types of cases it was possible to advise on over the phone. HCPs believed it to be effective for dealing with simple queries but less so for more complex cases with more context.

> *'I think it's relatively useful if it's utilised properly. I think for a simple query – yes, but for a complex query – no. So something very involved and complex or you actually need to see, because a DM or someone might just pick up one piece of evidence or one piece of information and there's a lot more around it which would influence that and would influence your overall advice.'*
>
> (Atos HCP)

Having said that, HCPs generally thought that DMs would benefit from using the helpline more, particularly so that they could continue to understand the HCP point of view.

6 Guidance and training for Decision Makers

This chapter explores Decision Maker (DM) guidance and training needs as perceived by DMs themselves as well as Atos Healthcare Professional (HCPs). The chapter has a particular focus on what support DMs require to confidently deal with more complex cases.

Most DMs interviewed did not feel that they had received much training on the decision making process and that any training that had been delivered had not been particularly tailored to their role.

6.1 Training requested by Decision Makers

In line with earlier findings that DMs experienced particular difficulty in assessing cases where the claimant had a mental health condition, they stated that they would like to receive training on interpreting these descriptors.

Some DMs had received such training and found that it had been helpful, particularly when it had been delivered by Atos HCPs. In addition to this, some DMs had access to the handbook used by Atos staff which was valued as it provided an insight into how and why Atos HCPs award certain descriptors in certain circumstances.

Similarly, a minority mentioned that sitting in on a Work Capability Assessment (WCA) would give them a better idea of what the assessment entailed and how the Atos HCP comes to advise in the way they do.

> *'Yes, what happens when they turn up* [at the WCA]*? How are they spoken to? How are they observed?'*
>
> (Less experienced Employment and Support Allowance (ESA) DM)

None of the DMs interviewed for the research had, at any point, received information on the number or types of decision they had made that had been overturned at the appeal stage. Without this, DMs felt that it was currently difficult to improve or learn. It also meant that there was no way for them to know whether new processes that had been introduced (such as needing to write more detailed justifications) were having an impact on the appeal rate. It was felt that if this feedback were available it would help inform DMs how to approach more complex or borderline cases in the future.

Less experienced DMs were especially keen to receive a broader training package that covered the 'benefit context'. They wanted a better understanding of the full claimant journey and the options available to claimants after being disallowed ESA. DMs felt such training would be important in helping them deliver the outcome notification phone calls (but also for understanding the impact of decision making on the support that claimants would receive).

6.2 Atos involvement in training for Decision Makers

In comparison to the DMs working on Disability Living Allowance (DLA), Atos HCPs considered ESA/IBR DMs to be less well trained, particularly on medical conditions. While HCPs accepted that DMs could and should not be trained to the same standards as a medical professional there was a feeling that ESA/Incapacity Benefit Reassessment (IBR) DMs could be provided with more reference materials to give them some information on what to expect from certain conditions.

HCPs also felt that ESA/IBR DMs generally approached the descriptors too literally and needed to consider the scope of the descriptor definition. Accordingly some had been invited to, or had already given training to, DMs on the change in descriptors that came about in Spring 2011, the scope of the descriptors and clarification on how they differ from one another. They also mentioned the importance of ensuring that all DMs had access to the descriptor handbook to guarantee consistency in the way that the descriptors were interpreted both at the assessment and decision making stages.

A few HCPs mentioned they had been involved in slightly more informal training sessions where they discussed with DMs medical conditions, recommended treatments and how levels of medication or hospital intervention should be interpreted in the context of an individual's ability to work.

6.3 Healthcare Professionals' views on training for Decision Makers

Atos HCPs were asked whether they thought there was any sort of training that should be provided to ESA/IBR DMs both when dealing with borderline cases and on the role of the DM and their interactions with Atos.

Several HCPs mentioned the importance of DMs having their own 'Bible of Conditions' or database developed by a medical officer, to which they could refer to get a better understanding of how a condition (at various intensities) could affect an individual's ability to complete day–to-day tasks.

> *'I think they need key training in medical conditions and a good database. The DLA DMs have a very good system and I don't know why the ESA/IBR DMs don't have a look to see what they're doing. They could have a list of conditions and see how that condition impacted on work capability.'*
>
> (Atos HCP)

HCPs also felt that training on mental health and other variable conditions was required by DMs as these were the types of conditions which they often referred back to Atos for further clarification. It was suggested that training could usefully be delivered in the form of one-to-ones with medical professionals, so that cases could be discussed in depth and pointers identified to apply to future cases.

7 Conclusions and policy implications

7.1 Strengths and limitations of this study

This was a relatively small-scale qualitative exercise conducted across a small number of Jobcentre Plus Benefit Centres. As such it is difficult to draw firm conclusions about the extent to which the findings apply to other Benefit Centres. However, the common ground in the challenges experienced across the sites that were included give some confidence in the wider applicability of the findings.

It should also be borne in mind that this study included Decision Maker (DMs) whose roles focused on cases that Atos advised should be disallowed and hence it provides very little information about the difficulties in reaching decisions on cases at the Work Related Activity Group (WRAG) and Support Group borderline. This also means that this study does not provide much information on cases where the Atos advice would suggest a claimant is allowed Employment and Support Allowance (ESA) but the DM felt that perhaps they should be disallowed (although DMs generally felt this was a rare scenario).

However, the discussions held with DMs were very detailed and discussions were quite frank, allowing in-depth exploration of the way in which they conduct their role, the cases that are hardest to assess and the guidance that they have received. The study covered both Jobcentre Plus staff and Atos staff, which allowed corroboration of the points discussed.

7.2 Conclusions

DMs were varied in their opinions on the extent to which they considered themselves to be at the heart of the decision making process.

Despite an initial movement towards greater empowerment of DMs following the Harrington Year 1 Review, many felt that by the time of the research, the guidance that they had been given had been revisited in such a way as to give them less control over decision-making. Some felt that they still had some ability to reach their own decision over borderline cases where they had queries over Atos advice while others felt limited in this respect.

Generally, DMs felt that they were receiving conflicting advice about their role and needed further clarity on how they should approach decision making.

The term ‘borderline’ was not commonly recognised by DMs and there were no specific processes in place at any of the Benefit Centres visited to identify such cases. Most considered borderline cases simply to be those that they came across in their normal caseload of claimants likely to be disallowed but where they felt that there was reason to question the advice of the Healthcare Professional (HCP) who had conducted the Work Capability Assessment (WCA). Cases that were more complex or where DMs were more likely to query the advice given by Atos were not necessarily on the boundary between two outcome categories.

The proportion of cases where the Atos advice was to disallow ESA and DMs sought further clarification or acted against the advice was very small – around one in forty.

There was some discrepancy in how DMs felt they should deal with these complex cases. At one end of the spectrum some felt they could not go against Atos advice without an HCP's express agreement, others felt they could exercise their discretion in whether or not Atos should be involved.

DMs missed the on-site Atos presence which had stopped shortly before the research took place. This presence was deemed to be useful by DMs who valued being able to talk through cases which they found more difficult to reach an outcome on with an Atos HCP in person. DMs expressed a desire for more training and more life-like case studies to which they can refer specifically when dealing with more complex cases. They also felt that feedback on the number or types of decisions they had made that had been later overturned at appeal stage would be useful.

7.3 Implications for policy and practice

The research has identified some areas of the process that may be worth reviewing. These focus on the role of the DM and, more specifically, how DMs deal with borderline cases. We discuss each of these below. It is worth noting that these are largely based on the interpretation of the findings by the researchers conducting the study rather than direct recommendations from participants.

7.3.1 Communication of guidance on role of Decision Makers and Atos

The research found considerable variation in DMs' views of their role in the decision-making process, and some felt that the consistency of the communication of guidance about their role could be improved. Although most reported that the publication of the first Harrington Review had initially led to them feeling more empowered to reach decisions based on their experience and expertise, many felt that they had since received instructions that removed some of the control that they had over decision-making.

Some felt that they still had some ability to reach their own decision over borderline cases where they disagreed with the Atos advice, while others felt limited in this respect. In the latter group were those who felt they had been expressly told that they could not make a decision that ran contrary to the Atos advice without securing Atos agreement to do this (which they had found Atos reluctant to provide).

7.3.2 Decision Maker handling of mental health cases

DMs were more likely to query or go against the Atos advice in cases involving mental health issues, compared to those relating to physical impairments. In some cases, this was because these claimants were more likely to fill in the ESA incorrectly or leave sections blank. However, it was also because DMs felt that the descriptors that could be applied to mental health cases were vaguer and more subjective. There was a feeling that there was scope for more guidance and training on using these descriptors, but ultimately DMs (and Atos staff) felt that mental health cases would always be more difficult to assess.

7.3.3 Collection of monitoring information

Evidence from this research suggested considerable variation in the volume of cases returned to Atos from the Benefit Centres for clarification, and the volume of cases where the final decision went against the advice in the Atos WCA report. It may be helpful to get an indication of the variation in DM approaches by collecting information about these aspects of cases.

7.3.4 Feedback on Decision Maker assessments

Deciding the outcome of ESA claims is a complex process and the original decision can be changed on appeal, leading DMs to feel that they need feedback to judge their own performance and therefore improve their decision making. More effective feedback mechanisms on decisions (including the level of cases that are successfully appealed), and communication with DMs on the factors that lead to successful appeals, could be beneficial.

7.3.5 Claimant calls from Decision Makers

Not all Benefit Centres had introduced the calls to claimants to inform them of the likely outcome of their claim and to give them the opportunity to provide additional evidence at the time of the research, but those not making the calls knew that they would need to in the near future. DMs felt that it would be more in keeping with a move to empower DMs if they had some discretion over which claimants they made calls to. This would enable them to focus their efforts on borderline cases where they felt there was potential for their decision to be influenced by the call. While this focuses on the aim of the call to obtain any previously undisclosed evidence, rather than its aim to provide good customer service, DMs often doubted that the call actually met the latter aim because claimants were frequently too shocked to react rationally to the information provided (although some felt that if the call followed written communication then it could have value from a customer service perspective).

7.3.6 Reintroducing site visits from Atos Healthcare Professionals

In all Benefit Centres, regular site visits from a dedicated Atos HCP had been withdrawn as a result of workload pressures. However, the majority of DMs felt that these visits had been very positive in developing working relationships between DMs and Atos and improving the knowledge of DMs about how particular impairments or conditions might affect claimants, and would welcome their return. There was an indication that this regular presence encouraged greater discussion of borderline cases than is currently the case when DMs only have the ability to formally refer a case to Atos or to use a telephone helpline.

7.3.7 Training for Decision Makers

Most DMs felt that they had not received any training that had been specifically designed for DMs. Instead, they felt that the training they had received had been adapted from material designed with other operational staff in mind. Some DMs felt they would benefit greatly from talking through case study claims and how they should be interpreted.

Some less experienced DMs felt that they would benefit from a better understanding of the implications of outcomes of ESA claims (i.e. what happens when claimants are disallowed or enter the WRAG). They felt that a better understanding of the support mechanisms in place for claimants in these groups would put them in a better position when explaining the implications of their decisions to claimants and in determining the suitability of particular outcomes for individual claimants.

Appendix A
Decision Maker topic guide

Private and Confidential J5043

ESA Borderline Cases - DM Face-to-Face

A Introduction (c. 5 mins)

- Introduce self and IFF.
- Background to study: IFF Research has been commissioned by the Department for Work and Pensions to explore how decisions are reached when assessing claims for ESA, specifically those cases that are considered to be 'borderline'. The aim of the research is to understand if and how these borderline cases are different from others and the findings will inform future guidance for Decision Makers in assessing borderline cases. The research will feed into Professor Harrington's ongoing review of the Work Capability Assessment and address his recommendation from the first review to empower and invest in Jobcentre Plus DMs.
- Stress confidentiality, that no comment will be personally attributable, MRS Code of Conduct and that there are no right or wrong answers.
- Ask permission to record.

B Warm Up (c. 10 mins)

- How long have you worked for Jobcentre Plus? And in this particular role?
- Have you previously handled calls or processed claims relating to either Incapacity Benefit or Employment Support Allowance?
- What is your role in assessing ESA claims? Can you briefly describe the typical process of reaching an award decision for an ESA claim?
- Are you aware of the ongoing Harrington Review? IF YES: What do you think of the review and his recommendation to empower DMs? Is this a good idea? Why/Why not?
- Has there been a change in the way you work since the publication of the first Harrington Review? IF YES: How/in what way(s)? Are the changes good/bad?

C Defining borderline cases (c.15 mins)

- We want to talk now specifically about 'borderline cases' By borderline we mean cases where you might be unsure whether or not to award a claimant ESA, and/or which group to place them in. What sort of recent examples have you got of this? What happened in these cases? Can you remember the final decision?
- What makes a case 'borderline' or difficult to assess?
- What makes these cases different from more a straightforward claim?

- What sorts of cases are more likely to be borderline?
  - Do they involve certain types of claimant?
  - Certain types of condition?
  - Inclusion of certain evidence or lack of evidence?
- What are the typical characteristics of a borderline case?
- How important is the ESA50 in making a decision? And the WCA report? What role does other evidence have?
- How common are these types of cases?
- What proportion of the decisions you make would you say are 'borderline'?
- Are there any systems or processes for identifying these sorts of 'borderline' cases? If so, who decides whether a case is borderline case or not? Is there any sort of agreed definition? If so, where did this come from (team leader/someone else within Benefit Centre/outside of Benefit Centre)?
- At which part of the process is this decision made?
- What impact, if any, does this have on the process?

D Decision making process (c. 30 mins)

- Can you explain how you would go about reaching an outcome for a borderline case? Is this different from a non-borderline case?
- What or who else do you consult when making a decision in a borderline case?
- What documents do you refer to when making the decision? Why? How do these help with you in making a decision?
- How accurate do you consider ATOS' recommendations to be? Do you ever overrule a recommendation made by ATOS?
- What do you do if you disagree with their recommendation?
- In what circumstances, if any, would you overrule the Atos advice? How often do you overturn an ATOS suggestion?
- Why do you tend to disagree with an Atos advice? Are there particular types of cases where you're more likely to disagree?
- How accurate do you consider the claimant's completed ESA50 form to be? Or an ESA50/ supporting letter completed by an advocate or care worker? And what about any other evidence you may receive, e.g. ESA113 or letter from a GP, specialist or other representative?
- What do you do if you disagree with the ESA50/other medical evidence?
- In what circumstances, if any, would you disagree with the ESA50/other evidence? How often do you disagree with the ESA50/other medical evidence?
- Why do you tend to disagree with the ESA50/other medical evidence? Are there particular types of cases where you're more likely to disagree?

- Are there any general guidelines that you can refer to, or do you tend to deal with these borderline claims on a case by case basis?

IF GUIDELINES IN PLACE:

- Who put these together? How helpful are they? Why/Why not?
- How often is information missing in these borderline cases? What sort of information tends to be missing?
- Does this tend to be omitted by the claimant, ATOS staff or someone else?
- What do you tend to do in these situations? What would ideally happen?
- How often is the information presented contradictory? What tend to be the main contradictions?
- What do you tend to do in these situations? What would ideally happen?
- What pieces of evidence are given most consideration when making a decision on a borderline case?
- What are the key pieces of information you need when making a decision on a borderline case?
- Is there any other evidence that you require aside from the ESA50 and the ATOS report when dealing with these borderline cases?
- Why are these pieces of information so important?
- What other difficulties do you face when making a decision on borderline cases?
- How do you overcome these difficulties? What help or support do you need?
- How much individual discretion can you exercise when making these decisions?
- Do you discuss your decision with other colleagues? (Who – other DMs, team leader, others?) Do you have to justify it?
- What sorts of justification do you have to provide? What do you include in the DM justification for a decision on a borderline case? Are there specific ways in which this should be done?
- How easy or difficult is it to make these justifications?
- Do you contact claimants directly during the decision-making process?
- IF NO: Is this something planned for the future?
- IF YES: How often do you do this? How long have you been doing this for?
- What do you discuss in these phone calls?
- What impact does this have/will it have on your decision making process? Why?

E Case studies (c. 30mins)

During this next section, DMs will be split into two groups and provided with different example borderline cases for them to review. Ensuing discussion will explore the decisions made by staff and how they were reached. General areas for discussion for each case study are set out below (NB: specific prompts will be developed once example cases have been reviewed).

- What decision did you come to? Why?
- How did you reach this decision?

- What specific information did you consider when making your decision? What else?
- Was there any information missing that you would liked to have seen? What else?
- Was there anything that was contradictory? What was this? In what way was it contradictory?
- How helpful or unhelpful were the ESA50 and the ATOS report with respect to making the decision? Why?
- Did you all agree on the same outcome? Why?/Why not? What areas did you disagree over?
- How easy or difficult was it to come to this decision? Why?
- If you had dealt with this case in real life, would you have sought more information/consulted with anyone else? What/Who? Why?
- Is this case fairly typical of a borderline case? Why/why not?
- What would have made it easier to come to a decision more quickly/make the same decision?
- Would any specific guidance have been beneficial? What sort? What would it say? To what extent is it possible to provide guidance for cases like this versus each case needing to be reviewed on an individual basis?

F ATOS (c. 10mins)

- How much interaction do you currently have with the ATOS HCPs? (Probe: face-to-face, telephone, email).
- In what circumstances do you tend to talk to them? What sort of additional information do you need from ATOS? How responsive/helpful are they?
- What effect does this interaction have on your ability to make a decision?
- How would you describe your relationship with ATOS when dealing with these borderline cases?
- How could your relationship with the ATOS staff be improved?

G Training and support (c. 15 mins)

- How well prepared do you feel when dealing with these borderline cases?
- What training and guidance have you received to date about the decision making process in general?
- And have you received any guidance, support or training from Jobcentre Plus specifically about dealing with borderline cases? When? What sort of training?
- How useful were the training materials? What was the most useful format? Were there any ‘gaps’ in the training/information resources?
- What was most useful about this training?
- How could this guidance, support or training be improved? In what other ways?
- What evidence should be provided as standard when you come to assess a claimant’s claim? What else?
- What other resources are available for you to consult at the moment? How helpful are these? In what ways could they be improved?

- How do these resources help you with the decision making process for borderline cases?
- Based on your experience, if you were designing guidance for other DMs or new DMs on how to approach borderline cases what would you advise including? What tips/pitfalls would you mention? What lessons have you learnt in how to handle these cases since you started this job?

Finally I would just like to confirm that this survey has been carried out under IFF instructions and within the rules of the MRS Code of Conduct. Thank you very much for your help today.

I declare that this survey has been carried out under IFF instructions and within the rules of the MRS Code of Conduct.

Moderator signature: Date:

Finish time: Interview Length Mins

Appendix B
Atos topic guide

Private and Confidential J5043

ESA Borderline Cases - ATOS Face-to-Face

Respondent Name/Id:

A Introduction

- Introduce self and IFF.
- Background to study: IFF Research has been commissioned by the Department for Work and Pensions to explore how decisions are reached by Jobcentre Plus Decision Makers when assessing claims for ESA. The research is particularly interested in claims that are considered 'borderline". The aim of the research is to understand if and how these borderline cases are different from others and the findings will inform future guidance for Decision Makers in assessing borderline cases. The research will feed into Professor Harrington's ongoing review of the Work Capability Assessment and address his recommendation from the first review to empower and invest in Jobcentre Plus DMs.
- Stress confidentiality, that no comment will be personally attributable, MRS Code of Conduct and that there are no right or wrong answers.
- Ask permission to record.
- How long have you worked for ATOS? And in this particular role?
  - Have you previously conducted medical assessments in relation to claims for either Incapacity Benefit or Employment Support Allowance?
  - Briefly explain what their current role entails – assessment and/or advisor to DMs.

B Defining and handling borderline cases

- We want to talk specifically about cases which might be considered 'borderline cases' By borderline we mean cases where DMs may be unsure whether or not to award someone ESA/which group to place them in.
- Are there any types of cases you would consider 'borderline'? If so, which type?
  - Cases that are awarded certain descriptors – which?
  - Cases involving particular types of condition – which?
  - Cases with/without particular types of evidence – which?
- Are there any of the descriptors used in the assessment that you feel are more 'grey'/open to interpretation?
- Do you think DMs handle these cases any differently? In what way?
- Do DMs tend to send particular types of cases back for rework? Which type of cases?

How common is this?

- What sort of recent examples have you got of this? What happened in these cases? Can you remember your recommendation in these cases?
- Do DMs tend to contact you more informally (aside from a request for rework) to discuss particular cases? Which type of cases? How common is this?
- What sort of recent examples have you got of this? What happened in these cases? Can you remember your recommendation in these cases?
- Do you ever review medical reports completed by other HCPs in light of a request or query by DMs? Which type of cases? How common is this?

  What sort of recent examples have you got of this? What happened in these cases? Can you remember your recommendation in these cases?
- What are your views on the role of the DM in this process? What weight do you think the medical report should carry in the final decision? (PROBE: versus the ESA50, versus other medical evidence, versus the DMs experience of handling these sorts of claims).
- What do you see as the key strengths/risks in the process as it stands?
- Do you think DMs should consult an HCP if they are considering amending the score awarded by the HCP after the WCA? Why/why not? In what cases should/shouldn't they? Who should have the final say?
  - If further medical evidence is submitted?
  - If they have further information after speaking to the claimant?

C Relationship with DMs

- How would you describe your relationship with DMs? And Jobcentre Plus generally?
  - How could your relationship with Jobcentre Plus/DMs be improved?
- How much interaction do you currently have with the Jobcentre Plus DMs? (Probe: face-to-face, telephone, email). Has this always been the case?
- Did/do you ever conduct site visits to Benefit Centres? WHERE HCP USED TO OR CURRENTLY VISITS BENEFIT CENTRE IN PERSON: What happened in these visits? What sort of cases would you review?
- Where the DMs thought the recommendation from the medical report should be changed, do you tend to agree with the DMs view or do you tend to agree with the recommendation in the medical report? What happens in these cases?
- How useful were these visits – for Jobcentre Plus? For Atos?
- Do you work on the ATOS helpline/Claimant Service Desk? WHERE HCP IS INVOLVED IN HANDLING QUERIES TO THE HELPLINE: What sort of cases do DMs call about?
- Where the DMs thought the recommendation from the medical report should be changed, do you tend to agree with the DMs view or do you tend to agree with the recommendation in the medical report? What happens in these cases?
- How useful is having this helpline contact – for Jobcentre Plus? For Atos?
- Are there any other reasons the DMs contact you?

- Have you assisted with any training or guidance for DMs or other Jobcentre Plus staff? If so, what did this cover? What was the reaction?
- Is there any training or guidance for DMs that you think would be useful when they are assessing borderline cases?
- Is there any training or guidance you would find useful specifically relating to the role of DMs and their interactions with you?
- Are you aware of the ongoing Harrington Review? What have you heard about it? IF YES: What do you think of the review and his recommendation to empower DMs? Is this a good idea? Why/Why not?

Finally, I would just like to confirm that this survey has been carried out under IFF instructions and within the rules of the MRS Code of Conduct. Thank you very much for your help today.

I declare that this survey has been carried out under IFF instructions and within the rules of the MRS Code of Conduct.

Moderator signature: Date:

Finish time: Interview Length Mins

This report covers findings from a small-scale qualitative study commissioned to understand more about how Decision Makers make judgements in Employment and Support Allowance cases where they face conflicting evidence, or are unsure about the outcome that should be awarded ('borderline' cases).

The study involved group discussions with Decision Makers and depth interviews with Atos Healthcare professionals to understand the types of cases where decision making can be particularly difficult, and the different approaches that are used to reach a decision on these cases. The study also explored Decision Maker views on some of the changes that have been made to working practices since Professor Harrington's Year 1 (2010) Review of the Work Capability Assessment. The report identifies some areas of the process that may be worth reviewing. These focus on the role of the Decision Maker and, more specifically, how Decision Makers deal with 'borderline' cases.

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