

An Independent Review of the Work Capability Assessment – year four

Dr Paul Litchfield

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Any enquiries regarding this publication should be sent to us at

WCA Independent Review Team
Department for Work and Pensions
2nd Floor
Caxton House
Tothill Street
London SW1H 9NA

Email: wca.evidence@dwp.gsi.gov.uk

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Foreword

The Welfare Reform Act 2007 established the Work Capability Assessment (WCA) as a means of distinguishing between people who could not work because of health related problems from those who were fit for some work or could, with support, eventually return to the world of work. The legislation also provided for an independent assessment of the WCA in its first five years of operation. This is the fourth such review but the first that I have carried out. The first three reviews were conducted by Professor Malcolm Harrington to whom I am indebted for his wise counsel when I took over the baton.

I was appointed shortly before Easter in 2013 and, despite 35 years of having been engaged in the world of work and health, I was surprised at how much I had to learn about the benefits system and its special language. The system is enormously complex, probably unnecessarily so, and efforts to simplify it should be of benefit to all. Even the limited part of the system which is the WCA is complicated with multiple hand offs, each of which adds delay, expense and the potential for error. This complexity is compounded by an unusual use of language which is handled skilfully by officials and independent benefits advisers but which can be impenetrable to ordinary people trying to navigate the system, often at a time of particular vulnerability. It is, perhaps, therefore no surprise that the WCA remains highly controversial with a number of people expressing strong views about its perceived fairness.

That perception of objectivity is fundamental if the WCA is to survive in its current form and I was pleased that it was specifically called out in my terms of reference. I have been influenced strongly by the notion of organisational justice in my career as an occupational physician. People need to feel that they are being treated fairly when dealing with an organisation and it is their perception that drives attitudes and behaviours more than any objective assessment of what has happened. In the context of the WCA, it is not just people making a claim for benefit who need to feel that the assessment is fair but also the staff administering the system and the taxpayer that funds it. The distributive element of the WCA (who gets benefit and how much) is clearly a matter for others but I have tried to look at both the procedures and the communication with people through the lens of organisational justice.

Previous reviews have paid particular attention to the clinical assessment conducted by Health Care Professionals and have also focused on appeals against decisions. While I have looked at both these elements and made some recommendations relating to them, I felt that the core of the WCA in which DWP Decision Makers operate should be my main focus for this year. I also noted in an early examination of the data that the number of people being moved to the Work Related Activity

Group (WRAG) by Decision Makers has been growing steadily and I have sought to understand why that might be.

Another area of particular focus for me in this review has been mental health. Mental health problems, unlike many other medical conditions, are common in every age group and feature large in people claiming Employment and Support Allowance (ESA). The impaired capability associated with mental health problems can be difficult to assess and this can be compounded by the stigma that still exists in relation to this group of conditions. Professor Harrington made specific recommendations about reviewing the WCA mental, intellectual and cognitive descriptors and I had hoped that the resultant Evidence Based Review would have been completed to inform my work; unfortunately this was not possible and I have not been able to comment on descriptors. Nevertheless, there are a number of other mental health related issues that I have been able to examine and I hope that the resultant recommendations will help in this often neglected area of health.

Much has changed since ESA was introduced. Professor Harrington made 49 recommendations in his three reviews, almost all of which were accepted, and I felt it appropriate to review how those had been implemented and to try and gauge their impact. There have, however, been many other changes made to ESA and the WCA over the same period and disentangling the respective impact of particular interventions has proved extremely difficult. Nevertheless, I have tried to assess whether recommendations have been fully or partially implemented and I hope that there is some useful learning that comes out of the exercise.

The WCA has evolved since its introduction and will continue to evolve as circumstances change. There remain those who call for its abolition but suggestions for what to replace it with are rarely forthcoming. No “test” is ever perfect but the WCA has been designed with considerable rigour and it is subject to a process of continuous improvement in which I hope this review may play a small part. Good work is good for the health of most people and a benefits system that helps people back into employment when they have been incapacitated must be the aim of a compassionate society. An effective WCA which is fair and perceived to be fair can contribute to that overall aim.

Paul Litchfield

December 2013

Executive Summary

1. The Work Capability Assessment (WCA) is designed to determine eligibility for Employment and Support Allowance (ESA). It is a functional assessment based on the premise that eligibility should not be determined by the description of a person's disability or health condition but rather on how their ability to function is affected, which may vary considerably between individuals with the same diagnosis.
2. The WCA has now been in operation for five years. Earlier Independent Reviews carried out by Professor Malcolm Harrington concluded that the WCA is conceptually right but that more needed to be done to improve the system. As the fourth of five Independent Reviews and the first carried out by Dr Paul Litchfield, this Review provides an opportunity to reflect on the implementation of recommendations from previous years and to assess their impact. There have been many changes to the system since it was first introduced and it is therefore also appropriate to revisit the underlying design principles to determine whether the WCA continues to operate as originally intended.
3. In conducting this Review, it has become apparent that the length and complexity of the process contributes to dissatisfaction and negative perceptions surrounding the assessment. People need to feel that they are being treated fairly when dealing with an organisation and it is their perception that drives attitudes and behaviours more than any objective assessment of what has happened. This Review therefore makes a number of recommendations which aim to simplify the process and improve the way people feel they are treated.
4. Another area of particular focus in this Review has been mental health. Recommendations are made that seek to build on the foundation of Mental Function Champions and improve knowledge of mental health more broadly for Decision Makers and Healthcare Professionals (HCPs).

Implementation of recommendations from earlier Independent Reviews

5. Professor Harrington made a total of 49 recommendations over three Independent Reviews. 35 of these were accepted in full by the Department and 10 more were accepted in principle with others falling outside the remit of DWP.

6. Overall the Department has made good progress with implementing the recommendations and some notable improvements have been made, such as the way people with cancer are treated. Some recommendations have not yet been fully acted upon and the better sharing of information with Work Programme Providers should be a priority.
7. A key recommendation of Professor Harrington was for a comprehensive review of the mental, intellectual and cognitive descriptors. A major programme with independent oversight has been undertaken but, unfortunately, the work was not completed in time to be included in this Review.
8. A number of recommendations are made for how the Department could improve the way it implements changes in future. In particular, giving due consideration to the need for pilots and ensuring that any such pilots are designed with robust evaluation measures from the start. Both policy intent and practical matters should be considered and sufficient analytical input should be sought at the design stage to increase the chances of obtaining meaningful results.

Key findings and themes from this review

- **The assessment itself** – There are a number of ways of determining fitness for work and there is no absolute ‘gold standard’. Any “test” is necessarily a trade-off of many factors and the WCA appears to be a reasonable and pragmatic tool. It seems to function effectively as a yes/no assessment of eligibility for ESA although the underpinning points score is somewhat arbitrary. The descriptors are a useful way of capturing expert consensus in a form that can be applied consistently in a high volume operation. However, emphasising the points scale gives a false impression of scientific validity and appears to drive unhelpful behaviours. Various stakeholders expend considerable effort on deciding whether a points score should be altered even when it will make no difference to the outcome. The Department should review its use of WCA scores, place less emphasis on the number attained and simply use the calculation to determine whether the threshold for benefit has been reached.
- **Perceptions of objectivity** – To be a credible test, the WCA needs not only to be fair but to be perceived as such across a wide spectrum of opinion. In examining perceptions of the system, the Reviewer found considerable dissatisfaction with the WCA – this was most starkly illustrated, perhaps

unsurprisingly, in the responses to the Call for Evidence. The Review highlights areas for improvement, particularly ensuring that people are treated with dignity and respect and that communications are improved. Establishing better rapport at assessments is considered a critical component in the perception of fairness. Elements that might be improved include simple measures such as the layout of the room, better listening skills and the avoidance of inference. There remains a widespread lack of understanding of the different roles of HCPs and Decision Makers and this compounds the perception that the system is not operating fairly. Definitions of purpose for the two groups should be reviewed and woven into a simple narrative which is then used consistently. Written communications remain sub-optimal and input from the Behavioural Insights Unit at the Cabinet Office is recommended.

- **Improving decision making** – Decision making overall is not working as well as intended. Decision Makers appear to feel more empowered as a result of previous Independent Reviews but are less clear about what this means in practice. The data shows that the number of Health Assessment Provider (HAP) recommendations overruled by Decision Makers has increased over time. There appears to be an impaired relationship with HCPs, who should be regarded as trusted advisors, and undue weight given to information from medical records which rarely describe capability. The way DWP staff treat ‘complex’ and ‘non-complex’ cases and the resultant allocation of resource does not appear logical. As currently operated this aspect of the process appears to skew the system towards finding people unfit for work. The Review therefore recommends that DWP reengineers the case mix so that more senior staff consider the ‘borderline cases’ and more junior staff process all others.
- **Simplifying the process** – the WCA process takes too long and this does a disservice to people making claims for ESA and to taxpayers. There are a number of reasons why the process takes such a long time but complexity is undoubtedly a factor. The Reviewer has made proposals for alternative processes and initial modelling has been carried out to test whether they have the potential to improve speed and efficiency. The ESA113, currently requested in around a quarter of cases, can be improved considerably and it is recommended that this be undertaken through co-design with the BMA.
- **Mental Health** – The impaired capability associated with mental health problems can be difficult to assess. Diagnostic labels can be unhelpful in either understating the impact of functional capacity or stigmatising people and

condemning them to a life of worklessness. Redesigning the ESA50 to make it clear that evidence from professionals other than medical practitioners, such as Support Workers, is valuable and giving guidance on functional capability to help Decision Makers is recommended. Building on the foundation of Mental Function Champions, the Reviewer recommends improved training in mental health for Decision Makers and HCPs. In addition, all HCPs should have suitable and sufficient previous experience of dealing with people with mental health problems to help contextualise their findings at assessments. Routine recall of people in the Support Group who have very severe or degenerative brain disorders which will not realistically improve should be extended to 5 years.

Northern Ireland

9. Section 10 of the Welfare Reform Act (Northern Ireland) 2007 provides for Independent Review of the WCA in Northern Ireland. As in previous years, the Minister for Social Development appointed the Independent Reviewer for Great Britain to undertake this task. The systems are broadly similar but the smaller scale of the operation in Northern Ireland reduces some of the complexity, there is a separate contract with the HAP and the Department for Social Development (DSD) has an in-house Health Assessment Adviser (HAA) undertaking oversight of the HAP.
10. Differences between the systems mean that not all of Professor Harrington's recommendations were relevant in Northern Ireland – where recommendations were relevant they have largely been implemented. Mental health appears to have an even higher profile than in Great Britain and better access to Mental Function Champions by Decision Makers is working well. The HAA role appears to have a beneficial impact on the effectiveness of the WCA in Northern Ireland and should be examined to ensure that value is maximised. Strengthening the feedback loop where decisions are altered will further enhance quality.

Chapter 1: Introduction – the Review outline

The Work Capability Assessment – purpose

1. The Work Capability Assessment (WCA) is designed to determine eligibility for Employment and Support Allowance (ESA). ESA is a benefit that provides support to people whose disability or health condition means they have limited capability to work; it was introduced in October 2008.
2. The WCA is a functional assessment, it is based on the premise that eligibility for ESA should not be determined by the description of a person's disability or health condition but rather by how their ability to function is affected, which may vary considerably between individuals with the same diagnosis.
3. An individual's capability for work is assessed against a number of descriptors which aim to cover the effects of any health condition or disability on their ability to carry out a range of everyday activities. The level of functional impairment is converted into a numerical score which is then used to determine whether a person is eligible for ESA.
4. The assessment aims to identify and place people making a claim into one of three categories:
 - Those who are fit for work
 - Those who have limited capability for work
 - Those who have limited capability for work-related activity
5. People considered Fit for Work would normally be informed that they may be able to claim Jobseeker's Allowance and be directed towards Jobcentre Plus for support to enter or return to employment.
6. A person deemed to have limited capability for work due to illness or disability would be expected to take steps towards moving into work in due course. These individuals are assigned to the Work Related Activity Group (WRAG).
7. A person classed as having limited capability for work-related activity is considered sufficiently impaired to prevent them making any steps towards moving into work. These individuals are placed in the Support Group.

End to end process

8. The WCA Process begins when a person contacts Jobcentre Plus to make a claim for ESA. Some basic information is gathered at this stage to determine eligibility and an initial 'assessment rate' of ESA is paid once Jobcentre Plus receives a medical certificate or Fit Note, issued by a General Practitioner (GP), from the person making a claim.
9. All cases are referred automatically to the Health Assessment Provider (currently Atos Healthcare), who send out a Limited Capability for Work Questionnaire (ESA50). The ESA50 is completed by, or on behalf of, the person making the claim and seeks information about their health problems or disability and the impact on their capability; it also invites the attachment of any relevant medical evidence that may be available to them. In a small number of cases, where even from the limited information available, it seems likely that the Support Group criteria will be met, a shorter Capability for Work Related Activity Questionnaire (ESA50A) is sent out instead of the ESA50. Those people who are identified as being terminally ill have their claims processed as quickly as possible and should be placed automatically in the Support Group.
10. The person making the claim returns the completed ESA50 (or ESA50A) to the Health Assessment Provider (HAP). On the basis of this information, and any other evidence submitted, the HAP determines whether there is sufficient evidence to assign the individual to the Support Group. In some cases (23%)¹ the HAP may seek further information from the person's GP via a standard form (ESA113) where it seems likely that a face to face assessment will be unnecessary and the Support Group criteria will be met. However, in the majority of cases (80% in 2012)² the claim proceeds to a face to face clinical assessment.
11. People required to attend a face to face assessment are invited to their local HAP Assessment Centre to see a Healthcare Professional (HCP). The HCP interviews, observes and may conduct a limited examination of the person making the claim while completing an on-line report template. The resultant report with a recommended "score" is returned to DWP for the attention of a Decision Maker.

¹ New and repeat claims reviewed by Atos Healthcare between January and June 2013. This data derived from unpublished management information and has not been quality assured to National Statistics or Official Statistics publication standard. It should therefore be treated with caution.

² New claims decided in 2012. Table 3 of DWP (2013) Statistics to support the Fourth Independent Review of the Work Capability Assessment. Ad hoc statistical release. These two figures do not sum to 100% because they cover different date ranges, and different types of claim, and the HAP need not always send out an ESA113 to make a recommendation without a face to face assessment.

12. The Decision Maker considers the HCP's report, the completed ESA50 and any additional evidence provided to determine if the person making the claim is fit for work or whether they should be placed in either the WRAG or Support Group.
13. A person is placed in the WRAG when they are deemed to have limited capability for work. This is determined by assigning points for limitation against 17 activities each graded by statements describing a 'level of function' (known as a descriptor). The threshold for being placed in the WRAG is 15 points, accumulated across the 17 activities. People in the WRAG receive a higher rate of benefit than the assessment rate.
14. A person is placed in the Support Group if, in addition to having limited capability for work, they are also considered to have limited capability for work-related activity. This is identified by assessing a person making a claim against 16 criteria and if they meet one (or more) of these criteria they are placed in the Support Group. People in the Support Group receive a higher rate of benefit than those placed in the WRAG.
15. There are limited circumstances where Decision Makers can assign people to the WRAG or the Support Group even if they do not meet the normal criteria. For example in 'exceptional circumstances' covered by Regulations 29 and 35 of the Welfare Reform Act 2007 where there would be a substantial risk to health of that person or another were the person found fit for work or 'special circumstances' such as terminal illness.
16. People assigned to neither the WRAG nor the Support Group are ineligible for ESA and are considered Fit for Work.
17. People can dispute the decision made about their eligibility for ESA. Previously, people have been able to either request reconsideration by a Decision Maker and if they remain dissatisfied then make an appeal which must be lodged within 30 days of receiving this second decision or they could move straight to lodging an appeal. Since 28 October 2013, reconsideration by a Decision Maker has been mandatory before an individual can lodge an appeal.

Independently reviewing the WCA

18. The Welfare Reform Act 2007 legislated for the introduction of the WCA. This statute provides the basis for the Independent Reviews. Section 10 states that:
"The Secretary of State for Work and Pensions shall lay before Parliament an independent report on the operation of the assessment annually for the first five years after those sections come into force."

19. This is the fourth of the Independent Reviews. Professor Malcolm Harrington, an occupational physician, led and published the first three Reviews in which he made a total of 49 recommendations. The implementation and impact of these recommendations is discussed in Chapter 2.

The Fourth Independent Review

20. In February 2013 the Secretary of State for Work and Pensions appointed Dr Paul Litchfield to carry out the Fourth Independent Review of the WCA. Dr Litchfield is an occupational physician and currently Chief Medical Officer for BT Group plc.

21. The terms of reference for the current Review are to:

- provide the Secretary of State for Work and Pensions with an independent report evaluating the operation of the assessments of limited capability for work and limited capability for work-related activity;
- evaluate the effectiveness of the limited capability for work assessment in correctly identifying those claimants who are currently unfit for work as a result of disease or disability;
- evaluate the effectiveness of the limited capability for work-related activity assessment in correctly identifying those claimants whose disability is such that they are currently unfit to undertake any form of work-related activity;
- evaluate perceptions of objectivity surrounding the assessments;
- take forward any outstanding areas of work identified in the years one, two and three reports during year four;
- monitor and report on the implementation of the recommendations in the years one, two and three reports that are adopted by Ministers; and
- provide independent advice to Ministers and the Department on any specific issues or concerns with the WCA that arise during the term of appointment, on which the Government may seek his independent view.

22. The Secretary of State for Work and Pensions also appointed an Independent Scrutiny Group to provide oversight, challenge and support to Dr Litchfield during the Review. As well as providing on-going support throughout the review process, the group met four times and was chaired by Professor David Haslam, Chair of the National Institute for Health and Care Excellence (NICE). The other four members of the group were:

- Neil Lennox, Confederation of British Industry and Head of Group Safety at Sainsbury's;
- Professor Keith Palmer, Professor of Occupational Medicine, University of Southampton;

- Hugh Robertson, Senior Policy Officer, Trades Union Congress; and
- Ciarán Devane, Chief Executive, Macmillan Cancer Support.

23. The Independent Scrutiny Group's terms of reference are to:

- ensure that the process for conducting the review is robust, comprehensive and fair and reflects the terms of reference for the review;
- ensure the process for gathering evidence and relevant data is in accordance with accepted standards and best practice;
- monitor progress of the review to ensure it remains on plan and discuss and challenge emerging issues and findings;
- be available to the Reviewer to provide advice and support as the review progresses;
- provide challenge as the final report is formulated to ensure the findings are robust and are presented in a clear and appropriate format; and
- ensure the Reviewer maintains his independence, acting as a point of contact and sounding board where necessary.

The scope

24. This is the fourth of five independent reviews and the first carried out by Dr Litchfield. It therefore seemed appropriate to review the implementation of recommendations from previous years and to attempt to assess their impact.

25. The WCA has now been in operation for 5 years and a number of changes have been made during that time, not only as a result of Professor Harrington's recommendations. It therefore also seemed appropriate to revisit the underlying design principles and whether they, and the associated procedures as amended, continue to deliver the intended differentiation between the groups in question.

26. The length and complexity of the process has been investigated as it became apparent that this contributes to dissatisfaction and negative perceptions surrounding the assessment.

27. Departmental data indicates that mental health conditions represent the primary cause of perceived incapacity in 40%³ of cases going through the WCA. The HAP

³ New claims going through the WCA in the year to May 2012 (by month of assessment) presented with a mental health condition as primary condition. Derived from table 2b of DWP (2012) Employment and Support Allowance: Work Capability Assessment Outcomes by Physical and Mental Health Condition. Ad hoc statistical release, and table 2a of DWP (2013). ESA: outcomes of Work Capability Assessments October 2013.

reports that 60%⁴ of people attending face-to-face assessments have some data captured about a mental health condition in the Mental State Examination part of the assessment. The assessment of mental health cases has also been a focus of particular concern by a number of voluntary sector organisations. These factors dictated that mental health should be afforded particular priority in this review.

The Review process

28. The Review was broken down into three broad stages though there was some temporal overlap:

- Examination of the end to end process from initial application to the determination of any appeal.
- Gathering of evidence including multiple stakeholder meetings and a formal Call for Evidence.
- Analysis of data, evidence synthesis and report writing.

Examining the WCA process

29. The Review examined all parts of the WCA process. Meetings and briefings were held with both senior and working level officials from DWP, Atos Healthcare and HM Courts and Tribunals Service. Visits were made to four Benefit Centres (Stratford, Worcester, Leicester and Belfast) where the main focus was on observing and speaking to Decision Makers as they reviewed cases. Three HAP Assessment Centres were visited (Worcester, Marylebone and Belfast) where both HCPs and people making a claim were interviewed and some Healthcare assessments were observed. Fourteen tribunal hearings were attended at Fox Court in London and the opportunity was taken to listen to the views of tribunal members.

Evidence gathering

30. The Call for Evidence was launched on 1 July 2013 and closed on 27 August 2013 with flexibility for those who needed to make their submissions after the deadline. This year's Call for Evidence differed from previous years in that it could be completed via an online form as well as by post and email submission - this method was included to provide an easier, more structured way for people to

⁴ Percentage of cases with some data in the Mental State Examination carried out as part of the face-to-face assessment - all face-to-face assessments between January and June 2013. This data derived from unpublished management information and has not been quality assured to National Statistics or Official Statistics publication standard. It should therefore be treated with caution.

respond. This year's Call for Evidence also differed in that it had a separate set of questions for individuals and organisations; this approach was taken to reflect the fact that the nature of the evidence organisations and individuals are able to provide about the WCA is different.

31. Responses were received from a broad range of stakeholders including individuals who had been through a WCA, welfare rights advisors and local and national voluntary groups. 273 responses were received from individuals and 131 from organisations.
32. Four stakeholder seminars were held in August to supplement the Call for Evidence; one specifically focused on mental health and one for Healthcare Professionals. The Reviewer also met with the Disability Benefits Consortium twice and held a number of group and individual meetings with interested groups including a video conference with stakeholders from Scotland. In total, over sixty stakeholder organisations took up the opportunity to attend a meeting or seminar with Dr Litchfield.
33. Throughout the Review, a dialogue was maintained with DWP Ministers and senior officials from DWP Policy and Operations.

Research and Analysis

34. The operation of analogous systems in other countries was examined by a desk based review. Departmental research specific to the WCA was examined and the Review was kept apprised of on-going research being conducted by DWP. Access was provided to routine management information collected by both the Department and Atos Healthcare and, additionally, specific data analysis and modelling was conducted to explore specific facets of the process.

Chapter 2: Implementation of the years one to three recommendations

Background

1. The Independent Reviews carried out by Professor Malcolm Harrington have made a significant contribution to refining the Work Capability Assessment (WCA).
2. Over the three reviews, Professor Harrington made a total of 49 recommendations covering every aspect of the WCA. 35 of these recommendations were accepted in full by the Department and 10 more were accepted in principle or provisionally. Three further recommendations from year one fell within the remit of the First-tier Tribunal rather than DWP and are therefore out of scope for this review. Recommendation 5 from year three concerned future Independent Reviews exploring the quality of training outcomes.
3. This chapter focuses on those recommendations considered to be of particular significance, either by the Reviewer or by the contributors to the Call for Evidence. It considers in detail how these have been implemented and what the impact has been. Annex 2 summarises the position for all recommendations.
4. The recommendations fall into six broad categories as follows:
 - Contact and support
 - Descriptors
 - The face-to-face assessment
 - Decision making
 - Reconsideration and appeals
 - Smoothing the transition into work
5. This chapter concludes by considering how implementation has been evaluated and how the Department should look to implement and evaluate the recommendations covered in this review.

Contact and support

6. The first recommendation of Professor Harrington's First Independent Review concerned changes to the end-to-end claim process.

DWP Operations manages and supports the claimant during the course of their benefit claim and identifies their chosen healthcare adviser.

7. Professor Harrington stated:
"Specifically, the review recommends that DWP Operations staff should contact claimants by telephone or face-to-face at least twice during the course of their claim. This should include when they first claim ESA, after they have had their Atos assessment and for those who wish to appeal their decision, on appeal."
8. The Department piloted a number of measures from June 2011. These included:
- letters to explain the process to people making new and repeat claims (the ESA35/ESA35A letters respectively);
 - follow-up telephone calls a few days after issue of the ESA35 letter, to check people's understanding of the process and give them the opportunity to ask any questions;
 - calls to people found Fit for Work to discuss the proposed decision and offer them the opportunity to provide further documentary evidence if appropriate (Decision Assurance Calls);
 - calls to people placed in the Work Related Activity Group (WRAG) or Support Group, to explain the outcome, and, in the case of the WRAG, the need to attend Work Focused Interviews (Allowance Calls).
9. A number of these measures either did not progress beyond the pilot stage or, having been implemented, have subsequently been ceased:
- the ESA35A, sent to people making a repeat claim, was not produced after February 2013
 - the follow-up call pilot was terminated in March 2012
 - 'Allowance' calls to people placed in the WRAG were stopped in October 2013
10. As the fourth Review goes to press, the principal telephone contact between DWP and people claiming ESA is the Decision Assurance Call (see below) made by the Decision Maker to those found Fit for Work. People placed in the WRAG should now also receive a telephone call before their first Work Focused Interview. Those in the Support Group receive no telephone or face-to-face contact from the Department.

11. The stated purpose of the additional contacts recommended by Professor Harrington was to “explain the process, .. explain the need for the claimant to gather corroborative evidence, .. promote the support that is available to the claimant... and route those who need to be in the Support Group to that group as soon as possible.” The Department recognised that these changes would add costs to the process but anticipated that they would also produce compensating savings, for example by reducing the number of people failing to return their ESA50 claim form and by reducing numbers of appeals.
12. However the anticipated savings did not materialise and the Department has gradually withdrawn most of these additional contacts. The ESA35A letter which explains the end-to-end process to people making a repeat claim may be considered redundant, as people now claiming have already applied for benefit under the current system. Similarly the ESA ‘Allowance’ calls for people placed in the WRAG have recently stopped, because they seemed to duplicate other communications.
13. DWP evaluation studies have examined the financial costs and benefits of these contact measures, introduced in response to the Harrington reviews, with a focus on process. However, they have not always addressed or prioritised the qualitative benefits, such as improved understanding by those who received an ESA35 letter or an Allowance call.
14. In summary, people found Fit for Work (42%) are called once as are those who are placed in the WRAG (23%) but no calls are made to those placed in the Support Group (35%)⁵. This recommendation has therefore been partially implemented. Support to people making a claim appears to be significantly more limited than envisaged in the original report.

Decision Assurance Calls

15. As part of the recommendation outlined in paragraph 6, Professor Harrington envisaged that a call from DWP to the person making a claim should "promote the support that is available to a claimant, dependent on their result. Importantly this should include JSA so that people who are found fit for work know what support is available and can access it."

⁵ Outcomes for new ESA claims completed between December 2012 and February 2013. DWP (2013) ESA: outcomes of Work Capability Assessments October 2013.

16. The Department decided to introduce a 'Decision Assurance Call' at the end of the process with a much-expanded remit from that set out in Professor Harrington's report. The purpose of the Decision Assurance Call now is:
- to identify and discuss any perceived inaccuracies in the Healthcare Professional (HCP) report;
 - to provide any additional evidence; and
 - to help the person making a claim understand their options if found Fit for Work.
17. In the Third Review, Professor Harrington considered that the opportunity for people to provide additional evidence during a Decision Assurance Call was a key part of their ESA claim. He wrote that "the Decision Assurance Call is an important opportunity to examine with the claimant the importance of further documentary evidence to help ensure that the correct decision is made from the outset. This, in turn, should help to reduce the number of reconsiderations and appeals received, and ultimately the number of decisions which are overturned at appeal."
18. The success rate of Decision Assurance Calls, defined as any call in which the person picks up the phone and the Decision Maker speaks to them, varies considerably by Benefit Centre but the average is around 32%⁶. Some centres with higher success rates are seeing lower rates of appeals, raising the possibility that the Decision Assurance Call may be a contributing factor by helping people understand the reason for the decision. However, gaps in the available data render interpretation somewhat uncertain.
19. Evidence seen by the review⁷ also suggests that some of the Benefit Centres with higher success rates in Decision Assurance Calls go against the Health Assessment Provider's (HAP) Fit for Work advice more often than other Centres. An alternative explanation for a lower appeal rate from these Benefit Centres may therefore simply be the Decision Makers' willingness to adjust their decision after speaking to a person who would otherwise have gone on to appeal.
20. Based on the available evidence, it is not possible for the Review to determine whether the Decision Assurance Call is making a material difference in terms of reducing the numbers of reconsiderations, appeals or overturns at appeal. Since

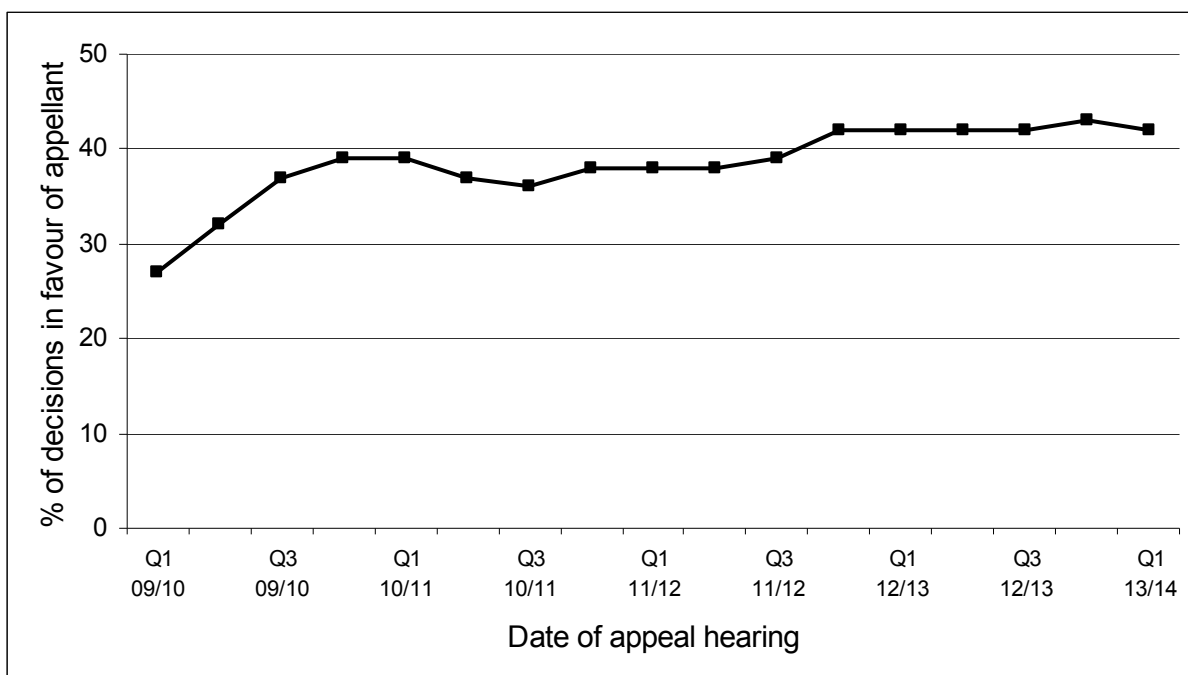
⁶ Average for April to August 2013. This data derived from unpublished management information and has not been quality assured to National Statistics or Official Statistics publication standard. It should therefore be treated with caution. The data gather is reliant on Decision Makers manually recording the information.

⁷ DWP internal data.

publication of the first Review the overall appeal rate has fallen slightly⁸ and the total number of decisions overturned at appeal has slowly drifted upwards (Figure 1).

21. The Review returns to the subject of decision making in Chapter 5, including the issue of Decision Assurance Calls, and makes proposals for consideration of a re-engineered process with enhanced face-to-face contact between the person making a claim and Decision Makers in Chapter 6.

Figure 1: Percentage of ESA appeals upheld at hearing over time, by date of hearing.⁹



⁸ Derived from tables 1a and 4 of DWP (2013) ESA: outcomes of Work Capability Assessments July 2013.

⁹ Data shows decisions in favour of the appellant for all ESA appeals (appeals against WRAG and Fit For Work decisions, new and repeat assessments and Incapacity Benefit re-assessment) cleared at hearing. Excludes cases cleared without a hearing, e.g. withdrawals prior to a hearing. Ministry of Justice. (2010-2013) Tribunal statistics series. <https://www.gov.uk/government/collections/tribunals-statistics>

Descriptors

Evidence Based Review

22. The key recommendation relating to descriptors was Recommendation 3 in the Second Independent Review.

<p>A 'gold standard' review be carried out, beginning in early 2012. Future decisions about the mental, intellectual and cognitive descriptors should be based on the findings of this review.</p>
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23. Professor Harrington went on to say:

"The 'gold standard' review should provide robust evidence on the way in which the current descriptors are working and test the proposed descriptors to see if they will improve the assessment. This will be an important step in establishing whether the proposed descriptors are more accurate than the current ones. This review needs to be thoroughly conducted and independently overseen to ensure fairness in the process.... until then any further decisions about the mental, intellectual and cognitive descriptors should be put on hold. Similarly, if, as hoped, the fluctuating conditions descriptors work is included in this 'gold standard' review then decisions about those should only be taken once that work is completed."

24. Professor Harrington invited Mind, Mencap and the National Autistic Society to recommend refinements to the mental, intellectual and cognitive descriptors. A group led by the MS Society and including Arthritis Care, Crohn's and Colitis UK, Forward ME, the National AIDS Trust and Parkinson's UK were also asked by Professor Harrington to provide recommendations on refining the approach used to assess fluctuating conditions in the WCA. Their recommendations, which were endorsed by Professor Harrington, were designed to account better for fluctuations and produce a more nuanced assessment of people's impairments.

25. 'The 'gold standard' review became the Evidence Based Review (EBR) conducted by the Department with Professor Harrington chairing the steering group. The intention had been for the EBR to be published in summer 2013 and it was therefore anticipated that the findings would inform this Review. However, delays to the completion of the EBR have meant that it remains unpublished at the time of writing of this report. The recommendation has been implemented and the findings of this important piece of work should be used to inform the Year 5 Independent Review.

Involving outside experts in changes

26. Recommendation 5 in the Second Independent Review concerned how future changes to descriptors should be implemented.

<p>This 'bottom up' model - involving a wide range of experts as well as DWP - should also be adopted in any future changes to the WCA descriptors, where appropriate.</p>
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27. He wrote that "there is a strong case for making use of the expertise of the relevant representative groups should this process be repeated."

28. The Department used this process for the cancer treatment provisions which were originally proposed by Macmillan Cancer Support, and this was commended by Professor Harrington. Macmillan's proposals included evidence from sixteen oncologists and other cancer care specialists. Their recommendations were based on an iterative process designed to achieve consensus.

29. DWP subsequently developed proposals and conducted an informal consultation in early 2012, which attracted 90 responses, not only from representative groups such as Macmillan, but also from the Royal College of GPs, Royal College of Radiologists, NHS Trusts and professional associations.

30. As a result, the Department revised its original proposals to adopt a presumption that an individual awaiting, receiving or recovering from treatment by chemotherapy or radiotherapy should be in the Support Group, subject to confirmatory evidence gathered on a paper basis. Also in response to the consultation, the Department decided to remove the condition that treatment must be continuous for a period of more than six months.

31. This recommendation has been implemented. There, nevertheless, remain areas where the process could be improved further for this group of particularly vulnerable people and some of these have been highlighted by Macmillan Cancer Support. The lack of clarity in DWP documentation means that people do not necessarily appreciate that their Clinical Nurse Specialist or Consultant can complete the relevant section of the ESA50 instead of their GP. This sometimes results in unnecessary delay and expense for people making a claim. A simple amendment to page 20 of the ESA50 would obviate many of these problems.

The face-to-face assessment

Staff training

32. Recommendation 16 of Professor Harrington's Second Independent Review stated:

DWP should continue to monitor the quality and appropriateness of DWP Operations and Atos training

33. DWP Operations training is considered in Chapter 5. At the time of writing, Atos Healthcare remains the Department's only HAP for the WCA. When undertaking the second review, Professor Harrington spent time at an Atos training centre and scrutinised training materials. This Review has focused more on the process by which the Department and the HAP jointly identify training requirements, and re-accredit HCPs.

34. DWP has measures in place to monitor the quality and appropriateness of HCP training. The HAP is contractually required to deliver an annual training needs analysis, a training plan and a training evaluation report all of which are subject to approval by the Department. This subject is addressed further in Chapter 7 but it appears that measures are in place to monitor quality and appropriateness of HCP training. This recommendation has therefore been implemented.

Audio recording

35. Of all of the recommendations made by Professor Harrington in his three reviews, the one that attracted the most comment in this Call for Evidence was Recommendation 8 from the first review, concerning audio recording of assessments.

The review recommends that Atos pilot the audio recording of assessments to determine whether such an approach is helpful for claimants and improves the quality of assessments.

36. Call for Evidence responses included:

"Record as standard every face to face. Always give a copy of recording to the client. This way it is very easy - if a reconsideration is required the DM can just pull up the audio recording to see what actually was said during the assessment."
Individual respondent, Ms C

"The recordings might in fact assist both DWP and ATOS to rebut challenges and complaints regarding the contents of the ESA85 reports." Disability Solutions West Midlands

37. After the results of an initial inconclusive pilot conducted by Atos Healthcare in June 2011, the Department continued to offer audio recording although this was not widely publicised. The Department asked Atos Healthcare to try to accommodate requests for audio recordings within four weeks. Where this was not possible the assessment would go ahead without a recording. The Department has now removed the four week deadline.
38. The guidance leaflet (WCA AL1C) sent to people making a claim was amended in August 2013 to publicise the option to request an audio recording. This should mean that people attending a face to face assessment are now aware of this option and that everybody who requests a recording should be provided with one. The recommendation is therefore fully implemented.

Publishing HCP Guidance

39. Recommendation 9 in Professor Harrington's First Independent Review stated:

Atos should develop and publish a clear charter of claimant rights and responsibilities, and should consider publishing the HCP guidance online for claimants and advisers.

40. He wrote that "a well publicised charter outlining a claimant's rights and responsibilities would help reduce negativity with the process and ensure that claimants know what to expect from their Atos assessment" and that "Atos and DWP have developed a considerable amount of information and guidance to support the Atos HCPs in their work. This guidance sets out clearly how assessments should be carried out. The review believes that if this was made available to claimants it would do much to dispel the fear and myths that have built up around the Atos assessments."
41. The Reviewer has seen the charter when visiting HAP Assessment Centres and it appears to be well promulgated. The Department has published the WCA Handbook online though publication of supplementary guidance has been judged to be disproportionate.
42. The Call for Evidence produced few responses mentioning surprise or confusion about the content of face-to-face assessments and indicated a clearer understanding of the WCA than has been evident previously. This recommendation has therefore been implemented fully and, apparently, to good effect.

Decision making

43. Recommendation 6 of the First Independent Review stated:

Every claimant is sent a copy of this personalised summary and is able to discuss any inaccuracies with a Decision Maker

44. Sending copies of the HAP's Personalised Summary Statement (PSS) to people making a claim was trialled in 2011 at Wrexham Benefit Centre. The pilot demonstrated some issues with accuracy of the content and that many people did not feel that the document was useful to them.
45. At that time, Professor Harrington was working on the second Independent Review, and was kept abreast of the pilot's progress. With his approval, DWP decided to instead introduce a Decision Maker Reasoning, piloted in 2011 and rolled out nationally in January 2012. This is an extended piece of prose for people found Fit for Work, outlining their case and drawing from the HAP's report, the claimant's ESA50 and any other evidence provided. The aim is to give people found Fit for Work a clear understanding of the reasons why the decision was reached. In his third Review Professor Harrington wrote that "DWP Operations are to be commended for this excellent initiative."
46. This Reviewer concurs that the Decision Maker Reasoning is a useful document, if done well, and that simply forwarding the more limited Personalised Summary Statement to the person making a claim is less useful. However the continuing availability on request of the Personalised Summary Statement, which is referred to in the Decision Notice issued to the person making a claim, is important because factual errors that are material to the decision may be identified.
47. Consequently, although the recommendation, as originally made, has not been fully implemented, the end result is considered to meet and to exceed the intent behind it.
48. Chapter 5 of this report considers decision making more broadly.

Reconsideration and appeals

49. Professor Harrington made a number of recommendations relating to appeals as part of the first review. Two of these are shown below.

The review recommends that feedback from the First-tier Tribunal should be routinely shared with Jobcentre Plus staff and Atos healthcare professionals. As part of their professional development, Jobcentre Plus Decision Makers should be encouraged to attend Tribunals.

The review recommends that Tribunal decisions are better monitored, including monitoring of the relative or comparative performance of Tribunals.

50. Although Tribunals fall outside the ambit of the DWP and are necessarily independent of it, progress has been made in this area as described below.
51. Professor Harrington also made a recommendation part-way through his second review which informed the production from July 2012 of a drop-down menu of one line statements. This gives the primary reason for the Tribunal upholding or overturning a decision.
52. Recognising the limited nature of this feedback, Professor Harrington recommended in his third Review that:

DWP should continue to work with the First-tier Tribunal Service, encouraging them to, where appropriate, ensure robust and helpful feedback about reasons for decisions overturned by the First-tier Tribunal.

53. From June 2013, HM Courts and Tribunals Service (HMCTS), working closely with the DWP, introduced on a 'controlled start' basis Summary Reasons in appeals against ESA decisions where Tribunals upheld or overturned the Department's decision. The Summary Reasons take the form of written text which is incorporated into the Decision Notice issued by the Tribunal and is provided to both the appellant and DWP.
54. Early indications are that this initiative appears to have been a success, with a high level of judicial cooperation throughout the exercise. Although this was carried out initially for four tribunal sites on ESA appeals only, HMCTS is working with the Judiciary to implement Summary Reasons across other Tribunal venues. Good progress is therefore being made on implementing this recommendation.
55. Analysis of the Summary Reasons in the 'controlled start' sites revealed areas where the Department's approach to decision making and handling of appeals can be strengthened. Improving decision making and the critical role of feedback is revisited in Chapter 5.

Smoothing the transition into work

56. The eighth recommendation of Professor Harrington's 2011 review concerned the sharing of information with Work Programme Providers.

DWP consider ways of sharing outcomes of the WCA with Work Programme providers to ensure a smoother claimant journey.

57. Work Programme Providers have reported consistently that they receive very little information about people referred to them who have been through the WCA process. As a consequence, Work Programme advisers have to determine afresh relevant information such as health conditions, functional impairments and real or

perceived barriers to work.

“Specifically, ERSA would like to see the information gathered at the WCA stage being passed on to employment services providers. Whilst a trial is about to begin, progress has been slower than ERSA would have liked.” Employment Related Services Association

58. DWP ran several pilots between July 2012 and August 2013 in which better information sharing with Work Programme Providers was explored. A number of process challenges have been highlighted to the Reviewer and it is understood that piloting was also hindered by concerns around the quality of information provided by the HAP. The Reviewer has been advised that from November 2013 some sharing of information has been instituted nationally with Personal Advisers in Jobcentres but the further dissemination to Work Programme Providers has yet to be addressed. This recommendation has therefore been partially implemented in that consideration has clearly occurred but the fundamental issue of sharing information between the key parties remains unresolved.
59. There are clear advantages for all parties in sharing relevant information between the Department and Work Programme Providers, with the informed consent of the person concerned. That information should focus on capability for work rather than medical information. Process considerations should not be allowed to dominate this issue and DWP should now address with some urgency the issue of sharing information appropriately.

Measuring the impact of the changes

60. As stated above, most of Professor Harrington’s recommendations have been accepted by DWP. The Department accepted 35 recommendations in full of which, in the opinion of the Reviewer, 29 have been fully implemented, 3 have been partially implemented and 3 are in progress. Additionally, the Department accepted 10 recommendations in principle of which 5 appear to have been fully implemented, 2 partially implemented and 3 are in progress.
61. A number of significant policy changes to ESA have happened since the Independent Reviews commenced including the time limiting of contributory ESA, the introduction of Incapacity Benefit Reassessment and two sets of changes to the descriptors. It is often not possible to disaggregate the impact of these policy changes from the Harrington recommendations.
62. Notwithstanding these difficulties the Department has attempted to evaluate a number of the changes made. Unfortunately, the methodology used has sometimes compromised the results. Examples include:

- Absence of controls. Some interventions have been piloted without monitoring outcomes at non-pilot sites. For example, claimant satisfaction measures were used to endorse the introduction of Decision Maker Reasonings, but claimant satisfaction was not measured at other centres. It is therefore not possible to state that the intervention as piloted resulted in the observed changes.
- Assumption of causal effect. Strong inferences about associations have been drawn when only weak evidence was available. For example, higher numbers of Decision Assurance Calls at some Benefit Centres are assumed to result in lower numbers of appeals. There may be alternative explanations for this association (not least a higher overturn rate following a decision assurance call).
- Choosing appropriate outcome measures. The additional contacts recommended by Professor Harrington were primarily intended to improve the ease of the end-to-end process for people making a claim. However the measures used to evaluate their impact focused on process metrics such as numbers of people returning ESA50s rather than qualitative success factors.
- Over-reliance on staff opinion. In some instances such as the Allowance Call, decisions to amend Professor Harrington's recommendations appear to have been based on operational staff views of what would be effective rather than formal evaluation. Some of these decisions appear to have been taken without seeking input from departmental policy owners.

63. Piloting of proposed changes is a prudent action when the impact of an intervention is uncertain. Departmental piloting appears to have had a strong focus on testing whether changes would be operationally practical but a weaker emphasis on whether they would result in the changes for which they were recommended. Not all changes to the WCA in future will require piloting but, where they do, particular attention should be paid to the means of evaluation. Both policy intent and practical matters should be considered and sufficient analytical input should be sought at the design stage to increase the chances of obtaining meaningful results.

Summary

64. This chapter has considered the implementation of a selection of earlier Independent Review recommendations made by Professor Malcolm Harrington. A fuller analysis of the implementation of all recommendations is available in Annex 2.

65. Of Professor Harrington's 49 recommendations, the Department accepted 35 in full and 10 more in principle. Of those accepted in full, 29 have been fully implemented, 3 have been partially implemented and 3 are in progress. Of those accepted in principle, 5 appear to have been fully implemented, 2 partially implemented and 3 are in progress.
66. The analysis of the implementation of recommendations from earlier Independent Reviews has shown that some notable improvements have been made. These include involving experts in changes to descriptors, implementing audio recording and the work with HMCTS to obtain better feedback. It has also shown that further simple changes could be made to build on the good work around cancer treatment provisions.
67. Where recommendations have not been fully implemented it has generally been for good reasons. The introduction and sharing of the Decision Maker Reasoning appears to be a better solution to the issue identified than the original proposal to share the Personalised Summary Statement. Conversely the continuing inability to share information with Work Programme Providers appears to be a matter worthy of urgent attention to overcome remaining process issues.
68. A “gold standard” review of the descriptors was a key recommendation of Professor Harrington and it has been implemented through the Evidence Based Review. Publication delays preclude comment in this report but its findings should be considered fully in the next Independent Review.
69. The Reviewer has identified some issues with the way in which the Department has piloted and evaluated recommendations from earlier Independent Reviews. Recommendations for improvement are made.

Recommendations

70. In relation to the implementation of previous reviews the Reviewer recommends:

- Sharing information from the WCA on capability for work with Work Programme Providers should be addressed as a priority.
- The Evidence Based Review and the actions taken by the Department as a result of its findings should be evaluated as part of the Year 5 Independent Review.
- The Department should build on the improvements for people with cancer by amending page 20 of the ESA50 to make it clear that Clinical Nurse Specialists and consultants may also complete that section of the form.

71. The Reviewer further recommends that when considering its response to this Review the Department should:

- Give due consideration to whether piloting is required for interventions and, if so, to design pilots with particular attention to the means of evaluation. There should be suitable and sufficient analytical input to any pilots at the design, implementation and evaluation stages.
- Ensure that proposed adjustments to accepted recommendations are fully considered in advance by both policy officials and operational staff so that policy intent and practical considerations are harmonised.

Chapter 3: Effectiveness of the WCA

Design of the WCA

1. The Work Capability Assessment (WCA) is designed to determine eligibility for Employment and Support Allowance (ESA). It is based on the premise that eligibility for benefits should not be based on a person's condition, but on the way that the condition limits their ability to function.
2. The assessment aims to identify and place people making a claim into one of three categories:
 - Those who are fit for work
 - Those who have limited capability for work
 - Those who have limited capability for work-related activity
3. People are placed in the Work Related Activity Group (WRAG) when they are deemed to have limited capability for work (score 15 or more points across 17 activities) and are placed in the Support Group when they are considered to have limited capability for work-related activity (meet one or more of 16 criteria).
4. There are many ways of determining eligibility for benefits of this type. For example, in the Netherlands, reduction in earning capacity is sometimes used to determine eligibility for disability benefit. This is done by identifying what jobs an individual can perform based on their level of capacity. The difference between the salaries attached to these jobs and the salary the individual previously earned is then used to determine if they are eligible for benefit and what level of benefit they should receive.¹⁰ In Denmark, a person's eligibility for disability benefit is assessed by looking at twelve areas including education and skills, learning ability, job preferences and social competence and then determining if that person could perform a subsidised job.¹¹ Both of these examples go beyond capability and unlike the WCA, include measures of employability.

¹⁰ OECD (2007) Sickness and Disability Schemes in the Netherlands.
<http://www.oecd.org/social/soc/41429917.pdf>

¹¹ OECD (2013) Mental health and work: Denmark.
<http://www.oecd.org/els/emp/mentalhealthandworkdenmark.htm>

5. These assessments are complex and a main benefit of the WCA in contrast is simplicity. Applying points to stated levels of incapacity is relatively easy to do, with rules that are simple to follow. It makes assessments easy to record and simple to understand. It allows assessments to be carried out reasonably quickly. Also it ensures a degree of consistency in scoring and final allocation to groups.
6. The Reviewer sought to understand the thinking underpinning the original design of the WCA, the evidential basis behind its development and testing and how effectively it had performed in practice.

Effectiveness

7. 'Effectiveness' is defined here as the degree to which something is successful in producing a desired result. In practice, this must embrace considerations of feasibility, affordability (cost-effectiveness), and practicality – and not solely accuracy of assessment.
8. Inevitably there is a trade off between these things – a very elaborate assessment, for example, may be unaffordable and impractical given the volume of claims that must be handled.
9. There is no absolute “gold standard” by which to judge fitness for work that is certain always to be correct. Even experts may disagree in a given case since the outcome could well depend on what type of work is available, how much support can be offered, an individual’s coping skills and many other factors.
10. As a consequence, while absolute perfection is an aspiration, any assessment process must be a compromise or “best fit”. The aim when devising a “test” should be to adopt a standard that is well supported by evidence and by credible expert opinion and which is as reasonable and fair as possible within available constraints. It is important to recognise these general imperfections and to understand how a particular vehicle, such as the WCA, performs in this context. This subject is returned to later in the chapter.
11. Various changes have been made to the WCA (often as an attempt to improve the assessment) but the impact on effectiveness has not yet been quantified. Each change to a descriptor potentially alters the discriminatory power of the assessment at a given threshold and no study has been carried out to assess the cumulative impact all of the changes.

The numerical construct of the WCA

12. The decision to place someone in the Support Group is based on meeting at least one criterion from a list of 16 descriptors.
13. However the decision to class someone as being either Fit for Work or to place them in the WRAG is dependent upon the aggregate of points they accumulate over a range of descriptors. Most descriptors are graded at 0, 6, 9 and 15 points with no 3 or 12 point scores. If someone scores 15 points or more in total they are considered to have limited capability for work and are placed in the WRAG.
14. The creation of a numerical scale, based on an aggregation of points, implies an ordered, linear relationship between the scores. The rationale for using multiples of 3 in the scoring system, the reason for having scoring levels which are not equidistant and the basis for setting the threshold at 15 points were not clear to the Reviewer at the outset and were therefore investigated.
15. The rationale appears to have been historical. ESA succeeded Incapacity Benefit (IB), which relied on a Personal Capability Assessment (PCA) - this was different to the WCA but was also points based. The PCA had a 15 point qualifying threshold for benefit, though the reasoning for that decision has yet to be discovered by the Reviewer. It appears that with the introduction of ESA the 15 point threshold was retained by default and descriptors were developed with that threshold in mind. The avoidance of a 3 point level, which had been a feature of the PCA, was to minimise the risk of multiple trivial incapacities being aggregated to a level which would unfairly result in the award of benefit.
16. The WCA was developed in 2006-07 by a group of appropriately qualified experts with a particular cut off point in mind – i.e. ensuring that people who were thought to be Fit for Work or had Limited Capability for Work ended up on the ‘right side’ of the 15 point threshold. The experts then reviewed 300 cases in two phases to “road test” the effectiveness of the descriptors in discriminating between these groups. Activities and descriptors were amended after each phase so that the outcome of the WCA matched expert opinion, as far as possible. A different process was followed in the subsequent Department-led Review of the WCA in 2009-10. The focus of the analysis was on understanding the impact of the changes the Department was proposing and ensuring they worked as expected.
17. The descriptors are an attempt to capture and distil expert consensus in a form that is simple and clear for trained Healthcare Professional (HCP) assessors to apply with reasonable consistency, without reference to the original experts, and in a high volume scheme. They were not formally “fitted” to the data in a mathematical way, but conceived by the expert group and DWP officials to offer a tool expected to perform reasonably at the chosen threshold.

18. In focusing on the chosen threshold (separating people who may be considered fit for work and people currently unable to work) the process did not seek to ensure, for instance, that people who scored an aggregate of 12 points were more functionally impaired than people scoring 9 points, or that people who scored 18 points in total were more functionally impaired than those scoring 15 points.
19. It is self-evident that multiple disabilities will tend to have a cumulative impact on capability and this appears to be the justification for the methodology. However, this points based system cannot be assumed to offer an accurate measure of functional impairment across the full range of scores. A person scoring 18 points is not necessarily three times more severely affected than a person with 6 points. Similarly someone scoring 18 points over several activities may be less functionally impaired than somebody scoring 15 points on a single descriptor.
20. This points based system must therefore be applied with caution. It has been designed, with some care, around the threshold separating those who may be considered fit for work from those who are currently unable to work and subsequent testing has focused on its discriminating power in this regard. However, extrapolation beyond this narrow but important function may be unwise.
21. Understanding this issue about points, how the threshold was determined and the limitations of extrapolating the significance of scores has a practical purpose. In conducting the Review it has been apparent that scores attained in the WCA are afforded great importance by all groups of stakeholders. At times considerable effort is expended in deciding whether a score should be adjusted even if the outcome remains that a person is not eligible for the benefit. This nugatory effort may be driven by a misplaced faith in the value of numbers for their own sake.

Summary

22. The WCA is fundamentally a relatively simple process that aims to sort people claiming ESA into one of three categories. Its simplicity is strength in many ways but it also runs the risk of oversimplifying multifaceted health conditions and the way that people deal with those conditions which may be very complex.
23. The numerical basis for the test appears to have been designed to provide continuity with the system used to assess Incapacity Benefit. This has produced some illogicalities and, more importantly, conveys an impression of a scale of impairment assessed with a precision which is hard to justify.
24. The assessment has been designed around the 15 point threshold and considerable effort has been applied to ensure that discrimination at this point is as robust as is practicable. No valid assumptions can be made about the numerical relationship between other scores and the 15 point threshold.

25. The WCA was developed and implemented without a reference standard and there has been no large scale study testing its reliability since then despite numerous changes. It is understood that the Evidence Based Review (EBR) is addressing these issues and this is welcomed by the Reviewer.
26. Overall the WCA as originally designed appears to the Reviewer to be a reasonable pragmatic tool for sorting people making a claim into the various categories. The impact on effectiveness of the various changes made (often as an attempt to improve the assessment) is as yet unquantified; each change to a descriptor potentially alters the discriminatory power of the assessment at the threshold.
27. As a yes/no measure of eligibility for ESA, the WCA appears to be a reasonable test. The accompanying points scale however is somewhat arbitrary and has only a limited scientific underpinning. Emphasising the points scale gives a false impression of scientific validity and appears to drive unhelpful behaviours – a subject returned to later in the report.

Recommendations

28. The Reviewer therefore recommends that:

The Department reviews its use of WCA scores, places less emphasis on the final number attained and uses the calculation simply to determine whether the threshold for benefit has been reached.

29. Any further changes to the descriptors, as a result of the EBR or otherwise, should be considered in the light of their overall impact on the effectiveness of the WCA in achieving its purpose of discriminating between the different categories of people assessed.

Chapter 4: Perceptions of the assessment

Perceptions of the WCA

1. For the Work Capability Assessment (WCA) to be credible it must not only be fair but it must also be seen to be fair across a broad spectrum of opinion. People going through the WCA must feel engaged as participants in the decision making process. Staff undertaking assessments must feel that their work is of value. The general public must have the reassurance that the right people are receiving support and that the system is operating effectively.
2. The Review sought to examine perceptions of the WCA. Evidence was collected throughout the course of the Review from the various stakeholders consulted. The Review also considered what may be learned from the model of organisational justice, a concept with a sound evidence base which has been shown to have a major impact on human behaviour.

Fairness and the concept of organisational justice

3. Organisational justice relates to the behaviour of organisations and is divided into three main components – distributive justice, procedural justice and interactional justice¹². Distributive justice relates to the fairness of outcomes - whether the organisation has made the correct decision. Procedural justice relates to the fairness of the organisation's decision making process - whether the decision was made in the correct way. Interactional justice focuses on how people are treated and the quality of communication with them. Earlier Independent Reviews have focused, albeit not explicitly, on the distributive and procedural aspects of the process so particular attention was given this year to the interactional component.
4. Interactional justice is concerned with both **interpersonal justice**, the degree to which people are treated with dignity and respect by an organisation, and **informational justice**, how processes and outcomes are explained to people. Research evidence shows that the extent to which people are treated with respect

¹² Greenberg, J. (1990). 'Organizational justice: yesterday, today, and tomorrow', Journal of Management, 16, 399-432.

and consideration as well as how well they are informed determines, in part, how they assess the quality of the service they receive¹³. The evidence also shows that people are unlikely to trust an organisation if decision making is not clearly justified and honestly explained to them¹⁴.

Dignity and respect

5. Ensuring that people are treated with dignity and respect, both by DWP and its Health Assessment Provider (HAP), is a critical component in their perception of the assessment's fairness.
6. The Department's HAP carries out monthly surveys of customer satisfaction soon after people attend their face to face assessment. The headline findings of these surveys suggest that the majority are content with their experience at this point - during the period from May to October 2013, overall claimant satisfaction¹⁵ remained at over 86%. However, the Call for Evidence responses prompted many reports of dissatisfaction. This is understandable, and perhaps inevitable, in that negative experiences are more likely to be reported than positive ones. Furthermore, some of the issues raised have already been addressed as a result of Professor Harrington's recommendations in earlier reviews. Nevertheless, there is further learning to be gained from this feedback and some of the aspects that impact on perceptions are set out below.

Establishing better rapport

7. Establishing rapport at the outset of an assessment can have a significant impact on how people feel they have been treated. The Reviewer observed that all assessment rooms visited were configured so that the Healthcare Professional (HCP) sat behind a desk opposite the person being assessed with a computer placed between the two. This arrangement was also demonstrated in the HAP's training film and would appear to be common across the country for the WCA. This confrontational set up is not accepted practice in clinical healthcare settings and is not the style adopted for the recently introduced Personal Independence

¹³ Parasuraman, A. Zeithaml, V.A and Berry, L.L. (1985). 'A Conceptual Model of Service Quality and its implications for Future Research', *The Journal of Marketing*, 49: 41-50

¹⁴ Colquitt, J.A. and Rodell, J.B. (2011). 'Justice, trust, and trustworthiness: A longitudinal analysis integrating three theoretical perspectives'. *Academy of Management Journal*, 54: 1183-1206

¹⁵ Overall satisfaction is a composite measure based on the individual's satisfaction with arranging and re-arranging their appointment, how they were dealt with by the receptionist at their face-to-face, and the health care professional's courtesy/politeness, professionalism and gentleness. This data derived from unpublished management information and has not been quality assured to National Statistics or Official Statistics publication standard. It should therefore be treated with caution.

Payment (PIP). In these other settings HCPs sit offset at 90° or side by side with the person being assessed. The alternative arrangement has been shown to put people more at ease and is likely to foster a greater sense of trust and therefore a perception of fairness.

Use of the Logic Integrated Medical Assessment (LiMA) application

8. The HAP is required by DWP to use the Logic Integrated Medical Assessment (LiMA) computer system which was designed to support HCPs completing assessments and allow them to pull customisable sentences from a drop-down menu of stock phrases. This brings certain advantages but there is a perception that the LiMA system dominates the assessment and gives the impression that the process is computer driven rather than an interaction between human beings.
9. Similar concerns have been raised in previous Independent Reviews, particularly about a lack of eye contact, and as a result touch-typing training has been made available to HCPs to help them maintain eye contact throughout the assessment, whilst still making notes on the LiMA system. However, it appears that concerns still remain.
“The overall feedback and our experience is that there is very little empathy with the claimants, people find it to be quite a cold process and that there is little eye contact from the examiner with much of the time spent inputting information on to a computer”, Runnymede and Spelthorne CAB
10. The advantages of a computer based assessment system in terms of consistency, accuracy and reliability are considerable but the system must remain an adjunct to the human relationship between HCP and person being assessed rather than dominating it. The Reviewer witnessed a number of consultations and some HCPs demonstrated skill in using the system while maintaining a good rapport with the person being assessed. A key attribute was making the subject feel that they were being listened to and that they were a valued party in the assessment. The approach in PIP of sharing sight of what is being entered on the system may well facilitate this and enhance the perception of interpersonal justice.

Interview style

11. Another frequently reported concern that compromises the perception that people have been treated with dignity or respect is a sense of not being given adequate opportunity to explain the impact of their condition or not being listened to if they were.
“I was ignored and talked over and the questions asked were peeled off

regardless of if I was still talking and they were not relevant to my medical conditions”, Ms B

12. Others felt that the line of questioning drove them into a particular response which was not appropriate or sufficiently nuanced.

“When I stated that I hardly ever went to the local shop, pressure was put on me to say how far away the shop was and when I did so this was recorded as the distance I could walk, without qualification. I stated that most days I had difficulty moving from room to room - this was not recorded”, Ms G

13. Inference is often used to determine capability and this can result in inaccuracies in the final report.

“I was asked ‘what do you feed your cat?’ to which I replied honestly ‘cat food’, only then was I asked if it was tinned, dry or in a sachet. This question (I assume) will be to determine if someone can use a can opener (although a lot of tins are ring pull now!) or, if sachets are used, as a measure of the dexterity of their fingers (although they could cut it open with scissors!) I was not asked if I had a problem opening cans or sachets, I was not asked if anybody opened them for me.... The question is a waste of time unless the assessor elaborates”, Ms R

14. The current HAP does train its staff in interview techniques and does aim to promote a facilitating style. However some practices, such as inferring capability from indirect questioning, clearly cause resentment and are interpreted by some as “trying to catch people out”. Transparency and integrity are key components of interactional justice and techniques that undermine these (albeit unwittingly) should be reviewed and revised.

Companions at assessments

15. Some people need (or feel they need) support at an assessment. If they perceive that the system won't allow that then they will feel more vulnerable and are more likely to feel that they weren't treated fairly. Some people reported that when they do take someone along (as they are entitled to) that person is then either denied participation or their input is demeaned. That too impacts adversely in terms of perceptions of fairness.

16. The WCA Handbook states explicitly that people having an assessment are able to bring a companion with them into the assessment to help them feel more at ease. It is of concern to the Reviewer that some Call for Evidence respondents reported problems with this.

“At the last review the assessor refused to let me speak and recorded incorrect facts given to her by my husband about his treatment and medication. When I asked for permission to speak to correct these the assessor said to me (as if he were not there) “Why's he telling me the wrong information” to which I explained

that, as stated on all his forms he is unable to manage his medication and treatment”, Mrs A

17. Current guidance on having a companion at the face to face assessment appears to be only partly effective in communicating the Department’s policy. This should be reviewed for clarity of expression along with the channels through which it is disseminated. Even more importantly, the lived experience should always accord with the policy and staff in assessment centres must apply the policy consistently, whatever their personal views.

Contact with DWP

18. Problems were also reported with some interactions with the Department, especially when things go wrong. Whilst a certain number of mistakes or misunderstandings are to be expected in any high volume process, the way these are handled has a strong impact on perceptions of fairness.

“I also had my money stopped for 6 weeks because someone had handed in a wrong paper to the wrong department and I was basically told tough, deal with it until we get it sorted out... that was also my only income and there was no remorse or help from [DWP] over the matter. The only reason it took ONLY 6 WEEKS was because my local MP stepped in”, Mr S.

Again, clients who are physically well but who have MH problems struggle with this system. They report that they are told different things whenever they call up the DWP (as have I, when I call), Northlands Community Mental Health Team

19. The Reviewer was impressed by the diligence and compassion shown by DWP staff observed at work in the various centres visited. Nevertheless, it is important for all staff to keep at the forefront of their minds the precarious nature of the finances of most people navigating the system and the significant impact that delays can have on peoples’ lives. Similarly, all staff must have a good understanding of the end-to-end system and be able to communicate that effectively. Enquiries relating to potential benefit errors should be resolved as quickly as possible with regular updates on progress if there are delays. The distress that mistakes can cause should be recognised and acknowledged by staff.

Reassessment following an appeal

20. The issue of being called for reassessment shortly after an appeal is upheld generates considerable comment and antipathy. The Reviewer understands that, since appeals relate to the person’s condition at the time of the original assessment, it is logical to link the reassessment date to that date and not the date of the appeal. Nevertheless, it seems odd to most people to receive contact

from the Department about reassessment sometimes only days after attending a tribunal hearing at which their appeal has been upheld. Some people clearly view this as being unjust and even cynical.

“The tribunal took less than 5 minutes to overturn the decision and put me in the support group with a recommendation of review in 2 years. I received another ESA50 form before I even got the back pay”, Mr P

“We were successful at tribunal - moved to support group but the whole process took the best part of a year. My client then had another ESA50 form to complete on the original application anniversary of a year and the whole process started once again”, Ms W

“It tests the same people repeatedly preventing them from recovering or not relapsing. It causes fear, traps people in a merry go round of assessment and appeal”, Ms J

21. The frequency of this phenomenon is linked to the length of time taken to deal with appeals and reducing backlogs will mitigate the effect. However, it would seem sensible to apply some sort of minimum “cooling off period” between the resolution of one episode and the commencement of the next.
22. The automatic linkage in every case of reassessment periods to the original decision should be reviewed to try and avoid the recall of people a short time after an appeal is upheld. Any Tribunal recommendations on review periods should be applied as the default and should only be altered where there is strong justification. Consideration should be given to a minimum period between a successful appeal decision and a recall notice.

Communications

23. The Reviewer identified a number of examples of where improvements might be made to the way that processes and outcomes are explained to people.

Inaccurate assessment reports

24. Use of the LiMA system is sometimes seen to be a constraint on accurate reporting of conditions. The Reviewer has heard people’s perceptions that LiMA produces descriptions of impairment which people do not recognise. Although the free text advocated by the respondent below is already allowed, it does not appear to be used as widely as it might.
“I think that the drop down boxes used to generate statements are too inaccurate. It would be far better to either broaden the options or allow free style writing”, Peabody Trust.

25. These perceptions of unfair treatment are compounded by the fact that many people only become aware of the content of their HCP assessment when they hear from the Department that they have been found Fit for Work.

“Many parts of the report were simply made up such as ‘goes to local shops most days’ when in fact my partner had clearly stated she had not been able to walk to a shop in 6 months. The HCP contradicted himself when he said that my partner was not incontinent and in the next sentence that she was...”, Mr M

Differentiation between HCP and Decision Makers’ roles

26. Some people fail to understand that the HCP is not making the decision on their benefit claim even though it was explained in every assessment witnessed by the Reviewer. Many others do not understand the difference between an HCP recommendation and a Departmental decision or how a Decision Maker can arrive at a different conclusion without apparent access to additional evidence.

The process is sometimes perceived as double-handling leading to delay.

“If the assessor’s decision on the claimant’s capability for work is to be accepted then it would save on administration costs if the decision was declared at the completion of the assessment. If the assessor’s decision can be overturned then the person who can overturn the assessor’s decision should become the assessor”, Mr S

27. The perceived remoteness of the DWP Decision Maker from both the person making a claim and the HCP can cause confusion and anger:

“Stop a person based in Newcastle - who has never met the person being reported on - overriding the medical reports, however flawed, written by people employed by the DWP as “experts”. What’s the point of employing the “experts” in the first place? How on earth can that Newcastle person judge a person’s mental health?”, Ms S

28. The issues of double handling, delays in the process and alternatives are addressed further in Chapters 5 and 6.

29. Current guidance is clearly not fully effective in explaining the different roles of HCPs and Decision Makers to people having a WCA. Conversations held by the Reviewer with HCPs and Decision Makers suggest that there is some confusion even among those operating the system. Definitions of purpose should be reviewed to remove any ambiguity and then be woven into a simple narrative that is applied consistently by all parties in every situation.

30. The perception of “faceless bureaucrats” making important decisions behind closed doors is hard to remedy under the current arrangement. Decision Assurance Calls have been introduced to mitigate this perception and are addressed in Chapters 2 and 5 of this report. Similarly, potential process changes

are discussed in Chapters 5 and 6 and these may impact favourably on this aspect of interactional justice.

Decision letters

31. Many respondents pointed to a lack of clarity in the Department's decision letters. The Reviewer shares the view that the letters can be difficult to interpret and do not appear to be set out as well as might be possible.

"The award letters are too complicated and generic. They should be adapted to the individuals circumstances to make the information clear...The letter my husband got, the important part ie which group he had been placed in was right at the bottom mixed in with another paragraph", Mrs S.

32. Contact with the DWP by telephone to get clarification of written decisions appears not to be particularly effective either:

"Receiving a copy of the report from the assessment helped me see how the decision process began, but after that point the letters from the DWP just didn't seem to be easily understood, and contacting them by telephone (through carer) did not appear to clear it up", Ms K

33. Professor Harrington's first review covered the issue of letters.

The review recommends that written communications to the claimant are comprehensively reviewed so that they are clearer, less threatening, contain less jargon and fully explain the process.

34. The Department carried out a review in early 2011 and evaluated the changes.

35. However, it is clear that more can be done to improve letters and forms. The Reviewer has shared letters with the Cabinet Office Behavioural Insights Unit who have suggested that the letters could be greatly improved to make them clearer. Specifically much of the information is repetitive. Letters could also be better structured and some of the language used could be simplified.

36. There are also early indications that the issues with some letters are focused not on the standard text, but on the free text contributions provided by DWP staff, such as the Decision Maker Reasoning. This point is covered in more depth in Chapter 5.

Summary

37. To be a credible test, the WCA needs not only to be fair but to be perceived as such. The views of staff and the general public need to be considered as well as those of people making claims. In examining perceptions of the system, the

Reviewer found considerable dissatisfaction with the WCA – this was most starkly illustrated, perhaps unsurprisingly, in the responses to the call for evidence.

38. The Review has highlighted areas for improvement. These are geared to helping ensure that people are treated with dignity and respect by both DWP and the HAP. Establishing better rapport at assessments is considered a critical component in the perception of fairness. Elements that might be improved include simple measures such as the layout of the room, better listening skills and avoidance of inference. Ensuring that there is a clear understanding of the different roles of HCPs and Decision Makers is important and that written communications are reviewed comprehensively.

Recommendations

39. The Reviewer therefore recommends that:

40. The face to face assessment:

- The Department should specify an assessment format that facilitates better rapport, such as the HCP and person being assessed sitting side by side.
- The assessor should avoid reporting inferences from indirect questioning as factual statements of capability.
- The guidance on companions should be made clearer and applied consistently.
- The person being assessed should be able to see what is being written during the assessment.

41. Staff guidance – the Department should update documentation and training to ensure that:

- There is clear differentiation between the purpose statements for HCPs and Decision Makers.
- A simple narrative explaining the differences is used consistently internally and externally.
- The distress that people can experience when things go wrong is recognised and acknowledged appropriately by staff.

42. Written communications – the ESA50 and all letters and forms are comprehensively reviewed with the input of the Behavioural Insights Unit at the Cabinet Office, to ensure that:

- all letters and forms meet Plain English standards.
- information is presented at the right point in the process.

- the person making a claim is clear about their rights and responsibilities at each stage of the process.
- decision letters set out clearly what the outcome means for the person concerned ideally in the opening section: the period that will elapse before the receive the benefit; what they will need to do to continue to receive the benefit; and what they will not need to do.

43. Reassessment post appeal – The Department should:

- Apply any Tribunal recommendations on review periods as the default and should only be altered where there is strong justification.
- Consider a minimum period (e.g. 6 months) between a successful appeal decision and a recall notice unless there are good grounds for believing that an earlier review is indicated.

Chapter 5: Decision making

Background

1. Professor Harrington's first Review focused on putting the Decision Maker back at the heart of the Work Capability Assessment (WCA) process: "empowering and investing in Decision Makers so that they are able to take the right decision, can gather and use additional information appropriately and speak to claimants to explain their decision". That injunction is supported fully by this Reviewer who has examined the detail of the decision making process and the outcomes to try and determine whether the aim has been achieved and what the impact has been.
2. The Department is clear that Decision Makers have been empowered and can point to considerable evidence to demonstrate that is the case. However the overwhelming sentiment in the Call for Evidence responses was that little or nothing has changed in terms of Decision Maker empowerment over the last three years. The Reviewer wanted to examine how decision making is functioning, how decision maker empowerment has been interpreted and what, if any, changes had occurred over time.
3. The review visited four Benefit Centres in order to gather evidence and observe the decision making process first hand. All of the Decision Makers interviewed appeared diligent, compassionate and keen to do the right thing.

Role of Decision Makers

4. Employment and Support Allowance (ESA) Decision Makers are responsible for making decisions about eligibility for the benefit. The Decision Maker must make a decision by considering all the evidence and applying the law, including any relevant case law, to the facts of each case. Where the legislation specifies or implies discretion, the Decision Maker's judgement must be reasonable and made with unbiased discretion.¹⁶
5. ESA decision making is in the most part carried out by Band B (AO grade) and Band C (EO grade) Decision Makers. The work is split so that more junior Band B staff process 'non complex' decisions - where people have been assessed by the Health Assessment Provider (HAP) as meeting the criteria for benefit - whereas

¹⁶ DWP (2013). Decision makers' guide: Vol 1: Decision making and appeals: staff guide. <https://www.gov.uk/government/collections/decision-makers-guide-staff-guide> - paragraph 01006.

more senior Band C staff review the evidence for people assessed as not meeting the criteria for benefit (found Fit for Work).

The Decision making process

Written evidence

6. As Professor Harrington noted in his first review, the report from the HAP to the Decision Maker is simply advice. Decision Makers should use this advice alongside the ESA50 and any other appropriate sources of evidence to make a decision. The system has been designed so that evidence gathering is largely conducted by the HAP which sends out the questionnaire (ESA50), decides if further medical evidence (via the ESA113) should be sought and undertakes the face to face assessment. While the primary responsibility rests with the person making the claim to submit evidence, the clear understanding is that the HAP will seek additional evidence where indicated and provide the Department with high quality professional advice on functional capability. This, in turn, allows the Decision Maker to apply the benefit rules effectively.
7. It became clear during the site visits conducted as part of the Review that this system is not working as well as intended. Decision Makers regularly expressed frustrations about the quality of some reports supplied by the HAP. Decision Makers are able to send provider reports back for rework but this happens rarely – on average in fewer than 0.4 % of cases¹⁷. The primary reason for this appears to be the incentive in the system to focus on process time rather than outcome. There is no established system for Decision Makers to obtain quick verbal clarification from the Healthcare Professional (HCP) who has written the report and the strict separation of DWP and HAP staff, even when collocated in a building, reinforces a “them and us” mentality. It was noticeable in Northern Ireland, where Healthcare Professionals have been transferred to a HAP much more recently, that levels of informal communication and mutual respect were very much higher.
8. Examination of a small sample of HAP reports with Decision Makers suggested that while quality improvements clearly could have been made in some cases there were also some unrealistic expectations about what the assessment process could deliver. Following a recent audit that showed an unacceptable reduction in the quality of assessment reports, the Department agreed a quality improvement plan with its HAP which has addressed the quality issues and this

¹⁷ Average for January to May 2013. This data derived from unpublished management information and has not been quality assured to National Statistics or Official Statistics publication standard. It should therefore be treated with caution.

report will not comment on that matter further. However, the practical result of this loss of confidence in the quality (real or perceived) of some HAP reports is that Decision Makers tend to undervalue the professional advice the Department has paid for and sometimes give undue weight to information from other sources. A related concern is that Decision Maker empowerment may have been interpreted by some as an obligation to challenge advice from the HAP.

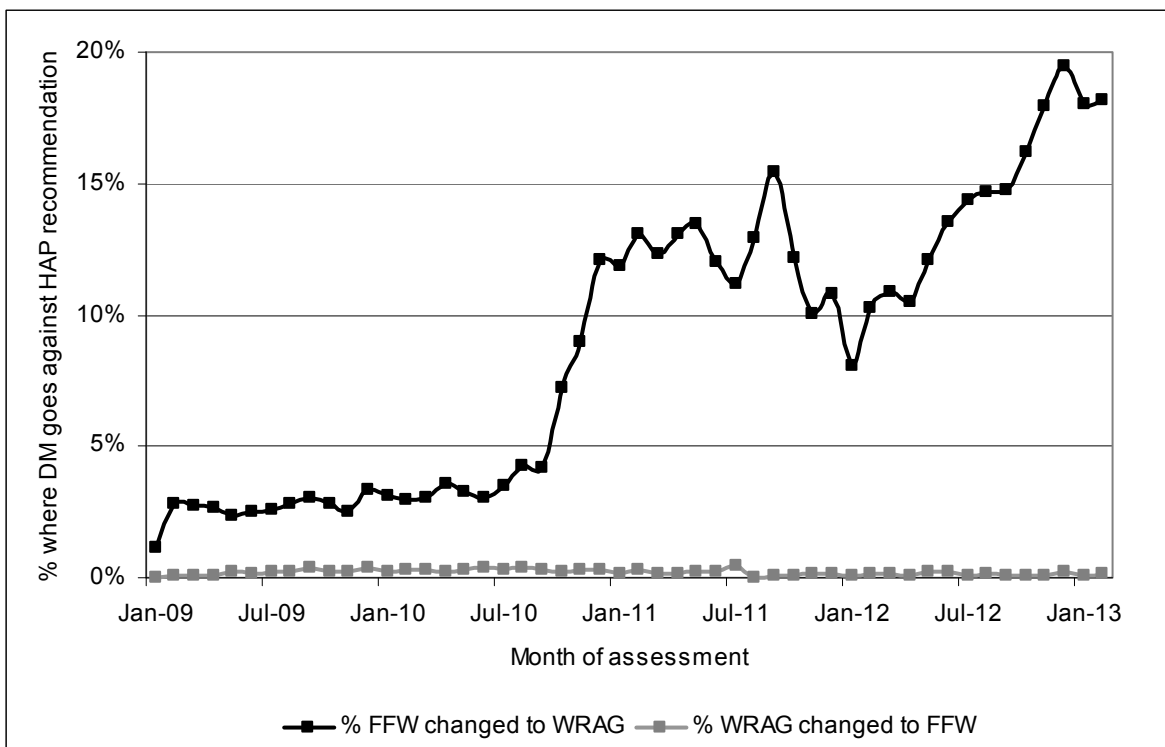
9. The Reviewer observed that many Decision Makers placed great reliance on information from medical records, even though these rarely describe capability. This leads to assumptions being made about capability on the basis of diagnoses even though Decision Makers have little training in assessing functional capability. If this practice is widespread then it is of considerable concern because it not only undermines the policy intent but it also reinforces the stigma that many people with health conditions face in trying to gain employment.
10. Additional non-medical evidence which might well be more useful in constructing a rounded picture of capability is not used as well as it might be. Information from Support Workers, Carers, etc. is not available in enough cases and, where it is available, it is not always given appropriate consideration. Better evidence from a range of sources would help Decision Makers get a more rounded picture of capability. This issue is discussed further in Chapters 6 and 7. Similarly, Decision Makers do not routinely consider relevant evidence that may be available in other parts of DWP, such as evidence in support of near contemporaneous claims for Disability Living Allowance (DLA) and Personal Independence Payment (PIP).

Complex and non-complex cases

11. DWP staff treat cases where the HAP has recommended the person to be eligible for benefit (i.e. placed in either the WRAG or the Support Group) as “non-complex”. Cases where the HAP has recommended that the person is Fit for Work and that benefit should therefore be denied are treated as being “complex”. This is an unusual use of language in that the only added “complexity” for the second group (which may be presumed to mostly comprise people with fewer problems) is that they are more likely to complain about the result of the process; moreover, from a lay perspective the cases that are not Fit for Work may appear (and from a medical perspective may well be) the more complex.
12. This categorisation is used to drive the decision making process. “Non-complex” cases are allocated to the more junior Band B staff that focus on checking the completeness and accuracy of information against standard instructions. There is little scrutiny given to the evidence itself; the emphasis is on checking that processes have been followed. In practice no “decision” is made and the HAP recommendation is rubber stamped.

13. “Complex” cases are allocated to the more senior Band C staff who scrutinise all of the available evidence. The main activities associated with this role are examining the facts and considering the relevant legislation to make a decision on matters related to the case including providing explanations of decisions, making reconsideration decisions and preparing appeal submissions. The HAP recommendation is overturned in a significant proportion of these cases as is discussed more fully later in this section.
14. This categorisation and consequent division of labour does not seem logical to the Reviewer. It appears to be founded on the premise that HAP recommendations should always be accepted if they class someone as unfit for work and always be scrutinised if they class them as fit. As currently operated this particular aspect of the process appears to tend to favour finding people unfit for work and granting them benefit. This view is supported by the data which shows that Decision Makers move around 15% of people considered Fit for Work into the WRAG but only about 0.1% from the WRAG to Fit for Work.¹⁸

Figure 2: Percentages of Fit for Work recommendations from the HAP which were changed to the WRAG by the Decision Maker over time, and WRAG recommendations which were changed to Fit for Work – new claims only.¹⁹



¹⁸ Table 1 of DWP (2013). Statistics to support the Fourth Independent Review of the Work Capability Assessment. Ad hoc statistical release.

¹⁹ Ibid – date shows month of assessment.

15. The requirement to operate the benefits system efficiently and economically is fully supported and it is understood that DWP made a conscious decision to increase AO (Band B) involvement in decision making to realise cost efficiencies in 2009. However, the same result could be achieved by focussing the efforts of more senior, experienced staff on borderline cases that straddle the cut-off point between groups and allocating clearer cut cases to junior staff. Not only would this remove the current apparent process bias but it would provide Band C Decision Makers with a more representative case load which should help improve the accuracy of decisions over time.
16. An additional Band B administrative duty is sorting cases into “complex” and “non-complex” when they are returned from the HAP. This appears to the Reviewer to be an unnecessary additional step in the process which adds time. Departmental administration/processing time could be saved at this point if the HAP were to batch cases into point bands when they send them to the Department.

Telephone contact

17. As discussed in Chapter 2, the main telephone contact that Decision Makers have with people going through the WCA process is the Decision Assurance Call. This call has several objectives but is principally concerned with validating the face to face assessment and identifying additional evidence which may not have been considered.
18. Decision Assurance Calls are only made in “complex” cases where the Decision Maker is minded to support the recommendation that the person is Fit for Work. The general concerns already expressed about the current split between “complex” and “non-complex” cases therefore apply.
19. There is a drive within DWP to increase the number of successful calls (i.e. where contact is made with the person) from the current rate of about one third. This appears to be linked to the desire to reduce the number of appeals though the Reviewer’s doubts about a causal linkage between these events have already been expressed in Chapter 2. As part of this drive, call contact (‘success’) rates by Benefit Centre are being published on an internal ‘ESA dashboard’. This has created pressure on Decision Makers at Benefit Centres with lower rates to increase the proportion of successful calls.
20. A number of Decision Assurance Calls were monitored as part of the Review and their value as a source of robust evidence is questioned. The contact is a “cold call” and the person making a claim has little time to consider their responses. Decision Makers have limited training in interview skills, in how conditions may vary and the impact of health on functional capability; addressing these issues over the telephone is generally more difficult even for experienced HCPs than in a

face to face assessment. Additional “evidence” accepted over the telephone is simply uncorroborated testimony given in a situation where there are obvious incentives to maximise the impact of any condition. Encouraging the person making a claim to provide additional medical evidence simply adds a further stage to the process with consequential delay for all and without any reassurance that evidence will materialise or make a difference.

21. Decision Assurance Calls can be difficult for Decision Makers, as has previously been noted in Professor Harrington’s reviews, since they are only made when benefit is likely to be denied and people may express anger or disbelief at the outcome. The simplest way for a Decision Maker to avoid such unpleasantness is to accept verbal evidence obtained on the call and to change their provisional decision. Given the context in which they are made, these calls can only alter the outcome in the case if the person making the claim is classed as being unfit for work and benefit is allowed. Decision Assurance Calls made in this way are therefore likely to strengthen the apparent process bias described above.
22. The one benefit apparent to the Reviewer of Decision Assurance Calls is that they give the person making a claim the opportunity to speak to and potentially influence the Decision Maker. This links to the issue of perceptions of fairness discussed earlier and it is a very powerful reason to continue the practice. However, to be effective, they require considerable attention to define better the purpose, the skills required and circumstances in which they are likely to be of benefit. It appears to be a major deficiency that they are not currently monitored as part of the Quality Assurance Framework (QAF) and the plans to incorporate them should be expedited. No date has yet been specified by the Department.

Decision Maker Reasoning

23. As discussed in Chapter 2, the purpose of the Decision Maker Reasoning, sent to people who have been found Fit for Work, is to provide them with a clear explanation of the rationale for disallowing their claim. This is not only a common courtesy but it is also intended to support the view that organisational justice has been served and to create a positive perception of the WCA process. It is also a key document if a case goes to appeal.
24. The review examined examples of Decision Maker Reasonings during visits to Benefit Centres and conducted a desk based review of a sample of documents. The quality of the documents examined was very variable. Common issues included a failure to reference the full range of evidence considered, poor written English, use of DWP jargon and a lack of cogent reasoning. In general, documents did not appear to be written with the person making the claim in mind.

Quality

25. The Quality Assurance Framework (QAF) was introduced in summer 2011 as a continuous improvement tool intended to act as a rigorous and robust measurement of decision making quality.
26. The QAF requires that Decision Makers make justifiable decisions, but there are limited incentives to make ‘accurate’ decisions. Correct application of the law is rightly emphasised but the coherence of the reasoning applied in reaching a conclusion is given less prominence. The QAF focuses principally on whether processes have been followed correctly. There is less emphasis on outcomes than on the manner in which decisions have been reached so, for example, individual Decision Maker overturn rates are not monitored.
27. The Reviewer noted examples of the QAF being applied inconsistently between Benefit Centres.
28. It would seem appropriate for DWP to review the QAF and its application. Existing strengths in process adherence should be supplemented by measures to examine other elements of Decision Maker quality. In particular, the outcome of decisions and the logic underpinning them should be monitored more closely.
29. The reasons for successful appeals are not currently communicated to the Decision Makers who made the original decision. This lack of a feedback loop is a general failing affecting not just appeals but also cases where a Decision Maker overturns the recommendation of an HCP. The missed opportunity for learning compromises continuous improvement throughout the system.

Empowerment and independence

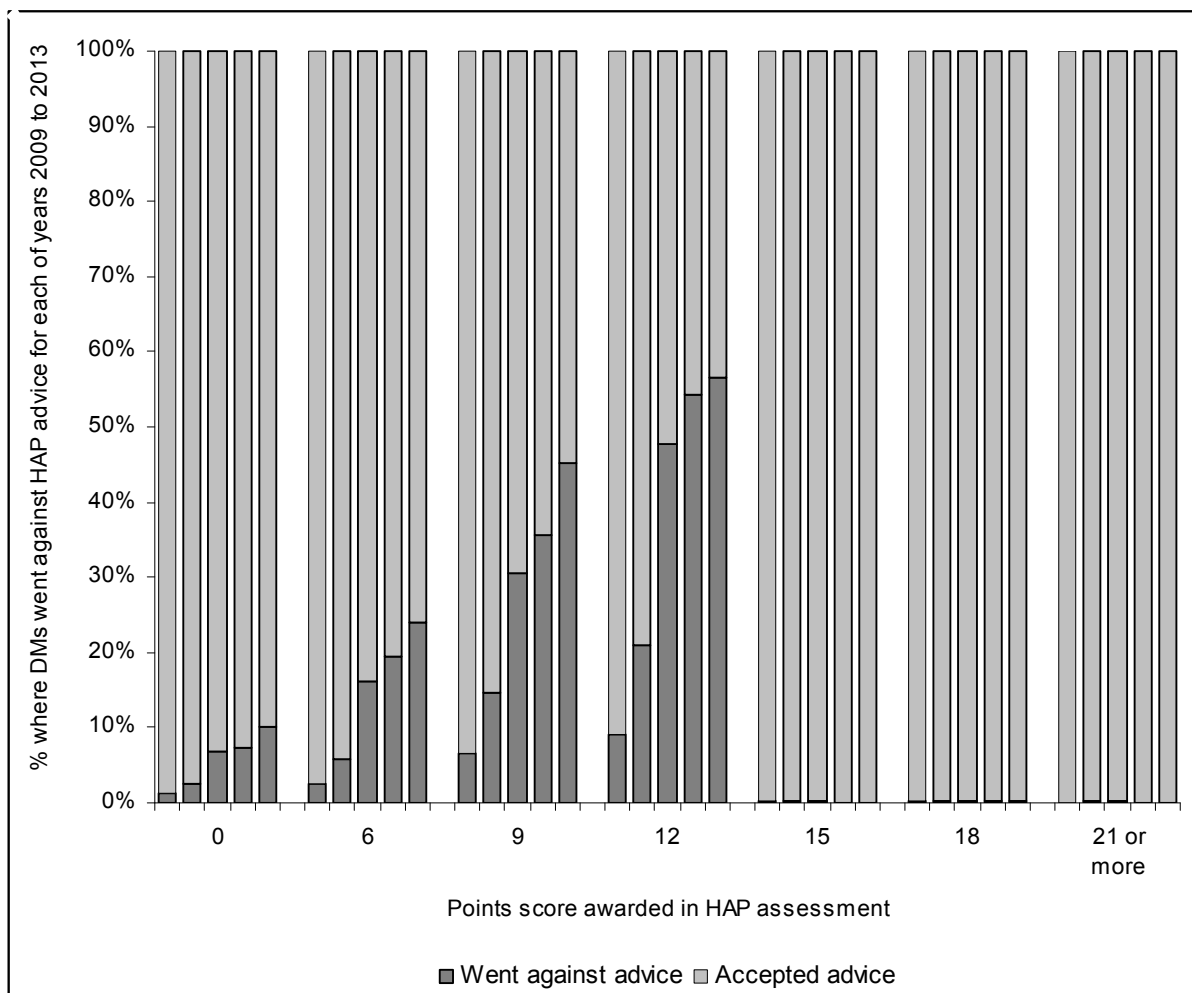
30. DWP research²⁰ suggests that a lot of Decision Makers were unhappy with their perceived role ‘rubber-stamping’ decisions. They therefore welcomed the recommendation from the first Independent Review of the WCA to put the Decision Maker back at the heart of the system and empower the Decision Maker to make an independent decision.
31. The Reviewer has found that Decision Makers appear to feel more empowered as a result of previous Independent Reviews. It was reported that some Decision Makers appear to consider a greater willingness to ‘overrule’ recommendations from the HAP a proxy for empowerment and independence. Examples include some Decision Makers, with good intentions, appearing set on “finding extra

²⁰ Adams, L., Oldfield, K. and Riley, K. (2012) Decision making on Employment and Support Allowance claims. Research Report No 788. DWP.

points” for people making a claim and awarding them on the basis of weak additional evidence or the reinterpretation of what an HCP had reported.

32. The number of HAP recommendations ‘overruled’ by Decision Makers has increased over time as shown in Figure 3. The effect of the apparent “process bias” described above can be seen clearly since the overturn rate drops to a negligible level at the point where cases are categorised as being “non-complex”. The situation has now been reached where Decision Makers move around 15% of people classified by HCPs as Fit for Work into the WRAG; at the 12 point level this constitutes well over half the complex cases considered.²¹

Figure 3: Percentage of HAP assessments where Decision Makers went against HAP advice, for each of the calendar years 2009 to 2013 inclusive, plotted against the points which the HAP recommended in their report.²²



²¹ Table 2 of DWP (2013). Statistics to support the Fourth Independent Review of the Work Capability Assessment. Ad hoc statistical release.

²² Ibid.

33. The driver for this rising rate of overturning HCP advice is likely to be multi-factorial. The perceived deficiencies in some HCP reports have already been discussed. The barrage of public criticism, largely levelled at the HAP component of the process, may well have coloured Decision Maker views and the silo working practices do not promote a team spirit.
34. Additionally, the Department has had a strong focus on reducing the high appeal rate for ESA. This is a creditable focus since the large number of appeals has created substantial delays in the system as well compromising confidence in the WCA. However, an unintended consequence may have been to promote an “avoid appeals at all costs” mind set in which finding a reason to allow claims is seen by individual Decision Makers as acting in the Department’s interests. It is pertinent to note that whilst Decision Maker overturn rates have increased substantially, there has been no corresponding decrease in the number of people appealing against decisions or succeeding at appeal over this period.
35. Whatever the precise reasons driving this behaviour it is not considered by the Reviewer to be a legitimate manifestation of empowerment as recommended by Professor Harrington. If there are quality issues with the HAP they should be addressed and if there are lessons to be learned from appeals they should be applied. It seems odd to spend time and money obtaining independent medical advice on functional capability and then to ignore it on a systematic basis.

Summary

36. Site visits conducted as part of the Review suggested that decision making is not working as well as intended. There appeared to be undue reliance on information from medical records which only rarely describe capability. Additional non-medical evidence, where it is available, might well be more useful in constructing a rounded picture of capability but it is not used as well as it might be.
37. DWP staff treat cases where the HAP has recommended the person making a claim to be eligible for benefit (i.e. placed in either the WRAG or the Support Group) as “non-complex”. Cases where the HAP has recommended that the person is Fit for Work and that benefit should therefore be denied are treated as being “complex”.
38. This approach is used to drive the decision making process. “Non-complex” cases are allocated to the more junior Band B staff. There is little scrutiny given to the evidence itself; the emphasis is on checking that processes have been followed. In practice no “decision” is made and the HAP recommendation is rubber stamped. “Complex” cases are allocated to the more senior Band C staff who scrutinise all of the evidence available.

39. This categorisation and consequent division of labour does not seem logical. As currently operated the process appears to favour finding people unfit for work and granting them benefit. This view is supported by the data which show that Decision Makers move around 15% of people considered Fit for Work into the WRAG but only about 0.1% from WRAG to Fit for Work.
40. Focussing the efforts of more senior, experienced staff on borderline cases that straddle the cut-off point between groups and allocating clearer cut cases to junior staff would appear to offer several benefits. Not only might it help achieve efficiencies but it would also remove the current apparent process bias and provide Band C Decision Makers with a more representative case load helping improve the accuracy of decisions over time.
41. Decision Makers appear to feel more empowered as a result of previous Independent Reviews. The data shows that the number of HAP recommendations overruled by Decision Makers has increased over time. The driver for this rising rate of overturning HCP advice is likely to be multi-factorial. The perceived deficiencies in some HCP reports and the barrage of public criticism, largely levelled at the HAP component of the process, may well have coloured Decision Maker views. It seems odd to spend time and money obtaining independent medical advice on functional capability and then ignore it on a systematic basis.

Recommendations

- 42. The Reviewer recommends that the Department takes immediate steps to:**
- Give greater clarity about the role and parameters of Decision Makers with a particular focus on the meaning of “empowerment”.
 - Review the QAF so that existing strengths in process adherence are supplemented by measures to examine other elements of Decision Maker quality. In particular, the outcome of decisions and the logic underpinning them should be monitored more closely.
 - Build a better relationship between HCPs and Decision Makers to engender more team spirit and to help Decision Makers view HCPs as their trusted advisers.
 - Improve Decision Maker training to recognise the strengths and weaknesses of further medical evidence and other information on capability to supplement the HAP report.
 - Re-engineer the case mix for the two levels of Decision Maker so that more senior staff consider “borderline” cases (e.g. 6 – 21 points) and more junior staff process all others.

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- Ensure the provider batches cases into point bands when they send to the Department to save departmental admin/processing time.
- Review the place of Decision Assurance Calls and apply them only in “borderline” cases handled by Band C Decision Makers who should be up-skilled to make the intervention more effective.
- Review the guidance on the preparation of Reasoning and audit completed documents on a regular basis to further improve quality.
- Monitor overturn rates on an individual Decision Maker basis. Investigate exceptionally high and low rates as part of performance management.

Chapter 6: Simplifying the process

1. There are a number of challenges in assessing fitness for work. This chapter will focus on the length and complexity of the current process, how it might be simplified and the importance of better initial evidence.

Length and complexity of the process

2. The end to end process takes far too long which contributes to perceptions of unfairness with the assessment – this does a disservice to both people who are left in limbo and taxpayers who foot the bill. The process is over complex with multiple handoffs, each of which causes further delay. Processing times have tended to increase with a significant number of cases exceeding the 91 days stipulated in regulations. Between October 2008 and May 2011, 63% of initial claims took longer than 91 days²³. By the second half of 2011 this had risen to 77%²⁴ and by the first eight months of 2012 this figure stood at 82%²⁵. The Department has confirmed to the Reviewer recently that the average end to end processing time is now significantly longer than the period stipulated in regulations.
3. A person making a claim to Employment and Support Allowance (ESA) enters what is known as the ‘assessment phase’. Under regulation 4 of the Regulations, the assessment phase lasts 91 days (13 weeks) during which a person receives ESA rate of benefit equivalent to Jobseeker’s Allowance. ESA is paid at this rate until capability for work has been determined regardless of how long that takes.
4. When ESA was designed, the Department determined that 91 days would be a reasonable period within which a person’s benefit claim should be processed and their capability for work assessed. The 91 days is broken down into:
 - Department processes the initial claim (10 days);

²³ DWP (2011). Duration of the Assessment Phase for Employment and Support Allowance claimants. Ad hoc statistical release.

²⁴ Derived from DWP (2012). Employment and Support Allowance assessment phase durations. Ad hoc statistical release.

²⁵ HC Deb, 4 March 2013, c890W

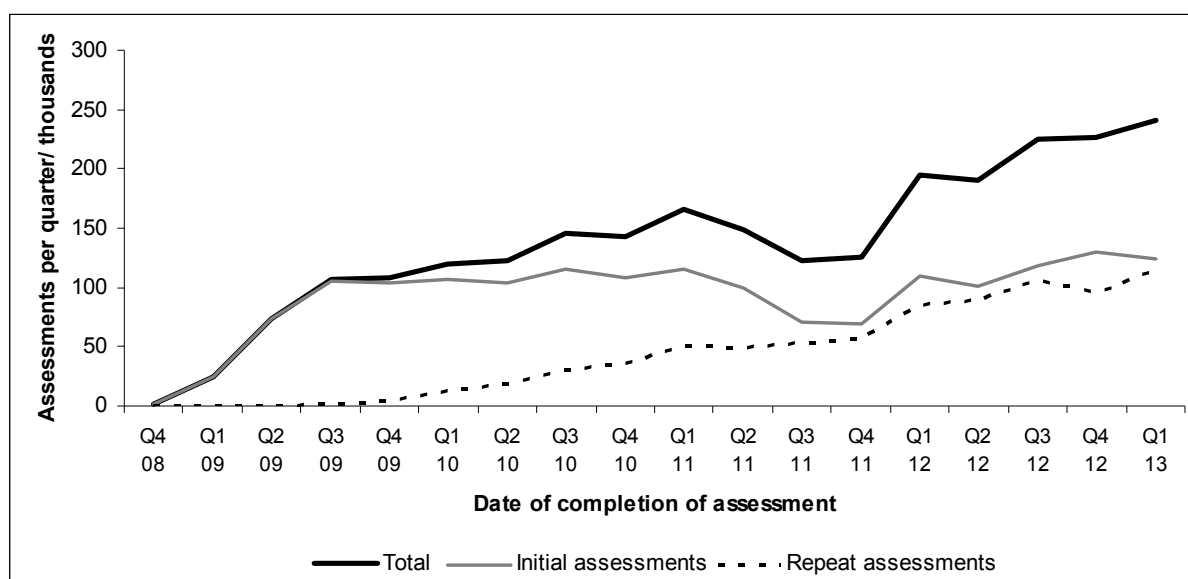
http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm130304/text/130304w0004.htm#130304w0004.htm_wqn75

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- Department refers the case to the Health Assessment Provider (HAP) (18 days);
 - HAP sends the person making a claim an ESA50, reviews the evidence, seeks further evidence (some cases), carries out a face-to-face assessment (most cases), writes up the outcome and returns the case to the Department (49 days);
 - Department reviews the evidence and makes a decision (14 days).
5. Overall this process can, in some instances, involve up to thirteen exchanges, or hand-offs, between the individual, the Department, the HAP and the individual's medical practitioner as follows:
- Initial claim
 - Referral to the HAP
 - ESA50 sent from HAP to individual
 - ESA50 returned by individual
 - HAP requests medical evidence
 - Individual's medical practitioner responds
 - Individual invited to face-to-face assessment
 - HAP sends recommendation to Department
 - Department returns case to HAP with further queries
 - HAP responds
 - Department make Decision Assurance Call
 - Individual provides further evidence
 - Department communicates decision
6. The number of hand-offs increases and the time taken to process the claim takes considerably longer in cases where an individual does not comply with all of the departmental requirements, or where an individual requests a reconsideration or lodges an appeal.
7. As the benefit has matured the time taken to process a claim and determine capability for work has tended to increase so that the average duration now greatly exceeds the anticipated 91 day expectation. By definition, many claims take even longer than the average to settle.
8. There have been three main reasons for the increase in the time it takes to process claims.
- Reassessment of people claiming Incapacity Benefit has added extra numbers into the system.

- An increasing number of WCAs are being carried out each year because people claiming ESA face repeat assessment, new people apply, and people previously found Fit for Work opt to apply again. The total number of initial and repeat reassessments per calendar year has increased by 170% between 2009 and 2012²⁶ (see figure 4 below), and it is likely that this figure will continue to increase.
- More recently, the increased focus on quality with the current HAP, has had a significant impact on waiting times for WCAs.

Figure 4: Volumes of Work Capability Assessments per quarter over time (excluding Incapacity Benefit Reassessment)²⁷



Impact of a longer process

Impact on people making claims

9. If an individual is placed in the Work Related Activity Group (WRAG) or the Support Group following assessment, they become eligible for an extra financial payment starting from the 92nd day of their claim. However, if their assessment takes more than the 91 days they remain on the lower rate and will receive back-payment from that point if found eligible for benefit. Delays therefore result not only in uncertainty but also potential financial hardship for people navigating the system.

²⁶ Derived from tables 2a and 2b of DWP (2013). ESA: outcomes of Work Capability Assessments October 2013.

²⁷ Ibid.

10. Delays also impact adversely people who are found Fit for Work. The uncertainty for them is the same as for the other groups and the delay can have a detrimental effect on their chances of securing employment, their sense of self-esteem and (potentially) their health.
11. Concerns about delays in the process were raised in the Call for Evidence.
“The process should be far quicker than it is..... This is a long time of stress and tension for a person, and can be extremely detrimental”, Mr K M.
12. Chapter 4 explained how the multiple handoffs can create confusion about who is making the decision, and why.
“if the assessor’s decision can be overturned then the person who can overturn the assessor’s decision should become the assessor, thereby cutting the costs of using an outside agency to make a decision which is only a nominal exercise”, Mr S.

Impact on the Department and taxpayers

13. The assessment phase is essentially a period in limbo. Until a decision has been made people are not required to look for work or undertake work related activity and they do not receive support to get into work from Jobcentre Plus.
14. Departmental research indicates that many people who were found Fit for Work did return to employment and less than half went on to claim Jobseeker’s Allowance (JSA).²⁸ Those who receive support from Jobcentre Plus move into work more quickly than those who do not. Therefore it is reasonable to conclude that delays in making a decision may keep those found fit for work on benefits for longer than necessary²⁹ with consequential additional costs to the taxpayer.

Simplifying the WCA process

15. There are a number of reasons why the WCA process takes such a long time but its complexity is undoubtedly a factor. The Reviewer has developed proposals for alternative processes and initial modelling has been carried out on behalf of the Reviewer which indicates that the alternative processes have the potential to improve speed and efficiency.

²⁸ Table 4.1 of Barnes, H., Sissons, P. and Stevens, H. (2011) Employment and Support Allowance: Findings from a follow-up survey with customers. Research report 745. DWP.

²⁹ Middlemas, J (2006), Jobseeker’s Allowance intervention pilots quantitative evaluation. Research report No 382. DWP.

Better Initial Evidence

16. The ESA50 does allow people making a claim to submit supporting evidence but guidance on what might be most useful to a Decision Maker is lacking. Furthermore the structure of the document can be interpreted as implying that the Department will seek reports from the health professionals for whom consent is given whereas the onus lies squarely with the person making a claim. Strengthening this aspect of evidence gathering is fundamental to making progress in providing suitable and sufficient information for the Decision Maker in one process stage.
17. On receipt of the ESA50 the HAP currently requests additional information from GPs in 23% of cases using form ESA113. GPs are contractually required to respond to ESA113 requests and the success rate is 83% (45% within 14 days)³⁰. The current pro-forma is not well designed and cannot be completed electronically which adds to the administrative burden of already hard pressed GPs. However, the Reviewer was told that a greater pressure on GPs is the increasing number of requests from their patients for information to support an appeal against WCA decisions. Such requests are often made by people in considerable distress and against a tight timescale for submission.
- "CAS believes that if better evidence were gained through more effective and timely use of the ESA113 form, this could reduce the need for supplementary evidence at later stages of the process, including at appeal.... The Scottish Parliament Welfare Reform Committee took evidence Georgina Brown, representing BMA Scotland, suggested there were a number of issues that needed to be addressed...including unclear or unrealistic timescales for returning forms, and sometimes unrealistically short timescales for them to respond, as well as difficulties with pulling information from their systems into the format required on the form. "* Citizens Advice Scotland
18. It is clear that the current system is perceived as imperfect by both GPs and people making claims. The Reviewer was heartened by the positive attitude of the British Medical Association (BMA) in seeking to improve matters. In particular, in making constructive suggestions about the co-design of an electronic ESA113 which might be used more flexibly to reduce the pressures that appeal submissions place on all parties. This appears to be a fruitful area for discussion building on the work that the Department has already initiated with the BMA on the ESA113.

³⁰ New and repeat claims reviewed by Atos Healthcare between January and June 2013. This data derived from unpublished management information and has not been quality assured to National Statistics or Official Statistics publication standard. It should therefore be treated with caution.

19. An improved ESA113 that focusses on factual evidence relevant to capability could be used by the Decision Maker to seek information without looping through the HAP. This would provide an important mechanism for both shortening the WCA process in many cases and potentially enhancing the quality of evidence available.

Decision Maker Triage

20. The current process results in two administrative hand-offs between the Department and the HAP. All cases are referred to the HAP to issue an ESA50, seek further evidence and consider whether a face-to-face assessment is necessary. For new claims, where the HAP believes it is likely that a person can be placed in the Support Group 'on scrutiny' without a face-to-face assessment and in re-referral cases where the HAP believes it is likely that a person can be placed in either the Support Group or WRAG 'on scrutiny', the case returns to the Department with a recommendation. For new and repeat claims this happened in 31% of cases where the outcome was decided in 2012³¹. As outlined in Chapter 5, the DWP almost always accepts these recommendations.
21. Some of these steps appear unnecessary – they add time to the process and contribute to delays. One administrative handoff could be removed if DWP sent out the ESA50 and then Decision Makers determined whether further evidence was required and by what means it should be obtained. It follows that where suitable and sufficient evidence is available and a face to face assessment would provide no additional value, the Department should make a decision without referral to its HAP. It may be helpful for Decision Makers to have access to a decision support tool or telephone health advice in some cases. Face to face assessments are the major contributing factor to delays and minimising unnecessary appointments would have a significant impact.
22. Where a person is found Fit for Work on paper without a face to face assessment and subsequently disagrees with a decision, the case would move to a mandatory reconsideration. A second Decision Maker would then review the evidence and determine the need for a face to face assessment.

Collocation of Decision Makers and Healthcare Professionals

23. At present the DWP and HAP elements of the process are undertaken in silos so that activities can only occur sequentially. The impact this system has on working relationships between the two sets of staff has been described earlier. Also

³¹ Table 3 of DWP (2013). Statistics to support the Fourth Independent Review of the Work Capability Assessment. Ad hoc statistical release.

described earlier is the perception that Decision Makers can be “faceless” and that their decisions are made without the benefit of seeing the person whose life they are impacting. In process efficiency terms it also means that information has to be transferred from one site and organisation to another, building in delay.

24. Collocating Decision Makers and Healthcare Professionals (HCPs) undertaking assessments therefore has some attractions. Decision making should be speeded up and the Decision Maker would have the benefit of seeing the people making the claim. Seeing the person making a claim on the same day at the same place should reduce the overall process time and promote an improved perception of organisational justice. Collocation should also improve communication between HCPs and Decision Makers and allow for easier clarification of reports.
25. An extension of collocation would be to undertake joint HCP/Decision Maker assessments. This would, potentially, further reduce the complexity of the process and the misunderstandings that can occur whenever information is transmitted from one agency to another. This arrangement would replicate the format used by appeal tribunals and might be expected to produce greater concordance in outcomes between the two systems; a current source of adverse comment.

Summary

26. The end to end process takes far too long which contributes to perceptions of unfairness with the assessment – this does a disservice to both people making a claim who are left in limbo and taxpayers who foot the bill. The process is over complex with multiple handoffs, each of which causes further delay. The expectation is that the process will be completed within 91 days. However, the average end to end processing time is now significantly longer than the period stipulated in regulations.
27. There are a number of reasons why the WCA process takes such a long time but its complexity is undoubtedly a factor. The Reviewer has developed proposals for alternative processes and has carried out initial modelling to test whether they have the potential to improve speed and efficiency. The Review recommends that the Department carries out a full impact assessment into the feasibility of these alternative processes. In addition, the ESA113, currently requested in around a quarter of cases, can be improved and it is recommended that this be undertaken through co-design with the BMA.

Recommendations

28. The Reviewer therefore recommends that steps are taken to simplify the WCA process.

29. Immediately, the Reviewer recommends that:

- DWP continues to work with BMA to develop and co-design a revised electronic ESA113 with the aim of simplifying the process for GPs and improving the quality of evidence available.

30. In the medium term, the Reviewer recommends that:

- The Department carries out a full impact assessment on an alternative process whereby DWP Decision Makers triage cases;
- DWP, rather than the HAP, issues the ESA50 and reviews the response with any supporting evidence supplied;
- The Decision Maker determines (with the help of decision support materials) whether further evidence is required and, if so whether to obtain that by face to face assessment or other means;
- Where suitable and sufficient evidence is available on paper and a face-to-face assessment would provide no additional value, the Department should make a decision without referral to its HAP;
- Where a person is found Fit for Work on paper without a face-to-face assessment and subsequently disagrees with the decision, a second Decision Maker then reconsiders the need for a face to face assessment as part of the new mandatory reconsideration process.

31. In the longer term, the Reviewer recommends that:

- The Department should carry out a full impact assessment on the feasibility of a DWP Decision Maker being colocated with the HCP undertaking a face-to-face assessment and either seeing the person making a claim jointly or separately.

Chapter 7: Mental health

1. Mental health has been a particular focus for this Review. Departmental data indicates that mental health conditions represent the primary cause of perceived incapacity in 40%³² of cases going through the WCA. The HAP reports³³ that 60% of people attending face-to-face assessments have some data captured about a mental health condition in the Mental State Examination part of the assessment. The assessment of mental health cases has also been a focus of particular concern by a number of voluntary sector organisations. These factors dictated that mental health should be afforded particular priority in this review.

The assessment

2. The spectrum of mental health disorders giving rise to incapacity is broad and ranges from mild, generally self limiting conditions, to the most severe and enduring problems. However diagnostic labels can be unhelpful in either understating the impact on functional capacity at a given time or stigmatising people and condemning them to a life of worklessness. The “unseen” nature of impairment and its variability, sometimes on a day to day basis, compounds the difficulty in assessing the range of conditions.
3. The WCA aims to address this by applying a specific set of mental health descriptors which have been formulated to capture the commonest forms of impairment experienced by people with these conditions. These descriptors have been the subject of considerable debate and one of the aims of the Evidence Based Review (EBR) has been to test a new set of descriptors as discussed in Chapter 2.
4. Whatever descriptors are finally adopted, the fundamental difficulties remain and assessment in the area of mental health arguably requires a greater degree of skill than for many physical conditions. The DWP has recognised this and

³² New claims going through the WCA in the year to May 2012 (by month of assessment) presented with a mental health condition as primary condition. Derived from table 2b of DWP (2012) Employment and Support Allowance: Work Capability Assessment Outcomes by Physical and Mental Health Condition. Ad hoc statistical release, and table 2a of DWP (2013). ESA: outcomes of Work Capability Assessments October 2013.

³³ Percentage of cases with some data in the Mental State Examination carried out as part of the face-to-face assessment - all face-to-face assessments between January-June 2013. This data derived from unpublished management information and has not been quality assured to National Statistics or Official Statistics publication standard. It should therefore be treated with caution.

following a recommendation in Professor Harrington's first report, Mental Function Champions have been established as a resource for Healthcare Professional (HCPs) and the Reviewer found evidence that they are being used, especially by less experienced staff. There, nevertheless, remains considerable concern that the current system is not operating as well as it might for this group and that may be reflected in the higher rate of decisions being overturned at appeal for people with a mental health condition³⁴.

Further evidence

5. A common criticism levelled by groups representing people with mental health disorders is that while they can portray a good level of functioning for the limited time of an assessment, maintaining such a level in an employment situation is beyond their capability. It is therefore argued that such assessments are insufficient of themselves in many cases and that additional background information is required. This argument has been extended to press for the Department to obtain further medical evidence in every mental health case but the premise is not accepted by the Reviewer.
6. The great majority of mild to moderate mental health cases are managed medically in a primary care setting and many such people may only interact with a healthcare professional intermittently. GPs – and others in primary care teams – may therefore have only a limited knowledge of the functional effects of their patients' condition in many cases. People with severe and enduring mental health conditions are much more likely to have contact with psychiatric services, albeit increasingly in a community setting. The most frequent contact such people will have is with a Community Psychiatric Nurse (CPN) or Support Worker and they are more likely to prove a useful source of information about functional capability than a traditional medical report.
7. The aspiration to have suitable and sufficient background information at the beginning of the assessment process is a sensible one but the practical issues of where to source such information and how to obtain it must be considered.
8. The current ESA50 encourages people to submit supporting evidence for their claim but focuses heavily on medical reports and, by seeking consent to approach a person's medical practitioner, may convey the impression that the information will be sought routinely.
9. Redesigning the ESA50 to make it clear that evidence, particularly in mental health cases, from CPNs, Support Workers, Carers etc is valuable and giving

³⁴ DWP Internal data.

guidance on the functional aspect that will help Decision Makers is therefore recommended.

Healthcare professionals

10. The perceived need for HCPs to have specific skills in mental health has been mentioned above. The appointment of Mental Function Champions has been a creditable attempt to address this but it would seem appropriate to now build on this foundation. The alteration in skill mix among HCPs to incorporate a greater proportion of physiotherapists did not appear to have affected the quality of assessment in mental health cases when measured in a pilot evaluation of November 2010.
11. However the public perception that knowledge of mental health has been eroded by the move away from an assessor group that is all medically qualified is both substantial and material. It is therefore considered important that the Department strengthen its requirements for HCPs working on the contract to have suitable and sufficient previous experience of dealing with people with mental health problems so that they can contextualise their findings at assessment.
12. Similarly the current training in mental health that HCPs receive should be reviewed to ensure that it is adequate and the evaluation results for these and other key modules should be considered by the Department before approving any individual HCP. Approvals should be reviewed on a periodic basis and reaccreditation should be dependent upon effective refresher training in key subject matter areas.

Decision Makers

13. The difficulties for Decision Makers in dealing objectively with mental health cases are even greater than for HCPs, most of whom already have relevant past experience. The Reviewer noted that some written guidance has been produced by the Department but use appears patchy and there is no condition specific guidance for Decision Makers other than a directory of conditions which often directs users to the NHS website. There were also examples of briefing sessions for Decision Makers being undertaken by Mental Function Champions but this appears to have been a local initiative rather than part of a comprehensive programme.
14. The Reviewer came across a few examples of assumptions about capability and prognosis being made on the basis of psychiatric diagnoses. While such assumptions were well intended and were applied to allow claims for benefit, they nevertheless represent stigmatisation which is potentially harmful to vulnerable

people. Condemning people with mental health problems to a life on benefit is no kindness and inadvertently depriving someone of the opportunity to experience the dignity of work is a tragedy.

15. It is inappropriate for Decision Makers to have detailed medical training but it is prudent to provide a foundation level of knowledge on the impact that the most common conditions (such as mental health) are likely to have. This is particularly important for mental health conditions where features of an illness can easily be misinterpreted as failure to cooperate or lack of volition. Decision Makers need sufficient knowledge to allow them to strike a reasonable balance in their assessments. They need to understand not only the types of impairment that people may describe but also that most common mental health conditions are self-limiting and that good work can be beneficial for recovery and the prevention of recurrence. Similarly, even severe and enduring conditions do not necessarily preclude gainful employment and many people succeed in work despite long term or recurrent difficulties.
16. A particular area of difficulty is the assessment of Regulations 29 and 35 (substantial risk to health) in mental health cases. People may well exhibit signs of considerable distress during Decision Assurance Calls and several Decision Makers described calls they had made where they were worried about the person self-harming. While it is understood that national guidance does exist, staff in the centres visited appeared to have established alternative local arrangements to deal with such circumstances, including support for the staff themselves. No evidence was found of a consistent approach based on best practice and it is recommended that mental health training for Decision Makers should be reviewed. Training should include dealing on the telephone with distressed people, interpreting warning signs of potential self-harm and signposting to appropriate sources of help.

Support in the WRAG

17. Some of the attributes of mental health conditions, and especially the commonly encountered depression and anxiety, warrant particular types of support to facilitate a return to productive employment. Most people with these conditions will experience an improvement in their incapacitating symptoms, such as fatigue, impaired memory and slowed cognition, over a defined period. It is therefore understandable that about one third of people with mental health problems undertaking the WCA are assigned to the WRAG³⁵.

³⁵ DWP Internal data.

18. The on-going barrier to productive employment for many people recovering from acute episodes of these conditions is the loss of confidence and self-esteem that frequently occurs. These secondary psychological effects, while not issues defined as preventing work related activity, do need to be addressed if people are to successfully enter the job market. Specific attention should therefore be paid by Work Programme Providers to these elements and sharing of appropriate information, as discussed in Chapter 2, becomes particularly pertinent for this group.
19. While it is outside the scope of this review, it is the Reviewer's opinion that better integration of support in the WRAG with proven psychological interventions would benefit a great many people and society as a whole. Talking therapies for people with mild to moderate conditions and Individual Placement and Support for those with more severe and enduring states have been shown to be effective in promoting better mental health and providing a route out of worklessness.

Stable and degenerative conditions

20. The changing demographic and the associated increases in the state pension age mean that the incidence of dementia and other degenerative brain disorders is rising in the working age population. Similarly, advances in medicine over the past 30 years mean that more people with severe learning difficulties are surviving into adult life. Many people with such conditions are keen to be in work and benefit from the experience. However, functional capability cannot realistically be expected to improve in most cases and for some conditions deterioration is inevitable.
21. The Reviewer received evidence of several cases where the routine recall for assessment of people with very severe impairment had caused considerable distress to them and their carers. While the policy intent of never writing anyone off is both understood and endorsed, it would seem neither practical nor compassionate to treat this group in exactly the same way as others. It is recommended that the review period for people with severe brain disorders who have been assigned to the Support Group should be increased to 5 years and that reviews should be conducted on a "papers only" basis unless there is good reason to believe that there has been a material improvement in their functional capability.

Summary

22. The impaired capability associated with mental health problems can be difficult to assess. Diagnostic labels can be unhelpful by either understating the impact of

functional capacity or stigmatising people and condemning them to a life of worklessness. Redesigning the ESA50 to make it clear that evidence, from professionals other than medical practitioners, such as Support Workers, is valuable and giving guidance on functional capability to help Decision Makers is recommended.

23. Building on the foundation of Mental Function Champions the Reviewer recommends improved training in mental health for Decision Makers and Health Care Professionals. In addition, all HCPs should have suitable and sufficient previous experience of dealing with people with mental health problems to help contextualise their findings at assessments.
24. Routine recall of people in the Support Group who have very severe or degenerative brain disorders which will not realistically improve should be extended to 5 years.

Recommendations

25. The Reviewer therefore recommends that:

- The Department strengthen its requirements for HCPs working on the contract to have suitable and sufficient previous experience of dealing with people with mental health problems so that they can contextualise their findings at assessment.
- The current training in mental health that HCPs receive should be reviewed to ensure that it is adequate and the evaluation results for these and other key modules should be considered by the Department before approving any individual HCP. Approvals should be reviewed on a periodic basis and reaccreditation should be dependent upon effective refresher training in key subject matter areas.
- Mental Health training for Decision Makers should include dealing on the telephone with distressed people, interpreting warning signs of potential self-harm and signposting to appropriate sources of help
- The ESA50 is redesigned to make it clear that evidence, particularly in mental health cases, from CPNs, Support Workers, Carers etc is valuable and giving guidance on the functional aspect that will help Decision Makers.
- Consideration is given to a new reassessment period extending to 5 years in the Support Group for people who have very severe incapacity resulting from brain disorders that are degenerative or which will not realistically improve.

Chapter 8: Northern Ireland

Introduction

1. Based on the parity principle, Great Britain and Northern Ireland administer the same range of benefits, paid at the same rate and subject to the same conditions. Social Security benefits in Northern Ireland are administered by the Social Security Agency (SSA), an executive agency of the Department for Social Development (DSD).
2. Section 10 of the Welfare Reform Act (Northern Ireland) 2007 places a duty to independently review the WCA in Northern Ireland. As in previous years, the Minister for Social Development appointed the Independent Reviewer for Great Britain to carry out the review.
3. The Health Assessment Provider (HAP) in Northern Ireland is also Atos Healthcare but the contract, which commenced in 2011, is separate to that with the DWP. Prior to 2011 sessional doctors who were not civil servants and were not under any contractual obligation to the Social Security Agency provided the Agency with medical expertise to facilitate the assessment of benefit eligibility in Northern Ireland.
4. The Reviewer was pleased this year to be able to visit Northern Ireland in September. During the visit evidence was received from:
 - Officials in the NISSA and DSD working on the policy and operational delivery of ESA and the WCA
 - Atos Healthcare representatives
 - The Minister for Social Development
 - The Social Development Committee
 - The Advice Service Alliance
 - The President of the Appeals Tribunal for Northern Ireland
5. This Review focused in particular on the implementation of the recommendations from earlier Independent Reviews, decision making, mental health and realising the potential of the Health Assessment Adviser role.

Context

6. Different legislation governing Northern Ireland gives some scope for the DSD to do things differently from the rest of the United Kingdom although this is limited in practice by the requirement to use DWP systems. A key difference between the systems is the oversight of the HAP with an in-house Health Assessment Adviser (HAA) undertaking a quality assurance role. The smaller scale of the operation also reduces some of the complexity with, for example, a single centre processing ESA claims for the whole of Northern Ireland.

Implementation of the years one to three recommendations

7. The DSD accepted many of the recommendations from the three Harrington reviews. Due to the different context in Northern Ireland, there were some differences in the approach to implementation. For example:
 - Visits to Benefit Centres and Medical Assessment Centres (year 2 recommendation 2) - due to the centralisation of units in Northern Ireland, Professor Harrington considered that these visits were not required.
 - On audio recording (year 1, recommendation 8) – attendees at the face-to-face assessment are able to record their own assessment provided they request in advance, abide by reasonable conditions designed to protect the HCP and the integrity of the process and provide a complete and accurate copy of the recording at the end of the consultation.
 - Audit of Decision Maker performance (year 2 recommendation 9) – DSD does not use the Quality Assurance Framework (QAF) described in Chapter 5. Instead an annual report is produced based on an audit by the Standards Assurance Unit and the Standards Committee.³⁶ This audit of decisions looks at whether there is enough evidence on which to base a decision, whether all relevant questions have been considered, whether the correct facts have been found from the evidence available at the time of the decision and whether the law has been correctly interpreted and applied. In the 2012 report, 99% of ESA decisions were judged to be correct based on a statistically valid sample of 120 ESA cases over the year.
 - Sharing outcomes of assessments with Work Programme providers (year 2 recommendation 8) – The Work Programme does not exist in Northern Ireland

³⁶ Report on Decision Making and Financial Accuracy 1 January to 31 December 2012 - http://www.dsdni.gov.uk/publications-dm_ssa.htm

but the Department of Employment and Learning (DEL) is responsible for employment programmes which includes the Condition Management Programme and Workable (NI). The outcome of assessments is shared with the DEL Personal Adviser.

8. In some cases, the DSD came to a different conclusion to DWP on the best way forward on the basis of the available evidence following a pilot.
 - Managing and Supporting the Claimant through their claim (year 1 recommendation 1) - an allowance call was piloted for Incapacity Benefit reassessment and new ESA cases. Following evaluation, the call was considered beneficial for Incapacity Benefit Reassessment cases and introduced.
 - Touch typing training (year 2 recommendation 13) – The HAP and the DSD’s Health Assessment Adviser advised that HCPs in Northern Ireland do not require this training as keyboard skills were already sufficient.
 - Where the recommendations have been implemented, evaluation appears to have been undertaken in a similar manner to DWP.

Call for Evidence

9. The Call for Evidence in Northern Ireland received 48 responses. The issues raised were similar to those cited in Great Britain and included:

Improvements to the WCA

10. Some respondents highlighted improvements to the WCA:

"Following the Year 3 Independent Review of the WCA, it was recommended that decision makers should actively consider the need to seek further evidence in every claimant's case. The Social Security Agency has proven to be increasingly willing to take additional evidence for reviewing decisions, which has resulted in positive outcomes for many clients. Advisers have noted that this has been an encouragingly constructive step in the ESA application process." Citizens Advice NI

A Perception of unfair treatment

11. A number of respondents highlighted a perceived unfairness with the assessment:

"The WCA remains impersonal and mechanistic. Despite assurances from previous reviews there is still a lack of communication between all the parties involved. It is still bureaucratic and I have seen little evidence of empathy in the whole process." Leslie Cree, Ulster Unionist MLA

12. Specific areas of concern included the nature of the face to face assessment:

"There also needs to be further consideration given to how the information recorded on the ESA85 reports can include more detail and allow for the assessors to ask more open questions and record additional information which may be relevant. HCPs need to ensure that they probe information accordingly, and do not just take answers as given, particularly for people with learning disabilities." Disability Action Northern Ireland

"She mostly typed away on her computer while I talked, some of the questions seemed very yes or no. There was no opportunity to see what she was actually typing." [Ms S]

Mental health

13. The treatment of people with mental health conditions and the training of assessors in mental health conditions were common concerns:

"Our network has examples of clients with mental health conditions being awarded 0 points, with HCP notes giving reasons such as, "the claimant was well-dressed and clean shaven", and where mental health was dismissed because claimants were not shaking or trembling. This displays a huge misunderstanding of the symptoms and indicators of mental health conditions." Citizens Advice NI

"Where it is not possible for a specialist psychiatric nurse or other suitably qualified person then there should be further evidence requested by the person's healthcare professional who may know about their condition in more detail"
Disability Action Northern Ireland

Reassessment post appeal

14. A number of responses raised issues about the timings of reassessment following a successful appeal.

"Sinn Fein is also very concerned about the 'revolving door' experienced by many of those who successfully appeal a decision and secure their entitlement to benefit only to find that within months of that decision, they are facing another WCA and the removal of their benefit once again." Sinn Fein

Better initial evidence

15. Another concern is that evidence should be provided at the outset of the process:

"CAB recommends revision of the ESA113 form and better use of it in order to ensure that decision-makers have access to all necessary medical evidence at the earliest stage, reflecting better DLA practice." Citizens Advice NI

Call for Evidence seminar

16. The Call for Evidence was supplemented by a seminar with the Advice Service Alliance where similar issues were raised and expanded upon. The seminar hosted by the Law Centre Northern Ireland was well attended and included representation from Citizen's Advice Bureau, Advice NI, NI Association of Mental Health, the MS Society along with Cancer Support Organisations and other Disability representatives.

The HAP and Health Assessment Adviser role

17. Northern Ireland has a separate contract with the HAP which runs until 2017. Unlike Great Britain, the HAP employs only doctors and nurses – there are no physiotherapists. It is unclear whether this different arrangement makes any material difference to the effectiveness of the WCA in Northern Ireland. However, it does appear to reduce some of the problems with negative perceptions about skill mix and this is addressed more fully later in this chapter in relation to mental health.

18. Another key difference between Great Britain and Northern Ireland is the role of the Health Assessment Adviser (HAA). Established in 2011, the HAA has responsibility for ensuring the quality of the medical output provided by the HAP in Northern Ireland in relation to assessments across Employment and Support Allowance, Incapacity Benefit, Disability Living Allowance and Attendance Allowance. This includes their audit processes, the standard of training and training materials provided to healthcare professionals, quality assurance of medical guidance and the approval of all appointed healthcare professionals. The key aspects of the role as described to the Reviewer are:

- Audit - for ESA, the HAA carries out quarterly monitoring of the medical quality of a statistically valid random sample of both papers only cases and face to face assessments. The HAA carries out validation of the HAP's internal audits, monitoring the quality of the internal audit process and outcomes.
- Complaints - The HAA provides medical input to any complaints that reach the Chief Executive of the SSA. Numbers of complaints are monitored as part of quality control.
- Quality assurance of medical guidance and the standard of training materials - The HAA approves the yearly Training Needs Allowance (TNA) for the HAP to ensure the training meets DSD requirements. The HAA checks training materials, attends and observes training events to ensure quality and checks that handbooks are updated appropriately.

- The approval of HCPs – Healthcare Professionals are subject to 100% audit during initial training to ensure the quality and consistency of their outputs and their appointment is only confirmed by the HAA when they consistently achieve four A grade reports. Reports continue to be audited monthly using an agreed random sample which has been approved by the DSD.

19. The Reviewer believes that this role has had a beneficial effect on the effectiveness of the WCA in Northern Ireland and that it has the potential to contribute more. Although the role has been subject to continuous improvement by the Department since its inception, it would seem timely now that arrangements with the HAP have bedded down to conduct a more formal review of the role. Areas that might usefully be considered as priorities for a refreshed role include:

- Acting as an interface between HCPs and Decision Makers to promote a greater sense of team working
- Extending the quality role to oversee a comprehensive feedback loop between appeal tribunals, Decision Makers and HCPs
- Using data generated by audit, etc to give better insight to areas for improvement
- Playing a role in the education and training of both Decision Makers and HCPs

20. It is therefore recommended that the terms of reference, role profile and job description of the HAA be reviewed with input from a senior occupational health professional to further enhance the value of the position.

Decision making and Appeals

Decision making

21. The Reviewer visited the ESA Centre in Belfast and was impressed by the quality of the Decision Makers interviewed and the compassion they showed. The Reviewer noted a dedicated team (CAST) whose role was to support people formerly claiming Incapacity Benefit who had been found Fit for Work after an assessment. The team provided people with a “better off calculation” together with advice and support about relevant other benefits. The Reviewer understands that the work of the team will come to an end once Incapacity Benefit Reassessment is complete and that the SSA will review how learning from this function can be applied elsewhere.

22. Although the Reviewer was unable to spend as much time with Decision Makers in Northern Ireland as in Great Britain, the phenomenon of “finding extra points”

for people making a claim and awarding them on the basis of weak additional evidence was not observed. However the split between complex and non-complex cases with the allocation to different grades of staff is identical to Great Britain. There is therefore reason to believe that the apparent “process bias” already described in Chapter 5 may apply in Northern Ireland.

23. An important element in the evidence from Great Britain that indicates there may be an issue in this area is the overturn rate by Decision Makers of HCP recommendations as analysed at different point levels over time. Unfortunately it has not been possible to carry out the same analysis in Northern Ireland because the DSD does not record Decision Maker overturns of HAP recommendations. This would appear to deny the Department a valuable source of management information and it is recommended that the data should be captured and monitored to track future trends.

Appeals

24. The Appeals system in Northern Ireland is entirely separate from that operated in Great Britain. The Northern Ireland Courts and Tribunal Service (NICTS) is an agency within the Department of Justice for Northern Ireland. The Reviewer was pleased to meet with the President and to note that, as in Great Britain, the independence of the judiciary is valued extremely highly by all concerned.
25. Northern Ireland does not have the drop down menu feedback from appeals that now exists in Great Britain nor did they choose to take part in the Summary Reasons Controlled Start discussed in Chapter 2. There is some evidence that the lack of feedback hinders the ability of the DSD to learn from the outcomes of Tribunals which could help improve decision making quality and the quality of advice from the HAP.
26. In common with Great Britain, there is a general need for a more consistent, better quality feedback loop that works across all agencies involved in the WCA process, not just between the Tribunals and the Social Security Agency. The Reviewer understands that work is ongoing to explore and agree arrangements which will take into account the feedback already provided by Tribunals in Northern Ireland and the new Tribunal feedback arrangements being rolled out in Great Britain. This initiative is welcomed and it is recommended that the feedback loop be extended to ensure that learning is communicated to the HAP as well as to Decision Makers.

Mental Health

27. The case mix in Northern Ireland is somewhat different to Great Britain. There is a strong focus on mental health and a perception was apparent through the evidence gathering process for this Review that much of this difference is attributable to the consequences of the social conflict experienced in recent decades. Mental health therefore has an even higher profile as an issue than in Great Britain.
28. It was reported to the Reviewer that mental health issues (usually mild to moderate illnesses) are often introduced late in the assessment process when physical conditions are the initial presenting condition. There is a suggestion that, at least in some cases, this may be related to a perceived stigma surrounding mental ill health which can compound the stigma associated with claiming welfare benefits. These issues, while not unique to Northern Ireland, do appear to be more prevalent than in Great Britain.
29. Given this greater focus on mental health, it is unsurprising that the introduction of Mental Function Champions has been welcomed. Seven Mental Function Champions have been in post in Northern Ireland since April 2012 with four always on duty. One of these is reported as always being available to Decision Makers for telephone advice during normal working hours; this is different to Great Britain where Mental Function Champions are not routinely available, although a more general advice line is. This arrangement appears to be working well and it is recommended that it is maintained.
30. Since the transfer of responsibility for functional assessments to the HAP in 2011 the skill mix of HCPs has been altered to introduce nurses as well as doctors to the process. However, unlike Great Britain, no other professions allied to medicine (e.g. physiotherapists) have been included. Stakeholders in Northern Ireland did raise doubts about whether all HCPs have suitable and sufficient skills and experience in mental health but with less intensity than in Great Britain. The recommendations in the main part of the report relating to experience and training in mental health are considered applicable to Northern Ireland. However, it is recommended additionally that DSD give careful consideration to both the public perception as well as the objective evidence relating to understanding of mental health issues before agreeing to any further adjustment of the HCP skill mix.

Summary

31. Different legislation governing Northern Ireland gives some scope for the DSD to things differently from the rest of the United Kingdom but this is limited in practice by the requirement to use DWP systems.

32. A key difference between Great Britain and Northern Ireland is the separate contract with the Assessment Provider (HAP) which runs until 2017. An in-house Health Assessment Adviser (HAA) undertakes a quality assurance role which appears to have a beneficial effect on the effectiveness of the WCA in Northern Ireland but has the potential to contribute more.
33. The Appeals system is entirely separate from Great Britain. Northern Ireland does not have the drop down menu feedback from appeals nor did they take part in the Summary Reasons Controlled Start. In common with Great Britain, there is a general need for a more consistent, better quality feedback loop that works across all agencies involved in the WCA process. Work is ongoing to explore and agree arrangements which will take into account both the feedback already provided by Tribunals in Northern Ireland and the initiatives being rolled out in Great Britain. These developments are welcomed and it is recommended that the feedback loop be extended to ensure that learning is communicated to the HAP as well as to Decision Makers.
34. Mental health has an even higher profile in Northern Ireland than in Great Britain. Of the seven Mental Function Champions in Northern Ireland, four are always on duty and one is always available to Decision Makers for telephone advice. This arrangement appears to be working well.
35. The HAP employs only doctors and nurses – there are no physiotherapists. It is unclear whether this makes any material difference to the effectiveness of the WCA in Northern Ireland and it is recommended that DSD gives careful consideration to any alteration in the current skill mix.

Recommendations

36. The Reviewer therefore recommends that the DSD:

- Reviews the terms of reference, role profile and job description of the HAA with input from a senior occupational health professional to maximise the value of the position.
- Captures and monitors data on Decision Maker overturns of HAP recommendations to track future trends to give the Department a valuable source of management information.
- Extends the feedback loop from Appeals to ensure that learning is communicated to the HAP as well as to Decision Makers.
- Maintains the arrangement whereby a Mental Function Champion is available to Decision Makers via the advice line.

- Gives careful consideration to both the public perception as well as the objective evidence relating to understanding of mental health issues before agreeing to any further adjustment of the HCP skill mix.

Annex 1: List of recommendations

Chapter 2 - Implementation of years one to three recommendations	
1.	Sharing information from the WCA on capability for work with Work Programme Providers should be addressed as a priority.
2.	The Evidence Based Review and the actions taken by the Department as a result of its findings should be evaluated as part of the Year 5 Independent Review.
3.	The Department should build on the improvements for people with cancer by amending page 20 of the ESA50 to make it clear that Clinical Nurse Specialists and consultants may also complete that section of the form.
Chapter 2 - Implementation of Year 4 Recommendations	
4.	Give due consideration to whether piloting is required for interventions and, if so, to design pilots with particular attention to the means of evaluation. There should be suitable and sufficient analytical input to any pilots at the design, implementation and evaluation stages.
5.	Ensure that proposed adjustments to accepted recommendations are fully considered in advance by both policy officials and operational staff so that policy intent and practical considerations are harmonised.
Chapter 3 - Effectiveness of the WCA	
6.	The Department reviews its use of WCA scores, places less emphasis on the final number attained and uses the calculation simply to determine whether the threshold for benefit has been reached.

7.	Any further changes to the descriptors, as a result of the EBR or otherwise, should be considered in the light of their overall impact on the effectiveness of the WCA in achieving its purpose of discriminating between the different categories of people assessed.
Chapter 4 - The face to face assessment	
8.	The Department should specify an assessment format that facilitates better rapport, such as the HCP and person being assessed sitting side by side.
9.	The assessor should avoid reporting inferences from indirect questioning as factual statements of capability.
10.	The guidance on companions should be made clearer and applied consistently.
11.	The person being assessed should be able to see what is being written during the assessment.
Chapter 4 - Staff Guidance and Training	
12.	<p>The Department should update documentation and training to ensure that:</p> <ul style="list-style-type: none"> • There is clear differentiation between the purpose statements for HCPs and Decision Makers. • A simple narrative explaining the differences is used consistently internally and externally. • The distress that people can experience when things go wrong is recognised and acknowledged appropriately by staff.
Chapter 4 - Written Communications	
13.	<p>The ESA50 and all letters and forms are comprehensively reviewed with the input of the Behavioural Insights Unit at the Cabinet Office, to ensure that:</p> <ul style="list-style-type: none"> • all letters and forms meet Plain English standards. • information is presented at the right point in the process. • the person making a claim is clear about their rights and

	<p>responsibilities at each stage of the process.</p> <ul style="list-style-type: none"> • decision letters set out clearly what the outcome means for the person concerned ideally in the opening section: the period that will elapse before they receive the benefit; what they will need to do to continue to receive the benefit; and what they will not need to do
Chapter 4 - Reassessment Post Appeal	
14.	Apply any Tribunal recommendations on review periods as the default and should only be altered where there is strong justification.
15.	Consider a minimum period (e.g. 6 months) between a successful appeal decision and a recall notice unless there are good grounds for believing that an earlier review is indicated.
Chapter 5 - Decision Making	
16.	Give greater clarity about the role and parameters of Decision Makers with a particular focus on the meaning of “empowerment”.
17.	Review the QAF so that existing strengths in process adherence are supplemented by measures to examine other elements of Decision Maker quality. In particular, the outcome of decisions and the logic underpinning them should be monitored more closely.
18.	Build a better relationship between HCPs and Decision Makers to engender more team spirit and to help Decision Makers view HCPs as their trusted advisers.
19.	Improve Decision Maker training to recognise the strengths and weaknesses of further medical evidence and other information on capability to supplement the HAP report.
20.	Re-engineer the case mix for the two levels of Decision Maker so that more senior staff consider “borderline” cases (e.g. 6 – 21 points) and more junior staff process all others.

21.	Ensure the provider batches cases into point bands when they send to the Department to save departmental admin/processing time.
22.	Review the place of Decision Assurance Calls and apply them only in “borderline” cases handled by Band C Decision Makers who should be up-skilled to make the intervention more effective.
23.	Review the guidance on the preparation of Reasoning and audit completed documents on a regular basis to further improve quality.
24.	Monitor overturn rates on an individual Decision Maker basis. Investigate exceptionally high and low rates as part of performance management.
Chapter 6 - Simplifying the Process	
25.	DWP continues to work with BMA to develop and co-design a revised electronic ESA113 with the aim of simplifying the process for GPs and improving the quality of evidence available.
26.	<p>The Department carries out a full impact assessment on an alternative process whereby DWP Decision Makers triage cases;</p> <ul style="list-style-type: none"> • DWP, rather than the HAP, issues the ESA50 and reviews the response with any supporting evidence supplied; • the Decision Maker determines (with the help of decision support materials) whether further evidence is required and, if so whether to obtain that by face to face assessment or other means; • where suitable and sufficient evidence is available on paper and a face-to-face assessment would provide no additional value, the Department should make a decision without referral to its HAP; • where a person is found Fit for Work on paper without a face-to-face assessment and subsequently disagrees with the decision, a second Decision Maker then reconsiders the need for a face to face assessment as part of the new mandatory reconsideration process.
27.	The Department should carry out a full impact assessment on the

	feasibility of a DWP Decision Maker being colocated with the HCP undertaking a face-to-face assessment and either seeing the person making a claim jointly or separately.
Chapter 7 - Mental Health	
28.	The Department strengthen its requirements for HCPs working on the contract to have suitable and sufficient previous experience of dealing with people with mental health problems so that they can contextualise their findings at assessment.
29.	The current training in mental health that HCPs receive should be reviewed to ensure that it is adequate and the evaluation results for these and other key modules should be considered by the Department before approving any individual HCP. Approvals should be reviewed on a periodic basis and reaccreditation should be dependent upon effective refresher training in key subject matter areas.
30.	Mental Health training for Decision Makers should include dealing on the telephone with distressed people, interpreting warning signs of potential self-harm and signposting to appropriate sources of help
31.	The ESA50 is redesigned to make it clear that evidence, particularly in mental health cases, from CPNs, Support Workers, Carers etc is valuable and giving guidance on the functional aspect that will help Decision Makers.
32.	Consideration is given to a new reassessment period extending to 5 years in the Support Group for people who have very severe incapacity resulting from brain disorders that are degenerative or which will not realistically improve.
Chapter 8 - Northern Ireland	
33.	Review the terms of reference, role profile and job description of the HAA with input from a senior occupational health professional to maximise the value of the position.

34.	Capture and monitor data on Decision Maker overturns of HAP recommendations to track future trends to give the Department a valuable source of management information.
35.	Extend the feedback loop to ensure that learning is communicated to the HAP as well as to Decision Makers.
36.	Maintain the arrangement whereby a Mental Function Champion is available to Decision Makers via the advice line.
37.	Give careful consideration to both the public perception as well as the objective evidence relating to understanding of mental health issues before agreeing to any further adjustment of the HCP skill mix.

Annex 2: Review of year one to three recommendations

Based on the information available to the Reviewer, this annex offers a view of how the recommendations made in the years one to three Independent Reviews of the WCA have been implemented by DWP.

In deciding whether a given recommendation has been implemented, the Reviewer considers whether the desired outcome has been reached. Where the recommendation has only been partially implemented an explanation is offered of why this is thought to be the case.

Yr	No	Recommendation	DWP Response	DWP Action	Implemented?
Claimant experience					
1	1	DWP Operations (formerly Jobcentre Plus) manages and supports the claimant during the course of their benefit claim and identifies their chosen healthcare adviser.	Accepted in full.	Various interventions piloted and not rolled out. ESA35 letter for new claimants; Decision Assurance Call for people found Fit for Work, call to people in WRAG prior to Work Focused Interview – see chapter 2 for more information.	Partially – support appears to be more limited than envisaged in the original review.
1	2	Initial questionnaire (ESA50) includes a more personalised justification so the claimant can express the issues that they face in a short paragraph.	Accepted in full.	ESA50 revised in March 2011 to include a free text section asking people to explain how their illness/disability affects them.	Yes
1	3	In the longer term, the Government reviews the ESA50 to ensure it is the most effective tool for capturing relevant information about the claimant.	Accepted in full.	The ESA50 has been reviewed biannually since March 2011 and revised in January 2013. DWP concluded in 2011 that ESA50 remained most appropriate tool.	Yes

An Independent Review of the Work Capability Assessment – year four

Yr	No	Recommendation	DWP Response	DWP Action	Implemented?
1	4	Written communications to claimants are comprehensively reviewed so that they are clearer, less threatening, contain less jargon and fully explain process.	Accepted in full.	All communications reviewed and revised where deemed necessary by DWP in March/April 2011. Some subsequent revisions to other written communications.	Yes
Descriptors					
2	3	A 'gold standard' review be carried out, beginning in early 2012. Future decisions about the mental, intellectual and cognitive descriptors should be based on the findings of this review.	Accepted in principle.	Evidence Based Review (EBR) carried out by the Department with participation of charities, and overseen by an independent steering group chaired by Professor Harrington. As yet unpublished.	Yes
2	5	This 'bottom up' model – involving a wide range of experts as well as DWP – should also be adopted in any future changes to the WCA descriptors, where appropriate.	Accepted in full.	The bottom-up model was used to develop the provisions for cancer treatment introduced in January 2013 – see chapter 2.	Yes
2	6	Work on the specific wording of the sensory descriptors and an additional descriptor which addresses the impact of generalised pain and/or fatigue should be considered early on in the year three Review.	Accepted in full.	Covered in the 3 rd review. <ul style="list-style-type: none"> • Sensory - Professor Harrington advised that that the representative groups' report showed "no conclusive evidence that descriptors themselves are not working". • Pain/fatigue – Professor Harrington advised that "neither appear to warrant their own, separate descriptor". 	Yes
2	7	As and when changes to the descriptors are made, DWP and other relevant experts should monitor the impact of these changes to ensure both that they are working and that they are not causing any unintended consequences.	Accepted in full.	DWP and Macmillan Cancer Support are collaborating on reviewing the impact of the provisions for cancer treatment. This work is at an early stage.	In progress

An Independent Review of the Work Capability Assessment – year four

Yr	No	Recommendation	DWP Response	DWP Action	Implemented?
Health Assessment Provider (HAP)					
1	5	Every Atos assessment contains a personalised summary of the assessment in plain English.	Accepted in full.	From mid 2011 Personalised Summary Statement included in ESA85 sent to Decision Makers for all claimants.	Yes
1	7	Atos provide mental, intellectual and cognitive champions in each medical assessment centre. These champions should spread best practice amongst Atos healthcare professionals in mental, intellectual and cognitive disabilities.	Accepted in full.	Mental Function Champions have been in place from May 2011. Training sessions delivered to Decision Makers from February 2013. See chapter 7 for more information.	Yes
1	8	Atos pilot the audio recording of assessments to determine whether such an approach is helpful for claimants and improves the quality of assessments.	Accepted in full.	Initial pilot carried out in June 2011. Availability of audio recording now being publicised from 1 August 2013.	Yes
1	9	Atos should develop and publish a clear charter of claimant rights and responsibilities, and should consider publishing the HCP guidance online for claimants and advisers.	Accepted in full.	Claimant Charter has been displayed in all Assessment Centres from March 2011. WCA Handbook is the main source of information for Healthcare Professionals (HCPs), and has been published on DWP website since April 2011. Publication of supplementary guidance judged to be disproportionate. See chapter 2 for more information.	Yes
2	11	These changes [to LiMA, based on comments from the stakeholder seminars] should be adopted, and that further changes to LiMA should be considered as and when they are raised.	Accepted in full.	LiMA was updated in Summer 2012. Subsequent changes have been made to LiMA as a result of requests by the Department and claimant representative groups.	Yes

An Independent Review of the Work Capability Assessment – year four

Yr	No	Recommendation	DWP Response	DWP Action	Implemented?
2	12	Atos and DWP monitor and audit the use of free text within LiMA to ensure a consistently high standard of accurate reports.	Accepted in full.	Health Assessment Provider (HAP) produces monthly Medical Quality reports that include monitoring information on HCP word count used in free text section. Quality of Personalised Summary Statement monitored by DWP.	Yes
2	13	If needed, Atos HCPs are provided with the relevant IT training – especially typing – to enable them to use the LiMA system intelligently and ensure that the quality of the face-to-face assessment does not suffer.	Accepted in principle.	Training package made available. Typing skills considered as part of training and approval process for new staff.	Yes
2	14	Given the importance of the quality of assessments (especially with Incapacity Benefit reassessment fully underway) DWP should consider tightening the target for C-grade reports.	Accepted in principle.	Under consideration for the future.	In progress – under consideration for the future.
2	18	DWP should closely monitor the recruitment, and retention, of Atos HCPs in year three.	Accepted in full.	Recruitment and retention information is supplied monthly by the HAP.	Yes
Decision Making					
1	6	Every claimant is sent a copy of the Atos personalised summary and is able to discuss any inaccuracies with a Decision Maker.	Accepted in full.	Trialled. Some issues with accuracy of content and many people did not feel document was useful. Then piloted sharing Decision Maker Reasoning, for claimants found Fit for Work. Rolled out nationally from January 2012. Claimant is informed of the option to request a copy of the HCP report, including the PSS in their decision notification.	Yes – Year 2 review recognised that the Decision Maker Reasoning 'seems to be a considerable improvement on the year one recommendation'.

An Independent Review of the Work Capability Assessment – year four

Yr	No	Recommendation	DWP Response	DWP Action	Implemented?
1	10	DWP Decision Makers are put back at the heart of the system and empowered to make an independent and considered decision.	Accepted in full.	<ul style="list-style-type: none"> Quality Assurance Framework introduced (see year 2 recommendation 9 below). Monthly 'Every Decision Counts' sessions introduced from Oct 2010, recently replaced by 'Ask the Expert' sessions. Guidance and communications on Decision Maker discretion, handling of evidence and focus on quality. 	Yes – but there are caveats about how empowerment has developed. Decision Makers appear to feel more empowered. Emphasis however has been to focus on processes rather than outcomes. It was reported that some Decision Makers appear to consider a greater willingness to 'overrule' recommendations from the HAP a proxy for empowerment and independence. See Chapter 5 for full analysis.
1	12	Decision Makers are able to seek appropriate chosen healthcare professional advice to provide a view on the accuracy of the report.	Accepted in full.	Decision Makers can seek corroborating evidence, when appropriate, after the Decision Assurance Call.	Yes
1	13	Better communication between Decision Makers and Atos healthcare professionals to deal with borderline cases.	Accepted in full.	<p>Pilot of HCP deployment in Benefit Centres in early 2011.</p> <p>Replaced by telephone helpline launched in Dec 2011 and re-launched in Sept 2012.</p>	Yes – but more work needs to be done. See Chapter 5.
1	14	Decision Makers receive training so that they can give appropriate weight to additional evidence.	Accepted in full.	Training delivered to all staff between September and December 2011. All new Decision Makers also receive this training.	Yes
2	9	DWP undertake regular audit of Decision Maker performance.	Accepted in full.	<p>Quality Assessment Framework (QAF) introduced in August 2011, but this is not a full audit tool – see chapter 5.</p> <p>Calibration exercises carried out in Nov 2011, Sept/Oct 2012 and Nov 2013.</p>	Partially – QAF is not a full audit tool, as it does not cover Decision Assurance Call or capture rates at which Decision Makers go against HAP advice.

An Independent Review of the Work Capability Assessment – year four

Yr	No	Recommendation	DWP Response	DWP Action	Implemented?
3	1	Decision Makers should actively consider the need to seek further documentary evidence in every claimant's case. The final decision must be justified where this is not sought.	Provisionally accepted.	A pilot to test this recommendation is at the time of writing on hold due to ongoing judicial review.	In progress – but on hold due to ongoing judicial review.
3	2	In order to build on the progress already made DWP Operations need to find an appropriate balance between better quality decisions that are carefully considered and 'right first time' and the achievement of appropriate benchmarks at a local level, otherwise there is a real risk of derailing the positive progress made to date.	Accepted in full.	New lower benchmarks for decisions introduced.	Yes
Reconsideration and appeals					
1	11	Better use of the reconsideration process.	Accepted in full.	Additional telephone call introduced to explain original decision and gather more evidence. Mandatory reconsideration from October 2013.	Yes
1	15	Feedback from the First-tier Tribunal should be routinely shared with Jobcentre Plus staff and Atos healthcare professionals. As part of their professional development, Jobcentre Plus Decision Makers should be encouraged to regularly attend Tribunals.	Remit of the First-Tier Tribunal	See controlled start of Summary Reasons (year 3, recommendation 3). Benefit Centres are able to set up visits for Decision Makers to observe Tribunals.	N/A
1	16	Tribunal decisions are better monitored, including monitoring of the relative or comparative performance of Tribunals.	Remit of the First-Tier Tribunal	See controlled start of Summary Reasons (year 3 recommendation 3).	N/A

An Independent Review of the Work Capability Assessment – year four

Yr	No	Recommendation	DWP Response	DWP Action	Implemented?
1	17	Training offered by the Chamber President to Tribunal Judges and medical Members should include modules on the evidence of the beneficial effects of work to an individual's well-being.	Remit of the First-Tier Tribunal	Remit of the First-Tier Tribunal.	N/A
3	3	DWP should continue to work with the First-tier Tribunal Service, encouraging them to, where appropriate, ensure robust and helpful feedback about reasons for decisions overturned by the First-tier Tribunal.	Accepted in full.	Controlled start of Summary Reasons since June for ESA appeals from four Tribunal venues – Liverpool, Glasgow, Birmingham and London.	In progress - HMCTS working with judiciary on proposals for future rollout of summary reasons at other Tribunal venues.
3	Annex 2 - 1	Secretary of State for Work and Pensions asks the Tribunal Service for timely feedback on reasons for upheld appeals.	Accepted in full.	Drop-down menu providing limited one-line feedback implemented in summer 2012.	Yes
3	Annex 2 - 2	The Decision Maker's reasoning should be used as the basis of the Department's case for any reconsideration or appeal.	Accepted in full.	Decision Maker's reasoning always used as basis for reconsideration and appeal.	Yes
Data					
2	1	Implementation of the Review's recommendations should be monitored over time and on a regular basis, including focus on 7 specified indicators.	Accepted in full.	Most of this data has been collected but not all of it.	Partially – data on one of the 7 indicators (reconsiderations received) is not available, and another (rate of appeals) is partial - appeals against WRAG outcomes are not available.
2	10	In year three, further research is undertaken to examine in more detail what happens to people found Fit for Work and people placed in the Work Related Activity (including Work Programme outcomes) and Support Groups, and the factors influencing these outcomes.	Accepted in full.	This work was carried out by DWP analysts and published in chapter 3 and annex 3 of the Third Independent Review.	Yes

An Independent Review of the Work Capability Assessment – year four

Yr	No	Recommendation	DWP Response	DWP Action	Implemented?
2	15	To improve the transparency of the face-to-face assessment, data on Atos performance and quality should be regularly published.	Accepted in principle.	In progress – under consideration for the future.	In progress – under consideration for the future.
Training and guidance					
2	4	DWP should consider working with relevant representative groups and their clinical advisers to: <ul style="list-style-type: none"> • Update the handbook and guidance used by Atos HCPs; and • Produce practical guidance for Decision Makers. 	Accepted in principle.	HCP guidance shared with relevant health experts and claimant representative groups when it is reviewed.	Yes
2	16	DWP should continue to monitor the quality and appropriateness of DWP Operations and Atos training.	Accepted in full.	DWP training - subject to regular review as part of existing arrangements. HAP training - it appears that measures are in place to monitor this, through the annual training needs analysis – see chapter 6 for more information.	Yes
2	17	Where appropriate, there should be sharing of knowledge and training between the various groups involved in the WCA.	Accepted in principle.	Knowledge/training sharing sessions between Personal Advisers and Decision Makers (see year 2 rec 19 below). Decision Maker desk-aid produced (nationally from July 2013).	Partially – this has focused on sharing knowledge within DWP rather than between others involved in the WCA.
3	5	The year four and five Reviews should further explore the quality of the outcomes rather than simply on the quantity of the training offered.	Decision for the year 4 and 5 reviewer.	N/A	Yes – the year 4 reviewer has examined the QAF and current HAP training [see Chapters 5 and 7].

An Independent Review of the Work Capability Assessment – year four

Yr	No	Recommendation	DWP Response	DWP Action	Implemented?
Into work					
2	8	DWP consider ways of sharing outcomes of the WCA with Work Programme providers to ensure a smoother claimant journey.	Accepted in principle.	Piloted. Information now shared with Personal Advisers. Process concerns about further dissemination.	Partially – this has been considered but as yet no WCA information shared with Work Programme providers.
2	19	DWP Operations should improve internal communications to ensure that each part of the claims process and Personal Advisers have a broad understanding of the policy intent of the WCA, what a Fit for Work decision means for a claimant and the support available to them.	Accepted in full.	New intranet pages on ESA end-to-end process and ESA handbook produced (nationally from June 2013). Awareness sessions between Decision Makers and Personal Advisers (rolled out nationally from October 2013).	Yes
2	20	DWP Operations should continue to monitor the impact of the year one recommendations, particularly the additional 'touch points' with claimants, to better understand whether messages about the support available on Jobseeker's Allowance are fully understood by claimants.	Accepted in full.	Information sheet sent to claimant as part of decision notification. Separate sheets sent to claimants found Fit for Work, claimants placed in WRAG and claimants placed in Support Group.	Yes
2	21	DWP should ensure that Universal Credit considers the risks of applying conditionality to those claimants who are currently employed.	Accepted in principle.	Conditionality may be tailored at the discretion of DWP Personal Advisers/ Work Coaches.	Yes

An Independent Review of the Work Capability Assessment – year four

Yr	No	Recommendation	DWP Response	DWP Action	Implemented?
Miscellaneous Groups					
2	22	DWP Operations should consider seeking, and using, advice and guidance from the UK Drug Policy Commission (UK DPC) and other relevant experts in order to improve and enhance the knowledge and capability of Decision Makers and Personal Advisers in managing these cases.	Accepted in principle.	There is limited DWP Decision Maker guidance specific to problem drug users. Based on the National Treatment Agency's 'Employment and Recovery: a Good Practice Guide' DWP have produced guidance for Personal Advisers.	Yes
2	23	Similar advice should be sought by Atos for their Mental Function Champions and the UK Drug Policy Commission and other relevant experts could be involved in updating the relevant sections of the Atos Guidance Manual for their healthcare professionals.	Accepted in full.	Guidance for assessment provider HCPs is reviewed annually. UKDPC were asked to provide comments on guidance about substance abuse and assessment of claimants with drug or alcohol problems, in Feb and Sep 2012. Most comments were accepted. Other guidance has been shared with relevant health experts and claimant representative groups when it is reviewed.	Yes
3	6	DWP Operations and Atos Healthcare should take further steps to engage effectively and meaningfully with the UK Drug Policy Commission (UKDPC) and other related groups concerned with the needs and difficulties of problem drug users to improve the WCA processes for them.	Accepted in full.	Latest version of learning materials for HCPs on substance abuse was shared with related groups for comment in April 2013. Frontline staff encouraged to establish relations with treatment providers.	Yes

An Independent Review of the Work Capability Assessment – year four

Yr	No	Recommendation	DWP Response	DWP Action	Implemented?
3	Annex 2 - 3	A designated official in DWP should receive notification of victims of miscarriages of justice and support them through their claim.	Accepted in full.	Miscarriages of Justice Support Service (England/Wales) and Miscarriages of Justice Organisation (Scotland) report cases to dedicated DWP team, who provide dedicated telephone contact throughout process. Live in England and Wales (March 2013), and Scotland (May 2013).	Yes
Review conduct					
2	2	Unannounced visits to both Benefits Delivery Centres and Atos Assessment Centres should be carried out during the year three Review.	Accepted in full.	Professor Harrington made a total of 8 unannounced visits as part of the year 3 review.	Yes
Wider communications					
3	4	DWP must take the initiative and highlight the improvements that have been made where they exist, as well as being open about where problems remain and their plans to address these.	Accepted in full.	DWP and current HAP representatives have agreed an approach for internal and external communications, highlighting the improvements which have been made.	In progress

Annex 3: Acknowledgements

1. This was my first year as Independent Reviewer and I am grateful to everybody who has helped build my understanding of the Work Capability Assessment process and induct me in the language of the benefits system.
2. The Independent Scrutiny Group - Neil Lennox, Professor Keith Palmer, Hugh Robertson and Ciarán Devane ably led by Professor David Haslam, whose excellent guidance and support throughout the year I have greatly appreciated.
3. Decision Makers, Appeal Writers and other operational staff in Leicester, Worcester and Stratford Benefit Centres and the ESA Centre in Belfast were all very welcoming and I am appreciative of the time and care they took to explain the work they do.
4. The information and assistance from officials in DWP, particularly the analytical support provided to the Review by Shaun Donaghy and Leoni Belsman, was very helpful throughout the year.
5. I would also like to thank Roderick Duncan and others in the Scottish Government, as well as officials in the Welsh Assembly Government for their contributions which were important in developing a Great Britain wide understanding of the WCA.
6. Margaret Boyle, Paddy Rooney, Glynis Jones and others who supported the Northern Ireland Independent Review and were so accommodating when we visited Belfast. It was a pleasure to meet the Social Development Committee, Minister McCausland, Tommy O'Reilly, Pauline Collins, Will Haire, Conall Maclynn and others during the visit.
7. Atos Healthcare staff were very accommodating during visits to Assessment Centres. Jerry Ashworth in particular has played a key role in facilitating visits and sharing information.
8. I am especially grateful to Chamber President HH Judge Robert Martin and Chief Medical Member, Dr Jane Rayner for taking the time to meet me. Regional Tribunal Judge Jeremy Bennett, Tribunal Members and staff at Fox Court in London kindly allowed the Review team access to ESA Tribunals and provided insight into the wider Tribunals and Appeals process.
9. Dr Mark Porter and Dr John Canning at the British Medical Association who provided insightful and constructive contributions.

10. The Behavioural Insights Unit at the Cabinet Office gave valuable advice on communications in relation to the WCA and I am appreciative of their help – Joanne Reinhard in particular took time to meet with and advise the Review team.
11. Charities, representative groups and professional bodies provided invaluable insights into how the WCA is operating and made constructive suggestions for improvement. Thank you to the organisations and individuals (almost 500 including in Northern Ireland) who responded to the Call for Evidence or with whom I have had chance to discuss the WCA. I am particularly grateful to the Disability Benefits Consortium for organising extraordinary meetings to help with the evidence gathering stage of the Review.
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For more information about this publication,
contact:

WCA Independent Review Team

Department for Work and Pensions

2nd Floor

Caxton House

Tothill Street

London SW1H 9NA

Email: wca.evidence@dwp.gsi.gov.uk

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