Department for Work & Pensions

Evidence Based Review of the Work Capability Assessment

A study of assessments for Employment and Support Allowance

December 2013

Contents

Acknowledgements

This project emerged from Professor Malcolm Harrington's second independent review of the Work Capability Assessment. It started from representations by a number of disability representative organisations that the assessment itself should be improved, and a subsequent request from Professor Harrington to specific organisations for proposals on how this might be achieved.

We are grateful to the following organisations for their work on this exercise, particularly the development work to come up with testable proposals for an alternative version of the assessment, which involved a considerable commitment of time and effort:

Mencap

Mind

The National Autistic Society

Arthritis Care

Crohn's and Colitis UK

Forward ME

The MS Society

The National AIDS Trust

Parkinson's UK

A Steering Group of experts chaired by Professor Malcolm Harrington oversaw the study. We are most appreciative of the helpful contributions and insights provided by the group, which included:

Professor Stephen Bevan, Director, Centre for Workforce Effectiveness, The Work Foundation

Professor Rob Moots, Professor of Rheumatology, University of Liverpool

Dr Mark Scheepers, Consultant Psychiatrist in Learning Disability, 2gether NHS Foundation Trust

Professor Stephen Stansfeld, Wolfson Institute for Preventive Medicine, Barts and The London School of Medicine and Dentistry, Queen Mary University of London

Summary

Background

The Evidence Based Review of the Work Capability Assessment (WCA) is a study to examine the performance of the instrument used to assess entitlement to Employment and Support Allowance and an alternative version of the assessment that was developed by specialist disability representative groups.

The study arose from a recommendation in Professor Harrington's second independent review of the WCA. Professor Harrington asked several disability representative organisations to propose ways in which to improve the assessment of fluctuation in physical and mental health conditions, and the effects of cognitive limitations on work-related functioning. A systematic Evidence Based Review (EBR) was established to examine the validity and consistency of the WCA and the alternative assessment (AA) proposals. The research questions were:

- How did the two different assessments work when applied to claimants? What were the assessment outcomes?
- Which assessment performed better overall in terms of validity and consistency?

The project was overseen by an independent Steering Group, which was chaired by Professor Harrington.

The assessments

The WCA is a structured assessment of capability for work-related activity. The WCA comprises a number of **activity** headings which relate to different aspects of everyday functioning. Under each activity heading there are **descriptors** which indicate the level of functioning in that area.

The WCA was used as a basis for developing the AA. The two assessments are similar in structure but there some differences between them. In particular the AA requires an indication of the frequency of limitation that applies with any descriptor chosen. This approach was intended to improve the assessment of fluctuations in health conditions.

The EBR focuses on how the assessment criteria (descriptors) work when applied to claimants. In practice, this is just one part of the process used to assess claimants. The outputs of the assessment allow a healthcare professional to advise DWP on the claimant's fitness for work. The decision about the award of benefit is then made by a DWP decision maker.

Method

Sample

A sample of 600 ESA claimants was recruited for the study from claimants who attended one of two Medical Examination Centres for a WCA between 25 March and 20 September 2013. The consent rate for participation was 73 per cent.

Where an assessment finds that a claimant has limitations that prevent them from work, the claimant will be awarded ESA and allocated to either the Work Related Activity Group or the Support Group. People in the Support Group are those with the most severe limitations, who are paid a higher rate of benefit and are not required to engage in any preparatory activity for employment, though they may choose to do so. Claimants who were considered to be Support Group cases on the basis of pre-assessment scrutiny of their files or their face-to-face assessments were excluded from the study.

The sample included claimants with a range of health conditions, including those which would be commonly recognised as fluctuating conditions. For example, almost 20 per cent had back pain and 11 per cent had asthma. Over three-quarters of claimants (76 per cent) had mental health problem and 2.5 per cent had a learning disability.

Assessment of fitness for work

At the time that the claimant attended their face-to-face assessment for ESA, they were offered the opportunity to participate in this study. For those who consented, the assessment process involved claimants having two assessment discussions with Healthcare Professionals (HCPs). The first meeting was used for normal benefit assessment. Two HCPs were present at this meeting, one conducting the assessment and the second observing. At the second meting only one HCP (the observer) was present. The second meeting was used to collect any additional information needed to choose descriptors in the AA.

To examine the consistency of assessments repeated on multiple occasions, paper-based re-assessment of a sub-sample of 250 cases was undertaken, independently by another two HCPs who applied both the WCA and AA criteria. The two Medical Examination Centres involved in the study exchanged records of the face-to-face assessments they had completed to ensure that the HCPs who conducted subsequent paper-based assessments would not have been involved in the process of gathering information from the claimant. A pool of 26 HCPs in the two sites was involved in assessments for the study which were for the purpose of applying the WCA and AA criteria. All assessments were conducted by Atos Healthcare.

To assess the validity of each assessment, the study involved creation of an indicator of work-related capability to which assessment results using both methods could be compared. The method used involved seeking the opinion of healthcare and employment support experts. 90 expert volunteers were recruited for this purpose.

Working in panels of three, their task was to critically appraise all evidence gathered on a claimant and make a determination of the claimant's fitness for work.

Results

Assessment outcomes

A total of at least 15 points is generally required to be considered as having limited capability for work. Claimants were more likely to score 15 points or more with the AA compared with the WCA – 44 per cent of all claimants scored 15 or more points on the AA; the equivalent figure for the WCA was 20 per cent. The vast majority of claimants did not score any points for a given activity. In general, claimants were more likely to score points in the AA than in the WCA. The AA was also more likely to pick up limitations with specific areas of functioning even if they were relatively moderate and would not be considered to affect work capability.

The points scale in the WCA for an activity is 0, 6, 9 or 15 points. The AA also included descriptors which have a score of 3 points. This might be expected to increase the potential for people to score a relatively low number of points across a range of activities and meet the threshold of 15 points for limited capability for work. However, there was no clear pattern suggesting that a score of 3 points was an additional category for low scores.

Claimant and HCP views on the assessment

Claimants had a slight preference for their second assessment discussion (for the AA) with HCPs. The second discussion was a semi-structured interview to complete aspects of the AA that would not be explored in detail during a regular WCA discussion. Two-thirds of claimants felt that there had been a 'good' or 'very good' opportunity to discuss how their health conditions affect their daily activities in their first assessments; this was reported for the second assessment in three-quarters of cases.

HCP reports suggest that they found it useful to have a semi-structured interview topic guide at hand during the second assessment. In almost two-thirds of cases, they reported gathering useful additional information during discussions where the topic guide was a prompt. A range of factors affected HCPs' application of the assessment; mostly commonly this included the challenges of appraising conflicting evidence and assessing fluctuation.

Results of the expert panel process

Claimant files were generally reviewed by more than one panel. Expert panels rated claimants as having limited capability for work in 30 per cent of occasions. Their opinion was overwhelmingly unanimous (in 95 per cent of cases) and they were generally confident in the opinion they had formed. In 26 per cent of occasions, expert panels believed the claimant was on the borderline between being fit for work and having limited capability for work. This borderline group encompassed those who

were considered fit for work and those considered to have limited capability for work. On occasions where the panel felt a case was borderline, 58 per cent were rated as more likely to be fit for work and 42 per rated as having limited capability for work.

In cases considered to be fit for work by panels, either flexible or altered hours, or specific aids or adaptations were frequently recommended to help the claimant into work. These two types of adjustment were recommended in around half of reviews by panels.

While the majority of claimants were viewed as able to do some work, the panels highlighted the wide range of support needs among claimants, and sometimes expressed scepticism that claimants would get the help they needed. In particular, the panel highlighted the need for better management of common health problems and the need for support to address non health-related issues that could affect a claimant's employment prospects.

Correspondence between expert panel opinion and assessment outcomes

The WCA corresponded more closely with expert panel opinion across a range of indicators than did the AA. For example, the WCA fitness for work outcome was the same as the expert panels' in 77 per cent of cases; the equivalent figure for the AA was 65 per cent. The WCA and expert panel assessments were more likely to agree when panels felt someone was fit for work. However, where someone was considered to have limited capability for work by expert panels, the panels were more likely to agree with the AA.

Internal consistency of assessments

The WCA was found to produce more consistent results overall. The WCA had excellent internal consistency as measured by Cronbach's alpha statistic (.94). The internal consistency of the AA was moderate regardless of the method used to consider its performance. The highest alpha statistic achieved was .67.

Conclusion

This study was a detailed examination of how functional assessments for work perform in the welfare system.

The AA, developed by disability representative organisations, showed that semi-structured interview style of assessment could be used and was well-received. However, some aspects of the AA proved more challenging. For example *Mobilising* was an area in the AA where claimants were more likely to receive points, but where HCPs most commonly reported difficulty in assessing the activity. The AA was better at detecting limitations with specific areas of functioning, including those which would not be significant enough to have an effect on work capability, as it focused more on indicating fluctuations in health within the assessment criteria.

The overall findings suggest that the WCA performed better than the AA– the WCA produced consistent results on the whole, and is an accurate indicator of work capability as compared with expert opinion.

1 Introduction

The Evidence Based Review of the Work Capability Assessment (WCA) is a study to examine the performance of the instrument used to assess entitlement to Employment and Support Allowance and an alternative version of the assessment that was developed by specialist disability representative groups. The study is focused on examining how the assessment instruments work, particularly whether they produce accurate and consistent results.

Background to the project

The WCA is an assessment of a person's functional capability for work and work-related activity which is used to assess entitlement to Employment and Support Allowance (ESA). Employment and Support Allowance was introduced in October 2008 to replace a range of sickness benefits including Incapacity Benefit, Severe Disablement Allowance and Income Support paid on the grounds of incapacity. The WCA was introduced at the same time as the new benefit.

The WCA is structured using a number of activity headings about aspects of everyday employment-related functioning. Under each activity heading there are several descriptors that indicate the level of functioning in that area. This structure is designed to comprehensively assess work-related capability.

Following a WCA, there are three outcomes. The claimant can be:

- Found **fit for work**. Claimants in this group are not entitled to ESA but may claim Jobseeker's Allowance.
- Placed in the **Work-Related Activity Group** where they will be paid the benefit and expected to engage in activities to prepare for employment, such as Work Focused Interviews with employment advisers.
- Placed in the **Support Group.** People in this group are those with the most severe limitations. They are paid a higher rate of benefit and are not required to engage in any preparatory work activity but may choose to do so if they wish.

Since its introduction, the WCA has been revised in line with the intent that the assessment should be improved over time. A report of an internal DWP review of the WCA was published by DWP in 2010. The review group recommended several revisions to the WCA which were implemented in 2011.

The present study arose from a recommendation in Professor Harrington's second independent review of the WCA. Professor Malcolm Harrington was appointed to

conduct the first independent review of the WCA in 2010. As part of his second Independent Review of the WCA, which was conducted throughout 2011,[1] he asked two groups of disability representative organisations to provide recommendations to refine descriptors respectively for a) mental, cognitive and intellectual functioning and b) fluctuating conditions. Each group reported recommendations for changes to the descriptors to him, while recognising that more work would be needed to finalise the proposals. Professor Harrington recommended a 'gold standard' review as the next step to see whether the proposed descriptors would improve the WCA.

In response, DWP committed to conducting a systematic EBR of the existing and proposed WCA activities and descriptors. The specialist disability representative groups worked with DWP officials to develop a single alternative assessment (AA) that combined recommendations on mental functioning and fluctuating conditions and to ensure that the descriptors were suitable for testing with claimants.

DWP officials who specialised in medical policy and social research developed the testing approach and analysed the results. The project was overseen by an independent Steering Group, which was chaired by Professor Harrington. The research questions were:

- How did the assessments work when applied to claimants? What were the assessment outcomes?
- Which assessment performed better overall in terms of accuracy and consistency?

The assessments

The WCA was used as a basis for developing the AA. The two assessments are similar in structure but there are some notable differences between them.

Similarities include:

- Both assessments are structured by activity (Table 1). Within each activity, descriptors are organised in a hierarchy indicating the degree of functioning or severity of limitation.
- Both assessments distinguish activities related to physical functioning from those concerning mental or cognitive functioning.
- The number of points required to be deemed as having limited capability for work or 'not fit' for work is 15 in both assessments.

[1] Harrington M (2011) An Independent Review of the Work Capability Assessment – year two.

Table 1.1: Activities included in the assessment

Activity (WCA label if different)	**Code**	**Number of descriptors**	**Area of functioning**		
			Physical or sensory	**Mental or cognitive**	**Global**
Mobilising	w	6	✓		
Getting about	ga	5	✓		
Navigating	v	5	✓		
Sitting and standing	s	4	✓		
Reaching	r	5	✓		
Picking up and moving objects	p	6	✓		
Manual dexterity	m	5	✓		
Awareness of hazards	ah	3	✓		
Consciousness	f	3	✓		
Bladder/bowel continence	c	4	✓		
Understanding communication	h	5			✓
Making self understood	sp	5			✓
Social engagement (S*ocial interaction)*	cs	5		✓	
Organising self and planning *(Initiating & completing personal action)*	ia	5		✓	
Coping with change	cc	5		✓	
Appropriateness of behaviour	ib	4		✓	
Learning tasks	lt	4			
Executing tasks*	ex	5			✓
Maintaining focus*	mf	3			✓

*Not included in the WCA

Some differences are:

- In addition to measuring the severity of limitation with a descriptor choice, if a descriptor applies to a claimant, the AA requires an indication of the frequency of limitation. This approach was intended to improve the consideration of fluctuations in health conditions.
- The AA uses a different scoring approach. In the WCA, the points scale for an activity is: 6, 9, or 15 points. In the AA, there are opportunities to score 3 points for some activities, which might be expected to increases the chances of claimants picking up points over a wider range of activities.

- The AA includes a category of descriptors which are considered ‘global’, in addition to those which concern physical or mental functioning.
- There are fewer activities in the WCA (17) compared with the AA (19). The additional activities in the AA relate to ‘Executing tasks’ and ‘Maintaining focus’.

More detail on the assessments is included in Annex 1 (WCA) and Annex 2 (AA).

Scope and objectives

The study was designed to examine the reliability and validity of the assessment instruments. This means it did not seek to examine issues around the implementation of the assessments but, instead, to focus on whether the assessments themselves can be applied in a way that produces accurate, consistent results. It is not a real-world test of whether someone would be able find work but rather an examination of how well the assessments distinguishes between claimants on the basis of health-related capability for work.

The main objectives were to:

- Examine the extent to which scores on each version of the assessment are related to a reference measure of work-related functioning (criterion **validity**)
- Examine the consistency or **reliability** of assessments.
- Examine HCP and claimant acceptance of a semi-structured interview approach to assessments

A central part of the EBR was to create a defensible standard to which the results of each assessment could be compared in a test of criterion validity. There is no single instrument that measures work-related functioning that could serve this purpose. The majority of instruments available for measuring functioning are clinical and condition-specific. Therefore, the approach used in the study involved seeking the opinion of selected healthcare and employment support professionals on each claimant’s fitness for work. This process is described in Chapter 2.

2 Data and methods

Sampling and recruitment

A sample of 600 ESA claimants was recruited for the study. Participants were claimants who attended one of two Medical Examination Centres (MECs) in the North of England for a WCA between 25 March and 20 September 2013. The centres were chosen to ensure a spread of claimant characteristics in the final sample (for example people with range of health conditions and living in a mix of urban and rural areas) and to minimise the impact of the study on the normal business of assessments. Participant quotas were set on claimants' broad health condition (physical or mental), gender, and type of assessment (initial for a new claimant, repeat assessment of an existing ESA claimant, re-assessment of an existing IB claimant). In addition, special efforts were made to boost the number of participants with selected rarer conditions. The final sample included a total of 50 cases with these 'booster' conditions:

- Autistic Spectrum Disorder (ASD)
- Learning disability
- Chronic Fatigue, including Chronic Fatigue Syndrome, ME and Fibromyalgia
- HIV
- Hepatitis C
- Inflammatory Bowel Disease

Claimants who were considered to be Support Group cases on the basis of pre-assessment scrutiny of their case files or initial face-to-face assessment were excluded from the study. This exclusion was made because the differences between the WCA and the AA are mainly about descriptors for the Work-Related Activity Group.

The assessments were conducted by Atos Healthcare, a provider of medical assessments for DWP. In the majority of cases, claimants were recruited when they arrived at the MEC. Each day during the study, claimants who arrived at the centre for a scheduled WCA were asked if they would like to participate in the EBR. Claimants were provided with a leaflet about the process and discussed the process with an HCP. Claimants were offered a £20 gift voucher for their participation in the study. The consent rate for participation in the study was 73 per cent.

In the initial phase of the study, claimants were recruited and consenting claimants assessed when one of the assessors participating in the study became available. Therefore while quotas on broad participant characteristics were set, the sample was arguably semi-random.

Face-to-face assessments

The assessment process involved claimants having two assessment discussions with Healthcare Professionals (HCPs). The process was designed to allow separation between information collected for the study from that used for normal benefit assessment for legal and ethical reasons.

The first meeting was used for normal benefit assessment. Two HCPs were present at this meeting, one conducting the assessment and the second observing. Claimants who met Support Group criteria were excluded from the study at this point (for the reason discussed above).

At the second meeting only one HCP (the person who observed the first assessment) was present. The second meeting was used to collect any additional information needed to choose descriptors in the AA. The HCP who conducted the second meeting used a semi-structured interview topic guide to facilitate the discussion. When the claimant left, the HCP chose descriptors in both the current WCA and the AA.

The approach used means that a single HCP provided the descriptor choices used for the study, and that they were informed by both the initial 'regular' WCA discussion and the semi-structured discussion when they applied each assessment.

26 HCPs were involved in conducting assessments for the study.

Semi-structured discussions

The AA was designed to be conducted using a semi-structured interview style. Semi-structured interviews are a 'conversation with purpose'. The method used to develop the topic guide is described in Annex 3. The topic guide was developed by professional qualitative researchers in consultation with members of disability representative organisations and DWP officials. A workshop was held to discuss the ideas and create an initial draft of the topic guide.

Assessment outputs

For purpose of the study, HCPs recorded assessment outputs in an Excel form. For each claimant the HCP recorded:

- A note of the semi-structured interview discussion, structured under broad section headings.
- AA: for each activity, the HCP indicated their descriptor choices (more than one could be chosen within an activity). The HCP also responded to questions about any difficulty with assessing the activity
- WCA: the HCP chose a descriptor for each activity and noted whether there were any issues with applying the WCA in the case
- Overall views on the assessment of the case

Claimant feedback

Claimants who participated in the study were asked to complete a short paper questionnaire after their assessment before they departed from the MEC. This exit questionnaire provided an opportunity to collect information on claimants' health conditions, and their views on the assessment process.

The expert panel process

The expert panel process was designed to create an indicator of work-related capability to which the results of each assessment could be compared to examine their validity.

90 expert volunteers with healthcare or employment support backgrounds were recruited for the expert panel process. Working in panels of three, their task was to critically appraise paper-based information gathered on claimants (excluding descriptor choices) to make a determination of the claimant's work capability (fit for work or not). The information available to the panels included anonymised copies of:

- The claimant questionnaire complete at the outset of an ESA claim (ESA50)
- The ESA85 file, the final WCA report on the claimant and any supporting evidence, which Atos Healthcare provides to DWP Decision Makers. The copies seen by the panels excluded the descriptor choices from the WCA. In some cases, this would include medical evidence provided in support of the claim such as letters provided by a clinician that was treating the claimant.
- The write-up of the AA, which had been completed in a bespoke Excel form for the purpose of the study

Panel members received a day's training before they began the task and each volunteer worked for up to five days. All claimant files were reviewed by at least one panel member. A total of 560 cases were reviewed by the expert and had complete data. Of these, 295 (49 per cent) were reviewed multiple times and one case was reviewed by every panel. The panel considered each case and completed a structured questionnaire (Annex 4).

Quality assurance of the expert panel process

The expert opinion provided by expert panels on claimant fitness for work was quality assured by healthcare professionals that had not previously been involved in the process. A purposive sample of 28 cases representing approximately 5 per cent of the total sample size was selected for quality assurance. The sample was designed to achieve a range cases by condition type and where there was a spread of opinion about the claimant's fitness for work.

The six reviewers were recruited through professional bodies. They had expertise in the following areas or specific diseases: General Psychiatry (mental health), Learning disability, Bowel Diseases, Chronic Fatigue, Physiotherapy and visual impairments

Each reviewer worked independently. They were provided with all of the medical evidence on a case and asked to comment on the health and work needs of claimant and their fitness for work. This included identification of issues around the claimant's circumstances and their functional effects that the panel did not seem to identify. Reviewers were also asked to give their overall view on whether the panel ratings of fitness for work were appropriate and defensible. In around two thirds of cases, the reviewers believed the panels' ratings of fitness for work were appropriate. More information, including some illustrative case studies on the different views identified can be found in Annex 5.

Paper-based assessments

To examine the consistency of assessments repeated on multiple occasions, paper-based re-assessment of a sub sample of 250 cases was undertaken. This process was used to avoid undue burden on claimants. Two HCPs separately assessed each claimant using the paper-based outputs from the initial face-to-face assessment, and other medical evidence in claimant files. Both the WCA and AA were applied. Therefore, each assessment was applied a total of three times for this subsample: once face-to-face; and twice on paper.

Strategy for analysis

This is mixed methods study, which uses both quantitative and qualitative methods of analysis.

Quantitative analysis: The analysis in this report is generally based on descriptive statistics about the assessments. The focus is on the patterns observed in the data, but where differences are marginal, we also report whether the differences are statistically significant – in other words, whether the differences seen would be generalisable beyond the study sample.

The assessment data had to be transformed for some statistical analyses and to allow meaningful comparisons between the WCA and the AA because:

- The WCA is comprised of fewer activities (17) than the AA (19). This means that there are potentially more opportunities to receive points in the AA than in the WCA. Where appropriate, figures are give for the full 19 activities and the 17 activities that are comparable to the AA.
- The scoring approach used in both assessments did not lend itself to some types of statistical analysis, which require linear or ordinal scales.

Therefore, for some analyses the points were considered on ordinal scales (for example treating 0 points as '1', 6 points as '2', 9 points as '3' and so forth). The details are discussed within relevant sections.

Qualitative analysis: Qualitative thematic analysis was used to analyse the feedback provided by claimants, HCPs and Expert Panels. We also used the assessment data to create **case studies.**

Achieved sample

Table 2.1 shows the characteristics of the 600 sample members. The gender balance was fairly even: 53 per cent men and 47 per cent women. As with ESA claimants in general, sample members tended to be of older working ages. The greatest proportion (45 per cent) was aged 50 and over and fewer than one in seven were aged under 30.

Table 2.1: Sample characteristics

	Men	Women	All people
	%	%	%
Age group			
18 to 29	14.1	15.4	14.7
30 to 39	12.2	16.4	14.2
40 to 49	25.6	27.1	26.3
50 to 59	36.9	33.6	35.3
60+	11.3	7.5	9.5
Type of assessment			
Initial assessment	51.9	52.9	52.3
Re-assessment for existing ESA claimant	20.9	25.0	22.8
Re-assessment for IB claimant	27.2	22.1	24.8
Type of health problem recorded on assessment system			
Mental health problem	69.7	82.5	75.7
Musculoskeletal problem	50.3	50.7	50.5
Disease of the circulatory or respiratory system	41.3	37.1	39.3
Disease of the nervous system	15.0	11.8	13.5
Other types of health problem	65.0	74.3	69.3
Co-morbid physical and mental health problems noted by assessor	81.9	83.2	82.5
N (100%)	320	280	600

The sample was deliberately weighted towards claimants who were having an initial assessment (52 per cent) rather than a re-assessment for an existing ESA claim (23 per cent), or re-assessment for an existing IB claim (25 per cent).

In terms of their health conditions, participants were most likely to have a mental health problem. Mental health problems affected over three-quarters of claimants, and rates were higher among women (83 per cent) than men (70 per cent). Musculoskeletal problems were also very common – about half of sample members had a musculoskeletal problem. In addition, the vast majority of claimants (83 per cent) had both a mental health problem and a physical condition.

Many claimants in the sample had health conditions which are commonly seen as fluctuating or variable in nature (Table 2.2). For example, almost 20 per cent had back pain and 11 per cent had asthma. In addition, many claimants had health conditions that affected their mental, intellectual or cognitive function. For example, 18 per cent had depression and 2.5 per cent had a learning disability.

Table 2.2: Selected health conditions among claimants in the sample

	%	N
Back pain	19.5	117
Depression	18.0	108
Chronic Fatigue Syndrome or Fibromyalgia	3.5	21
Diabetes	7.2	43
Arthritis	1.2	7
Asthma	10.8	65
HIV	1.0	6
Inflammatory Bowel Disease	1.2	7
Learning disability	2.5	15
Epilepsy	2.7	16

Base: N= 600.

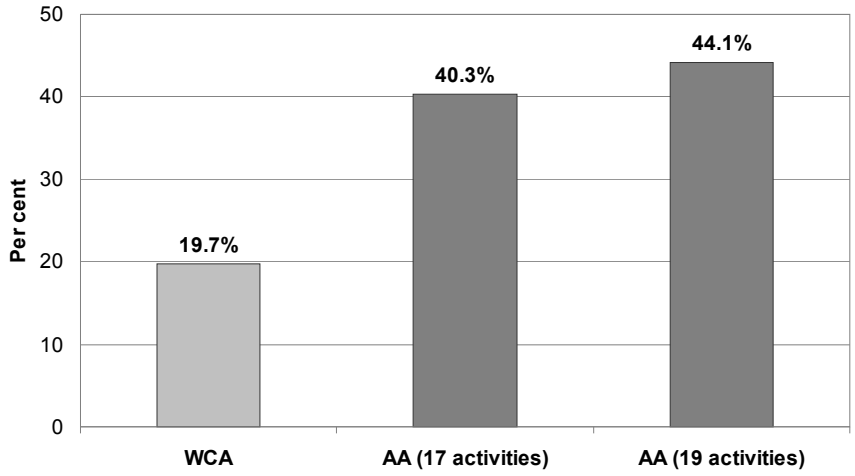
3 Assessment outcomes

This chapter considers the outcomes of applying each assessment, looking at the scores awarded overall and examining the detail of descriptor choices and scores for each activity. It also considers the feedback provided by HCPs and claimants on the process. The AA was generally more likely to pick up difficulties with an activity. Claimants were twice as likely to score at least 15 points with the AA, the threshold for being considered as having limited capability for work, compared with the WCA.

Total assessment scores and fitness for work

Claimants were more likely to score points with the AA than with WCA (Figure 3A). They were twice as likely to score 15 or more points with the full AA (44 per cent) compared to the WCA (20 per cent). In addition, very high scores of 30+ points were considerably more likely with the AA (20 per cent) compared with the WCA (3 per cent). Full details of the distribution of scores are provided in Table 3.1 at the end of the chapter, along with all underlying tables.

Figure 3A. Percentage of claimants scoring a total of 15+ points by assessment



Assessment of each activity

In the WCA, descriptors are organised in a simple hierarchical fashion indicating the degree of limitation with an activity. In the AA, the same score can be used for several descriptors within an activity, as illustrated in Box 3.1. In addition, some descriptors, which indicate a degree of limitation with an activity are scored zero points and, if selected, would not contribute towards meeting the points threshold for being deemed as having limited capability for work.

To create a rounded picture of how each activity was applied, this section looks at the scores awarded for each activity and the descriptors chosen. It also looks at whether the descriptors chosen indicated that an individual had some difficulty with an activity regardless of whether any points were associated with the descriptor choice.

Box 3.1: Example of a descriptor in the AA

2. Navigating (Sensory)

Navigating around familiar and unfamiliar places without being accompanied by another person reliably, repeatedly, safely and in a timely manner, using a guide dog or other aid if normally used, without experiencing difficulty due to sensory impairment.

Descriptor	Points		
a None of the below apply	**0**		
Due to sensory impairment, without being accompanied by another person:	**Occasionally**	**Frequently**	**Most of the time**
b Has some difficulty navigating around unfamiliar surroundings	**0**	**3**	**6**
c Has significant difficulty navigating around unfamiliar surroundings	**3**	**6**	**9**
d Has some difficulty navigating around familiar surroundings	**6**	**9**	**9**
e Has significant difficulty navigating around familiar surroundings	**9**	**15***	**15***

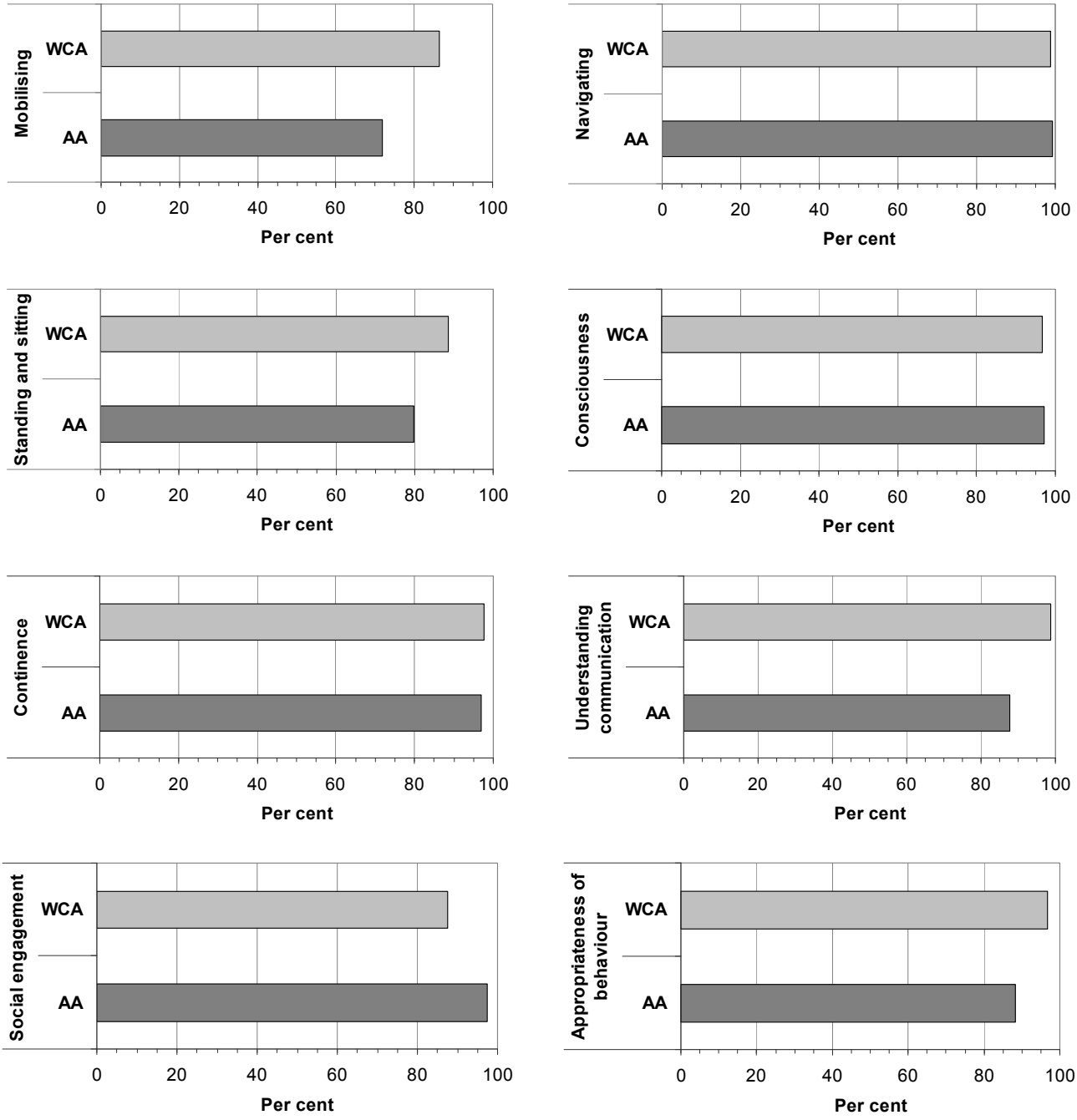
Scores awarded for each activity

The vast majority of claimants did not score any points for a given activity. Figure 3B illustrates this point, showing the proportion of claimants who scored zero points for selected activities. Full distributions of points scored are shown in Table 3.2 at the end of this chapter.

Very few claimants scored any points for the following activities: *Navigating, Awareness of hazards, Consciousness, Continence, Learning tasks,* and *Making self understood*. In both assessments, the proportion receiving any points for these activities was less than five per cent.

Figure 3B. Percentage of claimants scoring zero points for selected activities: WCA and AA compared

Base: All claimants (N= 600)

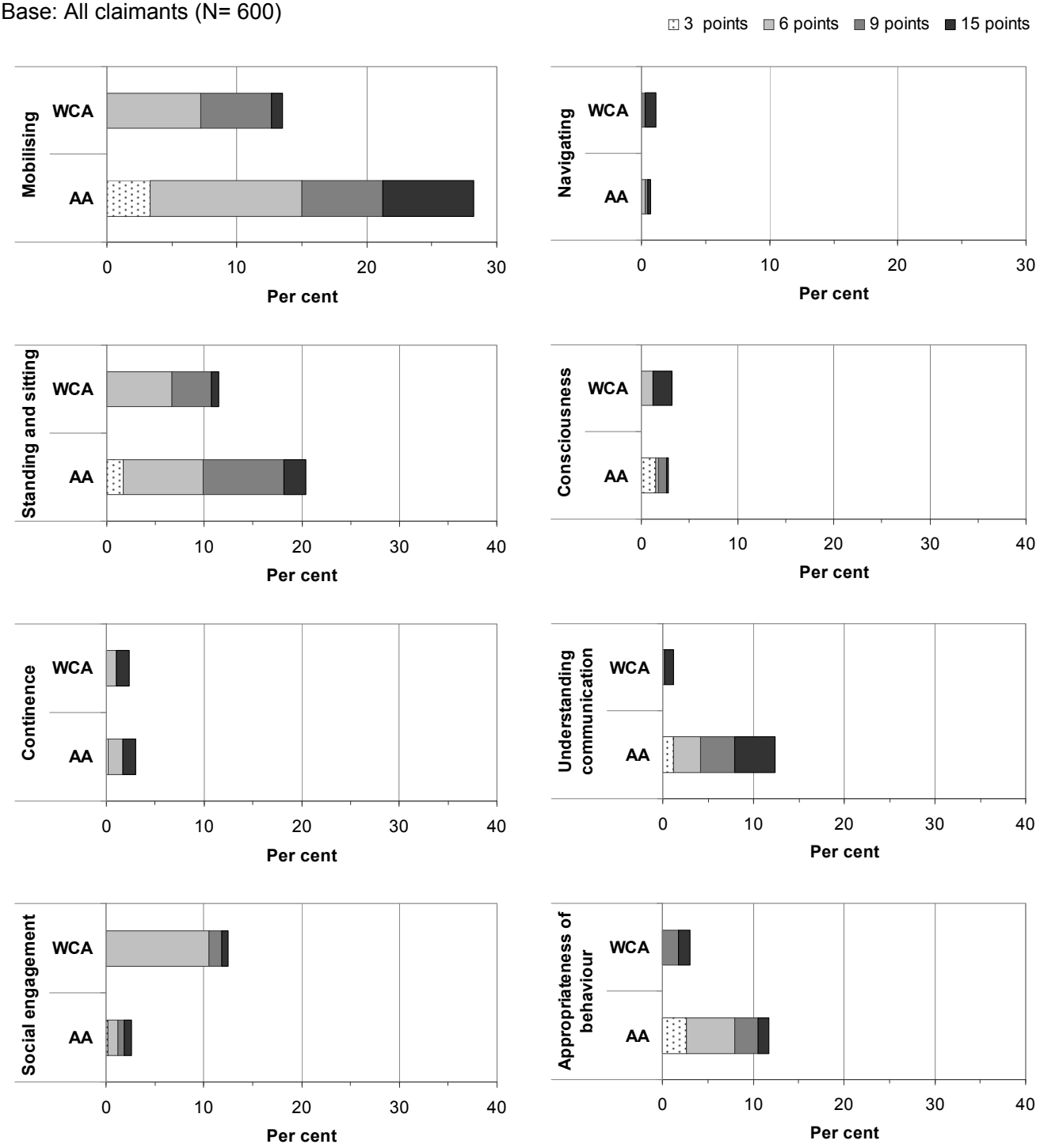


Overall, for a given activity, claimants were more likely to score points in the AA than in the WCA (Figure 3C). The exceptions, where some points were more likely in the WCA than in AA, were for the activities on *Navigating* (where the difference was insignificant), and *Social engagement.*

In general, less than one in six claimants scored any points for an activity. In both assessments, claimants were most likely score points for *Mobilising* (28 per cent on the AA, 14 per cent on the WCA).

Figure 3C. Percentage of claimants scoring points for selected activities: WCA and AA compared

Base: All claimants (N= 600)



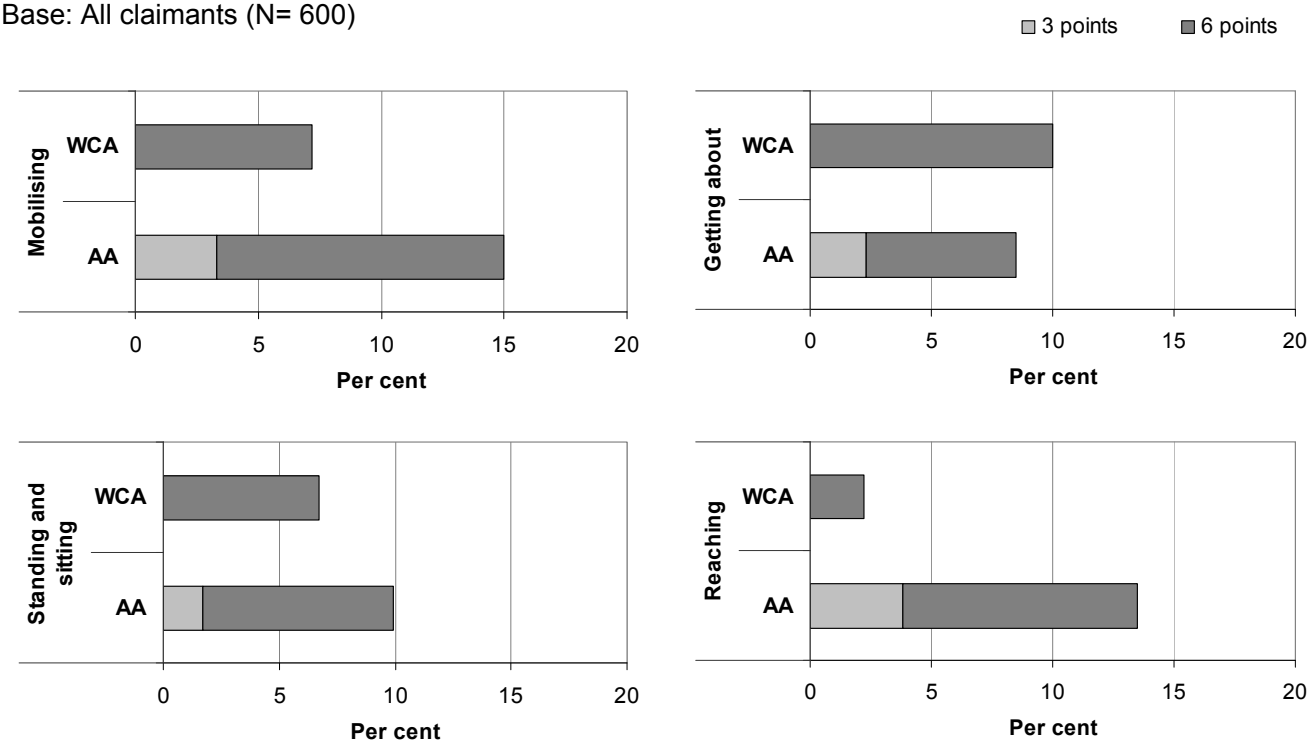
Scores of 3 or 6 points by activity

The AA scoring approach includes descriptors which have a score of 3 points. This might be expected to increase the potential for people to score a relatively low number of points across a range of activities and meet the threshold of 15 points for limited capability for work. In the AA, the activities where scores of 3 points were most likely to be given were *Executing tasks* (7.2 per cent) and *Picking and moving* (5.3 per cent).

Figure 3D illustrates the proportions scoring 3 or 6 points in the AA, versus those scoring 6 points in the WCA for selected activities on *Movement.* As can be seen, very small proportions of claimants (generally under 5 per cent) scored 3 points on an activity in the AA. There was no clear pattern suggesting that a score of 3 points was an additional category to a score of 6 points – there was some suggestion of this for *Mobilising and Standing and sitting,* for example, where the proportions scoring 6 points were similar on the WCA and AA. But for other activities the pattern was different. For *Getting about* the proportion scoring 6 points in the WCA exceeded the proportion scoring 3 or 6 points on the AA. For *Reaching* the proportion scoring 3 points on the AA exceeded the proportion scoring 6 points on the WCA.

Figure 3D Percentage of claimants scoring 3 points or 6 points by assessment: selected activities on *Movement*

Base: All claimants (N= 600)



Scores of 15 points by activity

In both assessments, typically less than 5 per cent of all claimants scored 15 points for an activity. For nearly every activity, a higher proportion of claimants scored 15 points on the AA compared to the WCA.

A score of 15 on a single activity was most likely for *Consciousness* in the WCA (2 per cent) and *Mobilising* in the AA (7 per cent). There were two activities where no claimants scored 15 points in the AA: *Executing tasks* and *Reaching*.

Difficulty with an activity

In addition to scores for an activity, it is possible to look at whether the descriptors chosen indicated some difficulty with the area – some descriptors which would suggest a degree of difficulty had a score of zero points in the AA.

The patterns were very similar to those observed for actual scores (Table 3.3). Overall, the AA was more like to indicate that a higher proportion of claimants had difficulty with a given activity compared to the WCA. The WCA was however slightly more likely to find that claimants had difficulty *Navigating* compared to the AA (1.2 per cent compared to 0.8 per cent).

In both assessments, claimants were most commonly found to have of difficulty with *Mobilising, Getting about, Standing and sitting,* and *Social engagement*. The AA tended to find that at least one in five claimants had some level of difficulty in these areas. For the WCA however, the equivalent figures were closer to one in ten.

Contribution of specific activities to total assessment scores

Table 3.3 shows that scoring on an activity was, in general, strongly associated with meeting the threshold for being considered as having limited capability for work. For example, with the AA 23 per cent of claimants had descriptors chosen which indicated some difficulty with *Standing and sitting, and* of this group 74 per cent scored at least 15 points in the AA overall. However, as the proportion scoring any points for an activity was generally quite low, these figures should be treated with caution.

Number of descriptors chosen for an activity in the AA

In the AA more than one descriptor could be chosen for an activity to indicate the frequency with which a particular level of limitation applied.[2]

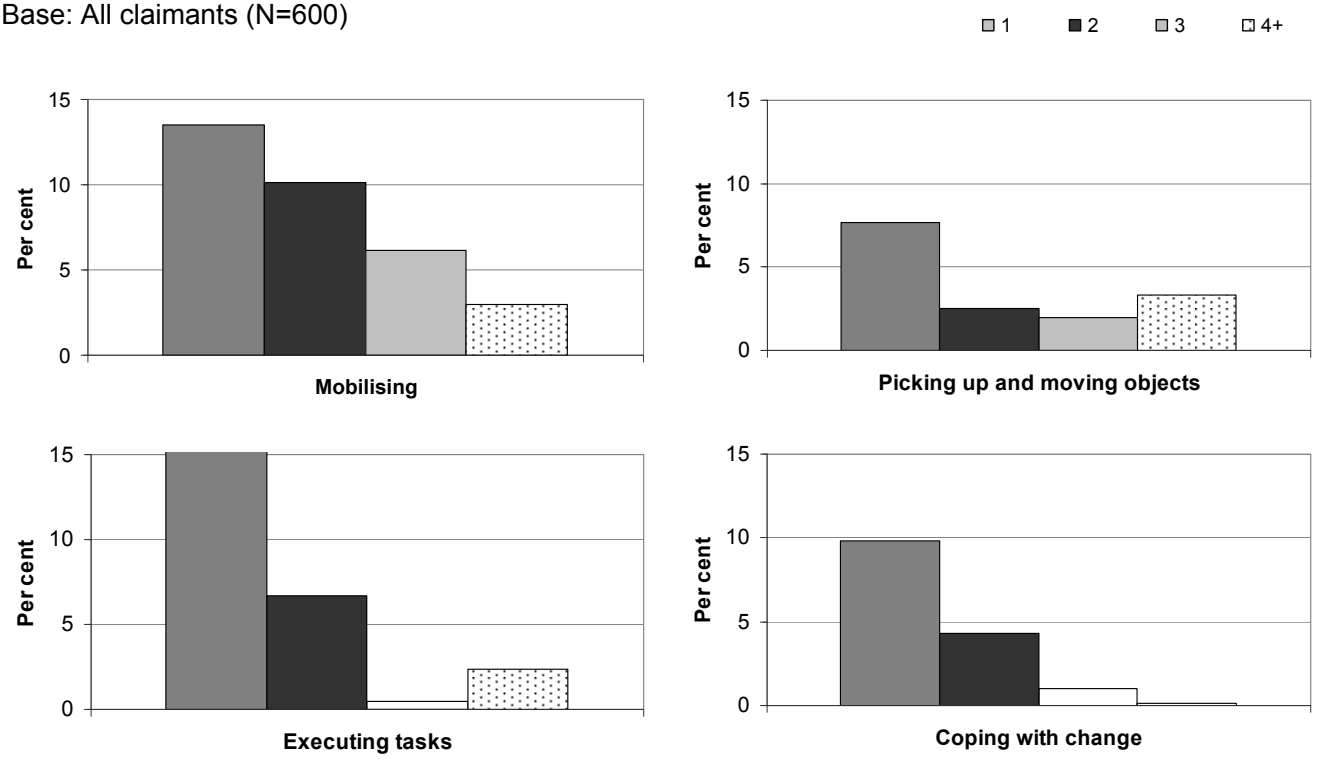
For every activity, fewer than one in three claimants had a descriptor chosen that indicated some difficulty. Where some difficulty with an activity was indicated, most frequently, only one box was chosen regardless of the activity. Figure 3E illustrates the number of descriptors ticked for selected activities in the AA. As can be seen, there was a clear downward gradient in the number of descriptors chosen for an activity - it was uncommon for three or more

[2] A scale of frequency was used to rate descriptors for all activities except *Learning Tasks,* for which the measurement level for descriptors was task complexity.

descriptors to be chosen for an activity. This generally occurred in fewer than five per cent of cases across activities, with the exception of *Mobilising* and *Picking up and moving objects*, for which 9.2 and 5.3 per cent had three or more descriptors chosen respectively.

Figure 3E Number of descriptors indicating limitation: selected activities in the AA

Base: All claimants (N=600)



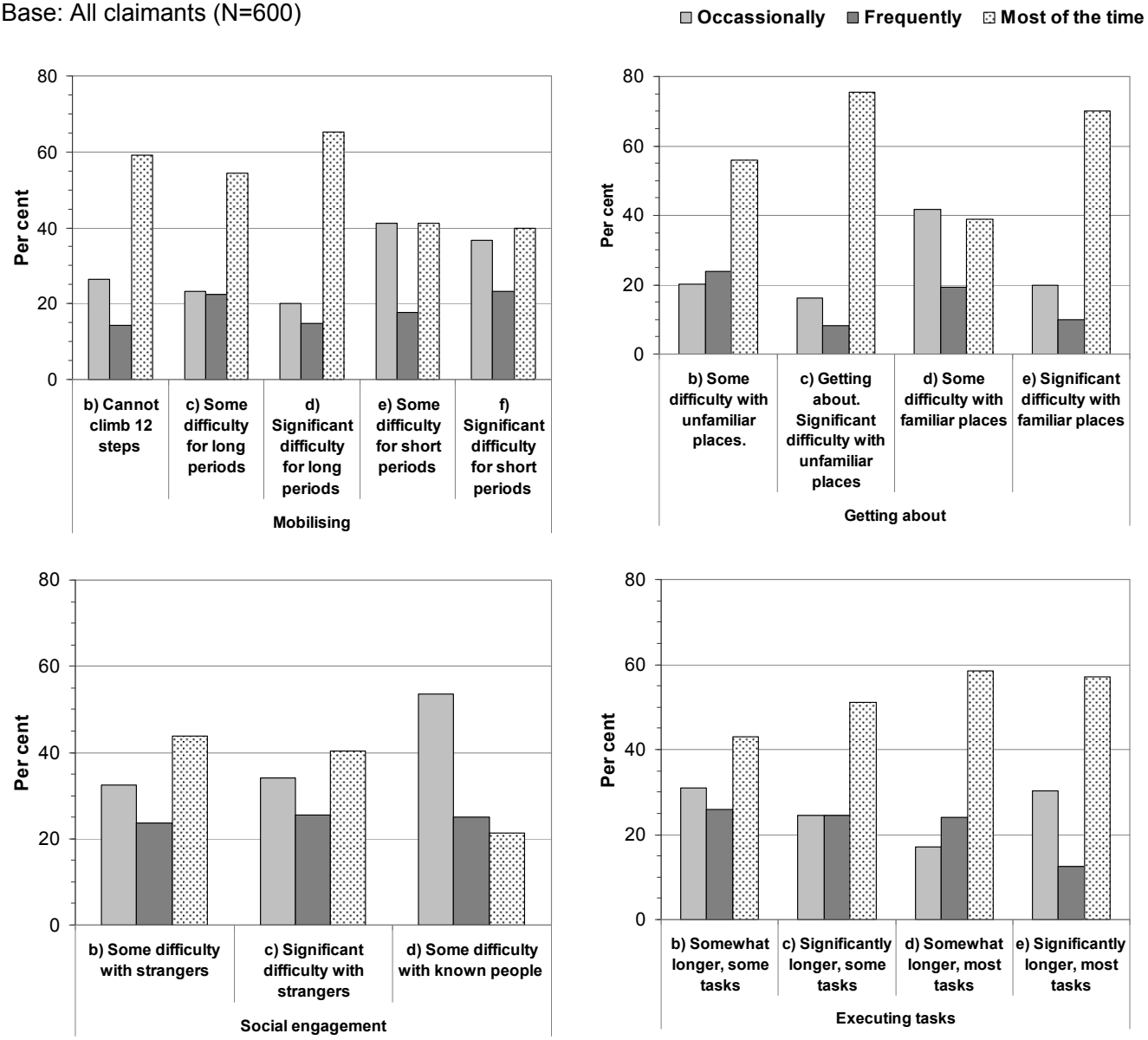
Frequency of difficulty indicated with descriptor choice in the AA

The AA approach requires an indication of the frequency with which a degree of limitation applies – this is integral to the descriptor choice. Limitations could be indicated to occur 'Occasionally' (20 to 49 per cent of the time); 'Frequently' (50 to 74 per cent of the time) or 'Most of the time' (at least 75 per cent of the time).

There was no clear pattern on which frequency rating was most likely to be selected. There was considerable variation in the frequency rating used for descriptors, although some suggestion that 'Most of the time' was most commonly chosen where there some degree of limitation (Figure 3F). For example, considering descriptor b on *Getting About,* 'Most of the time' was selected in 56 per cent of cases where the descriptor was chosen; equivalent figures for 'Occasionally' and 'Frequently' were 27 per cent and 14 per cent respectively.

Figure 3F Frequency of limitation ratings for descriptors: selected activities in the AA

Base: All claimants (N=600)



Claimant and Healthcare Professional views on the assessment

Claimants were asked for their views on the AA process using a pen and paper questionnaire which they completed before leaving the assessment centre.

Claimants had a slight preference for their second assessment discussions with HCPs. The second discussion was a semi-structured discussion used to collect information needed to complete aspects of the AA that would not be explored in detail during a regular WCA discussion.

For example, 66 per cent of claimants felt that there had been a ‘good’ or ‘very good’ opportunity to discuss how their health conditions affected their daily activities in the first assessment; the equivalent figure for the second assessment was 74 per cent.

When asked which assessment they preferred, the largest group of claimants had no preference (39 per cent), 38 per cent said they preferred the second assessment, and 24 per cent preferred the first assessment. This seems to be because the second assessment was shorter, more informal and perceived to be more personalised because of the opening question style. For example:

> *“The second did not feel like an interrogation. It was more relaxed and I was able to elaborate on my status/condition.”*
>
> *“Had more chance to express how I felt. More rapport-'going outside the box'*
>
> *“Because this interview was all about my medical condition and how I felt mentally and emotionally. Not bogged down with doing paperwork.”*

These points at least partly reflect the study conditions, where the second assessment was a ‘mini-discussion’ used to collect information needed to complete aspects of the alternative assessment that would not be explored in detail during the first, normal WCA discussion. The second assessment discussion would probably be longer than the current WCA if it were used as the sole discussion for benefit purposes.

Claimant preference for the second assessment may also reflect that they understood it was part of study and would not affect their entitlement to ESA:

> *“Was able to have a more honest discussion about…alcohol when not under WCA assessment”*
>
> *“…. it wasn't an assessment for my benefits. But the first assessment was ok too.”*

Where claimants preferred the first assessment this was because they felt the questions were more direct or the approach more structured. Many felt there was no difference between the two discussions.

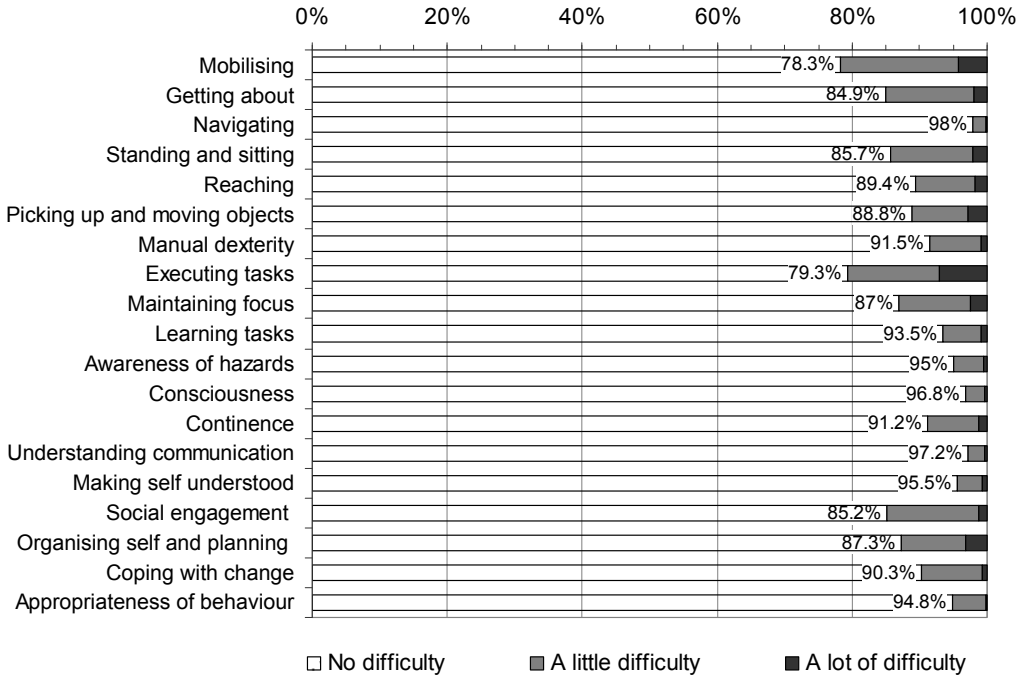
HCPs reports suggest that they found it useful to have the semi-structured interview topic guide at hand during the second assessment. In almost two thirds of cases they reported gathering useful additional information (Table 3.4).

In general, HCPs reported few difficulties with applying the WCA or AA (Figure 3E). In the vast majority of cases (90 per cent), HCPs said it was very easy or fairly easy to apply their medical judgement when choosing descriptors that applied to the claimant. In the assessment of each claimant, HCPs were asked to report whether they had any issues with applying the WCA overall, and any issues with apply each activity in the AA. In 13 per cent cases, HCPs reported some issues with applying the WCA; in 57 per cent of

cases HCPs reported some issues with applying any activity in the AA. Where they did report difficulties with the AA, this was most likely for activities on *Mobilising, Executing tasks, Getting about and Social engagement* – HCPs reported a little or lot of difficulty with using these activities in about 15 per cent of cases. Mostly, any difficulties with applying the activities were due to challenges with conflicting evidence or assessing fluctuation (Table 3.5).

Figure 3E HCP reports on whether difficulty with assessing activities in the AA

Base: All claimants (N=600)



For example, difficulties with assessing *Mobilising* for some claimants were due to difficulties reconciling different sources of information which indicated the variability in a claimant's capabilities:

> *"…With the mobility [activity] I found it hard to work out which descriptors applied and what frequency was appropriate. Felt I could not convert her typical day to match with the multi-dimensional scope."*
>
> *"He was not able to quantify a lot of his variability. He can walk the short distance to the local shop but due to pain and dizziness he has to go very slowly. He can use the stairs but finds this hard. He can walk about the supermarket sometimes but then other times he has to leave due to dizziness. I found it hard to decide what to apply here. He is on strong pain killers. While he states he has about three bad days a week with pain - the variability in his abilities does not always fit in to this."*
>
> *"Difficulty assessing the [claimant's] situation and…variability. She can drive a car, however only once a week - this uses all limbs. She walks slower [than other people], however gets around the supermarket once*

a week. She lives independently…However condition is significant. It was all very difficult to get a reasonable picture of ability that addressed good and bad days."

As can be seen, a range of factors affected HCPs' application of the assessment, which in addition to the challenge of appraising conflicting evidence and assessing fluctuation, included difficulty with eliciting evidence from claimants.

Tables

Table 3.1: Distribution of total points scored in each assessment

Number of points	**Assessment**		
	WCA	AA (17 activities)	AA (19 activities)
	%	**%**	**%**
0 points	60.7	32.2	31.3
3 to 6 points	13.0	12.7	11.8
9 points	2.3	7.3	6.5
12 points	4.3	7.5	6.2
15 points	5.7	6.5	7.3
18 to 29 points	11.2	18	16.5
30+ points	2.8	15.8	20.3
Total scoring 15+ points	19.7	40.3	44.1

Base: All claimants. N= 600

Table 3.2 Distribution of scores by activity in the WCA and AA

Activity	Number of points scored										
	WCA					AA					
	0	6	9	15	Any	0	3	6	9	15	Any
Movement within a work environment											
Mobilising (%)	86.5	7.2	5.5	0.8	13.5	71.8	3.3	11.7	6.2	7.0	28.2
Getting about (%)	86.7	10.0	2.5	0.8	13.3	81.3	2.3	6.2	6.2	4.0	18.7
Navigating (%)	98.8	0.0	0.3	0.8	1.1	99.3	0.0	0.3	0.2	0.2	0.7
Movement at a work station											
Standing and sitting (%)	88.5	6.7	4.0	0.8	11.5	79.7	1.7	8.2	8.3	2.2	20.4
Reaching (%)	96.5	2.2	0.5	0.8	3.5	84.5	3.8	9.7	2.0	0.0	15.5
Picking up and moving objects (%)	98.0	1.0	0.2	0.8	2.0	85.8	5.3	2.8	3.7	2.3	14.1
Manual dexterity (%)	97.8	0.0	1.2	1.0	2.2	88.2	3.2	4.7	1.3	2.7	11.9
Task risk											
Awareness of hazards (%)	98.3	0.7	0.2	0.8	1.7	97.0	1.5	0.5	0.7	0.3	3.0
Consciousness (%)	96.8	1.2	0.0	2.0	3.2	97.2	1.5	0.3	0.8	0.2	2.8
Continence (%)	97.7	1.0	0.0	1.3	2.3	97.0	0.2	1.5	0.0	1.3	3.0
Communication											
Understanding communication (%)	98.8	0.2	0.0	1.0	1.2	87.7	1.2	3.0	3.7	4.5	12.4
Making self understood (%)	99.0	0.3	0.0	0.7	1.0	97.5	0.2	1.5	0.7	0.2	2.6
Supporting behaviours for work											0.0
Social engagement (%)	87.5	10.5	1.3	0.7	12.5	97.5	0.2	1.0	0.7	0.7	2.6
Organising self and planning (%)	94.3	4.2	0.7	0.8	5.7	81.8	3.5	8.0	5.7	1.0	18.2
Coping with change (%)	91.0	7.5	0.5	1.0	9.0	90.5	2.3	2.2	2.2	2.8	9.5
Appropriateness of behaviour (%)	96.8	0.0	1.8	1.3	3.1	88.3	2.7	5.3	2.5	1.2	11.7
Task performance (%)											
Learning tasks (%)	98.3	1.0	0.0	0.7	1.7	96.7	0.0	1.2	1.5	0.7	3.4
						76.3	7.2	5.8	10.7	0.0	23.7
						92.2	2.5	2.3	1.5	1.5	7.8

Base: All claimants. N= 600

Table 3.3. Whether difficulties indicated overall fitness for work by activity: WCA and AA compared

Activity	Difficulty indicated on activity				
	Any difficulty		Of whom, total assessment score of 15+ points		
	WCA	AA	WCA	AA (19 activities)	AA (17 activities
	%	%	%	%	%
Movement within a work environment					
Mobilising	13.5	32.8	74.1	64.0	57.9
Getting about	13.3	21.0	75.0	73.0	70.6
Navigating	1.2	0.8	[57.1]	[80.0]	[80.0]
Movement at a work station					
Standing and sitting	11.5	22.7	78.3	78.7	74.3
Reaching	3.5	18.8	[81.0]	79.6	75.2
Picking up and moving objects	2.0	15.5	[66.7]	79.6	75.3
Manual dexterity	2.2	13.5	[76.9]	76.5	74.1
Task risk					
Awareness of hazards	1.7	2.8	[50.0]	[88.2]	[88.2]
Consciousness	3.2	3.8	[63.2]	[69.6]	[69.6]
Continence	2.3	12.3	[78.6]	78.4	74.3
Communication					
Understanding communication	1.2	2.5	[57.1]	[100.0]	[93.3]
Making self understood	1.0	2.8	[50.0]	[100.0]	[100.0]
Supporting behaviours for work					
Social engagement	12.5	22.8	73.3	69.3	67.2
Organising self and planning	5.7	12.5	82.4	85.3	81.3
Coping with change	9.0	15.3	83.3	80.4	78.3
Appropriateness of behaviour	3.2	3.3	[78.9]	[90.0]	[85.0]
Task performance					
Learning tasks	1.7	3.0	[70.0]	[94.4]	[88.9]
Executing tasks		31.8		81.2	
Maintaining focus		14.0		77.4	

Base: All claimants. N= 600

[ ] Denominator less than 30 cases.

Table 3.4. HCP feedback on the process of applying assessment

To what degree did you gather additional useful information during your discussion with the claimant?

	%
No useful additional information	36.1
Some useful additional information	61.6
A great deal of useful additional information	2.3
Total	100.0
Base: N= 596	

Overall, how easy or difficult was it for you to apply your medical judgement when choosing descriptors for this case**?**

	%
Very easy	34.3
Fairly Easy	54.9
Fairly difficult	9.4
Very difficult	1.3
Base: N= 597	

Table 3.5. Main reasons for difficulty with applying activities in the AA reported by HCPs

Reason for difficulty applying activity	Activity									
	Mobilising	Getting about	Navigating	Standing and sitting	Reaching	Picking up and moving objects	Manual dexterity	Executing tasks	Maintaining focus	Learning tasks
	%	%	%	%	%	%	%	%	%	%
Assessing fluctuation	20.6	7.8	8.3	10.8	8.6	6.3	8	19	8.1	2.6
Conflicting evidence	43.7	54.4	91.7	54.2	34.5	28.1	36	14.7	31.1	28.9
Lack of evidence	5.6	6.7	:	7.2	15.5	7.8	6	10.3	16.2	23.7
Eliciting information from claimant	6.3	4.4	:	4.8	6.9	7.8	2	4.3	12.2	13.2
Interpreting the activity	1.6	5.6	:	4.8	8.6	6.3	4	9.5	12.2	13.2
Interpreting the descriptor	13.5	8.9	:	10.8	20.7	35.9	30	32.8	13.5	18.4
Choosing descriptor	4.8	10	:	6	3.4	7.8	12	7.8	2.7	:
Other	4	2.2	:	1.2	1.7	0	2	1.7	4.1	:

	Awareness of hazards	Consciousness	Continence	Understanding communication	Making self understood	Social engagement	Organising self and planning	Coping with change	Appropriateness of behaviour
	%	%	%	%	%	%	%	%	%
Assessing fluctuation	10	:	4.1	0	:	5.8	6.8	6.9	:
Conflicting evidence	40	35.3	22.4	25	29.6	64	36.5	43.1	48.4
Lack of evidence	16.7	5.9	18.4	12.5	3.7	8.1	10.8	17.2	16.1
Eliciting information from claimant	10	23.5	8.2	:	3.7	3.5	14.9	10.3	12.9
Interpreting the activity	:	11.8	8.2	18.8	3.7	3.5	5.4	8.6	:
Interpreting the descriptor	16.7	:	30.6	37.5	55.6	5.8	17.6	6.9	16.1
Choosing descriptor	6.7	17.6	6.1	6.3	3.7	8.1	5.4	3.4	3.2
Other	:	5.9	2	:	:	1.2	2.7	3.4	3.2

4 Results of the expert panel process

The expert panel process was designed to create a defensible indicator of claimant fitness for work to which the results of the AA and WCA could be compared. Claimants were generally reviewed by more than one expert panel. Expert panels rated claimants fit for work in 70 per cent of occasions. In 26 per cent of occasions panels said that the claimant was on the borderline between being fit for work and having limited capability for work. In most cases the panels believed that claimants who they had deemed fit for work, would need adjustments such as flexible working hours to help them to work. They also highlighted the complexity of claimant needs and the range of issues which might affect their employment prospects. The panels were generally confident in their opinion about claimant fitness for work, although in some cases they believed more evidence would have helped them to form an opinion.

During the expert panel process, a total 1,025 appraisals of the 600 claimants were completed. About half of claimants (49 per cent) were reviewed by two or more panels, but some claimants were only reviewed by one panel. This chapter reports the panels' opinion on claimant fitness for work, including adjustments recommended to help claimants back to work, the complexity of claimant needs, and the overall quality of process. It reports findings for all the reviews provided panels. Some claimants will be represented more than once in the data if they were seen by more than one panel and therefore the base numbers in this chapter differ from those used elsewhere in the report.

Opinion on fitness for work

In 70 per of occasions where claimant files were considered by expert panels, panels thought the claimant was fit for work overall, rather than having limited capability for work. The panels reached unanimous decisions on overall claimant fitness in 94 per cent of occasions.

About a quarter of the time (26 per cent) expert panels believed that the claimant was on the borderline between being fit for work and having limited capability for work. This borderline group encompassed those who were considered fit for work and

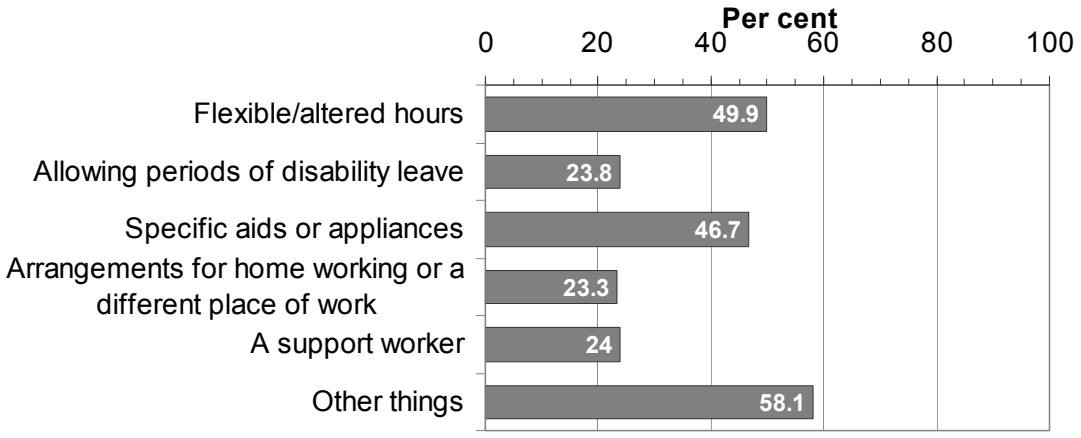
those considered to have limited capability for work. On occasions where the panel felt a case was borderline, 58 per cent were rated as more likely to be fit for work and 42 per rated as having limited capability for work.

Each panel members was also asked to indicate the degree of a claimant's fitness for work on scale of zero (completely unfit) to 10 (completely fit). They were given guidance that borderline cases should be indicated in the range four to six. The mean (average) fitness score was 6.45, within the borderline range.

Adjustments recommended

Where a claimant was considered to be fit for work, expert panels were asked to indicate whether the claimant would need adjustments to help them into work. In 83 per cent of the reviews completed by panels where they thought the claimant was fit for work, the panel also believed that the claimant would need adjustments to help them work. Most commonly, the adjustments recommended were flexible or altered hours (50 per cent) or specific aids or adaptations (47 per cent) (Figure 4.A).

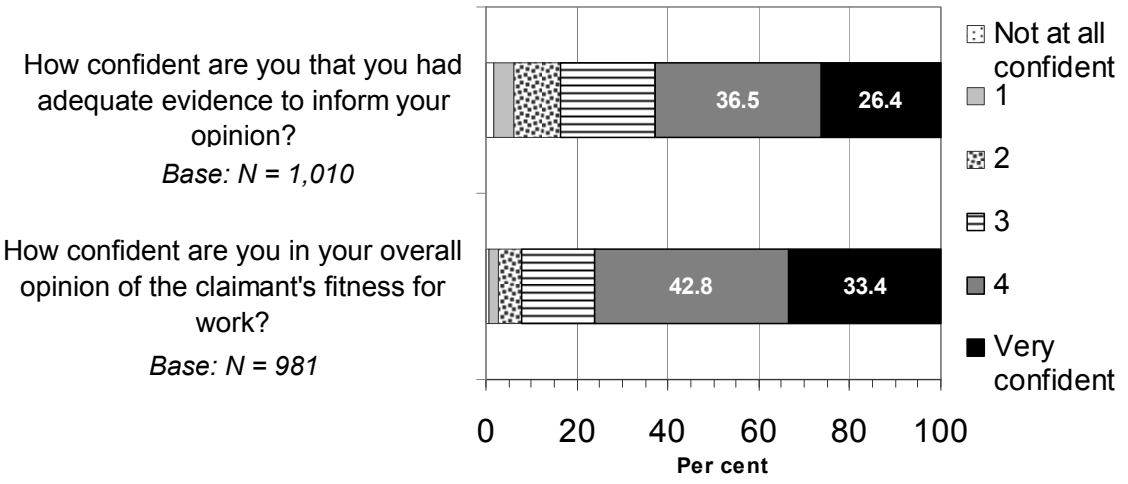
Figure 4A Adjustments recommended for claimants considered to be fit for work



Quality of panel opinion

As it was recognised that the panel process was imperfect, data were collected on the panels' confidence in their overall opinion about a claimant's fitness and whether they had adequate evidence on which to base their opinion on a scale of zero (Not at all confident) to five (Very confident) (Figure 4.B). As can be seen, in the majority of cases, panels indicated scores of four of five suggesting that they were generally confident in their opinion and that they had adequate evidence to inform it. The mean (average) ratings on confidence of evidence adequacy and overall opinion were 3.65 and 3.98 respectively.

Figure 4B Expert panel views on the quality of their opinion



Where panels reported that they would have liked more evidence, this generally related to additional medical evidence for example, the results of objective diagnostic tests. In some cases, the panels also highlighted inconsistencies between different sources of evidence, including the claimant's report of their situation, which could make the case more difficult to consider.

Claimant needs and circumstances

Panels were asked to provide a brief rationale for their overall opinion on claimant fitness. They were also asked to provide views on the types of jobs the claimant might be able to. In many cases the panels also commented on the claimant's wider support needs for work.

As we have seen, many claimants were considered able to do some work. However, there was some scepticism among panels that claimants (including those considered to have limited capability for work) would receive the support they needed to help them move into work. For example, in some instances panels queried why the claimant had not been referred for specific training, bereavement counselling, mental health services or vocational rehabilitation services.

On the other hand, in some cases, panels did not see any reason why the claimant would not be able to work, particularly if they had a condition which could be well-managed - in some cases the panels believed work would be beneficial for the claimant.

> *"In this client's self-interest to return to work as staying out of work her symptoms are likely to worsen further and her perception of herself as disabled will worsen."*

> *"Quite complex. She would need significant adjustments and support, but we feel she would be capable of some work and it would likely be beneficial to her wellbeing. Part time work would be appropriate plus support with pacing. Types of jobs-call centre, administrative, reception (with flexible, part time hours). The [health] problem would possibly require disability leave…."*

The panels sometimes highlighted problems apart from health as the limiting factors in a person's employment prospects

> *This individual needs counselling and possibly anger management, but this is separate from his ability to work.*

At the same time, in the panels' views some health problems were not being managed as effectively as they might be and could pose unnecessary limitations. For example

> *"Once again it would appear that this individual is being under- managed medically and lack of work activities is exacerbating condition."*

In many cases where the claimant was not fit for work, the panel identified a need to allow the individual to complete a course of treatment or therapy, and recover or have symptoms under control:

> *We felt the claimant is hopeful, which is a positive indicator for being fit for work in the future, with appropriate and possible ongoing support. We believe that an ESA re-assessment would be beneficial, following the course of CBT and a significant period on her new medication.*

Similarities and differences in panel opinion

Where a claimant was reviewed by more than one panel, there could be differences in opinion about the claimant's needs and overall fitness for work. The following cases studies further illustrate that range of claimants needs identified by panels and the complexity of assessing their cases.

Case study 1: Co-morbid mental health problems and substance misuse.

The claimant has low confidence and mental health problems – anxiety and depression. He is not taking any prescribed medication for these conditions, but regularly uses drugs and alcohol to cope with his anxiety. He also describes managing his anxiety by needing to plan ahead and ensure there are no surprises in his day. He has suicidal thoughts but no specific plans. He is on a waiting list for counselling.

He has [health problem] and has been referred for treatment, but is unable to commence it until he has had a month without alcohol (which he hasn't yet done). He has a problem with his right foot following a fall – gets numbness and pins and needles every few months for one or two weeks.

Panel decision and rationale

The case was considered by two panels. In Panel 1, two members found him 'borderline' and one fit for work; in Panel 2, all found him not fit for work.

Panel 1 emphasised the claimant's structured life, ability to interact with support services, and motivation to undertake training/voluntary work. They felt he would need a support worker with mental health expertise to help him get into work. The panel felt that information

from his GP on his progress in tackling his drug dependency would have been useful in making the decision.

Panel 2 emphasised the claimant's dependence on substances, the severity of his anxiety and depression, and history of mental health problems. They felt that his mental health needs should be met first, and that graded, supported voluntary work would be more beneficial for the claimant's progress.

Case study 2: Mental health problems and adjustment needs.

The claimant has anxiety and depression, which started three years ago. She has had counselling and is on medication which helps but she gets anxious at the thought of going out, and being around people she doesn't know. She stays in bed most days. However, she does see her friend three times a week, and manages to go out to attend appointments or get food.

She has arthritis in both legs. Standing and walking makes condition worse, but can manage a 10-15 minutes walk to the shops. The severity of her symptoms fluctuates and she is on medication for pain.

She has abdominal problems and experiences pain and minor incontinence.

Panel opinion and rationale

The case was considered by two panels. Both considered the claimant fit for work - her conditions and pain seemed well-managed, and would not affect her functioning. However, both panels highlighted that she would need adjustments: periods of disability leave, and either flexible or home working arrangements. The panels noted that the adjustments she would need are significant, but that she would be capable of *some* work if these adjustments were available, and that work would be good for her wellbeing.

Case study 3: Back pain

The claimant experienced the onset of lower back pain some months ago. Has had specialist investigations and assessment but his condition is worsening. He attends a specialist pain management clinic.

The pain is worsened by sitting or trying to walk. It has curtailed all of his hobbies - walking the dog and playing sports. Has had to stop working as a bus driver and his partner has to manage most of the household activities. He takes significant pain relieving medication regularly and his pain relieving options are reviewed regularly.

He has been diagnosed with diabetes. This is monitored and treated by his GP with standard medication and reports no functional problems as a result of diabetes.

Panel opinion and rationale

The case was considered by two panels. Both considered the claimant not fit for work. The panels noted that the functional effect of the high level of pain experienced by the claimant would prohibit work at this stage. However, they believed the claimant should be reassessed within six months, once his course of specialist treatment had been completed.

5 The correspondence between expert panel opinion and assessment outcomes

The chapter considers the validity of the WCA and AA by looking at the extent to which the outcomes of each assessment corresponded with expert panel opinion on claimants' fitness for work. Overall, the WCA corresponded more closely with expert panel ratings of fitness for work than the AA, and performed better on a number of indicators of validity. However, the AA was better at identifying those claimants who expert panels considered to have limited capability for work.

Measures

To examine the validity of each assessment, commonly used medical statistics were calculated. With this approach the purpose of assessment is to identify claimants who have limited capability for work (not fit for work) and the assumption is that expert panel opinion is the 'true' indicator of whether someone is not fit. In this case, for each assessment a 'true positive' case is someone found to be not fit with the assessment that was also not fit in expert panel opinion (Table 5.1). In these calculations the indicator of expert panel opinion used was based on the mean (average) scores on claimant fitness that were provided by each panel member. Scores of five or more were used to indicate that the claimant was fit.

Several measures are used to take into account the limitations of the expert panel process where panel members had to base judgement solely on paper-based evidence about the claimant.

Table 5.1: Groups used in calculations of sensitivity, specificity, positive predictive value and negative predictive value

Assessment	Expert panel opinion	
	Not fit	Fit
Not fit	True positive	False positive
Fit	False negative	True negative

Five measures were calculated:

- **Agreement or accuracy** measures extent to which the outcomes of assessments corresponded with expert panel opinion overall. Calculation: *True positives + True negatives / (Total cases)* Agreement can also be calculated where there a more than two outcome categories.
- **Sensitivity** is the ability of the assessment to correctly identify people who are not fit for work. It is the probability that the number of points scored on an assessment is 15 or more when the expert panel rated the claimant as not fit. Calculation: *True positives / (True positives+ False negatives)*
- **Specificity** is the ability of the assessment to correctly classify people as 'fit for work'. It is the probability that less than 15 points were scored on the assessment when the expert panels considered the individual to be fit. Calculation: *True negatives / (True negative+ False positives)*
- **Positive predictive value** is the proportion of claimants found to be not fit with an assessment who are actually not fit (in the opinion of expert panels). Calculation: *True positive / (True positive + False positive)*
- **Negative predictive value** is the proportion of claimants found to be fit with an assessment who are actually fit (as indicated by the opinion of experts). Calculation: *True negative / (True negative + False negative).*

Results

Table 5.2 shows the correspondence between expert panel opinion on claimant fitness for the WCA and AA respectively. The WCA corresponded more closely with expert panel opinion across a range of indicators than did the AA (Table 5.3). The agreement of the WCA with expert panel opinion was 77 per cent and, for the full AA, 65 per cent - in these cases, the fitness for work outcome in the assessment and from the expert panels matched. When fitness for work was considered in more than two categories, the level of agreement between each assessment and expert panel opinion was much lower. However it was still higher for the WCA than for the AA (Table 5.4).

The WCA also had much higher specificity (87 per cent compared with 68 per cent for the AA comprised of 17 activities, and 63 per cent for the full AA). This means that considering claimants which panels deemed fit, in the vast majority of cases, points scored on the WCA also suggested that the claimant was fit. This was less likely to be the case with the AA.

Both assessments had high negative predictive value (84 per cent for WCA, 89 per cent for the full AA). This indicates that in the vast majority of cases where claimants were considered to be fit for work, the expert panel also suggested this was the case. However, both assessments performed relatively poorly when their positive predictive value was considered: 49 per cent for the WCA and 36 per cent for the full AA. In practice, this means that many of the cases deemed to have limited capability for work by the

assessments, were in fact considered to be fit for work by expert panels.

When the sensitivity of assessments was considered the WCA performed worse (44 per cent) than the AA (89 per cent). The sensitivity rates indicate that in cases where the expert panel considered the claimant to have limited capability for work, points scored on the WCA were much less likely to reach this threshold compared with the AA.

Tables

Table 5.2: Correspondence with expert panel opinion: WCA and AA compared

Assessment	Expert panel opinion		
	Not fit	Fit	All
Frequencies			
WCA			
Not fit	56	58	114
Fit	70	376	446
All	126	434	560
AA (17activities)			
Not fit	88	141	229
Fit	38	293	331
All	126	434	560
AA (19 activities)			
Not fit	91	160	251
Fit	35	274	309
All	126	434	560
Row %			
WCA			
Not fit	49.1	50.9	100.0
Fit	15.7	84.3	100.0
All	22.5	77.5	100.0
AA (17activities)			
Not fit	38.4	61.6	100.0
Fit	11.5	88.5	100.0
All	22.5	77.5	100.0
AA (19 activities)			
Not fit	36.3	63.7	100.0
Fit	11.3	88.7	100.0
All	22.5	77.5	100.0
Column %			
WCA			
Not fit	44.4	13.4	20.4

Assessment	Expert panel opinion		
	Not fit	Fit	All
Fit	55.6	86.6	79.6
All	100.0	100.0	100.0
AA (17activities)			
Not fit	69.8	32.5	40.9
Fit	30.2	67.5	59.1
All	100.0	100.0	100.0
AA (19 activities)			
Not fit	72.2	36.9	44.8
Fit	27.8	63.1	55.2
All	100.0	100.0	100.0

Base: N= 560.

Table 5.3: Indicators of assessment validity: WCA and AA compared

	WCA	AA (17 activities)	AA (19 activities)
	%	%	%
Agreement	77.1	68.0	65.2
Specificity	86.6	67.5	63.1
Sensitivity	44.4	69.8	72.2
Positive predictive value	49.1	38.4	36.3
Negative predictive value	84.3	88.5	88.7

Base: N= 560.

Table 5.4 Agreement between different bands of limitation indicated by assessments and expert panel opinion

	%
Three bands of limitation†	
WCA	54.4
AA (19 activities)	40.4
AA (17 activities)	38.7
Four bands of limitation‡	
WCA	44.1
AA (19 activities)	33.6
AA (17 activities)	32.5

Base: N= 560.

† Three bands in the WCA and AA were created by grouping the following ranges of scores Band 1 (0 points); Band 2 (3 to 14 points); Band 3 (15+ points). Expert panel scores were based on the following ranges: Band 1 (8 to 10); Band 2 (6 to 7) Band 3 (3 to 5); Band 4 (0 to 4).

‡ Four bands in the WCA and AA were created by grouping the following ranges of scores Band 1 (0 points) Band 2 (3 to 14 points) Band 3 (15 to 18 points) Band 4 (19+ points). Expert panel scores were based on the following ranges: Band 1 (7 to 10); Band 2 (4 to 6) Band 3 (0 to 3).

6 The internal consistency of assessments

This chapter examines the reliability of the WCA and AA using Cronbach's alpha statistic and varying scoring approach used for the AA to see whether this makes any difference to results. The WCA was found to produce more consistent results overall with this analysis.

Measures

Cronbach's alpha is a coefficient of internal consistency and looks at the extent to which the items (or activities) measure the same thing. Alpha can range between zero and one and a common rule of thumb applied is that an alpha above 0.6 is 'acceptable'.

For both assessments, to calculate Cronbach's alpha, scores for activities had to be recoded. Four-point or five-point rating scales were used for each activity (scales of 1 to 4 and 1 to 5 respectively) and summed to give a total assessment score. The AA scores were coded in a variety of ways. The methods included:

- Combining scores of 0 and 3 into a single category (category 1 in a four-point scale)
- Combining scores of 3 and 6 into a single category (category 2 in a four-point scale)
- Combining scores of 6 and 9 into a single category (category 3 in a four-point scale)
- Combining scores of 9 and 15 into a single category (category 4 in a four-point scale)
- An interpretive method. Two researchers independently grouped the scores for each activity into four groups by interpreting the limitations and dimensions covered in the activity. Any inconsistencies were discussed and final scoring method agreed for each activity (Annex 6).

Results

The WCA had the higher internal consistency than the AA, with a Cronbach's alpha of .942, which is 'excellent' in many rules of thumb on interpretation (Table 1). The internal consistency of the AA was moderate and somewhat higher when all 19 activities were considered (alpha=.670) than when only the 17 activities comparable to the WCA were used (alpha= .567). Other methods for coding scores on the AA

yielded similar results, with the best results achieved when the interpretive method was used.

Tables

Table 6.1: Internal consistency of each assessment (Cronbach's alpha)

	α
WCA	.942
AA (19 activities)	.670
AA (17 activities)	.567

Base: N= 600.

Table 6.2: Internal consistency of the alternative assessment using different methods to create a four-point scale

Note: the scoring scale for the alternative assessment is a 5-point scale with following scores: 0, 3, 6, 9, 15.

	Full AA (19 activities)	AA (17 activities)
	α	α
Scores of 0 and 3 combined	.588	.544
Scores of 3 and 6 combined	.622	.572
Scores of 6 and 9 combined	.608	.559
Scores of 9 and 15 combined	.614	.566
Interpretive method	.643	.584

Base: N= 600.

7 Discussion and conclusion

How did the assessments work when applied to claimants?

With the WCA, claimants were less likely to meet the points threshold for being considered as having limited capability for work. Claimants were also less likely to be awarded points for a given activity in the WCA but this varied considerably by activity. For some activities where the rate of claimants with some limitation was very low on both assessments, there may be limited to scope to refine the assessment of these areas through descriptors. This applied to activities on *Consciousness, Continence and Making self understood*, which address impairments or conditions which are relatively rare among ESA claimants but could have significant implications for work capability.

The AA was better at detecting limitations with a specific area of functioning, even if they were relatively moderate and would not be considered to affect work capability in themselves. However, in practice there could be challenges with applying specific activities in the AA. This was particularly the case for the activity on *Mobilising* where claimants were most likely to receive points, and where HCPs most commonly reported difficulties assessing the activity. This suggests that where in doubt, for this activity HCPs choose a descriptor indicating a higher degree of limitation. This type of approach, where one descriptor is applied differently than others could present some difficulties with equity across condition or impairment groups were the AA used to assess claimants more generally.

The study also found that the semi-structured interview approach to assessments was favoured by claimants and HCPs alike. This may be partly a reflection of the study conditions, where the semi-structured discussion was used to gather information needed to apply the AA and was therefore a short supplement to the main WCA discussion. Nonetheless, this finding suggests that a semi-structured approach may be helpful for guiding assessment discussions more generally.

To what extent did each assessment provide accurate, consistent results?

The findings suggest that, overall the WCA produced more valid and consistent outcomes than the AA. As an instrument, the WCA functions well as a coherent whole and in the large majority of cases was a valid indicator of work capability as indicated by the opinion of experts.

The AA did not perform as well as the WCA overall in terms of consistency or accuracy, although on most indicators its performance was good.

In addition, where expert panels considered a claimant to have limited capability for work, the outcome of the AA was much more likely to correspond with this view than was the WCA. This reflects the higher rates of claimants deemed ‘fit for work’ with the WCA, which contrast with the high rates found ‘not fit’ with the AA. These classifications are a function of the scoring approach used in each assessment, which could be varied, which could increase the sensitivity of the WCA for instance.

Interpreting the results

The study was an exercise in applied policy analysis – it was done with finite resources and with a commitment to producing timely results. As such the process had to be approached in a practical way. The overall strengths and limitations of the approach pursued should be borne in mind when interpreting the results.

Strengths

This study is the first detailed study of the assessment for ESA which has examined how it works when applied to a large group of real claimants.

The process used was transparent and has involved a considerable degree of contribution from specialist disability representative groups

The method used was innovative and provides a basis for future work on developing and testing assessments for sickness benefits. It was a mixed methods study that attempted to create a rounded picture of how the assessments are applied.

Limitations

The expert panel process used to create a reference point on work-related functionality was an important part of the study, but had some limitations. The study assumes that expert panel opinion is a ‘true’ indicator of claimant fitness to give some indication of how each assessment performs. While some quality assurance of the process was undertaken the standard itself could not be validated scientifically. In practice the expert panel process is not a substitute for the type of systematic assessment that is used in benefit assessment and there is likely to be some misclassification in the ratings they provided.

It was not possible to pilot the AA before the study. This may have affected the results as it was not possible to give HCPs feedback on the process of applying the assessment.

The application of the WCA in the study may not be entirely representative of business as usual. In normal practice, HCPs would not have the additional time that was made available in the semi-structured interview designed for the AA.

Conclusion

This study looked at the way in which assessments of work capability perform in practice. It is one of the first major studies to examine the detailed design of functional assessments for work in a welfare system, and illustrates the complexity of

the task. Most claimants had multiple health problems and many faced other challenges which could affect their employment chances.

There was no evidence that the AA was a significant improvement on the WCA in terms of the accuracy or reliability of findings. However, the AA did reveal some areas – namely the way in which limitations and their fluctuations are noted, and the style of assessment discussion – which have relevance for ongoing refinement of the WCA.

8 Annexes

Annex 1: The Work Capability Assessment (WCA)

Background

The Work Capability Assessment (WCA) was developed in consultation with medical and other experts, including representative groups and was introduced in October 2008 to assess entitlement to Employment and Support Allowance (ESA).

The WCA considers an individual's ability in various "activities" relating to lower limb function, upper limb function, sensory function, continence, consciousness and mental function.

The assessment is based on "descriptors" in these areas. There are 17 descriptors; ten relate to physical function and seven relate to mental function. These descriptors are defined in the legislation and "describe" a restriction in an activity – for example "Cannot single-handedly use a suitable keyboard or mouse". The descriptors are presented in a hierarchical manner and attract various points.

The descriptor representing the most severe level of disability is at the top in each activity. This highest descriptor will attract 15 points meaning the person will be considered as having limited capability for work. In many of the situations, this will also mean the restriction is so severe that the person would also be considered as having limited capability for work related activity.

Within the WCA, there are two assessments:

- **Limited Capability for Work Assessment (LCW).** This aims to identify those people who currently have a limited capability for work but who would benefit from assistance and support with work and health related activity to maximise their full potential.
- **Limited Capability for Work Related Activity (LCWRA).** This assessment aims to identify the most severely disabled where interaction with work related activity is not required.

Limited Capability for Work Descriptors

Descriptors and scores for each physical activity

Mobilising unaided by another person with or without a walking stick, manual wheelchair or other aid if such aid is normally, or could reasonably be worn or used.	
Descriptor	**Points**
(a) Cannot either: (i) mobilise more than 50 metres on level ground without stopping in order to avoid significant discomfort or exhaustion; or (ii) repeatedly mobilise 50 metres within a reasonable timescale because of significant discomfort or exhaustion.	**15**
(b) Cannot mount or descend two steps unaided by another person even with the support of a handrail.	**9**
(c) Cannot either: (i) mobilise more than 100 metres on level ground without stopping in order to avoid significant discomfort or exhaustion; or (ii) repeatedly mobilise 100 metres within a reasonable timescale because of significant discomfort or exhaustion.	**9**
(d) Cannot either: (i) mobilise more than 200 metres on level ground without stopping in order to avoid significant discomfort or exhaustion; or (ii) repeatedly mobilise 200 metres within a reasonable timescale because of significant discomfort or exhaustion.	**6**
(e) None of the above apply	**0**

2. Standing and sitting.	
Descriptor	**Points**
(a) Cannot move between one seated position and another seated position located next to one another without receiving physical assistance from another person.	**15**
(b) Cannot, for the majority of the time, remain at a work station either: (i) standing unassisted by another person (even if free to move around); or (ii) sitting (even in an adjustable chair) or (iii) a combination of (i) and (ii). for more than 30 minutes, before needing to move away in order to avoid significant discomfort or exhaustion.	**9**
(c) Cannot, for the majority of the time, remain at a work station, either: (i) standing unassisted by another person (even if free to move around); or (ii) sitting (even in an adjustable chair); or (iii) a combination of (i) and (ii); for more than an hour, before needing to move away in order to avoid significant discomfort or exhaustion.	**6**
(d) None of the above apply	**0**
3. Reaching.	
Descriptor	**Points**
(a) Cannot raise either arm as if to put something in the top pocket of a coat or jacket.	**15**
(b) Cannot raise either arm to top of head as if to put on a hat.	**9**
(c) Cannot raise either arm above head height as if to reach for something.	**6**
(d) None of the above apply.	**0**

4. Picking up and moving or transferring by the use of the upper body and arms.	
Descriptor	**Points**
(a) Cannot pick up and move a 0.5 litre carton full of liquid.	**15**
(b) Cannot pick up and move a one litre carton full of liquid.	**9**
(c) Cannot transfer a light but bulky object such as an empty cardboard box.	**6**
(d) None of the above apply.	**0**
5. Manual dexterity.	
Descriptor	**Points**
(a) Cannot either: (i) press a button, such as a telephone keypad; or (ii) turn the pages of a book with either hand.	**15**
(b) Cannot pick up a £1 coin or equivalent with either hand.	**15**
(c) Cannot use a pen or pencil to make a meaningful mark.	**9**
(d) Cannot single-handedly use a suitable keyboard or mouse.	**9**
(e) None of the above apply.	**0**
6. Making self understood through speaking, writing, typing, or other means which are normally or could reasonably be, used, unaided by another person.	
Descriptor	**Points**
(a) Cannot convey a simple message, such as the presence of a hazard.	**15**
(b) Has significant difficulty conveying a simple message to strangers.	**15**
(c) Has some difficulty conveying a simple message to strangers.	**6**

(d) None of the above apply.	**0**

7. Understanding communication by

(i) verbal means (such as hearing or lip reading) alone,

(ii) nonverbal means (such as reading 16 point print or Braille) alone, or

(iii) a combination of (i) and (ii),

using any aid that is normally, or could reasonably be used, unaided by another person.

Descriptor	**Points**
(a) Cannot understand a simple message due to sensory impairment, such as the location of a fire escape.	**15**
(b) Has significant difficulty understanding a simple message from a stranger due to sensory impairment.	**15**
(c) Has some difficulty understanding a simple message from a stranger due to sensory impairment.	**6**
(d) None of the above apply.	**0**

8. Navigation and maintaining safety, using a guide dog or other aid if either or both are normally, or could reasonably be, used.

Descriptor	**Points**
(a) Unable to navigate around familiar surroundings, without being accompanied by another person, due to sensory impairment.	**15**
(b) Cannot safely complete a potentially hazardous task such as crossing the road, without being accompanied by another person, due to sensory impairment.	**15**
(c) Unable to navigate around unfamiliar surroundings, without being accompanied by another person, due to sensory impairment.	**9**
(d) None of the above apply.	**0**

9. Absence or loss of control whilst conscious leading to extensive evacuation of the bowel and/or bladder, other than enuresis (bed-wetting), despite the wearing or use of any aids or adaptations which are normally, or could reasonably be, worn or used.	
Descriptor	**Points**
(a) At least once a month experiences: (i) loss of control leading to extensive evacuation of the bowel and/or voiding of the bladder; or (ii) substantial leakage of the contents of a collecting device sufficient to require cleaning and a change in clothing.	**15**
(b) The majority of the time is at risk of loss of control leading to extensive evacuation of the bowel and/or voiding of the bladder, sufficient to require cleaning and a change in clothing, if not able to reach a toilet quickly.	**6**
(c) None of the above apply.	**0**
10. Consciousness during waking moments.	
Descriptor	**Points**
(a) At least once a week, has an involuntary episode of lost or altered consciousness resulting in significantly disrupted awareness or concentration.	**15**
(b) At least once a month, has an involuntary episode of lost or altered consciousness resulting in significantly disrupted awareness or concentration.	**6**
(c) None of the above apply.	**0**

Descriptors and scores for each mental, cognitive and intellectual function assessment

11. Learning tasks.	
Descriptor	**Points**
(a) Cannot learn how to complete a simple task, such as setting an alarm clock.	**15**
(b) Cannot learn anything beyond a simple task, such as setting an alarm clock.	**9**
(c) Cannot learn anything beyond a moderately complex task, such as the steps involved in operating a washing machine to clean clothes.	**6**
(d) None of the above apply.	**0**
12. Awareness of everyday hazards (such as boiling water or sharp objects).	
Descriptor	**Points**
(a) Reduced awareness of everyday hazards leads to a significant risk of: (i) injury to self or others; or (ii) damage to property or possessions such that they require supervision for the majority of the time to maintain safety.	**15**
(b) Reduced awareness of everyday hazards leads to a significant risk of: (i) injury to self or others; or (ii) damage to property or possessions such that they frequently require supervision to maintain safety.	**9**
(c) Reduced awareness of everyday hazards leads to a significant risk of: (i) injury to self or others; or (ii) damage to property or possessions such that they occasionally require supervision to maintain safety.	**6**
(d) None of the above apply.	**0**

13. Initiating and completing personal action (which means planning, organisation, problem solving, prioritising or switching tasks).	
Descriptor	**Points**
(a) Cannot, due to impaired mental function, reliably initiate or complete at least 2 sequential personal actions.	**15**
(b) Cannot, due to impaired mental function, reliably initiate or complete at least 2 personal actions for the majority of the time.	**9**
(c) Frequently cannot, due to impaired mental function, reliably initiate or complete at least 2 personal actions.	**6**
(d) None of the above apply	**0**
14. Coping with change.	
Descriptor	**Points**
(a) Cannot cope with any change to the extent that day to day life cannot be managed.	**15**
(b) Cannot cope with minor planned change (such as a pre-arranged change to the routine time scheduled for a lunch break), to the extent that overall day to day life is made significantly more difficult.	**9**
(c) Cannot cope with minor unplanned change (such as the timing of an appointment on the day it is due to occur), to the extent that overall, day to day life is made significantly more difficult.	**6**
(d) None of the above apply.	**0**
15. Getting about.	
Descriptor	**Points**
(a) Cannot get to any place outside the claimant's home with which the claimant is familiar.	**15**
(b) Is unable to get to a specified place with which the claimant is familiar, without being accompanied by another person.	**9**

(c) Is unable to get to a specified place with which the claimant is unfamiliar without being accompanied by another person.	**6**
(d) None of the above apply.	**0**

16. Coping with social engagement due to cognitive impairment or mental disorder.

Descriptor	**Points**
(a) Engagement in social contact is always precluded due to difficulty relating to others or significant distress experienced by the individual.	**15**
(b) Engagement in social contact with someone unfamiliar to the claimant is always precluded due to difficulty relating to others or significant distress experienced by the individual.	**9**
(c) Engagement in social contact with someone unfamiliar to the claimant is not possible for the majority of the time due to difficulty relating to others or significant distress experienced by the individual.	**6**
(d) None of the above apply.	**0**

17. Appropriateness of behaviour with other people, due to cognitive impairment or mental disorder.

Descriptor	**Points**
(a) Has, on a daily basis, uncontrollable episodes of aggressive or disinhibited behaviour that would be unreasonable in any workplace.	**15**
(b) Frequently has uncontrollable episodes of aggressive or disinhibited behaviour that would be unreasonable in any workplace.	**15**
(c) Occasionally has uncontrollable episodes of aggressive or disinhibited behaviour that would be unreasonable in any workplace.	**9**
(d) None of the above apply.	**0**

Annex 2: The Alternative Assessment (AA)

Overview of approach

The assessment is comprised of 19 activities. Each activity is comprised of a number of descriptors which can be rated on a scale of frequency. This provides a scoring matrix for each activity with points set for each cell of the matrix.

There are bands of points within each activity matrix. Assessors may choose a number of cells within a matrix (by selecting a frequency for each descriptor) but they not have to do this.

The highest points selected within a given activity matrix will be selected for that activity. '15*' is used to indicate Support Group descriptors.

The total assessment score is simply the sum of points for the 19 activities. Total assessment scores could therefore range from 0 points to 285 points.

The activities

Movement - within a work environment or travelling to work

1. Mobilising (Physical)

Mobilising reliably, repeatedly, safely and in a timely manner, unaided by another person, with or without a walking stick, manual wheelchair or other aid normally used, indoors and outdoors without stopping, and climbing and descending a flight of 12 steps, without significant discomfort or exhaustion.

Descriptor	Points		
a None of the below apply	**0**		
	Occasionally	**Frequently**	**Most of the time**
b Cannot climb and descend a flight of 12 steps	**0**	**3**	**6**
c Has some difficulty mobilising, indoors and outdoors, for long periods	**0**	**3**	**6**
d Has significant difficulty mobilising, indoors and outdoors, for long periods	**3**	**6**	**9**
e Has some difficulty mobilising, indoors and outdoors, for short periods	**6**	**9**	**15**
f Has significant difficulty mobilizing, indoors and outdoors, for short periods	**9**	**15***	**15***

2. Getting About (Mental/cognitive/intellectual) Getting to familiar and unfamiliar places reliably, repeatedly, safely and in a timely manner, unaided by another person, without significant distress or disorientation.			
	Points		
a None of the below apply	**0**		
Due to distress or disorientation:	**Occasionally**	**Frequently**	**Most of the time**
b Has some difficulty getting to unfamiliar places	**0**	**3**	**6**
c Has significant difficulty getting to unfamiliar places	**3**	**6**	**9**
d Has some difficulty getting to familiar places	**6**	**9**	**9**
e Has significant difficulty getting to familiar places	**9**	**15***	**15***

3. Navigating (Sensory) Navigating around familiar and unfamiliar places without being accompanied by another person reliably, repeatedly, safely and in a timely manner, using a guide dog or other aid if normally used, without experiencing difficulty due to sensory impairment.			
	Points		
a None of the below apply	**0**		
Due to sensory impairment, without being accompanied by another person:	**Occasionally**	**Frequently**	**Most of the time**
b Has some difficulty navigating around unfamiliar surroundings	**0**	**3**	**6**
c Has significant difficulty navigating around unfamiliar surroundings	**3**	**6**	**9**
d Has some difficulty navigating around familiar surroundings	**6**	**9**	**9**
e Has significant difficulty navigating around familiar surroundings	**9**	**15***	**15***

Movement – at a work station

4. Standing and sitting (Physical)

Reliably, repeatedly, safely and in a timely manner, using any aid that it is reasonable to expect them to use, and without receiving physical assistance from another person:

- Staying in one place (such as a workstation), either by standing or sitting, and
- Moving from a seated position in a suitable chair to a mobilising position

	Points		
a None of the below apply	**0**		
Cannot reliably, repeatedly and safely, without significant discomfort or exhaustion:	**Occasionally**	**Frequently**	**Most of the time**
b Stay in one place, either by standing or sitting, unassisted by another person, for more than one hour	**0**	**3**	**6**
c Stay in one place, either by standing or sitting, unassisted by another person in, for more than 30 minutes	**6**	**9**	**9**
d Move from a seated position in a suitable chair to a mobilising position in a timely manner, without physical assistance from another person	**9**	**15***	**15***

5. Reaching (Physical)

Reaching up and down from standing or sitting, reliably, repeatedly and safely and in a timely manner, unaided by another person, and without significant discomfort or exhaustion

	Points		
a None of the below apply	**0**		
Cannot reliably, repeatedly and safely and in a timely manner, without significant discomfort or exhaustion, from standing or sitting	**Occasionally**	**Frequently**	**Most of the time**
b Reach down (through bending, kneeling or squatting from standing or sitting) with either arm as if to pick up a light object situated on a low shelf 15cm from the floor	**0**	**3**	**6**
c Raise either arm above head height as if to pick up an object on a high shelf	**0**	**3**	**6**
d Raise either arm to top of head as it to put on a hat	**3**	**6**	**9**
e Raise either arm as if to put something in the top pocket of a coat or jacket	**9**	**15***	**15***

6. Picking up and moving (Physical)

Picking up and moving objects of a variety of sizes with one or both hands reliably, repeatedly, safely and in a timely manner, unaided by another person, and without significant discomfort or exhaustion.

	Points		
a None of the below apply	**0**		
Cannot reliably, repeatedly and safely, without significant discomfort or exhaustion:	**Occasionally**	**Frequently**	**Most of the time**
b Pick up and move a one litre carton full of liquid at arm's length with either hand	**0**	**3**	**3**
c Pick up and move a one litre carton full of liquid with one hand	**0**	**3**	**3**
d Pick up and move a bulky object (such as a cardboard box) up to 2kg	**0**	**3**	**6**
e Pick up and move a light bulky object (such as a cardboard box) up to 1kg	**3**	**6**	**9**
f Pick up and move a one litre carton full of liquid with either hand	**9**	**9**	**15***

7. Manual dexterity/hand movement (Physical)

Managing manual dexterity tasks reliably, repeatedly, safely and in a timely manner without significant discomfort or exhaustion

	Points		
a None of the below apply	**0**		
Cannot reliably, repeatedly and safely, without significant discomfort or exhaustion:	**Occasionally**	**Frequently**	**Most of the time**
b Has some difficulty in one hand with manual dexterity tasks	**0**	**3**	**3**
c Has significant difficulty in one hand with manual dexterity tasks	**3**	**6**	**6**
d Has some difficulty in both hands with manual dexterity tasks	**6**	**9**	**15**
e Has significant difficulty in both hands with manual dexterity tasks	**9**	**15***	**15***

Task – task performance

8. Executing Tasks (Global) Executing tasks reliably, repeatedly, safely and in a timely manner, unaided by another person.			
	Points		
a None of the below apply	**0**		
Cannot reliably, repeatedly and safely, without significant discomfort or exhaustion:	**Occasionally**	**Frequently**	**Most of the time**
b Takes somewhat longer to complete some tasks	**0**	**0**	**3**
c Takes significantly longer to complete some tasks	**0**	**3**	**6**
d Takes somewhat longer to complete most tasks	**3**	**6**	**9**
e Takes significantly longer to complete most tasks	**6**	**9**	**9**

9. Maintaining Focus (Global) Maintaining focus reliably, repeatedly and safely, unaided by another person, to complete tasks in a timely manner.			
	Points		
a None of the below apply	**0**		
Due to poor memory or concentration, disorganised thoughts or anxiety:	**Occasionally**	**Frequently**	**Most of the time**
b Has difficulty maintaining focus on some tasks	**0**	**3**	**6**
c Has difficulty maintaining focus on most tasks	**6**	**9**	**15**

10. Learning Tasks (Mental/cognitive/intellectual) Learning new tasks in order to undertake them reliably, repeatedly and safely, without support from another			
	Points		
a None of the below apply	**0**		
	Complex tasks	**Moderately complex tasks**	**Simple tasks**
b Has some difficulty learning new tasks	**3**	**3**	**6**
c Has significant difficulty learning new tasks	**6**	**9**	**15**
d Cannot learn new tasks within a reasonable timeframe	**9**	**15***	**15***

Task - risk

11. Awareness of Hazards (Global)

Being aware of hazards in order to avoid risk(s) of harm to self or others, or of damage to property or possessions.

	Points		
a None of the below apply	**0**		
	Occasionally	**Frequently**	**Most of the time**
b Some reduced awareness of hazards leads to risk(s) of harm to self or others, or of damage to property or possessions	**3**	**6**	**9**
d Significantly reduced awareness of hazards leads to risk(s) of harm to self or others, or of damage to property or possessions	**9**	**15***	**15***

12. Consciousness (Physical)

Maintaining consciousness during waking hours reliably.

	Points		
a None of the below apply	**0**		
	At least twice in last 6 months	**At least once a month over the last 6 months**	**At least once a week**
b Has an involuntary episode of lost or altered consciousness resulting in significant disrupted awareness or concentration, with a recovery time that is normally less than **one hour**	**0**	**6**	**15**
d Has an involuntary episode of lost or altered consciousness resulting in significant disrupted awareness or concentration, with a recovery time that is normally **more than one hour**	**3**	**9**	**15***

13. Bladder/ bowel continence (Physical)

Managing and maintaining effective control of bowel, bladder and/or a collecting device reliably, repeatedly and safely.

	Points		
a None of the below apply	**0**		
	Occasionally	**Frequently**	**Most of the time**
b Experiences an unusually urgent and/or frequent need to use the toilet (or manage a collecting device), due to an underlying health condition or the side effects of essential medication	**3**	**6**	**9**
c Without immediate urgent access to a toilet, suitably modified where appropriate, would experience loss of control	**6**	**9**	**15**
d Has experienced unpredictable or recurrent loss of control	**15**	**15***	**15***

Communication

14. Understanding communication (Global)

Understanding communication from a stranger reliably, repeatedly, safely and in a timely manner, by both verbal means (such as hearing or lip reading), non-verbal means (such as intonation or body language) *and* written means (such as reading 16 point print), using any aid(s) normally used.

	Points		
a None of the below apply	**0**		
Due to sensory, cognitive or social difficulties:	**Occasionally**	**Frequently**	**Most of the time**
b Has some difficulty understanding complex information from a stranger	**0**	**3**	**6**
c Has significant difficulty understanding complex information from a stranger	**3**	**6**	**9**
d Has some difficulty understanding basic information from a stranger	**6**	**9**	**9**
e Has significant difficulty understanding basic information from a stranger	**9**	**15***	**15***

15. Making self understood (Global)

Making self understood reliably, repeatedly, safely and in a timely manner to a stranger through speaking, writing, typing, or other means normally used, and using any aid(s) normally used, unaided by another person.

	Points		
a None of the below apply	**0**		
Due to sensory, cognitive or social difficulties:	**Occasionally**	**Frequently**	**Most of the time**
b Has some difficulty conveying complex information to strangers	**0**	**3**	**6**
c Has significant difficulty conveying complex information to strangers	**3**	**6**	**9**
d Has some difficulty conveying basic information to strangers	**6**	**9**	**15**
e Has significant difficulty conveying basic information to strangers	**9**	**15***	**15***

Supporting behaviours for work

16. Social Engagement (Mental/cognitive/intellectual)

Engaging socially with people known and unknown, reliably, repeatedly and safely, unaided by another person.

	Points		
a None of the below apply	**0**		
Because of difficulties interacting with others, anxiety, distress or lack of social understanding::	**Occasionally**	**Frequently**	**Most of the time**
b Has some difficulty with social engagement with strangers	**0**	**3**	**6**
c Has significant difficulty with social engagement with strangers	**6**	**9**	**9**
d Has some difficulty with social engagement with people known to the person	**6**	**9**	**15**
e Has significant difficulty with social engagement with people known to the person	**9**	**15***	**15***

17. Organising self and planning (Mental/cognitive/intellectual)

Organising self and planning throughout the day, reliably, repeatedly, safely and in a timely manner, unaided by another person.

	Points		
a None of the below apply	**0**		
	Occasionally	**Frequently**	**Most of the time**
b Has some difficulty organising self and planning to an acceptable standard for much of the day	**0**	**3**	**6**
c Has significant difficulty organising self and planning to an acceptable standard for much of the day	**3**	**6**	**9**
d Has some difficulty organising self and planning to an acceptable standard for short periods	**6**	**9**	**15**
e Has significant difficulty organising self and planning to an acceptable standard for short periods	**9**	**15***	**15***

18. Coping with Change (Mental/cognitive/intellectual)

Coping with planned and unplanned changes to daily routine, reliably, repeatedly and safely, unaided by another person.

	Points		
a None of the below apply	**0**		
	Occasionally	**Frequently**	**Most of the time**
b Experiences some difficulties with unplanned changes to daily routine.	**0**	**3**	**6**
c Experiences significant difficulties with unplanned changes to daily routine.	**3**	**6**	**9**
d Experiences some difficulties with planned changes to daily routine.	**6**	**9**	**9**
e Experiences significant difficulties with planned changes to daily routine.	**9**	**15***	**15***

19. Appropriateness of Behaviour (Mental/cognitive/intellectual)

Displaying appropriate behaviour in the workplace reliably, repeatedly and safely without support from another person.

	Points		
a None of the below apply	**0**		
	Occasionally	**Frequently**	**Most of the time**
b May display moderate verbally aggressive or socially inappropriate behaviour	**6**	**9**	**9**
c May display severe verbally aggressive or socially inappropriate behaviour	**15**	**15***	**15***
d May display physically aggressive behaviour	**15***	**15***	**15***

Annex 3: Developing a semi-structured interview topic guide for the Alternative Assessment

By Fiona Fylan and Beth Fylan Gwynn and Lauren Caveney, Brainbox Research

Background

The Work Capability Assessment (WCA) is an assessment of a person's functional capability for work and work-related activity used to assess entitlement to Employment and Support Allowance (ESA). The WCA comprises a series of descriptors that classify people according to how well they can complete different functions relevant to the workplace, such as picking up and moving objects, learning new tasks, behaving appropriately with other people, and making oneself understood. The healthcare professional (HCP) conducting the assessment draws on a number of sources of evidence when making their assessment, including forms completed by claimants, medical evidence provided by GPs and other healthcare professionals, and information provided by the claimant during their face-to-face assessment. The assessment typically takes place at a Medical Examination Centre, run by Atos Healthcare. The HCP critically appraises all available evidence on the claimant's fitness for work and provides a recommendation on whether a return to work could be considered, and if so, over what time period. DWP Decision Makers use the assessment to decide whether the claimant is entitled to ESA.

The current assessment has been criticised by a variety of organisations who have concerns about the extent to which the WCA accurately reflects a claimant's ability to work. Specific concerns include that: an artificial distinction is made between mental and physical functioning; that the assessment does not capture the fluctuations in functioning that people with some conditions can experience; and that there is too much reliance on task-based questions rather than having a discussion with claimants about their condition and how it impacts on their ability to work.

Independent reviews of the WCA were undertaken after one, two and three years[3]. The recommendations arising from these reviews form two strands. The first concerns improving the WCA process to make assessments fairer, more effective and more transparent. The second concerns improving the descriptors used to ensure that they are fit for purpose. Two aspects of the descriptors were of particular concern: those relating to mental, cognitive and intellectual functioning; and those relating to fluctuating conditions. As a result two charity stakeholder groups were commissioned to provide recommendations for refining the descriptors used in the WCA. They worked independently on the two areas of concern. The groups reported

[3] Professor Michael Harrington (2010, 2011, 2012). An Independent Review of the Work Capability Assessment. DWP Report.

their recommendations and further work with them produced a single set of assessment descriptors that combines the recommendations of both groups.

Because both groups identified the need to discuss the claimant's condition more directly with them during their face-to-face assessment they recommended that the HCP gathers information using a semi-structured interview.

The interview schedule needs to be practical for operational purposes. It should:

- provide a flexible, efficient method of collecting information that will enable the HCP to choose between WCA descriptors;
- explore issues that are not explicitly contained within the assessment schedule but which are relevant for descriptor choice;
- include appropriate and useful prompts that will help the HCP to facilitate the discussion with claimants.

Brainbox Research was commissioned by the DWP to work with the two charity groups to provide guidance on developing the semi-structured interview topic guide to be used by HCPs when using the new WCA descriptors. This report describes the topic guide and how it was developed.

Methods

It was important that the charity groups who developed the new descriptors were central to developing the interview topic guide. This enabled them to use their insight into the descriptors and their client groups to ensure that the questions, probes and prompts in the topic guide are likely to elicit the range and depth of information required. A facilitated workshop was therefore organised during which representatives of the charity groups could develop the topic guide.

Workshop participants

All the charities in the consultation groups were invited to send a representative to the workshop. Representatives of the following organisations attended:

- Action for ME and Forward ME
- Crohn's and Colitis UK
- Mencap
- Mind
- MS Society
- National Aids Trust
- Parkinson's UK

A small number of DWP officials involved in the project attended the start of the workshop. One DWP social researcher participated throughout the workshop and contributed to developing the topic guide.

Procedure

The workshop was facilitated by two expert qualitative researchers: Fiona Fylan and Beth Fylan Gwynn. It took place on 7 December 2012 at a meeting room at DWP's Caxton House office.

Following an introduction by the DWP project lead, the facilitators reviewed issues to consider when developing a topic guide. This included:

- key features of semi-structured interviewing;
- the stages of a semi-structured interview;
- the purpose of an interview topic guide;
- developing clear questions;
- using probes and prompts.

The participants then broke into three small groups, each of which worked on a specific group of descriptors. They developed a series of draft interview questions with associated prompts. While the small groups worked independently, they sometimes asked other workshop participants for advice about different conditions and how to phrase questions so that they are relevant and easy to understand. The small groups presented their draft questions to the rest of the participants, which generated further debate about the information required to decide between the different descriptors. The presentations and discussions were audio recorded, with the permission of the workshop participants.

Following the workshop the facilitators produced a draft topic guide from the questions developed in the workshop. The few changes made to the questions developed during the workshop were around combining similar questions to remove repetition. The draft was circulated to the participants for feedback. This feedback was used to refine the topic guide. Changes made included:

- making it clear that the aim of the interview is to assess the claimant's ability to work;
- simplifying the language so that people with learning difficulties could more easily understand what they were being asked;
- asking more detailed prompts that will gain more detailed insight into the extent to which a condition would be difficult to manage at work;
- asking whether the claimant had done anything to enable them to travel to and complete the interview;
- asking about the predictability of symptoms or fluctuations;
- asking about how the claimant anticipates their condition will change in the future.

A subsequent draft, together with briefing notes, was then circulated to the charities and to Atos Healthcare for further comment. This resulted in minor changes to the wording.

Results

The outputs of this project are the semi-structured interview topic guide, briefing notes for the HCPs, and some training materials for Atos Healthcare to use when they are training HCPs to conduct the assessment interviews. The final version of the topic guide is shown at the end of this Annex.

Discussion

We believe that the approach taken to developing the topic guide was very successful. This is evidenced by the small number of changes to the draft topic guide requested by the charity stakeholders and by Atos. This section identifies what we believe to be the key aspects that contributed to successfully developing the topic guide.

- Beginning the workshop with an overview of the epistemology of qualitative research and the use of semi-structured interviews as a data collection tool meant that the workshop participants began with a shared understanding of how the interviews operate and how a small number of questions can be combined with probes and prompts to gain an in-depth understanding of the claimant's condition.
- Enabling stakeholders from charities who represent people with a range of conditions and disabilities to develop the topic guide was extremely important. The workshop participants used their in-depth understanding of how these health conditions manifest and how they can affect a person's ability to work to ensure that the topic guide questions can elicit information that allow HCPs to identify the core challenges that the people could experience when starting or returning to work. It also meant that the process was time-efficient, as the workshop participants were able to quickly identify inappropriate items or wording, which would otherwise been removed at a later date.
- The semi-structured approach for the topic guide means that the question set is shorter because questions are not condition-specific but can apply to a wide range of different conditions.
- Grouping workshop participants into teams to develop questions around the different descriptors helped to generate a set of questions that are not condition-specific but nevertheless provide information to enable the HCP to differentiate between the descriptors. This keeps the topic guide short, thereby making it easier for the HCPs to become familiar with the guide.

Involving members of DWP team meant that the DWP and the charity stakeholders developed a shared understanding of what the topic guide aims to achieve.

Commissioning independent facilitators for the workshop who were experts in developing semi-structured topic guides meant that the charities felt their input was valued, and where their suggestions for questions or wording were not adopted there was a clear and unbiased reason for doing so.

The semi-structured interview topic guide

Briefing
Now we're going to talk a bit more about your health condition or disability. Like before, we'll be talking about how you spend your days and the things that you find easy to do and the things that you find more difficult. Some of the things I ask will be similar to what you've already told us about but I'll try not to ask you to repeat yourself too much. Not all of the questions that I have will seem relevant to you and your health condition or disability but I'll try to spend more time on the ones that are more relevant. There are no right or wrong answers: I just want to understand how your health condition or disability impacts on you and your daily life. I'll use what you tell me now, alongside the things that you've put on your form and information from your GP or other health professionals, to identify how much you can and can't do and how realistic it is for you to work and travel to work or the support you would need to work in the future.

Do you have any questions for me before we start?

Introduction
First of all I want to find out about your condition and how it affects you on a daily basis. Can you tell me about it?

Prompts

- Is it always the same or does it change? If it changes: How is it today? Have you done anything specially to make it easier for you to come here today? (If yes, what, what difference has it made?). What makes it worse? What makes it better? Are there any situations in which you have more or fewer problems? If yes, tell me about them.
- If the problems you have change, how often do they change? Do you know when they are going to get worse? When they are bad, how long are they bad for? When they are better, how long are they better for? Do you think the problems will be any different in a year's time? What about in five years?

Interviewer to summarise their understanding of the condition.

Note to interviewer
There is a core set of prompts to be used for all of the questions that you use in the topic guide. These prompts will help you to distinguish between the different descriptors. They are shown below, together with the decision you need to make about how much the difficulty affects the claimant.

- How often is this difficult for you? (this can refer to how often during the day, or how often during the year, depending on how rapidly their condition fluctuates). You need to distinguish between:
    - Occasionally (more than 20% but less than half of the time);
    - Frequently (more than half but less than 75% of the time);
    - Most of the time (75% of the time or more).

- How long does it take you? (to identify whether it takes more than twice as long as others)
- Do you need any help? (to identify whether they are unable to achieve this without assistance)
- How safe do you feel? (to identify whether they would feel distress or disorientation or physically unsafe or whether this activity could exacerbate their condition or cause further problems)
- How soon afterwards would you be able to do it again? (to identify whether a rest is needed or if they could repeat things in a reasonable timescale)

Getting around

Activities covered:

1. Mobilising (physical)

2. Getting about (mental/cognitive/intellectual)

3 Navigating (sensory).

Now I want to talk to you about how you get around, both inside your house and outside.

- Tell me what you would do on a usual day. Start off by telling me about getting up in the morning and what you would normally do through the day.
- Does your condition make it more difficult for you to get about, or not? If yes, how?

If getting around might be a problem, make use of the following prompts:

- Do you have any difficulties moving around your home? What about getting up and down the stairs? A few steps? A longer staircase of 12 steps or more? (if no stairs, ask about stairs when talking about moving around outside).
- Do you go outside much? Tell me about where you go and how you get there? A short journey, for example one that lasts less than 30 minutes? A longer journey? If you were walking somewhere, how far would you get in about a minute? (Some physical difficulty is 40-60m, significant difficulty is less than 40m.) What about 10 minutes? (Some physical difficulty is 400-600m, significant difficulty is less than 400m.) Is there anything that makes journeys more difficult for you?
- Are you able to get around on your own? Tell me about how you get to places that you know? And tell me about places that you don't know? (some difficulty such as taking an unusually long time, significant difficulty is being virtually unable to make the journey without assistance).
- How do you feel when you have to get to places that you don't know? *If distressed or disoriented*, what about places that you do know?

Movement at a workstation

Activities covered:

4. Standing and sitting (physical)

5. Reaching (physical)

6. Picking up and moving (physical)

7. Manual dexterity/hand movement (physical).

Now I want to talk about how easy or difficult it is for you manage to do things while you're sitting down or standing up.

Standing and sitting

- If you are sitting down, either at home or at work, are you able to sit in one position? Could you do this for an hour? (if not, 30 minutes?, if not, what about standing?)
- Is there anything that would make this difficult for you?
- Once you're sitting down, how easy or difficult is it for you to get up again to move around? (if the claimant is in a wheelchair: can you move from a chair to a wheelchair?).

Reaching up and down

- Imagine you wanted to pick up something quite light, say this book (or similar light item), from a shelf at about this height (interviewer to demonstrate 15cm from the floor), would you be able to pick it up?
- What about reaching for things that are higher, above head height, could you do this? If no, what about things that are about head height? If no, what about things at about the height of your chest?

Picking up and moving things

- Now think about picking something up and putting it down again (interviewer to demonstrate picking up and moving something across the desk). Think about a cardboard box, say about 2kg or two packs of sugar, could you pick it up and move it from here to there (demonstrate moving something about 30cm)? If no, what about one pack of sugar? If no, what about a carton of milk?
- Could you pick up a one-pint carton of milk it up and hold it out at arms length? Can you do this with both hands?

Manual dexterity

- What about using your hands to grip things or to pick up small things. Do you have any difficulty opening a lid on a bottle or jar, or turning a door handle? What about turning a dial on something like a radio? Are you able to button or unbutton things, say on a shirt? What about tying shoe laces? Opening a door with a key? Putting money into a slot machine? What about picking up a 5p piece? Can you pick up a

pen or pencil? Can you use it to write or draw something? Can you press the keys on something like a computer or a till or a mobile phone?

Task performance

Activities covered:

8. Executing tasks (global)

9. Maintaining focus (mental/cognitive/intellectual)

10. Learning tasks (mental/cognitive/intellectual)

11. Awareness of hazards (global)

12. Consciousness (physical)

13. Bladder/bowel continence (physical).

Now I want to talk about how easy or difficult it is for you to do everyday things such as …. Interviewer to select appropriate examples provided by the claimant, drawing on work situations where possible, or use the following:

(a) Planning and buying things for a meal (complex task), and if this presents a difficulty,

(b) Taking and remembering messages (moderately complex task), and if this presents a difficulty,

(c) Putting things away (simple task).

Speed

- Say if it takes a typical person without a disability 10 minutes to do this, how long do you think it would take you? *If slower*: would you be this much slower for just this sort of task, or for all different types? Why? Is there anything that helps you do things faster? (To decide between up to or more than twice as long).

Concentration

- Does anything make it more difficult for you to concentrate on it? Do you have any difficulties in concentrating on things generally? Do you have any problems finishing the things that you start?

Learning new tasks

- Tell me about a time when you had to learn how to use something new at home. Did you have any difficulties? If yes, what help did you get?
- *If yes, interviewer to identify a situation from prior discussions that would involve learning a new task of different complexities*, *such as making a round of hot drinks for visitors, or planning and cooking a meal.* Tell me about how you did this.
- If you were to start a new job (interviewer to add an appropriate example), what sort of new things do you think you would need to learn how to do? Do you think it would be difficult for you to learn how to do them? Would anything make it easier for you? More difficult?

Awareness of hazards

- Do you sometimes get into situations in which you or other people have got hurt or nearly got hurt? Can you tell me about what happened?

Consciousness

- Do you ever have faints or fits? If yes, tell me about what happens. How long does it last? How long does it take you to recover? When do they happen? (During the day or the night or both?) How often do they happen?

Continence

- Do you have any problems with wetting or soiling yourself (leakage, if they have a stoma)? *If yes*, tell me about what happens. How often does this happen? How quickly do you need to go? When does it happen? (when you cough or sneeze, during the night, when you are asleep, when you are physically active, at unexpected times, all the time). Do you know when it is going to happen? Do you wear pads? How often do you change them? How does it interfere with your life? (e.g. need to change underwear or clothes, ability to do household chores, ability to make a 30-minute car or bus journey, ability to engage in social activities outside the home).
- *If no*, but continence is a problem for the claimant, is there anything else about needing to use the toilet that affects your life? (such as needing to go often). *If yes*, tell me about it. How often does it happen? How long does it last?

Communication

Activities covered:

14. Understanding communication (global)
15. Making self understood (global).

I want to talk now about understanding other people and making yourself understood. I want you to think about communicating with people who you don't already know. This is even when you are using any help that you have such as hearing aids, speech aids or glasses.

Understanding others

- Do you have any difficulties in understanding what strangers tell you? *If yes,* tell me about what makes this difficult for you. Is this for things they say or written things or both? Can you understand short sentences such as somebody asking you to pass them a newspaper? *If yes,* what about things that are a bit more complicated, like giving you some instructions about the people who should come to an appointment or directions for where the appointment will take place?

Making yourself understood

- Do strangers have any difficulties in understanding what you tell them? If yes, is this for things you say or write or type? Are these difficulties just for long or complicated sentences, like telling people what you did yesterday? Or even for simple things like asking somebody to help you? Can you give me an example?

What about talking to a group of people? Is there anything that makes it easier? More difficult?

Supporting work behaviours

Activities covered:

16. Social engagement (mental/cognitive/intellectual)
17. Organising self and planning (mental/cognitive/intellectual)
18. Coping with change (mental/cognitive/intellectual)
19. Appropriateness of behaviour (mental/cognitive/intellectual).

Now I want to talk to you about spending time with other people and how other people respond to you.

Engaging with others

- Can you give me an example of when you've spent time with somebody you don't know? How easy or difficult was it for you? Why? Do you always feel like that with new people?
- And what about spending time with people you know: how easy or difficult is this for you? If this is difficult: why is it difficult? How often is it difficult? Is there anything that makes it better or worse?

Appropriate behaviours

- Do other people tend to get upset or angry with you or tell you that you are behaving inappropriately? If yes, tell me about this?

Organising and planning

- Now I want to talk about how you organise and plan your day.
- You've told me about what you might do on a normal day. How easy or difficult is it for you to actually carry out what you have planned for the day? Does anybody help you? Can you give me an example of when it can be difficult? When it is difficult, is it for everything you have planned for the day or just some things? What help do you need to manage your day?

Coping with change

- How well do you cope if your plans change? Is it different if you know in advance that your plans are going to change? Are there some changes that are more difficult for you to cope with?

That is all my questions. Thank you. Is there anything that we've not yet talked about that it would be useful for me to know about how realistic it will be for you to work?

Do you have any questions for me?

Annex 4: Expert panel questionnaire

Evidence Based Review of the Work Capability Assessment

Expert Panel opinion form

Panel id		Date completed (dd/mm/yy)	
Claimant id		Time started work on case	
Panel chair id		Time ended work on case	

Section A: Fitness for work

1. In your opinion, is the claimant fit for work or not? Tick one box
   - ☐ Fit for work — Go to Q2
   - ☐ Not fit for work — Go to Q4

2. Would the claimant need adjustments to help them work?
   - ☐ Yes — Go to Q3
   - ☐ No — Go to Q4

3. What adjustments would be needed? Tick all that apply
   - ☐ Flexible/altered hours
   - ☐ Arrangements for home working or a different place of work
   - ☐ Allowing periods of disability leave
   - ☐ A support worker
   - ☐ Specific aids or appliances. E.g. special equipment
   - ☐ Other. Please specify below.

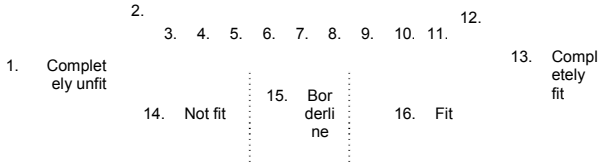
   .....

4. Is your opinion unanimous? Tick one box. **Answer in relation to your response to Q1.**
   - ☐ Yes
   - ☐ No

5. Is the case on the borderline between fit for work and not fit for work? Tick one box
   - ☐ Yes
   - ☐ No

6. In your opinion, on a scale of 0 to 10, to what degree is the claimant fit for work?

   Please write the score provided by each panel member into the spaces provided.



Panel member id	Score

7. Please give a brief rationale for your opinion. Where appropriate include comments on: the nature and degree of fluctuation in the individual's functioning, and what impact this had on your opinion; the types of jobs the individual would be capable of. Continue on a blank sheet if necessary.

Section B: Evidence appraisal and quality of decision						
8. On a scale of 0 to 5, how confident are you in your **overall opinion of the** claimant's fitness for w ork? Please circle the appropriate number.	0 Not at all confident	1	2	3	4	5 Very confident
9. On a scale of 0 to 5, how confident are you that you had **adequate evidence** to inform your opinion? Please circle the appropriate number.	0 Not at all confident	1	2	3	4	5 Very confident

10. If there is any other information that would have helped your decision making, what would it be and why? Please use a separate row for each piece of information you would like. Continue on a separate sheet if necessary.

Information that would have helped	Rationale (how would it inform your opinion)	Rank priority

11. Other comments. Please use this space to record any other comments you wish to make. Continue on a separate sheet if necessary.

Annex 5: Quality Assurance of the Expert Panel process

The quality assurance process was designed to review the work which had been undertaken by panels of expert volunteers to help produce a defensible indicator of Employment and Support Allowance claimants' fitness for work, which the outcomes of both the WCA and AA could be compared to.

In order to quality assure the opinions provided by Expert Panels, a small number of peer reviewers were recruited, with specific healthcare backgrounds. The purpose of the quality assurance process was to consider whether the expert panels' appraisal of claimants was appropriate and defensible.

Reviewers were first asked to read a case file and provide their own opinion on the claimant's fitness for work, using the process that has been followed by expert panels.

Next they read the opinion provided by the expert panels that have already considered the case and provided a narrative review on:

The health and work needs of claimants

- The claimant's health condition(s) and social circumstances
- Their opinion on the claimant's employability, the work tasks the claimant might undertake, and the types of jobs the individual might reasonably do and any support needs or adjustments that the claimant would need to help them into work.

Claimant fitness for work

- Opinion on the functional effects of the claimant's health condition
- Issues around the claimant's circumstances and their functional effects that the panel did not seem to identify
- Overall view on whether the panel ratings of fitness for work were appropriate and defensible
- The final rating of fitness for work that they believe should be used on a scale of zero (completely unfit) to ten (completely fit).

Findings

The six reviewers were recruited through professional bodies. They had expertise in the following areas or specific diseases: General Psychiatry (mental health), Learning disability, Bowel Diseases, Chronic Fatigue, Physiotherapy and Visual Impairments reviewed 28 cases which represents five per cent of the total completed assessments.

As part of the quality assurance process we asked the reviewers on a scale of 0 to 5 to what degree they thought the scores given by the expert panels were appropriate, with 0 being entirely inappropriate to 5 being entirely appropriate.

The 28 cases that were reviewed equated to 91 appraisals conducted by the expert panels. The reviewers gave a score of three or more in 62 per cent of appraisals indicating that they agreed that the scores given on fitness for work by the expert panels by appropriate.

Of the 28 cases which where reviewed, the reviewers agreed 100 per cent with their original assessment following their review of the appraisals undertaken by expert panels. In three cases the reviewers did change their fitness for work score by one point but that did not affect their overall decision

Two case studies to illustrate the findings of the quality assurance process.

Case study 1: Crohn's Disease

The claimant has Crohn's Disease and has had multiple surgeries including having a temporary stoma. As a result of the surgeries the claimant now has short bowel syndrome meaning that transit time through the digestive system is more increased. This means that the claimant can struggle to reach the toilet even in her own home.

Panel opinion and rationale

The case was considered by two panels. Both considered the claimant fit for work and suggested that with reasonable adjustments around being near a toilet.

Quality assurance opinion and rationale

The quality assurance reviewer thought that this claimant was not fit for work and disagreed with both appraisals by the panel giving both panels a score of two on the appropriateness of the scores they have given. The reviewer said that;

"it is difficult to imagine any employment the client might undertake, given her almost certain need to access a toilet at short notice, both panels have underestimated the extreme urgency being described"

Overall assessment of the panel decision

The quality assurance reviewer said that the panels had done a good job with reviewing cases of bowel disorders but that some struggled with the notion that it is important to not just focus on the condition and what work or work related activity the claimant can do but also about how the claimant will get to and get about at a job.

Case study 2: Mental health problems

The claimant has low self esteem, anxiety and depression, which is probably linked to the claimants high Body Mass Index (BMI). The claimant also self harms but does have a good family support system around them.

Panel opinion and rationale

The case was considered by one panel who considered the claimant fit for work and noted that the claimant had good educational qualifications but felt that she need help and support to become more motivated, potentially through a support worker. Their opinion was that her condition was not a barrier to employment but home working could be a good fit solution.

Quality assurance opinion and rationale

The quality assurance review thought that the claimant was fit for work and rated the appropriateness of the scores given by the panel as '3' (indicating that it was reasonably or somewhat appropriate). The reviewer said that;

"the claimant shows signs of emotionally unstable personality disorder characterised by repeated self harm, although I agree with the panel that the claimants educational qualifications and skills shows that they would be fit for work with the right motivation, encouragement and adjustments around working from home"

Overall assessment of the panel decision

The mental health reviewer stated that there was a range of mental health problems among claimants that he considered, but that the panels had picked up on the various aspects and suggested adjustment which would be reasonable. There were instances where the reviewer disagreed with the panels, particularly in cases which involved alcohol misuse. The reviewer suggested that that the panels might have reflected on the reasons for the claimant's alcohol use - that it might be self-medication or a coping strategy for other problems.

Conclusion

The quality assurance process helped us to understand that the approach we had used through the expert panel process was defensible. This is illustrated by the feedback the reviewers have provided, although it has been suggested that it might have been better to have panels relating to specific conditions to take better account of nuances.

Annex 6: Interpretive scoring approach for the Alternative Assessment

For the purpose of statistical analysis, this approach groups scores for each activity into four categories on a scale of one to four.

Movement - within a work environment or travelling to work

1. Mobilising (Physical) Mobilising reliably, repeatedly, safely and in a timely manner, unaided by another person, with or without a walking stick, manual wheelchair or other aid normally used, indoors and outdoors without stopping, and climbing and descending a flight of 12 steps, without significant discomfort or exhaustion.			
Descriptor	**Points**		
a None of the below apply	**1**		
	Occasionally	**Frequently**	**Most of the time**
b Cannot climb and descend a flight of 12 steps	**1**	**2**	**2**
c Has some difficulty mobilising, indoors and outdoors, for long periods	**1**	**2**	**2**
d Has significant difficulty mobilising, indoors and outdoors, for long periods	**2**	**3**	**3**
e Has some difficulty mobilising, indoors and outdoors, for short periods	**2**	**3**	**3**
f Has significant difficulty mobilizing, indoors and outdoors, for short periods	**3**	**4**	**4**

2. Getting About (Mental/cognitive/intellectual) Getting to familiar and unfamiliar places reliably, repeatedly, safely and in a timely manner, unaided by another person, without significant distress or disorientation.			
	Points		
a None of the below apply	**1**		
Due to distress or disorientation:	**Occasionally**	**Frequently**	**Most of the time**
b Has some difficulty getting to unfamiliar places	**1**	**2**	**2**
c Has significant difficulty getting to unfamiliar places	**2**	**3**	**3**
d Has some difficulty getting to familiar places	**3**	**4**	**4**
e Has significant difficulty getting to familiar places	**3**	**4**	**4**

3. Navigating (Sensory)

Navigating around familiar and unfamiliar places without being accompanied by another person reliably, repeatedly, safely and in a timely manner, using a guide dog or other aid if normally used, without experiencing difficulty due to sensory impairment.

	Points		
a None of the below apply	1		
Due to sensory impairment, without being accompanied by another person:	Occasionally	Frequently	Most of the time
b Has some difficulty navigating around unfamiliar surroundings	1	2	2
c Has significant difficulty navigating around unfamiliar surroundings	2	3	3
d Has some difficulty navigating around familiar surroundings	2	3	3
e Has significant difficulty navigating around familiar surroundings	3	4	4

Movement – at a work station

4. Standing and sitting (Physical)

Reliably, repeatedly, safely and in a timely manner, using any aid that it is reasonable to expect them to use, and without receiving physical assistance from another person:

- Staying in one place (such as a workstation), either by standing or sitting, and
- Moving from a seated position in a suitable chair to a mobilising position

	Points		
a None of the below apply	1		
Cannot reliably, repeatedly and safely, without significant discomfort or exhaustion:	Occasionally	Frequently	Most of the time
b Stay in one place, either by standing or sitting, unassisted by another person, for more than one hour	1	2	2
c Stay in one place, either by standing or sitting, unassisted by another person in, for more than 30 minutes	3	4	4
d Move from a seated position in a suitable chair to a mobilising position in a timely manner, without physical assistance from another person	3	4	4

5. Reaching (Physical) Reaching up and down from standing or sitting, reliably, repeatedly and safely and in a timely manner, unaided by another person, and without significant discomfort or exhaustion.			
	Points		
a None of the below apply	**1**		
Cannot reliably, repeatedly and safely and in a timely manner, without significant discomfort or exhaustion, from standing or sitting	**Occasionally**	**Frequently**	**Most of the time**
b Reach down (through bending, kneeling or squatting from standing or sitting) with either arm as if to pick up a light object situated on a low shelf 15cm from the floor	**1**	**2**	**2**
c Raise either arm above head height as if to pick up an object on a high shelf	**1**	**2**	**2**
d Raise either arm to top of head as it to put on a hat	**2**	**3**	**3**
e Raise either arm as if to put something in the top pocket of a coat or jacket	**3**	**4**	**4**

6. Picking up and moving (Physical) Picking up and moving objects of a variety of sizes with one or both hands reliably, repeatedly, safely and in a timely manner, unaided by another person, and without significant discomfort or exhaustion.			
	Points		
a None of the below apply	**1**		
Cannot reliably, repeatedly and safely, without significant discomfort or exhaustion:	**Occasionally**	**Frequently**	**Most of the time**
b Pick up and move a one litre carton full of liquid at arm's length with either hand	**1**	**2**	**2**
c Pick up and move a one litre carton full of liquid with one hand	**1**	**2**	**2**
d Pick up and move a bulky object (such as a cardboard box) up to 2kg	**1**	**2**	**2**
e Pick up and move a light bulky object (such as a cardboard box) up to 1kg	**2**	**3**	**3**
f Pick up and move a one litre carton full of liquid with either hand	**3**	**4**	**4**

7. Manual dexterity/hand movement (Physical) Managing manual dexterity tasks reliably, repeatedly, safely and in a timely manner without significant discomfort or exhaustion			
	Points		
a None of the below apply	**1**		
Cannot reliably, repeatedly and safely, without significant discomfort or exhaustion:	**Occasionally**	**Frequently**	**Most of the time**
b Has some difficulty in one hand with manual dexterity tasks	**1**	**2**	**2**
c Has significant difficulty in one hand with manual dexterity tasks	**2**	**3**	**3**
d Has some difficulty in both hands with manual dexterity tasks	**2**	**3**	**3**
e Has significant difficulty in both hands with manual dexterity tasks	**3**	**4**	**4**

Task – task performance

8. Executing Tasks (Global) Executing tasks reliably, repeatedly, safely and in a timely manner, unaided by another person.			
	Points		
a None of the below apply	**1**		
Cannot reliably, repeatedly and safely, without significant discomfort or exhaustion:	**Occasionally**	**Frequently**	**Most of the time**
b Takes somewhat longer to complete some tasks	**1**	**2**	**2**
c Takes significantly longer to complete some tasks	**2**	**3**	**3**
d Takes somewhat longer to complete most tasks	**2**	**3**	**3**
e Takes significantly longer to complete most tasks	**3**	**4**	**4**

9. Maintaining Focus (Global) Maintaining focus reliably, repeatedly and safely, unaided by another person, to complete tasks in a timely manner.			
	Points		
a None of the below apply	**1**		
Due to poor memory or concentration, disorganised thoughts or anxiety:	**Occasionally**	**Frequently**	**Most of the time**
b Has difficulty maintaining focus on some tasks	**1**	**2**	**2**
c Has difficulty maintaining focus on most tasks	**3**	**4**	**4**

10. Learning Tasks (Mental/cognitive/intellectual) Learning new tasks in order to undertake them reliably, repeatedly and safely, without support from another			
	Points		
a None of the below apply	**1**		
	Complex tasks	**Moderately complex tasks**	**Simple tasks**
b Has some difficulty learning new tasks	**2**	**3**	**3**
c Has significant difficulty learning new tasks	**3**	**4**	**4**
d Cannot learn new tasks within a reasonable timeframe	**3**	**4**	**4**

Task - risk

11. Awareness of Hazards (Global) Being aware of hazards in order to avoid risk(s) of harm to self or others, or of damage to property or possessions.			
	Points		
a None of the below apply	**1**		
	Occasionally	**Frequently**	**Most of the time**
b Some reduced awareness of hazards leads to risk(s) of harm to self or others, or of damage to property or possessions	**2**	**3**	**3**
d Significantly reduced awareness of hazards leads to risk(s) of harm to self or others, or of damage to property or possessions	**3**	**4**	**4**

12. Consciousness (Physical) Maintaining consciousness during waking hours reliably.			
	Points		
a None of the below apply	**1**		
	At least twice in last 6 months	**At least once a month over the last 6 months**	**At least once a week**
b Has an involuntary episode of lost or altered consciousness resulting in significant disrupted awareness or concentration, with a recovery time that is normally less than **one hour**	**2**	**2**	**3**
d Has an involuntary episode of lost or altered consciousness resulting in significant disrupted awareness or concentration, with a recovery time that is normally **more than one hour**	**3**	**3**	**4**

13. Bladder/ bowel continence (Physical) Managing and maintaining effective control of bowel, bladder and/or a collecting device reliably, repeatedly and safely.			
	Points		
a None of the below apply	**1**		
	Occasionally	**Frequently**	**Most of the time**
b Experiences an unusually urgent and/or frequent need to use the toilet (or manage a collecting device), due to an underlying health condition or the side effects of essential medication	**1**	**2**	**2**
c Without immediate urgent access to a toilet, suitably modified where appropriate, would experience loss of control	**2**	**3**	**3**
d Has experienced unpredictable or recurrent loss of control	**3**	**4**	**4**

Communication

14. Understanding communication (Global) Understanding communication from a stranger reliably, repeatedly, safely and in a timely manner, by both verbal means (such as hearing or lip reading), non-verbal means (such as intonation or body language) *and* written means (such as reading 16 point print), using any aid(s) normally used.			
	Points		
a None of the below apply	**1**		
Due to sensory, cognitive or social difficulties:	**Occasionally**	**Frequently**	**Most of the time**
b Has some difficulty understanding complex information from a stranger	**1**	**2**	**2**
c Has significant difficulty understanding complex information from a stranger	**1**	**2**	**2**
d Has some difficulty understanding basic information from a stranger	**2**	**3**	**3**
e Has significant difficulty understanding basic information from a stranger	**3**	**4**	**4**

15. Making self understood (Global) Making self understood reliably, repeatedly, safely and in a timely manner to a stranger through speaking, writing, typing, or other means normally used, and using any aid(s) normally used, unaided by another person.			
	Points		
a None of the below apply	**1**		
Due to sensory, cognitive or social difficulties:	**Occasionally**	**Frequently**	**Most of the time**
b Has some difficulty conveying complex information to strangers	**1**	**2**	**2**
c Has significant difficulty conveying complex information to strangers	**1**	**2**	**2**
d Has some difficulty conveying basic information to strangers	**2**	**3**	**3**
e Has significant difficulty conveying basic information to strangers	**3**	**4**	**4**

Supporting behaviours for work

16. Social Engagement (Mental/cognitive/intellectual) Engaging socially with people known and unknown, reliably, repeatedly and safely, unaided by another person.			
	Points		
a None of the below apply	**1**		
Because of difficulties interacting with others, anxiety, distress or lack of social understanding:	**Occasionally**	**Frequently**	**Most of the time**
b Has some difficulty with social engagement with strangers	**1**	**2**	**2**
c Has significant difficulty with social engagement with strangers	**1**	**2**	**2**
d Has some difficulty with social engagement with people known to the person	**2**	**3**	**3**
e Has significant difficulty with social engagement with people known to the person	**3**	**4**	**4**

17. Organising self and planning (Mental/cognitive/intellectual) Organising self and planning throughout the day, reliably, repeatedly, safely and in a timely manner, unaided by another person.			
	Points		
a None of the below apply	**0**		
	Occasionally	**Frequently**	**Most of the time**
b Has some difficulty organising self and planning to an acceptable standard for much of the day	**1**	**2**	**2**
c Has significant difficulty organising self and planning to an acceptable standard for much of the day	**1**	**2**	**2**
d Has some difficulty organising self and planning to an acceptable standard for short periods	**2**	**3**	**3**
e Has significant difficulty organising self and planning to an acceptable standard for short periods	**3**	**4**	**4**

18. Coping with Change (Mental/cognitive/intellectual) Coping with planned and unplanned changes to daily routine, reliably, repeatedly and safely, unaided by another person.			
	Points		
a None of the below apply	**0**		
	Occasionally	**Frequently**	**Most of the time**
b Experiences some difficulties with unplanned changes to daily routine.	**1**	**2**	**2**
c Experiences significant difficulties with unplanned changes to daily routine.	**1**	**2**	**2**
d Experiences some difficulties with planned changes to daily routine.	**2**	**3**	**3**
e Experiences significant difficulties with planned changes to daily routine.	**3**	**4**	**4**

19. Appropriateness of Behaviour (Mental/cognitive/intellectual)

Displaying appropriate behaviour in the workplace reliably, repeatedly and safely without support from another person.

	Points		
a None of the below apply	**0**		
	Occasionally	**Frequently**	**Most of the time**
b May display moderate verbally aggressive or socially inappropriate behaviour	**2**	**3**	**3**
c May display severe verbally aggressive or socially inappropriate behaviour	**3**	**4**	**4**
d May display physically aggressive behaviour	**4**	**4**	**4**