

# Welfare that Works: Employment and Support Allowance

## A Spartacus Report

by

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## Chapter 1: ESA data

### Summary

ESA isn't working. Any test that works has to be able to be repeated with consistent results and has to produce results that accurately reflect the real world. Data and evidence from the test can be considered to provide information on the reliability and validity. With ESA, there are multiple data and evidence that ESA does not work. These include:

- Inaccuracies in Atos reports;
- Variability in Atos assessments;
- Inaccuracy of guidelines for assessors;
- Variability in decision making;
- 42% success rate at appeal;
- The majority of overturned appeals are overturned on new oral evidence; and
- Low employment rate of claimants 12-18 months after a decision.

#### 1. Inaccuracies in Atos reports.

Welfare advisers and claimants frequently find inaccuracies in the report, including:

- Omission
  - e.g. not mentioning a medical condition;
- incorrect recording of observation
  - e.g. reporting that a claimant who could not sit easily could sit easily;
- incorrect recording of the history given by the claimant
  - e.g. can dress unaided when the claimant can't do this;
- incorrect medical evidence
  - i.e. the assessor reports on something which the assessor is not in a position to accurately report on;
- information not being gathered
  - e.g. not allowing time to answer or asking closed questions;
- inconsistency within the report
  - one claimant was reported separately as having weekly and monthly hypo attacks; the latter was used – incorrectly – to determine points; and
- supporting medical evidence is ignored
  - this can lead to inconsistency.

A study by Citizen's Advice found that 43% of reports included inaccuracies so serious that it could have impacted the decision made. Over half did not gather all information; 70% of the reports included incorrect factual recordings of the history given.

A study on the use of reconsideration by Decision Makers found that 17.3% of cases were referred back to Atos. This contrasts with 0.22% that had been referred back to Atos over the period 1 March 2011 to 31 May 2011. It is unclear if these two figures relate to the same or similar thing, but if so it is concerning that there is a difference of two orders of magnitude.

The report made by an Atos assessor is not routinely returned to the claimant for comment. If it were, this would be an opportunity for claimants to correct inaccuracies.

#### **Omission.**

Omissions are particularly worth noting, because the primary reason why appeals are overturned is presentation of new oral evidence. Whereas documentary evidence may not have been available at the time of the assessment, oral evidence would have been available. The assessor should have been able to elicit this evidence by appropriate questioning and listening.

#### 2. Variability in Atos assessments.

The Review's second year report included an analysis of the points awarded to claimants by assessors from different medical backgrounds. The Review found that doctors on average awarded more points, but this may be due to their assessing the more complex cases. Further work focusing on the 'simpler' cases would be useful, to see if doctors also award more points for these.

Nurses under-award points for claimants suffering from physical health conditions, and physiotherapists under-award points for claimants suffering from mental health conditions. This is concerning as it could be due to an under-appreciation of medical conditions that are outside an individual assessor's field.

### **3. Inaccuracy of guidelines for assessors.**

Several disability charities and organisations have reported that the guidelines given to Atos assessors are inadequate. The National AIDS Trust said,

“All HCPs undertake training which includes a module on HIV and have access to reference material on HIV. However, NAT has seen these training materials and it is clear that these have not been prepared specifically for use in the WCA process. The majority of the information concerns diagnosis, prognosis and prescribing treatment for patients with HIV in clinical care settings, which is not relevant to the WCA. HCPs receive no information on HIV and work in the UK context, or the most common HIV-related barriers to work. Atos has so far refused offers from leading HIV organisations to provide advice to improve these materials.”

The Muscular Dystrophy Campaign said,

“The lack of knowledge about neuromuscular conditions is highlighted in the Department for Work and Pension's Disability Handbook ... For example, the section on Becker muscular dystrophy categorically states that the condition does not affect the heart. This is simply incorrect—cardiomyopathy is a very serious complication of Becker muscular dystrophy. Furthermore the Handbook incorrectly describes the severity of muscle disease, providing misleading information for assessors, and needs to be revised and corrected as a matter of urgency.”

### **4. Variability in decision making.**

The Review noted in its first year report that the quality and consistency of decision makers varies between individuals and between benefit centres. Benefit centres vary depending on whether the manager focusses on accuracy and quality of decisions or on speed of decisions.

This means that ESA decisions are *not* consistent or replicable, an important measure of a test's ability. ESA is designed to be objective and replicable; that is, the same evidence before different decision makers should lead to the same conclusion, and for the same clear reasons. Without this consistency, the validity of the assessment process is seriously undermined.

### **5. 42% success rate at appeal.**

The latest data shows that for the past three quarters, 42% of those who took their ESA decision to appeal had the decision overturned in their favour. People who have a representative experience an even higher overturn rate:

- 70% at Citizen's Advice Scotland;<sup>1</sup>
- 94% at Oxford Welfare Rights;<sup>2</sup> and
- 100% at a London HIV organisation.<sup>3</sup>

It has been suggested that the reason for the higher overturn rate when a claimant is represented is due to a lack of understanding of how the appeal process works. At appeal, a judgement is made on whether the right number of points were awarded, not on whether there is a general ability to work. Evidence from medical professionals and from the claimants do not always explicitly address the disputed points, and thus are not always suitable as evidence for lack of ability to work.<sup>4</sup> A representative often works to explicitly address each descriptor and the points awarded, thus presenting a case that is more directly relevant to the appeal. Claimants may be losing their case because they were unaware of the format their presentation needed to take, not because they in reality do not meet enough descriptors to qualify for ESA.

<sup>1</sup> Dryburgh, Unfit for Purpose, 2010, Citizen's Advice Scotland. [www.cas.org.uk/publications/unfit-purpose](http://www.cas.org.uk/publications/unfit-purpose)

<sup>2</sup> Oxford Welfare Rights written evidence submitted to Work and Pensions Committee

<sup>3</sup> National AIDS Trust response to Work and Pensions Committee

<sup>4</sup> See Appendix 1 for quotes.

## **6. The majority of overturned appeals are overturned on new oral evidence.**

60% of ESA decisions that are overturned on appeal, and have a reason given for the over-turn, are over-turned because of “cogent oral evidence.” A further 27% are over-turned on the same evidence but with a different conclusion reached.

Of all appeals overturned – including those where no reason for the over-turn was given – this works out as 39% with cogent oral evidence and 18% with same evidence but different conclusion.

Shelia Gilmore, speaking as part of the Work and Pensions Committee, said, “It perhaps suggests that, indeed, the original process was not getting the information properly, if it was a face-to-face assessment—and this goes back to the question of whether the assessment is failing or not... When somebody goes to an appeal, which in many ways might be, I would have thought, more stressful and quite challenging for people, they are able to express themselves better than they appear to have been able—this is one hypothesis—at the assessment. The reason people have given for that is the very mechanical way—this goes back to the criticism that I think Glenda was trying to get at. I am not asking you to guess whether this is the cause for the 40% and the assessment was too narrow or somehow the judges are better at getting things out of people, but that surely shows just how important it is that we understand this process, because that is a large number.”

There is good reason to be concerned if new oral evidence is elicited at the tribunal that this should also have been elicited at the original face-to-face assessment with the Atos assessor. Given the inquisitorial nature of such assessments and tribunals, it may be considered a failing on the part of the assessor that this information was not elicited.

## **7. Situation 6-18 months after outcome.**

Claimants found fit for work are presumably judged to have health conditions that do not significantly disadvantage them or present significant barriers to work. If this were the case then these claimants should move into work at the same rate, or at a comparable rate, to people claiming Jobseeker’s Allowance.

80% of people on JSA leave within 6 months. Whilst not all of these move into work, it is believed that getting a job is the predominant reason for leaving JSA.<sup>5</sup>

Of those found fit for work, 25% are in employment 12-18 months later. This is substantially lower than the comparable figures for those leaving JSA. Figures for people placed in the Support Group or Work Related Activity Group are similar at 10% and 9% respectively, possibly indicating that on average there is little medical difference between the two groups in terms of their ability to work. These results suggest that the average person found to be fit for work is not fit for work, and that the average person placed in the WRA group is not closer to work than the average person placed in the Support Group. Either the assessment process has failed to award the correct points, or the descriptors are inadequate at capturing an individual’s capability for work.

## **Conclusion.**

There are multiple indicators that ESA is not working. The assessment process is inaccurate and inconsistent – as shown by the inaccuracy and variability in Atos assessors’ reports, the variability in decision making and the high overturn rate at appeal. The assessment itself is invalid – as shown by the low percentage of claimants who find work after a fit for work decision.

ESA is, at least to some extent, inaccurate, inconsistent, unreliable and invalid.

Used in the statistical sense, ESA is unreliable and invalid. Reliable means a test can be repeated and is consistent. Valid means a test accurately describes the real world. ESA is not reliable as it does not produce consistent results. ESA is not valid as reports are inaccurate and few claimants found fit for work do enter work, in comparison to claimants of Jobseeker’s Allowance.

There is urgent need to address the inaccuracy of assessments and decision making to produce an assessment that is reliable. There is urgent need to address the descriptors and decision making to produce an assessment that is valid.

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<sup>5</sup> Data available from [www.nomisweb.co.uk](http://www.nomisweb.co.uk)

### **Appendix 1: Evidence to the Work and Pensions Committee**

Sue Royston: People think it is about whether they can work; they do not understand it is technically about the descriptors, and that causes problems. It causes problems when people appeal on their own. The doctors do not understand the basis of the assessment process either. Certainly one adviser told us about someone who had very strong evidence from her doctor, her physiotherapist and her consultant that, at this point, she could not possibly work. She was too ill to go to the tribunal, so she sent the evidence in and was found fit for work. She was legally found fit for work because none of the letters said anything about the descriptors, and the decision is based on descriptors, not on whether you can work. I think there is a quite definite misunderstanding about it.

Professor Gregg: Still one of the problems around the appeals process is that people do not realise they are appealing on the descriptors rather than making a general appeal on how they can possibly be deemed fit for work. The appeals process centres on the descriptors, and there is still a problem there in that people do not quite know what they are appealing against when they are making their appeal unless they are getting professional support, but we are still in the zone that the descriptors are still a fundamental issue.

Professor Gregg: It says the obvious point, and that is where people are not necessarily being represented by people who understand how to run an appeal. When you have people there who know the appeals process, such as CAB, the number is significantly higher. It is suggestive that we have a problem of a significant number of people going through the Atos-type test process who are inappropriately being judged as being capable of work.

Stephen Lloyd: 40% is very high.

## Chapter 2: Individual's Experiences

"... there is no support - you've been thrown away regardless, and none of it was ever about illness, disability, ability or recovery: for them it was always only about the money. And they keep insisting we're not cheap, but I feel cheap."

### Summary

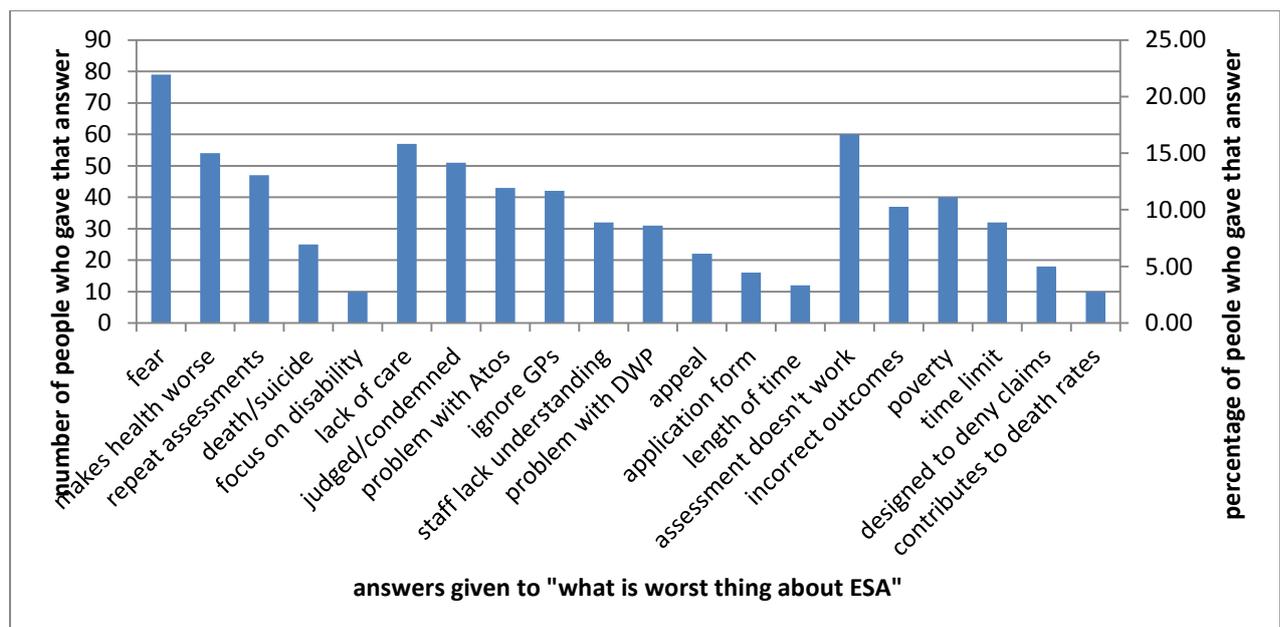
On 6<sup>th</sup> March Sue Marsh requested her blog readers to leave comments detailing what they considered to be the worst thing about ESA. The responses were as follows:

- 50% considered the worst part of ESA to be that it is a highly stressful process, frequently inducing fear in claimants;
- 40% identified specific flaws in the assessment process as the worst part;
- 30% expressed views that the process does not work;
- 29% were concerned by negative attitudes towards those on sickness benefits;
- 9% explicitly said that the time-limiting is one of the worst things about ESA; and
- 5% explicitly said that they consider ESA to have been designed to deny claims.

These responses reveal the huge amount of fear amongst the disabled and chronically ill community that is generated by ESA, its assessment process and the general attitude amongst the media, the public and politicians. ESA is largely regarded as not working and not fit for purpose. It is considered that

- the points system, descriptors and computer system are incapable of gathering the reality and complexity of people's conditions;
- the descriptors do not capture a person's state of health in a way that reflects their ability to work;
- that medical evidence from those who have detailed, accurate and relevant knowledge is ignored;
- the assessors lack the time, ability and medical knowledge to assess and understand an individual's condition and how it relates to work;
- decision makers lack the medical knowledge to make accurate and informed decisions; and
- the assessment is irrelevant to work, as no attempt is made to discover *what* work an individual is supposed to be capable of doing.

A system that works would need to address all of these issues.



## 1. FEAR

Many people have expressed fear and dread in relation to ESA. Uncertainty regarding outcome coupled with high frequency of assessments leads to insecurity – claimants, however ill, never feel sure that they will get or keep the support they need. Many of the responses included elements of fear alongside or as a consequence of other issues.

*“The worst thing about ESA/WCA is the fear; the fear that an assessment form may come through the door any day, the fear that the subsequent face to face assessment will be wrong, the fear of the appeal & trying to exist on 'assessment rate' pennies for over a year until tribunal”*

### 1.1 Stress makes health worse

Community mental health teams have expressed their concerns that ESA is damaging their clients' mental health, where previously under IB the involvement of the community MHT would be considered indicative of the severity of the claimant's condition.<sup>6</sup> A survey carried out by the Disability Benefits Consortium found that 78% of claimants agreed that the assessment process made their health worse; this was an increase from 69% in the previous year.<sup>7</sup>

*“Time and effort filling in forms invariably takes physical and emotional toll even when result is "good". I am ALWAYS ill as a result of a reassessment.”*

### 1.2 Stress of repeat assessments

The government has said that everyone on ESA will be reassessed at least every 2 years, even where there is no expectation of recovery or adaptation, in order to ensure that no-one is completely written off.<sup>8</sup> This has resulted in fear and insecurity for claimants who, despite either no change or a deterioration in condition, cannot guarantee that they will continue in either the WRAG or SG in future assessments. “Almost 90% [of welfare advisers] believed the frequency of reassessment was having a negative impact on the health of claimants.”<sup>9</sup>

*“No matter how ill and weak, you have to constantly battle -revolving door process, no security, just WCA, claim ended, appeal, win ... WCA ... and now we have the mandatory review ...”*

*“The worst thing about ESA/WCAs is the ongoing stress of assessment. I have been diagnosed with a long term chronic health condition with no cure, and which is made worse by stressful situations, yet have to be assessed every year or two and despite filling the form the same way every single time, the response can be totally different.”*

### 1.3 Beyond breaking point TRIGGER WARNING

The website 'Calum's list' contains names of 30 people who have died, where the death has been linked to welfare. 9 were cases where the family believe stress triggered the death; 20 where the person took their own life.<sup>10</sup> 7% of responses to this survey cited suicide as a consequence of or logical, sensible or only response to the stress of ESA.

*“The fear that it will drive my son to another suicidal mental breakdown and I won't have the strength to save him this time as I've become disabled myself through being his carer.”*

### 1.4 Forced to focus on disability

Whilst ESA is supposed to be about capability not incapability, it is necessarily the case that by thinking about what one *can* do, one thinks about what one *can't* do and the reasons why not. Given that such a focus is unavoidable, it is crucial that the assessment process be kind, compassionate and considerate. This is particularly important in instances of trauma or abuse.

*“Having to prove over and over again that you have many problems that are not going to go away is crucifying.”*

*“The worst thing is having to relive every psychotic episode while filling in the form, every abusive put down, every single personal detail when I hate revealing personal details about myself to anyone, driving me to psychosis, the WCA is biased against mental health conditions.”*

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<sup>6</sup> CAB advice on ESA

<sup>7</sup> Disability Benefits Consortium, September 2012, response to third call for evidence for Harrington Review [http://disabilitybenefitsconsortium.files.wordpress.com/2012/09/dbc\\_harrington\\_yr31.pdf](http://disabilitybenefitsconsortium.files.wordpress.com/2012/09/dbc_harrington_yr31.pdf)

<sup>8</sup> Mark Hoban, Hansard: 19 Dec 2012, Column 784W

<sup>9</sup> DBC 2012

<sup>10</sup> <http://calumlist.org/>

## 2. LACK OF CARE WITHIN THE SYSTEM

### 2.1 Lack of care

16% of respondents referred to the ESA system as inhumane, cruel or otherwise uncaring. There is widespread perception that there is no concern about the individuals undergoing the assessment within either the DWP or Atos. This is compounded by media rhetoric and government portrayals of workers/strivers versus shirkers/skivers, and by the attitude displayed by Iain Duncan Smith when he spoke of Remploy workers as “not doing any work... just making cups of coffee.”

*“That this government refuses to face the facts or that these are real people not just numbers.”*

*“Knowing the whole process was designed by people like Freud who labels, categorises and dismisses us all as “Stock”, thus seeking to strip us of our dignity.”*

### 2.2 Feel judged or condemned

There is support amongst the public for giving benefits to the sick and disabled, but at the same time there is wide-spread belief that a high proportion of claims are not genuine. The consequence is that many genuine claimants feel judged as scroungers by a public who do not understand the reality behind individual faces. Media use of pejorative language towards the sick and disabled has increased recently, contributing to the ‘climate of fear’ felt by many.

*“The worst thing about ESA, being made to feel that due to no fault of your own that you are an unnecessary burden on society despite paying into the system for 30 odd years.”*

## 3. PROBLEMS WITH THE ASSESSMENT PROCESS

### 3.1 Problems within Atos

#### 3.1.1 tick-box based computer system

Atos, the company contracted by the DWP to carry out Work Capability Assessments, uses the computer program ‘Logic Integrated Medical Assessment’ to record information obtained during the assessment. The program includes drop-down menus which the assessor selects on the basis of comments made by the claimant; the computer is programmed to use these to generate sentences and prompt or guide further questioning and selections on the part of the assessor. The system has been criticised for being inflexible and for contributing to inaccuracies.

*“Tickbox assessments that ignore the complexities of real people.”*

#### 3.1.2 inadequate training of assessors

Over 70% of Atos assessors are nurses or physiotherapists. All assessors must have had at least “three years broad-based clinical post-registration experience.”<sup>11</sup> Assessors have a minimum of 26 days training, depending on their qualification. Professor Harrington described the training as having impressive scope and depth; however Dr Margaret McCartney, in the British Medical Journal, questioned whether “a relatively short training course thereafter [is] enough to ensure the assessments are medically accurate and fair?”<sup>12</sup> The Royal College of Nurses was sufficiently concerned that it “refused to accredit the training of Atos nurse assessors” in 2009.<sup>13</sup>

*“The worst part of the WCA for me is the Atos staff who just don't understand the illness described to them and make no effort to understand its impact.”*

#### 3.1.3 Lies and inaccuracies on assessment forms

Serious inaccuracies were reported in 16 (43%) of 37 ESA claims analysed by the Citizen’s Advice Bureau between summer 2010 and 2011, with a further 10 have a medium level of inaccuracy.<sup>14</sup> A

<sup>11</sup> Grayling, Hansard, 11 Oct 2011 : Column 357W

<http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm111011/text/111011w0002.htm#11101197001019>

<sup>12</sup> McCartney, Well Enough to Work? 2011 British Medical Journal; 342:d599

<http://www.bmj.com/content/342/bmj.d599?ijkey=1MHG4NxT0uJX4Lq&keytype=ref>

<sup>13</sup> Royal College of Nurses, 2010, response to government’s call for evidence to the first Harrington review.

[http://www.rcn.org.uk/data/assets/pdf\\_file/0011/339347/Work\\_Capability\\_Assessment\\_call\\_for\\_evidence\\_Aug\\_2010\\_final.pdf](http://www.rcn.org.uk/data/assets/pdf_file/0011/339347/Work_Capability_Assessment_call_for_evidence_Aug_2010_final.pdf)

<sup>14</sup> Citizen’s Advice Bureau, Jan 2012, Right First Time? An indicative study of the accuracy of ESA work capability assessment reports

survey in August 2012 found that most – 85% - of welfare benefits advisers considered that Atos report accuracy had *not* improved.<sup>15</sup> 83% of decisions overturned at appeal are cases that were originally awarded 6 or fewer points – this indicates that “something was seriously wrong with the assessment.”<sup>16</sup>

*“Assessment Reports: Numerous basic inaccuracies, too many assumptions made and conclusions reached without regard to reports by Consultant & GP.”*

### **3.2 Inadequate understanding of medical conditions and of individual claimants**

Dr Margaret McCartney wrote in the British Medical Journal to question the ethics of allowing those without specialist knowledge to carry out assessments.<sup>17</sup> The Disability Benefits Consortium reported that “assessors’ knowledge and understanding of conditions, particularly mental health conditions, continues to be poor.”<sup>18</sup> A survey of ESA claimants by the same group found that 66% felt the assessor did not understand their impairment or health condition.<sup>19</sup>

*“Terrified that assessors won't understand a fluctuating condition - just because one day is manageable doesn't mean the pain won't be making me vomit the next day.”*

### **3.3 GP and other doctor’s evidence is ignored**

Atos is expected to request evidence from a claimant’s doctor when the claimant is likely to be placed in the Support Group. For the year up to October 2012, Atos requested such evidence (as an ESA113 form) in 27.2% of all ESA referrals; 23.8% of these were not returned. The House of Commons overturned a recommendation by the House of Lords that supporting evidence be sought in all ESA cases. Only 19% of the respondents to the Disability Benefits Consortium survey felt the assessor took into account the medical evidence that was provided.<sup>20</sup>

*“Worst thing about ESA is the fact that my doctor knows the extent of the struggle I go through daily, as he sees me at least once a month to discuss various things to do with mental and physical health, but they talk to me for 30 or 45 minutes a year and go, “NOPE, SHE'S FIT FOR WORK BECAUSE SHE CAN WALK INTO THE EXAMINATION ROOM USING HER WALKING STICK.” Pardon my language, but WHAT A LOAD OF BULLSHIT.”*

### **3.4 Problems with decision makers**

In his first independent review, Professor Harrington said that “Decision Makers do not in practice make decisions, but instead they typically ‘rubber stamp’ the advice provided through the Atos assessment.” Since then there has been a small increase in the number of decisions that disagree with the Atos assessor’s recommendation, suggesting a decrease in ‘rubber-stamping,’ although the total number remains small. The small number of people commenting on the role of *decision makers* specifically shows how much of the assessment process is still attributed to Atos assessors.

*“Worst is the feeling that my doctors could be invalidated by a clerk, at almost any time, and all long-term health management made unstable by knowing this.”*

### **3.5 Going to appeal is almost a necessity for accurate outcomes**

Many of the responses refer to an appeal as an all-but inevitable part of the process. The stress of an appeal is as much a part of the overall stress as is the stress of the original assessment; the cycle between reassessments includes reconsiderations and appeals. When 60% of the appeals that are found in favour of the claimant *originally had 0 points* this not a system where appeal is used for marginal cases: it is a system where appeal is used for people who are easily too ill to work.

*“Worst thing about ESA is the number of people that get the benefit refused only to win on appeal. This has to be proof that the test is severely flawed.”*

### **3.6 Forms are difficult to complete**

The 21-page form contains 18 questions about a variety of activities and functions. It often takes several sessions to complete. Despite this length, it is often felt that the form does not ask relevant

<sup>15</sup> DBC 2012

<sup>16</sup> CAB 2012

<sup>17</sup> McCartney, Well Enough to Work? 2011 British Medical Journal; 342:d599

<sup>18</sup> Disability Benefits Consortium response to second call for evidence, based on survey of claimants

<sup>19</sup> DBC 2012

<sup>20</sup> DBC 2012

questions regarding the individual's health and ability to work. Most claimants find the form difficult to complete, and it can be confusing and repetitive.<sup>21</sup>

*"The form. It's endless. And full of traps. You get 1 month to complete it- it takes my fit and healthy husband (I've no hope of doing it) all his spare evenings/weekends and even work time to fill it in to make sure every detail is there. Terrified to leave out something they may pounce on."*

### **3.7 Starting a claim to receiving an outcome takes too long**

Receiving an ESA decision can be expected to take at least 5 months: 4 weeks to return the questionnaire, 13 weeks to the Atos medical and several weeks to the decision. However, Atos and the DWP acknowledge that there are backlogs, requiring Atos to recruit more assessors and hold assessments in the evenings and at weekends.<sup>22</sup> In February 2012, 3122 claimants attended a centre for an assessment, but were unable to have one for reasons that are attributable to Atos.<sup>23</sup>

*"The sheer length of time it takes to apply, and the lengthy appeal/tribunal process."*

## **4. THE ASSESSMENT DOESN'T WORK**

### **4.1 ESA is not fit for purpose**

There are a variety of reasons to believe that ESA does not work, including those cited in the above section. In addition to these comments, many respondents explicitly stated that ESA does not work or is not fit for purpose.

*"Worst thing? That the design of the WCA is so bad that it can't even fulfil its function - to correctly assess someone's ability to work."*

*"The fact that the ESA forms avoid asking about things you can score points on –it's one of many things that leave me feeling like they are deliberately trying to make it as hard as possible for you to pass even if you qualify; its deceitful and underhanded."*

### **4.2 Many people are placed in the wrong group or incorrectly found fit for work**

#### **4.2.1 Incorrectly placed in the Work Related Activity Group**

The reasoning behind the Work Related Activity Group is that people should not be 'abandoned' on sickness benefits when they may be able to work in the future. However, many people report that they struggle to meet the work-related activity requirements. For those who can manage, the offered support is often deemed of little practical use – the DBC survey found that almost 50% had received no support, whilst others had had one interview and then very little else.<sup>24</sup>

*"The WRAG is unfair parking space for those not fitting JSA OR SG- it should only be used for those where health recovery is possible or only thing preventing work is support. Pushing meetings/workfare/time limits where health is never going improve is [the] worst thing."*

#### **4.2.2 Incorrectly found Fit For Work**

The government does not regularly track those who are found fit for work, and thus misses a lot of data on the accuracy of those decisions. A small study found that only 28% of those found fit for work are in work 12-18 months later – in comparison, three quarters of JSA claimants are in work 6 months

<sup>21</sup> DBC 2012

<sup>22</sup> E.g. Grayling, Hansard, 1 Mar 2012 : Column 425W

<http://www.publications.parliament.uk/pa/cm201212/cmhansrd/cm120301/text/120301w0001.htm#12030153000149>

<sup>23</sup> Grayling, Hansard, 12 Mar 2012 : Column 81W

<http://www.publications.parliament.uk/pa/cm201212/cmhansrd/cm120312/text/120312w0003.htm#12031240001145>

"During February 2012 there were 5,353 claimants who had been scheduled to attend a work capability assessment (WCA) for employment and support allowance and, although they attended the Medical Assessment Centre, the WCA could not be conducted by Atos Healthcare.

Of this number 2,231 were for reasons which it has been contractually agreed to be outside the control of Atos Healthcare, these reasons are: being unfit on arrival to be assessed; arrived late (over 10 minutes); nurse being unable to continue with assessment; inappropriate for HCP to see; accommodation problems; unable to be seen for health and safety reasons; no prior notification of special needs; arrived on time but not prepared to wait for up to 30 minutes."

<sup>24</sup> DBC 2012

after starting their claim. The high percentage of appeals overturned – various figures between 70 and 100% are reported when a representative is involved – are also indicative of how many Fit For Work decisions are incorrect.

*“The worst has to be when they sent me for a medical, I was that ill from the stress of it I suffered extreme psychosis on the day itself yet was still deemed fit for work. The shrink got involved and said no we appeal, waiting 9 months for appeal date, that was horrific felt like a criminal. I dread another medical or meeting or assessment.”*

## 5. POVERTY

Responses to the survey by the Disability Benefits Consortium showed that advisers overwhelmingly believe that “increasing numbers of people are being left without adequate support by the welfare system.”<sup>25</sup> This is exacerbated by lack of security over future retention of benefits.

Poverty does not just mean financial lack, but also covers social issues. Many people find themselves dependent on others or unable to adequately care for those who are dependent on them.

*“Having to rely on my 80 year old mum to send me money in the post every week, as reduced rate of ESA didn't even cover half of what was needed for bills, mortgage, Zilch left for food or petrol.”*

*“Fear of being found fit to work when I can't work at all, and losing custody of my son to his abusive father as a result of all the other consequences that would ensue.”*

## 6. TIME LIMIT

“The Department also considered the needs of the taxpayer as well as claimants in making its decision to introduce a time limit.”<sup>26</sup> “It is estimated that in steady state, without time-limiting, around 77% of contributory ESA claimants in the Work Related Activity Group or Assessment Phase would have a duration of 12 months or more.”<sup>27</sup> “ESA has always been intended to be a temporary benefit for those in the Work Related Activity Group. It is important that we rebalance the benefit system so that it is fair to recipients as well as being affordable to the taxpayer.”<sup>28</sup>

*“The 1 year limit. I'm not miraculously cured of my non-curable disease just because my partner is lucky enough to have a job.”*

## 7. ESA IS DESIGNED TO DENY CLAIMS

ESA is a much tougher benefit than its precursor, Incapacity Benefit: a simple comparison of the descriptors for the two benefits shows this (e.g. able to climb 2 steps [ESA] vs 15 [IB]). Its stated intention was to give more support to those who may, with that support, be able to work. However, part of its aim was also to reduce the incapacity benefit bill; and the Welfare Reform Bill and related acts carried out by the current government have given the impression that the focus is on cutting support, not giving it.

*“The worst thing about ESA is the fear, the test has been deliberately created for people to fail no matter how sick.”*

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<sup>25</sup> DBC 2012

<sup>26</sup> Grayling, Hansard, 1 Dec 2011 : Column 1112W

<http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm111201/text/111201w0004.htm#11120169001745>

<sup>27</sup> Grayling, Hansard, 3 May 2011 : Column 723W

<http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm110503/text/110503w0005.htm#1105041001309>

<sup>28</sup> Miller, Hansard, 31 Jan 2011 : Column 586W

<http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm110131/text/110131w0004.htm#11013139000675>

### **Chapter 3: Implementation of first-year Review recommendations**

#### **Summary**

Whilst the government says it 'accepted' all the recommendations, this does not mean that they have been incorporated into the ESA assessment process. Improvements to the ESA process therefore cannot be assumed based on the recommendations. It is necessary to examine what has been done regarding each recommendation. The results show that success has been much more limited than 'acceptance' would suggest.

Of 25 recommendations, almost two-thirds have not achieved success. Three were not implemented at all; five were implemented with limited success; and eight were not fully implemented, which consequently also means a limited success. This lack of success means the recommendations have not brought about the improvement to the ESA system that they could have brought, had the government fully accepted and implemented the recommendations.

#### **Overview of implementation**

Three recommendations were not implemented.

- Two of these were because they were beyond the Review's remit, being related to the Tribunal system.
- The third was that Decision Makers should be able to contact a claimant's chosen healthcare professional "to provide a view on the accuracy of the report." This has not been done and no explanation, reason or justification has been given for this.

Nine recommendations were fully and successfully implemented.

- Include a personal justification in the ESA50 form;
- Include a personalised summary from the Atos assessor;
- Increase the role of the Decision Maker;
- Make better use of the reconsideration process;
- Find out what happens to claimants after the decision;
- Examine consistency between Atos assessors of different professions;
- Monitor the implementation of recommendations
- Ask for recommendations on the mental, intellectual and cognitive descriptors (on-going); and
- Examine the descriptors, particularly for fluctuating conditions and possibly for generalised pain (on-going)

Five recommendations were fully implemented but with limited success.

- Review the ESA50 "to ensure it is the most effective tool for capturing relevant information about the claimant;"
- Atos should publish a charter of claimant rights and responsibilities, and consider publishing online the guidance that they provide for healthcare professionals;
- There should be better communication between Decision Makers and Atos healthcare professionals regarding borderline cases;
- Decision Makers should "receive training so that they can give appropriate weight to additional evidence;" and
- Examine the computer system used by Atos.

Eight recommendations were not fully implemented.

- Jobcentre Plus should manage and support the claimant during the course of their benefit claim and identify their chosen healthcare adviser;
- Written communications should be "clearer, less threatening, contain less jargon and fully explain the process;"
- Mental, intellectual and cognitive champions should be provided in each medical assessment centre. "These champions should spread best practice amongst Atos healthcare professionals in mental, intellectual and cognitive disabilities;"
- Carry out a pilot of audio recordings to see if this would be helpful;
- Research the use of "more 'real world' or work-focused elements" in the assessment;

- Send a copy of the Atos personalised summary to the claimant, and allow the claimant to “discuss any inaccuracies with a Decision Maker;”
- Share feedback from the First-tier Tribunal should be routinely shared with Jobcentre Plus staff and Atos healthcare professionals. “As part of their professional development, Jobcentre Plus Decision Makers should be encouraged to regularly attend Tribunals;” and
- Examine what happens to people who are found Fit for Work but are unable to claim Jobseekers Allowance.

### **Recommendation 1.**

#### **Harrington’s recommendation:**

The review recommends that Jobcentre Plus manages and supports the claimant during the course of their benefit claim and identifies their chosen healthcare adviser.

#### **Government response:**

Accept

The government will increase support for claimants by:

1. DWP staff telephoning the claimant
  - a. At the beginning of the claim to
    - i. Explain the Work Capability Assessment;
    - ii. Explain the claimant’s responsibilities;
    - iii. “Stress ... the importance of:
      1. Fully completing the ESA50 questionnaire,
      2. Identifying [the] chosen healthcare provider,
      3. Providing additional evidence;”
    - iv. Explain “the support that is available after the Work Capability Assessment;” and
    - v. “Allay fears about the process.”
  - b. At the outcome of the claim to explain:
    - i. The outcome of the assessment;
    - ii. Reasons for the decisions;
    - iii. Options for providing further evidence; and
    - iv. What will happen next, including:
      1. Information about Jobseeker’s Allowance for those found fit for work; and
      2. Routeing “those who need to be in the Support Group to that group as soon as possible.”<sup>29</sup>

#### **Evidence of application or success:**

Respondents to the call for evidence for the year three Review – evidence gathered in summer 2012 - largely felt that support from the Jobcentre had not improved. The Disability Benefits Consortium carried out a survey which they submitted to the DWP as their response to the call for evidence.<sup>30</sup> The survey results showed a lack of improvement in support from the DWP and Jobcentre:

- “Over 75% of respondents disagreed (or strongly disagreed) that support from Jobcentre Plus had improved over the last 18 months” – this is suggestive that the government has either not increased support or, if it has done so, the changes have not had significant effect
- “Over 80% disagreed that “customers feel better informed about what to expect and what their responsibilities are.”” – [see a.i & a.ii for the government action to which this refers].
- “Almost 80% disagreed that “customers are more aware of the need to collect evidence from their favoured healthcare professional.”” – [see a.iii.3 & b.iii].
- Over 90% disagreed that “customers know more about the financial and back-to-work support available to them, dependent on the result of their application for ESA.”” – [see a.iv & b.iv].

<sup>29</sup> p.33 <http://www.dwp.gov.uk/docs/wca-review-2010.pdf>

<sup>30</sup> DBC 2012. Quotes in italics are from the DWP call for evidence.

- “Almost 75% disagreed that “customers who need to go straight into the support group are being directed there more effectively.”” – [see b.iv.2].
- “Over 85% agreed that “people are increasingly struggling to access support and advice to help them claim benefits.”” – [see a.iv & b.iv.1].
- “Almost 90% agreed that “increasing numbers of people are being left without adequate support by the welfare system.”” – [see a.iv & b.iv.1].

Replies to the Disability Benefits Consortium survey show that the welfare system is continuing to offer very low support, with inadequate information given to the claimants. The following responses are based on experience of ESA during the 18 months preceding the call for evidence:

- “Over 80% disagreed that “people are being effectively supported back (or into) work.”” – [see a.iv & b.iv.1].
- “Almost 75% disagreed that “people's health is likely to improve as a result of support provided by the welfare system.”” – [see a.iv & b.iv.1].
- “Just 12% of claimants were signposted to relevant organisations who might support them when going through an appeal.”

Overall, the percentage of claimants who had received an explanation of the decision and what it means to them remains low.

- Over 75% said that no-one had explained how or why a decision had been reached – [see b.i & b.ii].
- 77% said no-one had “explained what the decision meant for them.” (75% after April 2011) – [see b.i, b.ii & b.iv].

There was some slight difference between those who had been assessed before April 2011 and those who had been assessed afterwards, with those in the later group having slightly more positive experiences:

- Those who had received an explanation of the decision increased from 22% before April 2011 to 25% after April 2011.
- Those who had an explanation of what the decision meant for them had increased from 29% to 35%.

It therefore does not appear that support is adequate or that it has improved.

In terms of phone calls, it appears that these now occur *after* the WCA but not before. Support before the WCA is presumably now considered to be adequately covered by the ESA35/35A. A new form of this letter has been drafted and trialled to improve understanding and increase ESA50 returns. The year three Review indicates that “Decision Makers now contact the claimant by telephone following the outcome of the WCA.” However, “Disappointingly many claimants reported that they had not received a call from the Department but would welcome such support. Nationally, approximately one in three calls get through to the claimant. This remains a concern and further efforts are needed to ensure as many claimants as possible receive the necessary help and support they need through the process.” There is great variation across the country. According to the Review, much of the variation in success rate is “down to the attitude of local managers towards the increased workload on Decision Makers and the inevitable slowing in the number of claimants handled in a week.”

These phone calls can be “demanding” for Decision Makers, as “claimants can be upset, aggressive or totally shocked.” Benefit centres where these calls have been in place for longest “have come through to the other side, so to speak.” It is to be hoped that Decision Makers do not find this to have long-term consequences on stress levels.

The DWP has trialled a system whereby text messages are sent to the claimant prior to the call. This “improved the success rate of the calls” and these trials are to be extended.

Contact remained difficult for claimants by the time of the year three review, as “some people, particularly those with mental health conditions, stated that there was too much contact and they found this stressful and could exacerbate their existing condition. Other respondents stated that there

had been none or little contact from DWP – despite the recommendations from the year one Review – and were often unaware what stage their claim was at.”

Overall, none of the changes put in place have had a noticeable effect on the assessment process. The evidence suggests that Jobcentre Plus is either not effectively, or not at all, managing and supporting the claimant during the course of their benefit claim. There is no evidence to suggest that claimants are being encouraged to name a healthcare provider.

The data from the DBC survey suggests a lack of information given during the phone call, as whilst 35% agreed that they received an explanation of what their decision meant for them, fewer than 25% agreed that they had received an explanation of the decision. It would be useful to know how this group broke down as regards phone calls from Decision Makers versus other sources of information.

**Conclusion:**

Partially implemented with limited success.

The Jobcentre Plus does not successfully manage (phone calls do not occur before the WCA) or support (support is limited) the claimant during the claim process.

No mention has been made of Jobcentre Plus identifying the claimant’s healthcare professional. Decision Makers call claimants *after* their WCA. Only 1 in 3 of these calls get through.

**Recommendation 2**

**Harrington’s recommendation:**

The review recommends that the initial questionnaire (the ESA50) includes a more personalised justification so the claimant can express the issues that they face in a short paragraph.

**Government response:**

Accept.

**Evidence of application or success:**

The ESA50 now contains a page with a text box to explain “what is your disability, illness or condition, and how does it affect you?” Although the box itself has been reduced in size in the latest version of the ESA50, the questionnaire encourages people to use extra space if needed.

**Conclusion:**

Implemented.

**Recommendation 3**

**Harrington’s recommendation:**

In the longer term, the review recommends that the Government reviews the ESA50 to ensure it is the most effective tool for capturing relevant information about the claimant.

**Government response:**

Accept

The government “will continue to keep the ESA50 questionnaire under review to ensure that it captures the most relevant information to support Decision Makers in making accurate decisions.” In response to this recommendation and to recommendation 2 (above), the government has added a text box for claimants to explain how their condition affects them. The government aims to make the ESA50 form “more user-friendly.”

**Evidence of application or success:**

The government say that the ESA50 form has been under constant review. However, it does not seem that the changes to the ESA50 form have made it “more user-friendly.”

- Almost 8 in 10 (79%) of DBC respondents to the 2012 survey found the application form ‘hard’ or ‘very hard’ to complete.
- The form has been described as lengthy, repetitive, ambiguous and tricky. Claimants report that completing the form can take many hours, spread over multiple days.

It is worth noting that any questionnaire designed to capture most of a wide variety of illnesses and abilities will almost certainly have to be long.

Claimants felt that the ESA does not capture “the most relevant information to support Decision Makers in making accurate decisions.” According to the DBC report, “Many claimants commented that

the form did not ask questions relevant to their life and condition (particularly those with mental health or fluctuating conditions), or that they found the form confusing, too long and repetitive.” Comments include:

- “Not relevant questions and not enough scope within tick boxes to answer efficiently when talking about long term condition fluctuations.”
- “Very ambiguous and tricky as though they were trying to catch you out.”
- “It did not appear to acknowledge mental health as a health condition.”

The year three Review itself reported that, “A consistent response [to the third year call for evidence] was that the ESA50 is too complicated and does not have enough space for the claimant to explain fully how their condition affects them on a daily basis.”

By the third year, the Review was able to say that, “the fluctuating conditions group have produced what the Review considers to be an excellent set of proposals to improve the initial ESA50 form which the Reviewer commended to DWP. Work to update the ESA50 is progressing and should be completed early in 2013.” It will be interesting to see if this new form is considered to be an improvement on the previous.

**Conclusion:**

Implemented with limited success.

Claimants continue to feel that the ESA50 is not an “effective tool for capturing relevant information.”

**Recommendation 4**

**Harrington’s Recommendation:**

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

**Government’s Response:**

Accept

Revised IB reassessment notifications will be issued from early 2011.

**Evidence of application or success:**

The Review’s first-year recommendation included decision notifications, those sent “at the beginning of the claim,” and those sent “as they [claimants] book their Atos assessment.”

Harrington specifically identifies the phrases, “your benefit may be affected” and “we may stop your benefit” as being potential causes of anxiety or confusion.

He considers that “large volume of communications that are sent to claimants do not as a whole add up to a coherent and easily understandable explanation of the process.”

He continues with concerns regarding advice on the ESA50 form: “For example, the guidance on completing the ESA50 tends to focus on what claimants should enter but does not explain how the information that claimants provide will be used.”

The year two Review said that, “The follow-up letters have also been made clearer and less threatening.” The government’s response to this review included the statement, “communications have been overhauled so the process is now more empathetic,” and “DWP Operations has also reviewed the key written communications sent to claimants to ensure they are clear, accessible and do not contain jargon.” However, the DBC’s response to the year two Call for Evidence showed that most claimants and welfare advisers did not consider that written communications had improved since early 2011.

In the third review, Prof. Harrington says that the DWP “sought views from claimants in the last eleven months” and these views indicate that the ESA35/35A “provides claimants with clearer information about the WCA and the next steps.”

The DBC concluded in its response to the third year call for evidence that, “Communications have improved to some extent – letters appear to be clearer ... however the majority of responses regarding communications remained negative.”

**Conclusion:**

Partially implemented with limited success.

The government has not addressed issues regarding advice provided with the ESA50 form.

Written communication may now be clearer, but there is little evidence from claimants or welfare advisers on whether this is the case, or on whether communication is now less threatening and more empathetic.

### **Recommendation 5**

#### **Harrington's Recommendation:**

The review recommends that every Atos assessment contains a personalised summary of the assessment in plain English.

#### **Government's Response:**

Accept

We agree that it is crucial that all ESA reports clearly convey the basis of the healthcare professional's opinion on capability for work. All Atos healthcare professionals will receive updated training to provide a robust justification in ESA reports in the year 2010 - 2011. We will also explore the feasibility of providing a personalised summary as part of the ESA report before the end of 2011.

#### **Evidence of application or success:**

The year two Review said that a personalised summary statement for Atos assessors to complete was introduced nationally in June 2011, and that this has been used by Decision Makers.

#### **Conclusion:**

Implemented.

### **Recommendation 6**

#### **Harrington's Recommendation:**

The review recommends that every claimant is sent a copy of the Atos personalised summary and is able to discuss any inaccuracies with a Decision Maker.

#### **Government's Response:**

Accept

It is essential that the basis of decisions is available and properly explained.

#### **Evidence of application or success:**

In the second year Review, it was clear that the Review had been in discussion with the DWP. The Review said that it had had "extensive discussions with senior DWP staff over this and understands the need to issue the statement to the right claimants, in the right context, at the right time." The phrases "right claimants," "right context" and "right time" suggest that the DWP and/or the Review was not intending at this stage to make the personalised summary available to all claimants.

It was suggested to the Review that it would be better "to issue the Decision Maker's Justification instead if a claimant is disallowed," on the basis of a trial carried out by the DWP over the summer. The Decision Maker's justification would cover all of the evidence available, whereas the Atos assessor would use only the report they had written. A trial then began to issue the Decision Maker's justification to claimants found fit for work, with the intention to implement this nationally – subject to the findings of the trial – to all claimants found fit for work from December 2011.

In Prof Harrington's third review, he said that, "Decision Makers Reasoning is issued to claimants found fit for work with the aim of providing a clearer explanation of the decision and all the evidence considered by the Decision Maker." The reasoning is "an extended piece of prose outlining the claimant's case and the reasoning behind the DWP decision to allocate an individual to a particular Group."

A survey conducted by Action for ME found that almost half of respondents did not see a copy of the report from their assessment. As this question does not refer to the Decision Maker's justification (reasoning), it is unclear whether these claimants received the Decision Maker's justification instead. However, it is clear that not all claimants see a copy of their WCA report, the Atos assessor's personalised summary or the Decision Maker's justification. All three would be useful for all claimants. Claimants with long-term conditions may find it helpful to have all information from previous claims, particularly when contesting the ruling of the most recent decision. Claimants found Fit For Work or placed in the WRAG who wish to appeal are likely to find it helpful to have the WCA report *and* the personalised summary in order to discuss accuracy at a reconsideration or appeal.

**Conclusion:**

Partially implemented.

Claimants found fit for work only are sent a copy of the Decision Maker's justification only. Other claimants do not receive this, and none routinely receive either the personalised summary or the WCA report.

**Recommendation 7****Harrington's Recommendation:**

The review recommends that Atos provide mental, intellectual and cognitive champions in each medical assessment centre. These champions should *spread best practice* amongst Atos healthcare professionals in mental, intellectual and cognitive disabilities (emphasis added).

**Government's Response:**

Accept.

DWP and Atos will establish healthcare professionals with enhanced skills as champions who will serve as a resource for all healthcare professionals.

**Evidence of application or success:**

The purpose of these champions, as stated by the Review in its first year report, was to "employ champions in mental, intellectual and cognitive disabilities. That is HCPs who have undergone further specific training in these conditions and are able to spread best practice and knowledge, help other HCPs with difficult assessment or take on some of the most difficult assessments involving mental, intellectual or cognitive disabilities."

It was originally suggested that each assessment centre have a Mental Function Champion. This however was reported in the second year Review to be "logistically impossible," so instead the DWP has put in place 60 MFCs on a regional basis. "The Review has been convinced that a regional approach is more efficient, conserving scarce resource and still delivering the desired result." Dr Gunneon reported that HCPs can always access Mental Function Champions: "There is always somebody available for healthcare professionals while they are doing an assessment, whether they want advice before they start an assessment, or to pause an assessment and go and seek advice, or to seek advice before they complete their assessment report."<sup>31</sup>

From Atos' perspective, Mental Function Champions are having a positive effect. According to the Review, Atos "said that their healthcare professionals found the Champions to be 'a great resource' and that they were of 'great use to put any uncertainties into perspective.'"

The Review further said that it had "met one of the Champions during its visit to an Atos Assessment Centre. He described being able to help healthcare professionals both locally and nationally. He had also built a series of contacts with Community Mental Health Trusts to ensure greater provision of further documentary evidence."

The Review has further recommended that "the Department may wish to explore the outcomes of assessments undertaken by Mental Function Champions in their supportive 'non-Champion' role to see if there are significant differences from non-specialists undertaking mental function assessments." The survey carried out by the Disability Benefits Consortium in September 2012 revealed that over 70% of advisors were not aware of ATOS Mental Function Champions. Those that were aware believed that the Champions had little or no impact on the quality of assessments for people with mental health problems, learning disabilities and autistic spectrum disorders. This reflects anecdotal evidence from local organisations that it has been difficult to make contact with Mental Function Champions and, perhaps more importantly, that it has been far from obvious what role they are playing in improving the Work Capability Assessment.

Concerns about the poor quality of mental health assessments remain high and widespread amongst charities, advisers and claimants. According to the Papworth Trust, "3/4 of advisors say that people with mental health conditions were most likely to be incorrectly assessed. Advisors often reported

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<sup>31</sup> Work and Pensions Committee, 21<sup>st</sup> November 2012

feeling helpless when asked to support a client with severe MH needs who they know is unsuitable to work.”<sup>32</sup>

A joint response from Centre for Mental Health, HAFAL, the Mental Health Foundation, Mind, Rethink Mental Illness, the Royal College of Psychiatrists and SAMH said that, “We believe that, without expertise in the causal conditions, healthcare professionals are not sufficiently equipped to understand why and how function may be impaired or to elicit the relevant information from an applicant who may have... difficulties in reporting their condition.” There is widespread feeling that MFCs should be health practitioners who had specialised in mental health *before* joining Atos as an assessor, not simply had extra training *after* joining Atos.

**Conclusion:**

Partial implementation with limited success.

**Recommendation 8**

**Harrington’s Recommendation:**

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

**Government’s Response:**

Accept.

Atos Healthcare has provision for the recording of medical assessments and we will shortly launch a pilot initiative to establish the feasibility and cost effectiveness of recording of all face-to-face assessments.

**Evidence of application or success:**

A pilot was carried out in Newcastle-Upon-Tyne Medical Assessment Centre in spring 2011. This trial offered audio recordings to 500 claimants, of whom 344 accepted and 230 recordings were made.<sup>33</sup> Prof Harrington reported that 70% of claimants in the trial thought that recording was a good idea, although this was split between those who agreed to a recording (85% considered it a good idea) and those who did not (36%). Only 47% thought they would find recording beneficial – it is difficult to interpret this in light of the previous statement.

The Atos assessors generally considered the recording as a positive procedure, and that it would support them if there were subsequent complaints. Most of the assessors “felt it would be appropriate for all HCPs to be required to undertake recordings if the recording were to be rolled out to all customers,” although there was recognition that some assessors may find this stressful.

The report suggested that audio recording did not improve the quality of the assessment. It did not consider the *accuracy* of the assessment in recording the claimant’s conditions and capabilities, a measure that might be considered more appropriate.

Prof Harrington concluded that, “The results of the pilot indicate that there are a significant proportion of clients who would welcome the opportunity to have their assessment recorded.” He also said that there is increasing demand for recordings, and that therefore “there is a need to make recordings more readily available on request.” He recommends that “recording should become routine as it is in a call centre or for example – NHS direct. There is therefore an urgent need to decide how the issue of recording of assessment is progressed and AH is keen to work closely with the Department to develop a measured and cost effective way of implementing this.”

The DWP have not done this. They have made audio recordings available on request – although claimants report that even after request a recording may not be made – but no information about this is available on either the relevant section of the DWP’s website or on the Atos website. Atos have only 5 recording machines,<sup>34</sup> to serve over 120 Medical Assessment Centres.<sup>35</sup> This is not close to Prof

<sup>32</sup> Papworth Trust, response to call for evidence for the third year Review

<sup>33</sup> 78 did not attend, 25 withdrew permission, and 11 were unable to have their assessment recorded

<sup>34</sup> FoI request regarding the number and state of repair of Atos recording machines. Reply dated 12<sup>th</sup> August 2012 [https://www.whatdotheyknow.com/request/state\\_of\\_repair\\_of\\_atos\\_medical](https://www.whatdotheyknow.com/request/state_of_repair_of_atos_medical)

<sup>35</sup> 123 permanent centres plus some others. Evidence given to the Work and Pensions Committee by Mark Hoban, 2012

Harrington's recommendation of universal recording, and cannot supply the number of claimants who, based on the evidence, would have a recording made if offered the opportunity.

The DWP's reasoning is that, "less than half of people wanted their sessions recorded and only a tiny number sought a copy of their recording."<sup>36</sup> The Work and Pensions Committee challenged this, saying, "Asking for the transcript is not necessarily an indication of how useful it is, because the fact that it was recorded at all is the guarantee for the claimant that what they said is there and has been recorded. For instance, calls to the CSA1 are all taped, but very, very few people ask for the transcript. It is only when there is a problem that they ask for the transcript, but the knowledge that it is being taped means that they are probably less likely to ask for the transcript, because there is less likely to be a dispute. That is the point of the audio recording."<sup>37</sup> Furthermore, the majority of claimants thought that a recording would be beneficial, as did the HCPs involved.

There does not appear to be good reason for the very poor provision of audio recording.

**Conclusion:**

Partial implementation with limited success.

Prof Harrington recommended universal recording. Instead, the government has provided only 5 machines available on request, but not guaranteed upon request, and no information is provided about this option on DWP, government or Atos websites.

**Recommendation 9**

**Harrington's Recommendation:**

The review recommends that Atos should develop and publish a clear charter of claimant rights and responsibilities, and should consider publishing the HCP guidance online for claimants and advisors.

**Government's Response:**

Accept

**Evidence of application or success:**

The Atos Customer Charter and WCA Handbook (HCP Guidance) are both available online.<sup>38</sup>

The government has fully implemented this recommendation. It would be beneficial to see greater advertising of these resources, as 67.2% of the Disability Benefit Consortium respondents were unaware of the charter in 2011.

Despite the charter, claimants continued to have negative experiences with Atos. As reported in the third year Review, claimants with mobility problems continue to have difficulty with access, assessors attitudes remains poor, and "there appears to be an increase in individuals who, having submitted further documentary evidence from their GP or chosen healthcare adviser, feel this is ignored or overlooked at the face-to-face assessment."

Accuracy of reports continues to be an issue, with many claimants saying that the report "does not reflect their experience of the face-to-face assessment. Incorrect details are input or important points omitted, and assumptions are made about a claimant's condition." Those with complex health conditions continue to feel that their Atos assessor "does not have the necessary skills or training to complete the assessment."

**Conclusion**

Implemented with limited success

An FoI request regarding the accessibility as Medical Assessment Centres gave 139 centres. Reply dated 14<sup>th</sup> September 2011. [https://www.whatdotheyknow.com/request/atos\\_assessment\\_centres\\_location](https://www.whatdotheyknow.com/request/atos_assessment_centres_location)

<sup>36</sup> Hansard, Mr Grayling, 22 Feb 2012 : Column 869W

<http://www.publications.parliament.uk/pa/cm201212/cmhansrd/cm120222/text/120222w0003.htm#12022278001695>

<sup>37</sup> Work and Pensions Committee, oral evidence on ESA and the WCA, 21<sup>st</sup> November 2012

<sup>38</sup> <http://www.dwp.gov.uk/publications/specialist-guides/#other>

[http://www.atoshealthcare.com/claimants/our\\_customer\\_charter](http://www.atoshealthcare.com/claimants/our_customer_charter)

## **Recommendation 10**

### **Harrington's Recommendation:**

The review recommends that Jobcentre Plus Decision Makers are put back at the heart of the system and empowered to make an independent and considered decision.

### **Government's Response:**

Accept

### **Evidence of application or success:**

The Review considers that the use of the 'Assurance Call' is "a good example of ensuring Decision Makers are driving the process." The success rates of calls is low with 1 in 3 calls getting through to claimants. According to the Review, much of the variation in success rate is "down to the attitude of local managers towards the increased workload on Decision Makers and the inevitable slowing in the number of claimants handled in a week."

Contact with Atos assessors remains variable, with many Decision Makers struggling to build relationships with assessors, and some assessors not engaging in reworking assessment reports. The Review said that, "Communications between DWP Decision Makers and Atos healthcare professionals appear to remain variable. A common theme ... was an apparent difficulty in persuading Atos healthcare professionals to rework assessment reports. ...

"Decision Makers appreciated the chance to discuss individual cases with Atos healthcare professionals when this facility was available, but building relationships through the phone advice-line was more difficult."

Regarding decisions involving mental health conditions, the Review said that, "Decisions on mental function claims remain complex, with training and support seen as the key elements rather than the specific wording of the legislative descriptors."

According to the third report of the Review, "Since the acceptance of the recommendations in the year one Review extensive training and development, and associated materials, have been developed for DWP Decision Makers. These have all been aimed at improving the skills and knowledge of Decision Makers to allow them to effectively sit at the heart of the WCA ... However, neither Review has been able to demonstrate satisfactorily the link between the training offered and the added value this offers to the individuals involved.

Only then can the Review be assured that the WCA is being undertaken to a standard commensurate with the importance the benefit system demands." (emphasis added)

The Review therefore recommended that, "In order to build on the progress already made DWP Operations need to find an appropriate balance between better quality decisions that are carefully considered and 'right first time' and the achievement of appropriate benchmarks at a local level, otherwise there is a real risk of derailing the positive progress made to date." It further commented that, "It was apparent that managers at different sites have a different approach to the implementation of the Review's recommendations: some were still concerned about meeting the Department's benchmarks whilst others have placed a stronger emphasis on the concept of 'right first time' decisions even if this takes more time. It is important that claims are administered in a timely fashion, but the Review strongly supports the concept of 'right first time' decision making which takes into account all available information to support it."

The Quality Assurance Framework shows that approximately 90% of decisions meet the current criteria. These are:<sup>39</sup>

- The aim of the Decision Making QAF is to identify any fundamental errors, rather than minor mistakes that have no potential impact on the decision making process or the outcome.
- A fundamental error is where the outcome is wrong, the customer has not been treated fairly, or an important stage of the decision making process has been handled incorrectly so that, even if the outcome was acceptable, there was potential for a wrong outcome.
- The standard set for Quality Checking requires that each of the following elements be met. A decision that fails on one or more of these points will not reach the required standard.

<sup>39</sup> Data obtained by FoI request on the Quality Assurance Framework.

[https://www.whatdotheyknow.com/request/quality\\_metrics\\_for\\_decisionmake#incoming-276968](https://www.whatdotheyknow.com/request/quality_metrics_for_decisionmake#incoming-276968)

- The crucial issues are correctly identified and the decision is focused on these;
- The necessary evidence gathered has been used appropriately to establish the relevant facts, if any of these were missing, or to clarify any points of doubt;
- The law, including the legislation, has been interpreted and applied correctly to the facts of the case;
- The DM is neutral and the customer has been treated fairly;
- The key conclusions and the reasons for them are recorded and the decision is soundly based in fact and law;
- The outcome of the decision is one that is right in the circumstances.

“In a very small sample of cases where the claimants were asked if they could recognise themselves in the Decision Maker Reasoning, 75 per cent stated they could. This is in marked contrast to claimants’ views from the call for evidence on the reports from the face-to-face assessment.”

Citizen’s Advice Scotland reported in their response to the second year Call for Evidence that, “Anecdotally, some advisers have reported an improvement in the role of DWP decision makers. One adviser explained how a decision maker took responsibility for helping a client get a reconsideration when the adviser showed that the initial assessment had been flawed. We hope that DWP decision makers continue to take an assertive role in the process.”

**Conclusion:**

Implemented.

Whilst this is a subjective recommendation, a number of things have been implemented to increase the role of the Decision Maker. There is some evidence that Decision makers are taking a more active role.

**Recommendation 11**

**Harrington’s Recommendation:**

The review recommends a better use of the reconsideration process.

**Government’s Response:**

Accept

An effective reconsideration stage is an important element of the decision making process.

Considerable progress has been made in strengthening the process with the piloting of new measures at Wrexham and we will expand this experience nationwide.

**Evidence of application or success:**

In the first year, the Review found that the reconsideration process is “rarely used by Decision Makers” such that claimants are therefore reliant on “the more lengthy appeals process.” However, the DWP said in evidence to the Work and Pensions Committee that “If a customer appeals this will also trigger the reconsideration process, as the Department aims to put decisions right at the earliest opportunity.” Following a trial in Wrexham, where claimants were offered a reconsideration, “15% of claimants who had appealed either withdrew their appeal or had their initial decision revised.” The majority of these were revised. 254 claimants were involved in the trial. An FoI request elicited the following information:

- 1.2% of cases were withdrawn by the claimant;
- 13.8% of cases were revised; and
- 17.3% of cases were referred back to Atos.

The Review noted in its second year that, “Increased use of the reconsideration process is now a standard part of the later stages of the claimant journey. This is proving to be useful as additional medical information from the claimant often only comes to light at this stage. In an ideal world, the Decision Maker should have this evidence early in the process, but the fact that it is being considered routinely before an appeal needs to be invoked is an advance on previous practice.”

Claimants and welfare advisers say that they have seen an increase in the use of the reconsideration process – although CAB qualified this by saying that there has been “much less improvement in the original decision making.”<sup>40</sup> The Disability Benefits Consortium noted a similar response, with 35%

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<sup>40</sup> CAB 2012

saying they had seen an increase in the use of reconsideration, but only 11% “thought that a decision maker was more likely now to overrule the Atos recommendation in the original decision.”

Whilst evidence shows an increase in use of reconsideration, advisers are split about whether this is beneficial. Slightly more advisers considered that reconsideration had not “had a positive impact on claimants receiving a fair outcome” than considered there had been a positive impact (36% vs 32%).

#### **Mandatory Reconsideration:**

The government has now brought in a process whereby reconsideration before appeal is mandatory. The assessment rate of ESA is not paid during this time, as it is whilst waiting for an appeal to be heard. The government says that, “Although the claimant (or other person) could ask initially for the decision to be reconsidered with a view to revision [...] in practice many people do not do so and make an appeal from the outset.”<sup>41</sup>

Serious objections have been made to this. Sue Royston, Policy Officer for the Citizen’s Advice Bureau, said that, “At present, when somebody puts in an appeal, DWP has to reconsider that decision, so the reconsideration is there [...] what is being proposed is imposing two time limits on the client. The reconsideration would be done; the client would get the decision; and then they would have to put in an appeal again. They would have two time limits to meet. That seems to me very wrong. It is putting the onus on clients to do the thing twice...”

“We completely agree that an effective use of the reconsideration process is in everyone’s interest. We do not however, believe that DWP has given any convincing justification of why this measure is necessary in order to achieve this. We believe that nothing in this measure will strengthen the reconsideration process. At present, the DWP has to reconsider the decision when someone appeals. This step needs to be used much more effectively, especially in the case of ESA decisions.”

The Disability Benefits Consortium said that, “In our experience it is almost unknown for the DWP not to carry out a reconsideration when an appeal is received, even though there has been no legislative requirement to do so. In practice, virtually all decisions are reconsidered before the appeal proceeds and the consultation document notes that a significant proportion of appeals are currently lapsed at this stage. We cannot therefore view making reconsiderations mandatory having a significant impact on improving the system.”<sup>42</sup>

The DWP themselves corroborated this in their evidence to the Work and Pensions Committee, saying twice that, “If a customer appeals this will also trigger the reconsideration process, as the Department aims to put decisions right at the earliest opportunity.” Sue Royston of CAB said that, “What we saw up until very recently is you would send an appeal in and, within the two days, you would get a decision back that it had been reconsidered. That reconsideration by DWP was basically a rubber-stamping of what had gone before. We saw very few properly reconsidered.”

In general, responses to this consultation suggested that:

- The original decision making needs to be improved;
- There is already a reconsideration process; making it ‘mandatory’ is unnecessary and will not add anything to the current process;
- Reconsideration needs to be properly used, not a rubber-stamp of the previous decision, but this will not happen as a result of adding extra bureaucracy on the claimant;
- Not paying ESA during this time is dangerous and discriminatory;
- Appeals can already take a year to be heard; this simply adds to the length of the process; and
- It adds extra bureaucracy and time limits that can be very difficult for ill, disabled and vulnerable people to meet.

#### **Conclusion:**

Implemented.

The government has gone beyond the Review’s recommendation to make reconsideration a mandatory part of the appeal process. There are multiple concerns with this as expressed by a number

<sup>41</sup>Work and Pensions Committee, 6<sup>th</sup> Report, Role of IB reassessment in helping claimants into employment. 2011

<sup>42</sup><http://www.disabilityrightsuk.org/department-work-and-pensions-september-2012-mandatory-consideration-revision-appeal-our-response>

of charities. It is not the purpose of this report to go into these in detail, but it is noted that this is widely considered an unnecessary change and may cause harm to claimants.

### **Recommendation 12**

#### **Harrington's Recommendation:**

The review recommends Decision Makers are able to seek appropriate chosen healthcare professional advice to provide a view on the accuracy of the report.

This was clarified by the Review that 'chosen healthcare professional advice' means a healthcare professional chosen by the claimant; i.e. a report from the HCP named by the claimant as explained below (emphasis added).

"In summary, the Decision Maker has a pivotal role in evidence gathering. They should ask the claimant to name a chosen HCP and seek a report from them (for some claimants, the Decision Maker may have to undertake that task). When the Decision Maker has received the Atos report, including a personalised, free text summary (see Chapter 5), they will offer to send it to the claimant's chosen HCP. When a report has been received, the Decision Maker reviews all the evidence and commissioned reports, including the ESA50 questionnaire with free text paragraph (see Chapter 4). Following liaison with the claimant and, if necessary, Atos and the claimant's HCP advisor, the Decision Maker makes a decision."

#### **Government's Response:**

Accept

"Decision Makers should seek appropriate advice and/or additional evidence in coming to their determination if they require. Different approaches, e.g., with Atos healthcare professionals providing advice and support in interpreting evidence on site through case consultations or "surgeries" and or workshops/training events, are currently being trialled."

#### **Evidence of application or success:**

The DWP has put in place measures for Decision Makers to contact an Atos healthcare professional [recommendation 13, below], but has not arranged for Decision Makers to be able to contact the *claimant's* chosen Health Care Professional.

The government therefore has not carried out this recommendation.

The DBC survey confirmed that this does not appear to have occurred:

- Almost 75% disagreed that Decision Makers were "more likely to seek advice from the customer's chosen healthcare professional." Less than 8% agreed.

#### **Conclusion:**

Not implemented

### **Recommendation 13**

#### **Harrington's Recommendation:**

The review recommends better communication between Decision Makers and Atos healthcare professionals to deal with borderline cases.

#### **Government's Response:**

Accept

#### **Evidence of application or success:**

In response to the first review, the DWP said, "To build on this progress [DMs telephoning claimants regarding their outcome], pilots are also underway to improve communication between Decision Makers and Atos healthcare professionals." They also indicated that Decision Makers already contact HCPs in some cases, and that this will be expanded.

As the Review recognised in its first year, pilots were already underway to improve communication between Decision Makers and Atos, having started in January 2010.

The Review said in its second year that, "Improving the communication between Atos HCPs and the Decision Makers has been trialled. The Review has seen at first hand that where this has been done it has been a valuable resource, particularly for Decision Makers who have had the opportunity to discuss difficult cases or complex medical evidence with Atos HCPs or to understand better the recommendations made by Atos following the face-to-face assessment. However, there has been no

national roll-out of this, instead a telephone advice-line is being introduced.” This decision was made based on cost.

The Review commented in the third year report that, “Communications between DWP Decision Makers and Atos healthcare professionals appear to remain variable. A common theme ... was an apparent difficulty in persuading Atos healthcare professionals to rework assessment reports. ...

“Decision Makers appreciated the chance to discuss individual cases with Atos healthcare professionals when this facility was available, but building relationships through the phone advice-line was more difficult.”

Decision Makers may contact the Atos HCP who carried out the assessment, or contact a separate HCP for general advice.

**Conclusion:**

Implemented with limited success.

For cost reasons, a telephone line has been introduced rather than have Atos HCPs at all decision maker centres.

**Recommendation 14**

**Harrington’s Recommendation:**

The review recommends Decision Makers receive training so that they can give appropriate weight to additional evidence.

**Government’s Response:**

Accept

**Evidence of application or success:**

The DWP has launched a forum for Decision Makers, “to spread best practice and empower Decision Makers.” Additional support tools include a “Quality Assessment Framework to improve the consistency of decisions,” and the government has also reviewed its Learning and Development. The Review commented in its third year that, “extensive training and development, and associated materials, have been developed for DWP Decision Makers. These have all been aimed at improving the skills and knowledge of Decision Makers to allow them to effectively sit at the heart of the WCA.”

It is not possible to comment on the efficacy of this training without further data on the quality, consistency and accuracy of Decision Maker’s decisions.

The government mentions training generally, not specifically so that Decision Makers “can give appropriate weight to additional evidence.” The responses to the DBC’s most recent survey suggest that any training is not having noticeable effect:

- Almost 75% disagreed that they had “been more likely to seek advice from the customer’s chosen healthcare professional.”
- Over 65% disagreed that they had “given greater weighting to additional medical evidence.”

**Conclusion:**

Implemented with limited success.

The DBC reports that Decision Makers are not thought to be using medical evidence appropriately.

The third Review has resulted in the recommendation that, “Decision Makers should actively consider the need to seek further documentary evidence in every claimant’s case. The final decision must be justified where this is not sought.”

**Recommendation 15**

**Harrington’s Recommendation:**

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

**Government’s Response:**

Will consider this recommendation, which is largely the remit of the First-tier Tribunal

**Evidence of application or success:**

The First-tier Tribunal indicated to the Review and the DWP that the actions of the tribunal are beyond the Review’s remit.

A summary feedback form has been developed for tribunals to send to the Decision Maker. Results of this have already been released, showing that new oral evidence is the main reason for appeals to be over-turned, followed by the tribunal reaching a different conclusion on the same evidence.

It does not appear to be the case that Tribunal decisions are sent to Atos healthcare professionals.

**Conclusion:**

Partially implemented.

Whilst feedback is sent to Decision Makers, it does not appear to be sent to Atos assessors. Nor does it seem to be the case that Decision Makers regularly attend Tribunals.

**Recommendation 16**

**Harrington's Recommendation:**

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

**Government's Response:**

Will consider this recommendation

**Evidence of application or success:**

This has not been carried out. In its second year, the Review said, "No progress has yet been made with the recommendation concerning the monitoring of appeal outcomes within and between Tribunals."

This is particularly concerning given that the Review went on to say that anecdotal evidence suggests there is wide variation in appeal outcomes between Tribunals and between individual judges.

**Conclusion:**

Beyond remit

**Recommendation 17**

**Harrington's Recommendation:**

The review recommends that training offered by the Chamber President to Tribunal Judges and medical Members should include modules on the evidence of the beneficial effects of work to an individual's well-being.

**Government's Response:**

Will consider this recommendation

**Evidence of application or success:**

In the second year Review, the Review explained that it is not the responsibility of First-Tier Tribunal Judges to consider socio-medical issues. This recommendation was therefore not pursued.

**Conclusion:**

Beyond remit

**Recommendation 18**

**Harrington's Recommendation:**

The review has asked Mind, Mencap and the National Autistic Society to provide recommendations on refining the mental, intellectual and cognitive descriptors. The review looks forward to receiving these recommendations in late November and will make any recommendations it sees fit to Ministers.

**Government's Response:**

Accept

**Evidence of application or success:**

Mind, Mencap and the National Autistic Society submitted reports on ESA descriptors to a Scrutiny Group in December 2010. The Scrutiny Group 'broadly agreed' with the proposals, and the Review endorsed them and submitted them to the DWP in April 2011. The DWP considered that the proposed new descriptors were not sufficiently evidence based, and therefore the DWP would not incorporate them into ESA.

The DWP agreed to build an evidence base, known as the 'Evidence Based Review' or 'Gold Standard Review.' It was hoped that the results would be released in early 2013, but this has not happened.<sup>43</sup> Instead, it was suggested during a debate in November 2012 that some results may be made available in the spring of 2013, with a full report in the summer.<sup>44</sup> By April 2013, this had moved to the study occurring some time between April and July.

The government has accepted the recommendation, but understandably it is taking time to implement.

Dr Gunnyeon reported on the progress of the review to the Work and Pensions Committee. He said that, "There are a number of components to the work we have been doing; the first one was to take the descriptors that were in a very general form, which the charities recommended, and to work with them to try to develop those into a format that would be testable, because clearly that is the first stage. That has been quite time-consuming. We have had something of the order of 25 to 30 meetings with the charities as we have developed the descriptors, but it has been incredibly helpful. We then have to put a process in place to test our current descriptors against those new descriptors, and that means that we have to train the healthcare professionals who are going to do the testing, so there is obviously quite a bit of work there. Having done the assessing of a not insignificant number of cases, and we are looking at doing 1,000 cases, there is then a need to put in place the expert panels that will look at the outcome of the existing descriptors, the outcome of the new descriptors and determine how they think that relates to their assessment, given the information about that individual case—whether or not they think it would have been reasonable to expect them to work. On top of all of that, we have to have an evaluation strategy, because clearly the most important aspect of this is to be able to determine, at the end of the day, whether the new descriptors work and whether they work better than the existing descriptors."<sup>45</sup>

#### **Conclusion**

Implemented and still in progress

#### **Recommendation 19**

##### **Harrington's Recommendation:**

In year two the review should examine the descriptors, in particular how they account for other fluctuating conditions and, possibly, generalised pain and provide any recommendations necessary.

##### **Government's Response:**

Accept

##### **Evidence of application or success:**

"In January 2011 a group led by the MS Society and also containing Arthritis Care, Crohn's and Colitis UK, Forward ME, the National AIDS Trust and Parkinson's UK were asked to provide recommendations on refining the approach used to assess fluctuating conditions in the WCA." As with the above group, the recommendations were submitted to an independent Scrutiny Group, in April 2011. Together they presented recommendations to the Review in November 2011. The Review endorsed these recommendations and submitted them to the DWP.

The DWP had the same reservations as for the submission on mental, intellectual and cognitive descriptors: that there was no evidence base. These descriptors have therefore been incorporated into the Evidence Based Review, with results to be released some time in 2013.

##### **Conclusion:**

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<sup>43</sup> Chris Grayling, Hansard, 25 Jun 2012 : Column 53W, "We hope to publish a report of the evidence-based review in the spring of 2013."

<http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm120625/text/120625w0002.htm#12062541000635>

<sup>44</sup> Dr Gunnyeon, Hansard, 28<sup>th</sup> November 2012 "The full report, because of some of the detailed evaluation, may be in the summer, but we still expect to have some results during the spring."

<http://www.publications.parliament.uk/pa/cm201213/cmselect/cmworpen/uc769/uc76901.htm> N.B. neither witnesses nor Members have had the opportunity to correct the record. The transcript is not yet an approved formal record of these proceedings.

<sup>45</sup> WPC, 21<sup>st</sup> November 2012

Implemented and still in progress

## **Recommendation 20**

### **Harrington's Recommendation:**

In year two the review should examine what happens to people who are found Fit for Work, people who are placed in the Work-Related Activity Group, in the Support Group and people who do not complete their WCA.

### **Government's Response:**

Accept

### **Evidence of application or success:**

A qualitative published in 2012 considered those had been found Fit For Work.<sup>46</sup> This excluded those who had closed their claim, and those who had appealed but not yet had an outcome.

Most of those whose claim had been closed or withdrawn said this was because their health had improved, and so they closed their claim. A small number had their claim closed because they had not carried on the process, in some cases because life events or the claimant's condition made it too difficult.

Of those found fit for work, "the view that it was 'pointless' to appeal was widespread." Some agreed to some extent, but others disagreed strongly, with their claim outcome. Some felt unable to claim JSA, because their health meant they could not comply with the work search and availability requirements. Most of those who had moved on to JSA "reported that they had received little individualised support that took into account their health problems."

Lack of money resulted in people "borrowing, spending savings, going without prescriptions and changing to interest-only mortgages."

A more detailed quantitative study found the following:

<b>ESA outcome category</b>	<b>Percentage in work 12–18 months after claim</b>
All ESA claims	25%
Fit for Work	25%
Work Related Activity Group	9%
Support Group	10%
Claim closed or withdrawn	39%
Claim in progress	22%

Of note are:

- People in the WRAG – who ostensibly are in better health and who receive work-related support - are no more likely to be in employment than those who are placed in the Support Group.
- Despite most of those who closed their claim doing so because their health improved, the majority are still not in work after 12-18 months
- Only 25% of those who are found fit for work are in employment 12-18 months later.
  - This group in theory should not face significantly greater health barriers to employment than do people on Jobseeker's Allowance, yet
  - 80% of people on Jobseeker's Allowance leave within 6 months, with most of these returning to work<sup>47</sup>

The Review also found that *for claimants awarded ESA* those who had had a job prior to claiming were more likely to be in a job 12-18 months later, at 26 vs 9% of people. Of those *either* found Fit For Work *or* who closed their claim, the difference was 48% compared to 21%.

These figures, combined with the overall figures, suggest two things:

- Most ESA claimants were *not* in work prior to their claim;

<sup>46</sup> Barnes, Oakley, Stevens and Sissons 2011 Unsuccessful ESA claims – qualitative research. DWP

<sup>47</sup> Data available from [www.nomisweb.co.uk](http://www.nomisweb.co.uk)

- Being in work prior to the claim has a substantial effect on the likelihood of being in work 12-18 months later. This may be because:
  - People with worse conditions are less likely to have been in work prior to their claim *and* less likely to be in work 12-18 months after the claim
  - Employer's attitudes and willingness to accommodate has a substantial effect on the ability of those with chronic health conditions to find a suitable job, as it may be easier to return to a previous employer than to be taken on by a new employer

**Conclusion:**

Implemented

**Recommendation 21****Harrington's Recommendation:**

In year two the review should examine what happens to people who are found Fit for Work but are unable to claim Jobseekers Allowance.

**Government's Response:**

Accept

**Evidence of application or success:**

In the second year, the Review examined what happened to people who were found Fit For Work but considered themselves too ill to work, or who are still in employment and would have to leave that employment to qualify for Jobseeker's Allowance.

The Review suggested – based on anecdotal evidence – that some of those found Fit For Work may be unhappy with that decision because they had not had “a proper explanation of the decision ... or the subsequent help and support available to them.” He considered that this “lack of clarity” could lead to appealing or making a new claim. Also implicated by the Review were “Personal Advisers in DWP Operations who tell claimants they cannot understand how the Fit for Work decision was reached.” He felt that this inconsistency within the DWP may further contribute to the appeal/new claim cycle. For those still employed, the Review recommended that the employer should consider reasonable adjustments; changing JSA legislation would be beyond the remit of the Review. He thought that Universal Credit may provide solutions to this problem.

Lack of money resulted in people “borrowing, spending savings, going without prescriptions and changing to interest-only mortgages.”

“Some customers described moving between JSA and ESA relatively frequently, over both the shorter and longer-term. This meant the back-to-work support they were receiving was fragmented and rather inconsistent.”<sup>48</sup>

**Conclusion:**

Partially implemented.

A qualitative study has been carried out to find out what happens to this group of people, but no detailed or quantitative study.

**Recommendation 22****Harrington's Recommendation:**

In year two the review recommends that research is undertaken to understand whether the assessment could and should incorporate more “real world” or work-focused elements.

**Government's Response:**

Accept

**Evidence of application or success:**

The Citizen's Advice Bureau was invited to present recommendations on this subject to the Review in July 2011. It was intended that a seminar be held in the autumn with the TUC, CBI, Work Programme Providers, Departmental Officials and representative groups.

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<sup>48</sup> Barnes, Oakley, Stevens & Sissons, 2012, Unsuccessful Employment and Support Allowance claims – qualitative research <http://research.dwp.gov.uk/asd/asd5/rrs-index.asp>

It was considered that the report did not offer clear or evidence based advice, and “lacked any information on what objective, measurable and fair criteria could be used to assess ‘employability,’” The above mentioned seminar was therefore not held, and the Review was unable to commend the report to the DWP.

It was felt that a real-world test would take too long to be incorporated in the WCA, and “poses many challenges” with “a number of practical considerations.”<sup>49</sup> Instead it may be better to improve communications with the Work Programme providers.

The Review said that it, “welcomes the on-going and constructive dialogue with Citizens Advice Bureau and will continue to work with them to explore some of their recommendations in more detail.”

There appears to be some conflict of opinion over the definition of ‘real-world test.’ Dame Anne Begg, the chair of the Work and Pensions Committee, put to Chris Grayling that,

“the WCA does not ask the questions about real life chances of that individual getting a job. It does not take into account labour market conditions in the area, educational ability or ability to retrain or any of that. Now, we have been told that it takes the contractors’ personal advisers about 15 minutes to decide if somebody is work ready or not. They are obviously using different criteria and a different assessment from the WCA. Is there any way that the WCA can start to take into account that kind of real life experience to make a more sensitive judgment as to just how work ready someone is? So it is not just a, “Yes, that person can work,” but also there is a second part to their assessment, which is, “Yes, they can work, but they will need this particular type of help and it is probably in these areas that they are going to be able to work.” Now, I understand that Professor Harrington is suggesting that that should be part and parcel of the process of the assessment as well.”

Chris Grayling’s response was that,

“The one thing I am absolutely unreservedly and implacably opposed to in all of this is a real world test. Either somebody is fit for work or they are not, and what I am not prepared to do is to countenance a situation where we are saying: “You are fit for work, but you should not be on JSA because there is high unemployment in your area.” ... But what I do not think we could possibly countenance is the situation where we are saying, “Because of circumstances in the labour market in your area, we will treat you differently.” I think that would be a huge mistake.”

Mr Grayling’s response suggests that he thinks of a ‘real world test’ as referring to the local job-market conditions. However, disabled people and organisations may think of a ‘real world test’ as meaning that there is explicit consideration of exactly what work the claimant is expected to be capable of. That is, there is a link to real work, not theoretical work that may not exist anywhere in the country.

This was considered in the Work Focussed Health-Related Assessment that occurred after the WCA assessment for claimants placed in the Work Related Activity Group. “The WFHRA – which, initially at least, took place on the same day as the medical assessment and usually involved the same Atos healthcare professional – focused on what the claimant was capable of doing and how their condition might be managed to help them obtain or stay in work. The purpose was to explore the claimant’s views about returning to work, what difficulties they faced in doing this, what they thought they could do to move back into work, and to identify health-related or workplace interventions which could support a move back to work. Following the assessment, the healthcare professional compiled a report for the claimant’s Jobcentre Plus Personal Adviser, to facilitate discussion of appropriate goals in subsequent Work-Focused Interviews (WFIs).”<sup>50</sup>

The WFHRA was suspended for two years from 19<sup>th</sup> July 2010 to allow the DWP to re-evaluate its resources given the introduction of the Work Programme. It is unclear why the WFHRA has not been re-introduced in the past year.

#### **Conclusion:**

Partially implemented without success

<sup>49</sup> Employment Related Services Association (ERSA), response to second call for evidence.

<sup>50</sup> The Work Capability Assessment for Employment and Support Allowance, SN/SP/5850, House of Commons Library, February 2011, para 2.4

**Recommendation 23****Harrington's Recommendation:**

In year two the review should examine the Atos computer system (LiMA) and how it can drive the right behaviours.

**Government's Response:**

Accept

**Evidence of application or success:**

The first review received comments that the computer system, Logical Integrated Medical Assessment (LiMA), can drive Atos assessors' behaviour and decisions, and lead to an impersonal and mechanistic assessment.

The Review observed the use of LiMA in several environments. It noted that "considerable changes have been made to the system in the last year." The logic of the system was sound, acting constructively to point Atos assessors to linked elements and providing guidance and structure. Atos assessors "remain in control."

Atos assessors are being increasingly encouraged to use the free text boxes, including the new personalised summary statement, as this allows for more individualised reports. They are also encouraged to have 'soft skills,' and the Review has noted that adequate IT skills are an important part of being able to maintain personal approach. IT training is available as an e-learning tool for Atos assessors to "complete as they see appropriate." The Review "hopes" that this is monitored, "both to track demand and identify any changes in amounts of free text used in reports," but appears not to know if this is the case.

The DBC survey shows that the behaviour of Atos assessors continues to be concerning to clients. Whilst Atos assessors are encouraged to develop 'soft skills' and to use the free text box, this does not appear to have improved the experience for claimants.

- "Almost 80% disagreed that assessors had "given more weight to the free text box on the ESA50 where applicants can describe how their disability affects them.""
- "Over 80% disagreed that assessors had "acted more sensitively towards applicants during assessments.""

The use of free text boxes by Atos assessors is now encouraged. This is monitored, with assessors in the highest and lowest deciles each month being identified. According to the Review, "there are considerable differences between the lowest and highest deciles." Without further information the importance of this cannot be estimated. It is concerning that some assessors use substantially less free text, and it would be very useful to compare this to accuracy of reports.

**Conclusion:**

Implemented with partial success.

**Recommendation 24****Harrington's Recommendation:**

In year two, the review should explore the use of other healthcare professionals in the Atos assessments and to check consistency of assessments by different professions.

**Government's Response:**

Accept

**Evidence of application or success:**

The Review considered 34 000 cases to assess the consistency of Atos assessors, particularly any differences between different professions (doctor, nurse or physiotherapist). This showed that "nurses are slightly less likely [than expected] to recommend points against physical health descriptors and physiotherapists are slightly less likely [than expected] to recommend points against mental function descriptors." Doctors overall recommend more points, but they also see the more complex cases, so to some extent this is to be expected.

		Doctor	Nurse	Physiotherapist	Total
	All cases	11670	20720	1420	33810
physical %	6 points	8	6	10	7
	9 points	3	2	2	2
	15 or more	9	7	8	8
	Any points	20	16	20	17
mental %	6 points	5	5	4	5
	9 points	2	2	1	2
	15 or more	11	10	9	10
	Any points	17	17	15	17
	<b>Total any points</b>	<b>37</b>	<b>32</b>	<b>35</b>	<b>34</b>

The Review concludes that, “The results show broadly consistent findings between HCP groups,” and that “The consistency of these findings would suggest that Atos’s training and audit of HCPs is having the desired outcome and that, regardless of profession, face-to-face assessments are being undertaken in a reliable manner.” However, the differences between professions are highly significant. Whilst it is not possible to determine whether the higher level of physical points awarded by doctors is due only to them seeing more point-worthy cases – and not due to their greater medical expertise – it is concerning that nurses and physiotherapists vary in the points they award. The fact that physiotherapists under-award for mental illnesses whilst nurses under-award for physical illnesses may indicate a medical-knowledge issue here.

It may be the case that nurse’s lack of knowledge of physical conditions means they do not recognise the full extent of people’s physical disability here; vice versa, physiotherapists may be underestimating the extent to which mental conditions limit work capability. Equally it may be the case that doctors’ greater medical knowledge gives them a better appreciation of the effect of people’s conditions on their ability to work.

The Disability Benefits Consortium asked respondents how well they thought their assessor understood their conditions. The answers were divided into those whose assessment was before 2011, and those after. The results below are for those assessed in 2011 or later, indicating that this concern continues.

- 66% of respondents considered that the assessor did not understand their impairment or health condition.
- 68% “stated that the assessor did not take into account how their symptoms/aspects of their impairment or health condition change/fluctuate.”

Claimants clearly feel that assessors are inadequately qualified. The majority - 65% - of assessments are carried out by nurses or physiotherapists, who do not award as many points as doctors do, and who also show under-awarding of points for physical and mental conditions respectively. It is concerning for the claimants that the qualification of their assessor can have an effect on the outcome of their claim.

**Conclusion:**

Implemented.

It is concerning that the qualification of an assessor can have an effect on the outcome of a claim.

**Recommendation 25**

**Harrington’s Recommendation:**

In year two the review should also monitor the implementation of those recommendations in the year one report which have been adopted by Ministers.

**Government’s Response:**

Accept

### **Evidence of application or success:**

The Review stated in its second year that, “The Government immediately accepted all of the recommendations.” A further recommendation was added in January 2011, asking Macmillan Cancer Support to review the provisions for claimants receiving treatment for cancer.

The Review said that, “Whilst there is firm evidence of change for the better in the way DWP has enthusiastically accepted the challenge presented by the Review’s recommendations, less concrete evidence exists to show that Atos have done all they could to play their part in improving their section of the WCA.”

“Implementation of the recommendations around the face-to-face assessment appears, from anecdotal evidence, to be patchy. The variability in the quality of Atos performance was a frequent complaint received from Decision Makers during the Review’s unannounced visits.”

Whilst this report cannot agree that the government has fully or successfully implemented all the recommendations, it can confirm that the Review has monitored the implementation of these recommendations.

### **Further work**

The Review and DWP have continued to work on recommendations and improvements after the first year report. Some of these are detailed below, as reported in the third year of the Review.

- Atos is now “signed up to a **regular Revalidation process** with the GMC.”
- **Training manuals** have been created or updated, although the Review notes that this has not necessarily improved standards. Atos “were able to provide an impressive list of around 100 training documents that had either been updated or created anew. These included a group of ‘train the trainer’ events which, in the Review’s opinion, are a good initiative.” However, the Review commented that, “Whilst Atos have developed an impressive list of training materials for their healthcare professionals and their trainers, the Review has seen little evidence to show the effectiveness of these courses in either driving up the quality of assessments or improving the skills and knowledge base of the attendees.”
- Concerns remain regarding the standard of the WCA. The Review said that, “the last two Reviews have considered the training offered as part of the WCA process. However, **neither Review has been able to demonstrate satisfactorily the link between the training offered and the added value** this offers to the individuals involved. Only then can the Review be assured that the WCA is being undertaken to a standard commensurate with the importance the benefit system demands.”
- **The Review remains concerned about the training of tribunal panel members.** Regarding training as compared to that provided by Atos, the Review noted that, “No parallel conclusions can be drawn concerning the skills or knowledge of the First-tier Tribunals Judges or Medical Members in their important work in the appeals process. This is disturbing, particularly given concerns raised elsewhere in this Review about the transparency of the appeals process.”
- Consultation with **the UK Drug Policy Commission** resulted in their comment that they “**have serious concerns about the quality of training given to assessors.**” On the basis of this, the third year Review says that, “this response suggests that, whilst some action has been taken, the year two recommendation has not been followed through to effective action and positive change.” The DWP “accepted in principle” that “the UK Drug Policy Commission work with Department for Work and Pensions (DWP) Operations and Atos Healthcare to improve and enhance the guidance and training available to Decision Makers and healthcare professionals.”
- For “**victims of miscarriages of justice,**” the government has accepted the recommendation that, “the MJSS of the RCJ CAB identify these cases as they arise and that a designated DWP official is in place to receive notification of each case. The DWP official then oversees the WCA process by ensuring that in the area of the country where the ex-prisoner resides, an experienced Decision Maker takes the case and identifies an Atos healthcare professional (who is an expert in mental health) to undertake the face-to-face assessment.”

- “Following a year two recommendation, **work has begun to improve communications within DWP**, and particularly between the Decision Makers and the Personal Advisors. Several different approaches are being piloted, which again reflects DWP’s willingness to try different approaches to see which works best.”

## **Chapter 4: recommendations for interim improvements to ESA**

### **1) Mandatory Reconsideration**

This was the third highest theme in the recent Spartacus survey ‘What one thing would you say to Mr Hoban?’ All responses were spontaneous – no suggestion of what people might want to say was given. There are concerns around the accuracy and quality of WCA reports. Possibly as a consequence of this the appeal success rate for ESA is higher than it is for any other benefit; furthermore, 60% of those winning their appeal were originally awarded 0 points. Given this, it seems reasonable to allow people to retain benefit during reconsideration. This need not be a permanent measure, if at some point it becomes the case that most of the people appealing are borderline cases.

This would very much improve the perception of ESA, by returning a small amount of confidence in the system. It would also help those who are putting in claims for ESA to feel that the government supports people who are too sick to work.

### **2) Accessible Centres**

We are aware that the DWP is working on this to improve accessibility, and that most of the turn-aways come from six centres. There is a perception amongst disabled people that Atos does not make reasonable adjustments to the disability of their clientele, and too often turn down reasonable requests for home visits.

Making this option more widely available and increasing awareness of the possibility and method of requesting a home visit (or alternative venue) from Atos will improve disabled people’s perception of the system and reduce stress. As you said to the Work and Pensions Committee, it sounds as if the administrative process relating to those six centres does not work. Improving the administrative process should be relatively easy to do at little cost to your department, and would improve the perception of Atos and the DWP as well as reducing delays caused by turning people away.

### **3) Min Limits on Re-assessment**

Disabled people find the ESA process stressful and detrimental to their health. In a Disability Benefits Consortium survey in 2012, 78% agreed or strongly agreed that stress or anxiety made health worse; this was up from 69% in 2010; and strongly agreed alone increased from 44% to 57%. In the same survey, 86% agreed that applying for ESA was stressful, up from 79% in 2010.

In two Spartacus surveys, stress was the highest and second highest theme – in both surveys the answers were spontaneous, not selected from a list.

Given this, it is likely to be beneficial even for people who are going to make a recovery in 6-9 months to be allowed to have that space to recover from their condition, rather than have worries about application processes and financial insecurity.

This would also have an impact on the backlog of cases waiting for a decision and the number of cases going to appeal.

### **4) Mental Health Champions**

As you have said, this is a challenging area and we need to get it right. Equally, the DWP has to use solutions that are cost-effective.

Unfortunately, disabled people and their groups have not seen evidence that the Mental Health or Mental Function Champions are improving the system for disabled people. There remains concern that people who are not trained mental health workers do not and cannot understand the impact of a mental health condition on an individual’s ability to work.

### **5) Division Cognitive and Physical**

The DWP has repeatedly said that the WCA is “based on the premise that eligibility for ESA should not be based on the diagnosis of a specific condition, but rather on the way that the condition limits an individual's functional capability.” (Chris Grayling).

Policy intent is clear that mental, cognitive and intellectual descriptors could be met by physical conditions. Whether the effect of a mental condition on a physical symptom could be considered was

not explicitly permitted, but given that it was also not explicitly forbidden – as had been the case for Incapacity Benefit – the case law is that there is no such dichotomy.

This dichotomy has the potential to be dangerous as major symptoms and/or side effects could be ignored. It is also contributing to the perception that the government does not want to help people, and is trying to find ways to get people off benefit even though those people cannot work. To remove this false dichotomy would be very simple, and could help reassure claimants that the government wants accurate assessments.

More information is available in the attached report on this mental/physical dichotomy.

#### **6) Recording Assessments**

The majority of participants, both claimants and Atos assessors, thought that audio recording of assessments is a good idea.

Although very few asked for a copy, as Dame Anne Begg pointed out it is the recording itself, not the possession of a copy, that gives the reassurance that there is evidence available in the event of needing it.

Given this and the increasing demand for audio assessments, Professor Harrington recommended that audio recordings of assessments be done for all assessments as a matter of routine. Should the claimant not wish for an audio recording it would be simple to accommodate this.

Each appeal is estimated to cost £400, based on answers recorded in Hansard. Consequently, if appeals were cut by 5% by using audio recordings, over 600 machines could be purchased, which is an average of four per assessment centre.

#### **7) EBR – New descriptors**

The current descriptors appear not to be working, as the employment rate of people who started a claim for ESA is low compared to the employment rate of people who start a claim for Jobseekers.

Employment rates 12-18 months after starting a claim are:

- 39% who end their claim before a decision is made
- 25% who are found FFW
- 9% who go into WRAG
- 10% who go into SG

In comparison, 80% of Jobseekers leave JSA within 6 months of starting a claim.

Consequently it would appear that the descriptors are too harsh, with many people being found fit for work who cannot work or can only work with support, and many people who cannot undertake 'work-related activity' being placed in the WRA group.

We understand that the government is undertaking a review and strongly urge that all findings, including detail of the data analysis (but not of the participants themselves), is made available as soon as possible. In the meantime the interim findings and progress so far should be published.

#### **8) The 'snapshot' issue**

Where a face-to-face interview asks questions that could as easily be asked in an assessment form, there is no added value to having the face-to-face interview. Indeed there may be decreased value as claimants in a stressful and potentially time-pressured situation may struggle to give complete answers.

Speaking about DLA, but also relevant to ESA as many people and organisations have raised the same points, Isledon Mental Health Resources Centre said, "People often spend many hours filling in their DLA questionnaires. They are often unable to complete the task by themselves and they ask a support worker for help. This is because the questionnaires are so long and require applicants to think about so many sensitive issues. When asked to describe their problems within a single interview they may not be able to contain their emotions and it may affect their ability to think about all essential aspects of their problems."

Where a face-to-face interview relies on the observation of the claimant by the assessor this also adds no value, as the assessor's observations cannot be as complete as the observation of someone who

has spent time with the claimant over many days. The assessor also, by observing the claimant for only one part of one day, necessarily observes only a snapshot of the claimant's abilities. Where the face-to-face interview involves medical tests such as a blow test, blood pressure reading or pulse rate this again is just one record on one day, and therefore is a snapshot. It would be more useful to have medical records from a nurse or GP, where these records are relevant to the claimant's condition and abilities.

#### **9) Health professional evidence**

In the recent Spartacus survey, this was the most common response on what one thing should be said to Mr Hoban.

The Review said that, "There should be a requirement in every claim to consider seeking further documentary evidence and, if that evidence is not sought, then the decision not to should be justified." Mr Hoban has said that such evidence should be submitted as early as possible, and not left until an appeal. Charities and disabled people have repeatedly said that evidence from GPs and other health professionals who care for the claimant should form a much bigger part of the assessment. This would be very simple to add in. The claimant's nominated GP or health professional(s) can be sent a form asking for their view on the risks of going to work (i.e., whether work might cause a decline in health) and for their views on the claimant's abilities on the limited capability for work and limited capability for work-related activity descriptors.

#### **10) Independent assessors**

An ex-Atos worker has been quoted as saying, "assessors were trained in such a way that they expected claimants to score too few points to qualify for ESA, and to award points "begrudgingly". The attitude drilled into assessors "leans towards finding reasons not to award points" and "The result was a bias against the disabled." <http://www.theguardian.com/society/2013/may/16/atos-doctor-claimants-biased-medical-assessments>

Tribunal panel members are trained to act inquisitorially. At present the feeling amongst disabled people is that assessors act adversarially – they are there to show how the claim is not justified, whilst the claimant is there to show how it is justified. In contrast, the Tribunal considers that it is their responsibility to enable the claimant to put his or her case. As the Tribunal – or DWP, or assessor – knows what questions need to be asked and what information needs to be gathered in order to have the necessary information to make a correct judgment, it is therefore the responsibility of the Tribunal, DWP or assessor to ask those questions and gather the information.

If they should already be working on such a basis, something has gone wrong somewhere - from what we understand, in training and management. HCPs could be given a contact outside of the contractor structure, in DWP, where they can report such things confidentially, and the Department can work to investigate and combat them as appropriate.

If they aren't already working on such a basis, we appreciate that this may take time to change, as the status quo may be built into contracts and management structures - but it should be changed. Both the perception and the actuality of balance in face-to-face sessions with HCP will reduce appeals, saving money, stress and time for all concerned. It will also improve the perception of the process by sick and disabled people, and show that the Government is interested in getting things right.