

Research report

Employment and Support Allowance: Customer and staff experiences of the face-to-face Work Capability Assessment and Work-Focused Health-Related Assessment

by Helen Barnes, Jane Aston and Ceri Williams

Department for Work and Pensions

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Department for Work and Pensions, Commercial Support and Knowledge Management Team,
Work and Welfare Central Analysis Division, 3rd Floor, Caxton House, Tothill Street, London SW1H 9NA

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Contents

Acknowledgements.....	vii
The Authors.....	viii
Abbreviations.....	ix
Glossary.....	vii
Summary.....	1
1 Introduction.....	7
1.1 The scope of this study.....	7
1.2 About Employment and Support Allowance (ESA).....	7
1.3 About the WCA.....	9
1.3.1 <i>How the WCA is applied</i>	10
1.4 Research methodology.....	10
1.4.1 <i>Sampling</i>	10
1.4.2 <i>Analysis</i>	11
2 Staff and customer views of the face-to-face Work Capability Assessment.....	13
2.1 Introduction.....	13
2.2 ESA50 completion.....	13
2.2.1 <i>Healthcare Professionals’ perspectives</i>	13
2.2.2 <i>Customer perspectives</i>	14
2.3 WCA timing and scheduling.....	16
2.3.1 <i>Customer perspectives</i>	16
2.3.2 <i>Adviser perspectives</i>	17
2.4 HCP experiences of the face-to-face WCA.....	18
2.4.1 <i>Training and preparation for the role</i>	18
2.4.2 <i>The format and content of the face-to-face WCA</i>	18
2.4.3 <i>Customer reactions</i>	18
2.5 Customer expectations of the face-to-face WCA.....	19
2.6 Customer experiences of the face-to-face WCA.....	20
2.6.1 <i>Travel to the face-to-face WCA</i>	20

2.6.2	Waiting times.....	21
2.6.3	Environment.....	21
2.6.4	The assessment.....	22
2.6.5	Customers' views of the HCPs.....	24
2.7	The use and value of other medical evidence for the face-to-face WCA.....	25
2.7.1	HCP perspectives.....	25
2.7.2	Customer views and experiences.....	26
2.8	Comparisons with the Personal Capability Assessment.....	26
2.8.1	HCP perspectives.....	26
2.8.2	Customer perspectives.....	29
2.9	WCA outcomes.....	29
2.10	Appeals.....	30
2.10.1	HCP perspectives.....	30
2.10.2	Customer perspectives.....	30
3	Staff and customer experiences and views of the WFHRA.....	33
3.1	Introduction.....	33
3.2	The timing of the WFHRA.....	33
3.2.1	Customer experiences.....	33
3.2.2	HCP experiences.....	33
3.3	The purpose of the WFHRA.....	34
3.3.1	HCP perspectives.....	34
3.3.2	Customer perspectives.....	35
3.4	WFHRA discussions and the work focus.....	37
3.4.1	HCP perspectives.....	37
3.4.2	Customer perspectives.....	38
3.5	WFHRA results and output.....	40
3.5.1	Customer views.....	40
3.5.2	HCP views.....	41
4	Customer and staff experiences of Work Focused Interviews.....	43
4.1	Introduction.....	43

4.2	Overall experience and views of WFIs	43
4.2.1	<i>Customer perspectives</i>	43
4.2.2	<i>Adviser perspectives</i>	44
4.3	Impact of the WFHRA on WFIs.....	45
4.3.1	<i>Customer perspectives</i>	45
4.3.2	<i>Adviser perspectives</i>	46
5	Conclusions and policy implications	47
5.1	Introduction.....	47
5.2	Training for ESA	47
5.3	The ESA50 form and overall process.....	47
5.4	The face-to-face WCA	48
5.4.1	<i>Customer expectations</i>	48
5.5	The face-to-face WCA	48
5.5.1	<i>Customer expectations</i>	48
5.5.2	<i>Travel and access issues</i>	48
5.5.3	<i>Conduct of the face-to-face WCA</i>	48
5.5.4	<i>The WCA compared to the PCA</i>	49
5.6	The WFHRA	49
5.6.1	<i>HCP experiences and views</i>	49
5.6.2	<i>Customer expectations</i>	50
5.7	WFIs.....	50
5.7.1	<i>Customer perspectives</i>	50
5.7.2	<i>Adviser perspectives</i>	50
5.8	Policy implications	51
5.8.1	<i>Overall process</i>	51
5.8.2	<i>The face-to-face WCA</i>	51
5.8.3	<i>Decisions and appeals</i>	52
5.8.4	<i>The WFHRA</i>	52
5.8.5	<i>Interaction with WFIs</i>	53

Appendix A	ESA claim process.....	55
Appendix B	Opt-out letter	57
Appendix C	Discussion guides.....	59
Appendix D	Coding frame	69

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The Authors

Helen Barnes is a Principal Research Fellow in the Unemployment and Labour Market Disadvantage team at the Institute for Employment Studies. Her research interests include welfare reform, labour market disadvantage, particularly in relation to age, ill-health and disability and ethnicity, poverty, well-being and living standards.

Jane Aston was a Senior Research Fellow in the Unemployment and Labour Market Disadvantage team at IES. She has carried out research into a range of employment issues since joining IES in 1998, but in more recent years has focused on disadvantage and diversity in the labour market, particularly disability and ethnicity.

Ceri Williams is a Research Fellow also in the Unemployment and Labour Market Disadvantage team at IES. She has contributed to a number of projects looking at labour market disadvantage, particularly related to disability, families and young people.

Abbreviations

BDC	Benefit Delivery Centre
CC	Contact Centre
DNA	Did not attend
ESA	Employment and Support Allowance
FFW	Fit For Work
FTA	Fail to attend
HCP	Healthcare Professional
IB	Incapacity Benefit
MEC	Medical Examination Centre
PCA	Personal Capability Assessment
WCA	Work Capability Assessment
WFHRA	Work-Focused Health-Related Assessment
WFI	Work Focused Interview
WRAG	Work-Related Activity Group

Glossary

Atos Healthcare	Contractor responsible for conducting the Work Capability Assessment and Work-Focused Health-Related Assessment.
Benefit Delivery Centre (BDC)	Where Employment and Support Allowance (ESA) claims are processed.
Contact Centre (CC)	Where most ESA claims are received, by phone.
Did not attend (DNA) or Fail to attend (FTA)	People not attending a Work Capability Assessment (WCA) or Work Focused Interview (WFI) when required to do so.
ESA50	A questionnaire customers have to complete, giving details of how their condition affects their day-to-day activities.
Fit for Work	Someone who was not found to have a Limited Capability for Work during the Work Capability Assessment, meaning they were not entitled to ESA.
Incapacity Benefit (IB)	A benefit paid to people who were unable to work because of a health condition or disability before ESA was introduced in October 2008.
Personal Capability Assessment (PCA)	The assessment which determined eligibility for IB, prior to the introduction of ESA.
Permitted Work	An amount of paid work which people are allowed to do while still claiming Incapacity Benefit/Employment and Support Allowance.
Pathways to Work Provider	Department for Work and Pensions (DWP) contractor supplying employment services.
Special Rules	A 'fast-track' claim process for those who are terminally ill and have a life expectancy of under six months.

Summary

The scope of this study

This study was designed to provide a detailed understanding, from a customer and staff perspective, of the Work Capability Assessment (WCA), which is used to assess entitlement to Employment and Support Allowance (ESA), and Work-Focused Health-Related Assessment (WFHRA). ESA was introduced in October 2008 to provide financial help and personalised support for people who maybe unable to work because of a health condition or disability. ESA has replaced Incapacity Benefit (IB) and Income Support (IS) paid on the grounds of ill-health for new claims. These two older benefits are being phased out, with people currently claiming them being reassessed for ESA nationally from February 2011.

In broad terms, this study explores:

- whether the WCA and WFHRA are being delivered as intended, and how the process could be improved;
- what Jobcentre Plus, Provider and Atos staff think about the WCA and WFHRA and what their experiences of delivering it are;
- how the WFHRA report is being used in WFIs;
- what customers' experiences and views of the WCA and WFHRA are and how they feel about the process;
- what extent customers' views about work are being influenced by the WCA and WFHRA.

A brief description of the WCA and WFHRA is provided below, but for more detail on these, and the ESA claim process, please refer to Chapter 1.

In addition to this study, the evaluation of ESA includes:

- an early implementation study with customers and staff (Barnes *et al.*, 2010)¹;
- case study research with customers and staff in six districts (scheduled for spring 2011);
- a face-to-face survey of a representative sample of 3,500 customers (Barnes, Sissons and Stevens, 2010)²; and
- a follow-up survey by telephone six months later (due to be published in early 2011).

Background: The face-to-face WCA and ESA50 form

The WCA is used to determine entitlement for ESA, and is conducted by Atos Healthcare on behalf of Jobcentre Plus. As part of the WCA, most people who apply for ESA are required to attend a face-to-

¹ Barnes, H., Sissons, P., Aston, J., Dewson, S., Stevens, S., Williams, C. and Francis, R. (2010). *Employment and Support Allowance: Early implementation experiences of customers and staff*. DWP Research Report No. 631.

² Ibid.

face assessment³. This is conducted by a Healthcare Professional (HCP), who may be a doctor, nurse, or physiotherapist. It assesses a person's physical, mental health, cognitive, and intellectual functions.

The face-to-face WCA is guided by information the customer provides on an ESA50 form, which they complete and return to Atos Healthcare before they are called for a face-to-face assessment. The ESA50 form is a questionnaire asking how a person's health condition and/or disability affects their ability to conduct activities of daily living. It also asks about any medication or treatment they are receiving, and details of their GP and any other professionals providing care.

Upon receipt of the completed ESA50, which is scrutinised by an HCP at Atos Healthcare, further medical evidence may be requested from a customer's GP, or other treating physician.

A Jobcentre Plus Decision Maker uses a report of the WCA provided by Atos Healthcare to help decide whether a person is entitled to ESA, and if so, whether they should be placed in the ESA Work-Related Activity Group (WRAG) or Support Group. Chapter 1 provides more detail on the WCA, WFHRA, and ESA claim process.

Of all completed initial WCAs (ie excluding those still in progress or withdrawn before completing assessment, and before taking into account any appeals) to the end of July 2010, 65 per cent were found Fit for Work (FFW), 25 per cent were allocated to the WRAG and ten per cent to the Support Group.⁴

The WFHRA and WFIs

At the time of this research, customers who were assessed as entitled to ESA and placed in the Work-Related Activity Group were also required to attend a WFHRA, and a number of Work-Focused Interviews with a personal adviser at Jobcentre Plus and/or Pathways to Work Provider. At the time of writing, the WFHRA is suspended.

The WFHRA was also conducted by Atos Healthcare on behalf of Jobcentre Plus, by a HCP who could be a doctor, nurse, or physiotherapist. It focused on what the individual was capable of doing and how to manage his/her condition at work. The WFHRA was intended to explore customers' views about returning to work, what difficulties they faced in doing this, and what they thought they could do to move back into work. The HCP made a recommendation of any health-related or other interventions which could improve a person's functional capacity and support a move back into work. This included the use of appropriate aids and adaptations.

Following the WFHRA, a report of the discussion was sent to both the customer and their Personal Adviser (PA) at Jobcentre Plus and/or a Pathways to Work Provider, for use in WFIs. The intention was for the adviser to use the report to facilitate a discussion with the individual to identify appropriate job goals.

³ Customers who are terminally ill with less than six months' life expectancy, or with the most severe conditions, can be exempted from the face-to-face assessment on the basis of information provided when they make their initial ESA claim, or on their ESA50 form.

⁴ DWP. (October 2010). *Employment and Support Allowance: Work Capability Assessment by Health Condition and Functional Impairment: Official Statistics*.

Methodology and sampling strategy

A total of 87 semi-structured interviews were carried out in four Jobcentre Plus districts in Wales, Scotland, London and Northern England. Interviews were carried out with 39 staff, composed of:

- Atos HCPs – 17;
- Atos Healthcare Service Managers – 3;
- advisers conducting WFIs – 19 (of which, 11 were from Jobcentre Plus and eight from Pathways to Work Providers);
- ESA customers in the WRAG, who had had both a WCA and WFHRA – 34;
- ESA customers who had had a WCA but not a WFHRA – 14. These had been allocated either to the FFW group or WRAG.

The weighting of the customer sample towards those in the WRAG, which was deliberate, in order to include views of the WFHRA, should be borne in mind when considering the findings, as claim outcome appears to be a key driver of customer views of the WCA⁵. A sample which included more of those found FFW may have generated additional views and experiences.

Fieldwork with Jobcentre Plus and Provider advisers was carried out in March and April 2010. The customer fieldwork was delayed by the General Election and carried out in June and July 2010, from a sample of 706 customers who had been seen for a face-to-face WCA or WFHRA in May or June.

Staff and customer views of the WCA

ESA50 completion

The ESA50 is a form which customers are sent to complete, giving details of how their medical condition affects their ability to carry out daily living activities. Some customers said they found completing this straightforward. However, others said that they had found it long and complex to complete, and that they had sometimes been confused as to how to answer, a finding which is consistent with experiences reported in a recent survey of ESA customers⁶.

HCPs confirmed that the ESA50 form was often poorly completed, and that this both created additional work for them, and limited the value of the information provided. Mental health was noted as a particular issue in this respect, both in terms of how well the form was completed, and whether or not the customer had completed and returned it, so that it was available to the HCP conducting the face-to-face WCA.

WCA timing and scheduling

According to the customers interviewed, the face-to-face WCA was generally taking place two to three months after they had begun their claim for ESA, although a few had waited longer than this. Most had attended at least one WFI by the time of their WCA, although there were exceptions to this.

⁵ Barnes, H., Sissons, P. and Stevens, H. (2010). *Employment and Support Allowance: Findings from a face-to-face survey of customers*. DWP Research Report No. 707.

⁶ Ibid.

Travel, wait times and environment

Travel to the face-to-face WCA was problematic for many of the customers in the study, especially for those with mobility problems or mental health conditions. This was exacerbated where local transport was poor or where customers had attended during the icy weather conditions in early 2010. Customers appeared to have received a rather inconsistent level of service regarding information on their possible eligibility for assistance with transport, and some had made difficult journeys unnecessarily as a result.

Customers generally reported being seen promptly on the day of the WCA, and the reported length of the assessment was in line with expectations. Some people were unhappy with the environment at the Medical Examination Centre (MEC), finding it rather forbidding, while others saw it as being in line with their general expectations of comparable medical settings, such as a GP or dentist's surgery. Some privacy issues were raised, in relation to both the soundproofing of rooms and the visibility of other customer's records.

The assessment

HCPs thought that the training provided had equipped them well for the role, and noted that there was a continuous process of audit and quality control in place. They felt that customers were generally not well prepared for the face-to-face assessment, being either totally lacking in knowledge about what was involved, or overly influenced by campaigning materials.

Customers' accounts confirmed that they were often expecting some kind of physical examination or diagnostic test. In practice, although some customers received a limited physical examination, the assessment mostly consisted of discussion, so that this did not match their expectations.

Customers also said they tended to view the WCA primarily as a means of weeding out fraudulent claims. They were often unhappy with the way the assessment had been conducted, and had not felt listened to by the HCP. Some had been found FFW, and most of these had appealed.

There were also some positive views from customers about their experience. Some reported that the HCPs were professional in their manner and the way in which they conducted the appointment; that they gave adequate explanations, and were appropriately understanding of the customers' condition and circumstances.

Some HCPs felt that additional medical evidence, where this was not available, would be beneficial in carrying out these assessments, but others argued that this was not necessary. Customers, however, reported that where such evidence was provided it had not generally appeared to be taken into account.

Comparisons with the Personal Capability Assessment

Staff felt that, compared to the Personal Capability Assessment (PCA), the WCA was a more objective functional assessment, and noted that the descriptors were improved, eliminating some duplication and dealing better with certain conditions, such as severe mental health conditions. Other conditions were viewed as somewhat more problematic to access using the WCA, as the HCPs felt they had less discretion. Conditions which were specifically mentioned in this respect were fluctuating conditions, some mental health conditions, and multiple sclerosis (MS). HCPs also noted that the move to the WCA represented a considerable shift in the threshold for claiming a sickness benefit. The reassessment of existing incapacity benefits customers for ESA, using the WCA, was noted as representing a considerable challenge.

Appeals

Given the much higher threshold for entitlement to benefit, staff were unsurprised at the high volume of appeals among customers against decisions that they were FFW (i.e. they were not entitled to ESA). However, some HCPs were unhappy at the lack of a rationale for decisions which had been overturned, and some felt that social factors unrelated to functional ability might have been given undue weight in the appeals process, as the results were so dissonant with their original assessment and they received no feedback on how the appeal decision has been reached. Several of the customers in the sample had appealed, and some had been reassigned to the WRAG as a result.

Staff and customer views of the WFHRA

Customers who had attended a WFHRA had not generally understood its purpose, thinking that they were being called for a second 'medical' or face-to-face WCA; some recalled the work focus, and some found this useful, but the general feeling was that this duplicated the WFIs to a large degree.

Staff delivering the WFHRA confirmed the low levels of customer understanding about this part of the assessment. They felt that they were trying to offer a positive and personalised intervention which would help someone move towards work, although not necessarily in the short term. Some were more focused than others on the potential value of the WFHRA as a tool for advisers. Not all felt that it was necessary for the WFHRA to be carried out by a healthcare professional.

WFIs and the impact of the WFHRA

Customers generally appreciated their WFIs and some spoke warmly about the help and support provided by their advisers, but there was little evidence that the report of the WFHRA provided to customers and personal advisers was playing a role in the WFIs or influencing customer views on work. This was due both to its content, which was perceived to be very general and to duplicate issues already covered in the WFIs, and to its timing, often fairly late in the sequence of WFIs

Conclusions and policy implications

There appears to be a clear need for more and better customer information at (and about) the different stages of this process, including when an initial claim for ESA is made (this is usually by telephone to Jobcentre Plus), the assessment process, when customers are notified of the WCA outcome, and when customers are engaging in work-related activity including the WFHRA and WFIs. This is likely to improve co-operation as well as improving the customer experience.

There is also a need to improve inconsistent and sometimes poor levels of customer service, for instance providing clear and consistent advice about the criteria for funding travel arrangements and the availability of home visits, and making it simpler to change appointment times where necessary.

The WCA is currently being reviewed, and it will be important that close attention is paid to the descriptors, particularly in assessing specific conditions which have been identified as problematic and where there are multiple or fluctuating conditions.

If the WFHRA is to be reinstated, it will be important to reconsider its purpose and intended outcomes and how these relate to both its coverage, target population and its timing in the sequence of WFIs.

The reassessment of IB customers and the introduction of the Work Programme are also an important context to any future changes in the delivery of the WCA and WFHRA. The former means that a great many more people will fall within the ambit of the ESA claim process, placing additional demands on staff delivering it. Customers who have claimed under the previous IB regime may also react differently to the WCA to those who are claiming a sickness benefit for the first time. The Work Programme should make it possible to provide additional tailored support for those who are found FFW but need help to manage the impact of a health condition. The WFHRA, amended in the light of this study and the ongoing review, may have a potential role to play in this process.

1 Introduction

1.1 The scope of this study

This study was designed to provide a detailed understanding, from a customer and staff perspective, of the Work Capability Assessment (WCA) and Work-Focused Health-Related Assessment (WFHRA). These form parts of the assessment process for Employment and Support Allowance (ESA), which was introduced in October 2008 to provide financial help and personalised support for people who may be unable to work because of a health condition or disability. ESA has replaced Incapacity Benefit (IB) and Income Support (IS) paid on the grounds of ill-health for new claims. These two older benefits are being phased out, with people currently claiming them being reassessed for ESA nationally from February 2011.

In broad terms, this study explores:

- whether the WCA and WFHRA are being delivered as intended, and how the process could be improved;
- what Jobcentre Plus, Provider and Atos staff think about the WCA and WFHRA and what their experiences of delivering it are;
- how the WFHRA report is being used in WFIs;
- what customers' experiences and views of the WCA and WFHRA are and how do they feel about the process?
- to what extent customers' views about work are being influenced by the WCA and WFHRA.

In addition to this study, the evaluation of ESA includes:

- an early implementation study with customers and staff (Barnes *et al.*, 2010)⁷;
- case study research with customers and staff in six districts (scheduled for spring 2011);
- a face-to-face survey of a representative sample of 3,650 customers (Barnes, Sissons and Stevens, 2010)⁸; and
- a follow-up survey by telephone six months later (due to be published in early 2011).

1.2 About Employment and Support Allowance (ESA)

ESA was introduced on 27 October 2008 for new customers to replace IB and IS received on the grounds of incapacity (collectively known as incapacity benefits), as part of a broader set of reforms introduced to move from a passive to an active welfare system, and as a response to the welfare reform Green Paper, *A new deal for welfare: Empowering people to work* (Department for Work and Pensions, 2006). It is to be rolled out to existing incapacity benefits claimants nationally from early 2011.

⁷ Barnes, H., Sissons, P., Aston, J., Dewson, S., Stevens, S., Williams, C. and Francis, R. (2010). *Employment and Support Allowance: Early implementation experiences of customers and staff*. DWP Research Report No. 631.

⁸ Barnes, H., Sissons, P. and Stevens, H. (2010). *Employment and Support Allowance: Findings from a face-to-face survey of customers*, DWP Research Report no. 707.

The introduction of the ESA regime has involved a number of important changes compared to the previous IB regime, including:

- Most customers are expected to be able to prepare for a return to work, with the majority of customers who are successful in their claim allocated to a Work-Related Activity Group (WRAG), under which they receive £25.95 per week in addition to the basic allowance of £65.45 per week, providing they comply with requirements for work-related activity which involve attending a number of Work Focused Interviews (WFIs) with an employment adviser.
- Those people whose illness or disability most severely affects their ability to undertake work-related activity are allocated to the Support Group (SG). They are not required to carry out any activity in order to receive their full benefit entitlement, which is an additional £31.40 on top of the basic allowance, a total of £96.85 per week.
- A WCA replaces the Personal Capability Assessment (PCA) which was used to determine eligibility for IB. Far fewer customers are exempt from assessment under the WCA than under the PCA regime, and the threshold for eligibility is higher than under the PCA. More detail on the WCA is provided at Section 1.3. Of all completed initial assessments (that is, excluding those still in progress or withdrawn before completing assessment, and before taking into account any appeals) to the end of June 2010, 65 per cent were found Fit for Work (FFW), 25 per cent were allocated to the WRAG and ten percent to the SG.⁹
- The process aims to provide a quicker assessment for customers, with a decision on eligibility by week 14 of the claim. This decision is made by the Department for Work and Pensions (DWP), taking into account the result of the WCA conducted by an Atos Healthcare Professional (HCP). Because delays to the WCA, for whatever reason, can limit the effectiveness of the WFI, the second and subsequent WFIs can now be deferred pending the outcome of the WCA.
- A WFHRA is carried out by an Atos Healthcare HCP who may be a doctor, nurse or physiotherapist. This is intended to explore customers' views about moving into work, their perceptions about their disabling condition, and identify workplace interventions that facilitate engagement in work. This was originally carried out on the same day as the WCA (and thus included those who were found FFW, as well as those in the SG, who are not expected to engage in work-related activity). It was subsequently 'decoupled' from the WCA, so that only those allocated to the WRAG were invited to this assessment, and at a later date.
- If those in the WRAG do not comply with the regime, they may be sanctioned 50 per cent of the work-related addition, of £25.95. If they have not complied after another four weeks, they receive another sanction of the remaining 50 per cent of this addition.
- An independent review of the WCA was recently completed and has now reported. This is a statutory requirement, which was agreed when ESA was introduced.¹⁰ The purpose of the review is to gather evidence to assess the effectiveness of the WCA under a framework of seven questions. These include how effectively it is identifying those claimants who should be in the SG, and those who should be in the WRAG; as well as looking at issues around assessing fluctuating conditions, multiple conditions and how to weight medical evidence gathered outside the WCA.

A diagram outlining the claim process for ESA can be found in Appendix A.

⁹ DWP. (October 2010). *Employment and Support Allowance: Work Capability Assessment by Health Condition and Functional Impairment: Official Statistics*. http://campaigns.dwp.gov.uk/asd/workingage/esa_wca/esa_wca_26102010.pdf

¹⁰ This report can be accessed online at <http://www.dwp.gov.uk/docs/wca-review-2010.pdf>
The Government's response to the report can be accessed at <http://www.dwp.gov.uk/docs/wca-review-2010-response.pdf>

1.3 About the WCA and WFHRA

This section provides detailed information on the WCA, which is used to determine entitlement to ESA, as this is the focus of this research. The WCA has some similarities to its predecessor the PCA, but there are also significant differences between the two. At the time of this research, the WCA was comprised of three different parts:

1 The limited capability for work assessment

This looks at whether the customer has a limited capability for work and supported to move towards employment. If this is not the case, the customer will not be entitled to ESA, although they can appeal against this decision. This part of the WCA is a points-related assessment of a person's physical, mental health, cognitive, and intellectual functions, considered across a range of activities. Points are awarded on the basis of any functional limitations. If the total reaches 15 points or more, the customer is assessed as having a limited capability for work and is entitled to ESA.¹¹

2 The limited capability for work-related activity assessment

This part of the assessment identifies those individuals with the most severe illnesses or disabilities who are eligible for the ESA WRAG, or the SG. The decision about a person's ESA entitlement is made by a Jobcentre Plus Decision Maker, taking into account a report of the WCA provided by Atos Healthcare, who conduct the WCA on behalf of Jobcentre Plus.

This part of the WCA has a list of descriptors relating to both physical and mental/cognitive functions. If a person meets at least one of these descriptors or one of the non-functional criteria¹², they are placed in the SG of claimants. Customers in the SG receive a higher rate of benefit and are not expected to engage in any work-related activity. If a person does not meet any of these descriptors or one of the non-functional criteria, they are placed in the WRAG.

3 The WFHRA

The WFHRA (which is currently suspended) was also conducted by Atos Healthcare on behalf of Jobcentre Plus, by a HCP who could be a doctor, nurse, or physiotherapist. It focused on what the individual was capable of doing and how to manage his/her condition at work. The WFHRA was intended to explore customers' views about returning to work, what difficulties they faced in doing this, and what they thought they could do to move back into work. The HCP made a recommendation of any health-related or other interventions which could improve a person's functional capacity and support a move back into work. This included the use of appropriate aids and adaptations.

¹¹ Detailed information on the descriptors, and the points awarded to different functional limitations, is available from *A guide to Employment and Support Allowance: The Work Capability Assessment*, published by Jobcentre Plus at:
http://www.direct.gov.uk/prod_consum_dg/groups/dg_digitalassets/@dg/@en/@disabled/documents/digitalasset/dg_177366.pdf

¹² Information on the descriptors under each of these activity headings and the non-functional criteria is available from *A guide to Employment and Support Allowance: The Work Capability Assessment*, published by Jobcentre Plus at:
http://www.direct.gov.uk/prod_consum_dg/groups/dg_digitalassets/@dg/@en/@disabled/documents/digitalasset/dg_177366.pdf

Following the WFHRA, a report of the discussion was sent to both the customer and their Personal Adviser (PA) at Jobcentre Plus and/or a Pathways to Work Provider, for use in WFIs. The intention was for the adviser to use the report to facilitate a discussion with the individual to identify appropriate job goals.

1.3.1 How the WCA is applied

The ESA50 form

Most customers are asked to fill in an ESA50 form as part of their ESA claim, unless it is clear from information collected when the initial claim is made that they are severely ill, or terminally ill with a life expectancy of less than six months.

The ESA50 form is a questionnaire which collects information on a person's health condition and/or disability and how this affects their ability to carry out activities of daily living. It also asks about any medication or treatment they are receiving, and details of their GP and any other professionals providing care, support or treatment (such as a physiotherapist or social worker).

Most of the ESA50 form is divided into two parts: the first asks about physical functions, the second about mental, cognitive and intellectual functions. Each part is divided into several headings, which relate to the activities described above in Section 1.2 for the limited capability for work assessment.

Once the customer has completed the ESA50 they post it back to Atos Healthcare, who scrutinises them and may also request further medical evidence from a customer's GP, or other treating physician, if they feel this is necessary. On the basis of this paper evidence, those customers with severe illness or disability, may be placed in the ESA SG without being asked to attend a face-to-face assessment. This applies to a small group however; most customers are called to attend a face-to-face WCA with a HCP, at a Medical Examination Centre (MEC).

The face-to-face WCA

The face-to-face WCA is carried out by a HCP working for Atos Healthcare, on behalf of DWP. Before this the HCP reviews a copy of the customer's completed ESA50 form, and any other medical evidence which has been provided. This information helps guide the assessment, which usually consists of questions relating to a person's physical and mental, intellectual and cognitive capabilities. In some cases, a physical examination is also performed (for example, to assess the range of movement in an affected limb).

The WCA decision and WFHRA

Atos Healthcare sends a report of the medical assessment to a Jobcentre Plus Decision Maker, who uses this report to help decide whether the customer has a limited capability for work, and whether they have a limited capability for work-related activity. If there is additional evidence, such as a GP report or any other relevant evidence submitted by the customer to Jobcentre Plus, the Decision Maker also takes this into account.

1.4 Research methodology

1.4.1 Sampling

To address the research questions, a total of 87 semi-structured interviews were carried out in four Jobcentre Plus districts in Wales, Scotland, London and North West England. A copy of the discussion guides used is provided at Appendix B. Interviews were carried out with 39 staff, composed of:

- Atos Healthcare HCPs – 17;
- Atos Healthcare Service Managers – 3;
- Jobcentre Plus advisers – 11;
- Pathways to Work Provider advisers – 8;
- ESA customers in the WRAG who had had both a WCA and WFHRA – 34;
- ESA customers who had had a WCA but not a WFHRA – 14. These were in both the FFW group and WRAG.

In addition to selecting customers according to their stage in the assessment process (the main sampling criterion), we also aimed to ensure a spread of age groups and a range of health conditions (although we did not sample on the latter). While we cannot rule out some degree of self-selection among customers, this was an opt-out rather than an opt-in design, and customers were purposively sampled by researchers, which tends to reduce this effect. The weighting of the customer sample towards those in the WRAG, which was deliberate in order to include views of the WFHRA, should be borne in mind when considering the findings, as claim outcome appears to be a key driver of customer satisfaction with the WCA¹³; a sample which included more of those found FFW may have generated additional views and experiences.

Fieldwork with Jobcentre Plus and Provider advisers was carried out in March and April 2010. The customer fieldwork was delayed by the General Election, and carried out in June and July 2010, from a sample of 706 customers who had been seen for a WCA or WFHRA in May or June at MECs serving the four areas. A copy of the opt-out letter sent is provided at Appendix B.

1.4.2 Analysis

All interviews (apart from a handful of cases where the interviewee declined consent to recording) were recorded and transcribed verbatim. They were analysed thematically using AtlasTi, using a coding framework developed from the original discussion guides, and from issues that arose spontaneously during the interviews. A copy of the coding frame used is provided at Appendix D.

Where direct quotations have been used in the report, we have indicated whether these are typical of a particular type of experience or response or represent the boundaries of a range of views. We have indicated the broad nature of customer health conditions, to maintain anonymity, as follows:

- cardio-vascular condition – heart and circulatory conditions, strokes, etc.;
- musculo-skeletal condition – refers to longer-term conditions, e.g. back pain, arthritis, rather than short-term injuries;
- mental health condition – refers to common mental health conditions such as anxiety or depression;
- severe mental health condition – refers to a condition such as schizophrenia, which is likely to involve use of secondary mental health services;
- systemic condition – e.g. multiple sclerosis (MS), cancer, chronic fatigue syndrome;
- ‘other’ health condition – conditions not covered above, such as allergies, HIV, visual impairment.

¹³ Barnes, H., Sissons, P. and Stevens, H. (2010). *Employment and Support Allowance: Findings from a face-to-face survey of customers*. DWP Research Report No. 707.

2 Staff and customer views of the face-to-face Work Capability Assessment

2.1 Introduction

This chapter compares staff and customer views of the Work Capability Assessment (WCA), including both Atos Healthcare, Jobcentre Plus and Pathways provider staff. It follows a chronological sequence, based on the stages of the claim process.

2.2 ESA50 completion

The first stage in the WCA process is the completion of the ESA50, a form which is sent to the customer to complete giving details of how their health condition affects their ability to carry out daily living activities¹⁴. Customers are required to complete and return the ESA50 within four weeks of receiving it, although a further two weeks can be allowed where there is deemed to be good cause for late return.

After the ESA50 has been completed and returned to Atos Healthcare, who scrutinise this form, most customers are invited to a face-to-face WCA. In some cases, further medical evidence is requested from a GP or treating physician. On the basis of information provided in the ESA50 and additional medical evidence, customers with the most severe health conditions or disabilities may be placed straight into the ESA Support Group (SG) without being asked to attend a face-to-face assessment, where they receive a higher rate of benefit and do not need to participate in any further assessment or attend Work-Focused Interviews (WFIs).

If a customer does not submit their ESA50 and there is deemed to be no good cause for this, their claim is closed by Jobcentre Plus. In cases where Jobcentre Plus is aware that the customer has a mental health condition, Jobcentre Plus make attempts to contact the customer and invite them to a WCA, even if the customer has not returned an ESA50 form¹⁵.

2.2.1 Healthcare Professionals' perspectives

Healthcare Professionals (HCPs) generally felt that the ESA50 forms were poorly completed by customers and some saw them as just a guide to the claimant's health condition. In some cases, the claimant was said to have merely signed the back of the questionnaire, while at the other end of the spectrum others were reported to have ticked every box. The latter would create additional work for the HCP, as each issue raised needs to be addressed in the assessment.

¹⁴ Those who are claiming under Special Rules because they are terminally ill do not have to complete the ESA50, and there are also some other defined exemptions for people with severe conditions.

¹⁵ Although people in the SG can volunteer to attend these, if they wish.

‘When the client’s filled out the ESA50, they haven’t had the information as to what they need to fill out, and they don’t focus in the way that the form’s written out, which says, physical problems, mental health problems. They just will tick every box.’

(Atos Healthcare HCP)

However, in most cases HCPs felt that having the ESA50 was better than nothing, especially if there was no other medical evidence, such as a doctor’s letter or specialist’s report. If available, the ESA50 was said to form the basis of the assessment, and often served as a focus for initial questions, but was described as being only one part of the assessment process.

Compared with how people appeared in the face-to-face WCA, HCPs sometimes felt that customers had tended to exaggerate their health conditions and their associated limitations. Therefore, there were cases where perhaps on the basis of the ESA50 alone, customers would have been awarded ESA, whereas following a face-to-face assessment they were found Fit for Work (FFW). However, HCPs also reported cases where the claimant appeared to have under-reported the impact of their health condition in their ESA50. This seemed to be particularly the case for people with mental health conditions. On this basis, a customer may have been found FFW on the basis of their ESA50, but the assessment may have found them eligible for ESA.

HCPs reported that completion of the ESA50 seemed to be a particular problem for some people with mental health conditions and this was also borne out by comments made by customers themselves (see Section 2.2.2). HCPs suggested that the ESA50 needed some improvements, particularly in relation to the mental health section. Suggestions included simplification of the questions, providing additional information about how to fill in the form, and better sign-posting of the different sections – for example, some claimants who only had physical health conditions filled in the mental health section of the form.

‘I think the problem is that the people don’t understand actually what the question is about. They mess up with mental health problems. They put physical problems in mental areas. So the questionnaire on its own is quite difficult, and difficult to understand.’

(Atos Healthcare HCP)

People with mental health conditions were also less likely to have completed the ESA50 before the assessment; as explained above, people with known mental health conditions can be invited to attend a face-to-face WCA even where they have not completed and returned an ESA50. One consequence of this was that HCPs could encounter someone with severe mental health conditions and not have any supporting documentation to assist them in making the assessment, which was reported to be challenging¹⁶.

2.2.2 Customer perspectives

Turning to customers, their views on the ESA50 form, and the process of completing it, were mixed. Some had found the ESA form to be ‘pretty straightforward’ to complete despite its length, and some said that they had appreciated the detailed information that the form requested, as it allowed them to fully explain the nature of their condition, and how it affected them, as this quote illustrates:

¹⁶ This is not a new issue, however, as similar provisions regarding mental health existed within the Personal Capability Assessment (PCA) process which was used to determine eligibility for Incapacity Benefit.

'I thought it was quite good because with the problems with my knees I can't kneel and things like that, and it actually asks those sorts of questions. It wasn't just like "can you walk", "how far can you walk", "when are you in pain", it actually asks "can you squat", "can you bend", you know, kneel, and it was really sort of detailed for me. I thought it was brilliant because you could actually answer a question that they were asking without going round the houses.'

(Customer age 45-54, Work-Related Activity Group (WRAG), musculo-skeletal conditions)

Others, however, had found the form too long, and perceived it as repetitive and unwieldy, as this quote illustrates.

'I was getting a bit annoyed in the end because it was the same questions being asked over and over again.'

(Customer age 45-54, WRAG, musculo-skeletal and systemic conditions, and cardiovascular condition)

The ESA50 had been especially problematic for those who were unused to filling out relatively long and complex forms, and for those who were on medication which affected their memory or concentration, like this customer:

'I had to get help because the tablets I'm on now, I can't concentrate.'

(Customer age 45-54, WRAG, injury and musculo-skeletal condition)

Some customers were wary of the ESA50 form, particularly the way in which the questions had been phrased, which they found difficult to understand:

'It's a little disconcerting. It's the way they phrase the questions and the question's always turned around. It almost feels like they're trying to catch you out. It also feels like some psychologist sat down in a room to make these difficult for human beings so that half the people won't claim...'

(Customer age 45-54, WRAG, musculo-skeletal conditions, systemic condition, mental health condition)

As noted above, some customers reported that they had needed support to fill in the ESA50 form, for instance because their concentration was impaired by medication, or because they found reading and writing difficult. There were occasional reports of assistance from Jobcentre Plus advisers, and some customers had filled in the form with the help of family members. Some customers who had claimed Disability Living Allowance (DLA) commented that help was provided with their applications, to help them fill in the form to reflect the true nature and effect of their health condition, and that it would have been helpful to have something similar for the ESA50.

Not all customers could remember how long it had taken them to complete their ESA50, but some said that they worked on it over a period of a couple of days, filling in sections at a time until it was completed and ready to send back. Some customers reported that it had taken them between half an hour to three hours, to complete their ESA50.

2.3 WCA timing and scheduling

2.3.1 Customer perspectives

According to the customers interviewed, the face-to-face WCA was generally taking place in line with the intended time period, two to three months after they had begun their claim for ESA, although a few had waited longer than this. Most had attended at least one WFI¹⁷ by the time of their WCA, although there were exceptions to this; some customers said they had not been called to any face-to-face WFIs at all, despite having attended a face-to-face WCA and sometimes a WFHRA too.

Some customers had found the appointment date and time they were given for the face-to-face WCA problematic, as it conflicted with stays in hospital, other health-related appointments, or family responsibilities such as picking children up from school or nursery. Some had been able to rearrange their appointments fairly easily, although there were some customer service issues that emerged with regard to contacting the call centres to change appointments. There were reports that it was very difficult to get through to make a new appointment.

'Well it doesn't really matter if it is or it isn't [convenient] because you can't phone them up. I mean [my support worker] tried to rearrange it so that she could go with me and it was just constantly engaged. It was like they'd got the phone off the hook. You can't rearrange it so you've just got to go.... I had to go on my own because it couldn't be rearranged.'

(Customer age 25-34, WRAG, cardiovascular condition, mental health condition)

One customer reported ringing up to try to reschedule the face-to-face WCA as it clashed with a hospital appointment, but was told that it was not possible to rearrange the date. Instead, the customer had to rearrange their hospital appointment. Another customer's first face-to-face WCA appointment clashed with scheduled heart surgery, and so he cancelled the WCA, but this was rearranged for the following week and he was told that he had to attend. When the customer attended, following his operation, the HCP he saw was very concerned about him, told the customer that he should not have been instructed to attend a medical assessment so soon after a major operation, and said that they would complain to their managers about this.

Not keeping face-to-face WCA appointments, and not reporting this to the call centre had led to some customers being told their ESA payments would be stopped, as this customer reported:

'They sent me a letter to say that I had to go and in fact they did stop my benefits because I didn't get there and the reason I didn't get there, it was when we had all that really heavy snow and ice.... I was trying to call the medical centre and then eventually I got a letter off them saying that my sickness allowance would be stopped if they didn't hear from me by the 30th of the month. I had been trying, even on that day I was trying to get [through to] them.'

(Customer age 55+, WRAG, respiratory condition, alcohol dependency)

¹⁷ At the time of the research, most customers were called to a WFI in around week 9 of the claim. From October 2010, the first WFI takes place after the WCA decision, for those in the WRAG only.

2.3.2 Adviser perspectives

The main focus of the first WFI was reported to be a discussion of what would happen next; for instance, if the customer had not yet had their face-to-face WCA, advisers would explain to them why they will be called for this, and what to expect in the assessment. If the customer had had their face-to-face WCA, and knew the result, the adviser reported that they talked through the options available.

Jobcentre Plus advisers reported that delays in ESA eligibility decisions limited the value of WFIs. Therefore, the decision which has been taken to delay starting WFIs until a customer's claim outcome is known, from October 2010, was welcomed by them. Up until that point, claim outcome decisions were generally not available for the initial¹⁸ and sometimes the second WFI.

'They're very slow to come through actually. Very slow. I don't think I have ever had one through by the initial and it's rarely that they come through by the first repeat. In fact I don't know what's happening with these but I haven't seen any new ones for quite a while.'

(Jobcentre Plus Adviser)

However, there was also a concern that some customers would be left without support for a considerable amount of time, especially in cases where they were waiting for the outcome of an appeal against a decision on their claim; in some areas this was reported to be taking at least six months. At the time of the research it was unclear to some staff whether customers could attend WFIs on a voluntary basis in the interim.

'Yes, thinking about it I'd be concerned. Yes there's no support there. Although they might be able to come in voluntarily. I'm not 100 per cent sure about that.'

(Jobcentre Plus Adviser)

Advisers reported on cases where customers were attending a first WFI then they were deferring future WFIs because the results of the face-to-face WCA were not known. In cases where the decision had not yet been made, advisers said they would treat the customer as if they had been put on the benefit, including referring them onto to other Pathways to Work provision.

In many cases, once a decision had been made, and (as was often the case) customers had been found FFW following the WCA, advisers reported that the main focus of the WFI was on the outcome and a customer's possible next steps. In some cases, the discussions focused on whether a customer would appeal against the decision. Under the new guidelines, customers are no longer required to attend WFIs until the outcome of their appeal is known.

Advisers felt there was an element of deadweight in cases where customers had a job to return to once they had recovered. In a few such cases, these customers had returned to work before their initial WFI.

Advisers also felt that there were some conditions which meant it would be difficult to support and progress customers towards work, the main ones mentioned being drug and alcohol issues, cancer, and severe mental health conditions. In these cases they felt that both the customer's condition and employer attitudes tended to rule out an early return to employment.

¹⁸ They were intended to be available by the second, rather than the first, WFI.

Advisers are able to defer WFIs with customers who have not had their WCA decision. A number of Jobcentre Plus advisers said they would also like the option to defer WFIs where they felt the customer's health condition was severe, or the customer was undergoing treatment or waiting for an operation. Jobcentre Plus advisers felt that some customers they were working with, who had been placed in the WRAG, were not ready for work and again, in these cases they would have preferred to defer these customers until their health had improved. In some cases, they had not realised that the changes to the threshold for benefit implied by the introduction of ESA and the WCA would result in such a marked change in the characteristics of the customers they would be seeing.

Customers who are placed in the SG can attend WFIs on a voluntary basis. However, advisers reported that they rarely saw customers in this group as they were often very seriously ill.

2.4 HCP experiences of the face-to-face WCA

2.4.1 Training and preparation for the role

The HCPs interviewed had a wide range of experience in dealing with Incapacity Benefit (IB) and ESA. Some people had been newly recruited in the last two to three years while others had over twenty years' experience with this customer group. Some had been recruited directly from abroad, and so were relatively new to the UK benefits system.

HCPs said that they had received training courses of varying length, depending on their existing level of experience. They were very positive about the training received, especially the role-playing by actors, which they felt had provided a good grounding in what would be involved in delivering the face-to-face WCA and WFHRA.

Following the training, HCPs reported that their performance was managed by a regular process of audit and quality control. However, some HCPs felt that they would like more positive feedback on their work, as they tended to be contacted only if there was a problem, and they felt they would have liked to be clearer about what kinds of output were most valuable.

2.4.2 The format and content of the face-to-face WCA

HCPs described following a fairly standardised format for the WCA, often involving a short physical examination (for instance of the range of movement in an injured limb), but mainly consisting of detailed questions about activities of daily living, often structured around a typical day.

2.4.3 Customer reactions

HCPs reported that there was *'a huge spectrum of preparedness'* among customers arriving for their face-to-face WCA; some had little idea why they were there, while others had clearly *'prepped'* for the assessment by using Citizens Advice Bureau checklists and other such materials. Although they acknowledged that there were leaflets and letters and information on the internet, nonetheless Atos Healthcare staff said:

'It's not unusual to have people coming in and not really knowing why they're here, why they've come for the assessment. Sometimes they don't know what it's to do with and whether it is to do with ESA. Sometimes they didn't even know that.'

(Atos Healthcare HCP)

HCPs commented that they usually spent the first few minutes of the face-to-face WCA explaining what would be covered, and setting the scene, but felt that providing more information in the appointment letter would also be beneficial. It was acknowledged that not everyone reads the letters they are sent, however, and that some people prefer to obtain information face-to-face. However, this was sometimes a customer's first face-to-face contact during the ESA assessment process, which could be problematic, as this quote acknowledged:

'I just think the whole way of giving them information is just not good enough, from the beginning, really. They're just completely confused when they come to us and very often the first people they meet face-to-face are our receptionists.'

(Atos Healthcare Service Manager)

HCPs also commented that many customers appeared to expect some kind of physical or diagnostic examination, or even thought that there was a process whereby they could be referred to a specialist in their health condition.

2.5 Customer expectations of the face-to-face WCA

Most customers said that were aware that the face-to-face WCA was to assess whether they were entitled to ESA because their health prevented them from working. A fairly widespread view was that the assessment was to check whether customers were genuinely ill or whether they were 'faking'. This comment is typical of these views:

'Well [the purpose of the medical was], to make sure you are sick and not telling lies really, I suppose.'

(Customer age 25-34, WRAG, cardiovascular condition, mental health conditions)

Others were less sure of the purpose and intention behind the face-to-face WCA, and felt that this lack of clarity was unhelpful, as this quote illustrates:

'I wasn't sure if this was to see if they could get me some support to see if they could get me off the benefit...I think that's the real shortfall that they just don't make it explicit enough what's going on.'

(Customer age 25-34, found FFW and appealing, injury)

Some customers expected that the face-to-face WCA would be conducted by a doctor, although this was often not the case. Many customers also thought that it would comprise what they considered to be a 'proper medical examination', which would include a diagnosis of their health condition(s). Others did not know what to expect, and this fear of the unknown made some people nervous, as this customer explained:

'Well I thought they were going to run tests on me and try and find out what was wrong with me, but they didn't do none of that... [I was] pretty nervous of going because I didn't know what to expect and I didn't know whether there'd be lots of people in the room, but it was just me and this woman.'

(Customer age 18-24, found FFW, severe mental health condition)

Some customers suggested that it could be better explained in advance what the face-to-face WCA would involve. Indeed, there certainly appeared to be a considerable mismatch for many customers between the medical examination they appeared to have expected of the face-to-face WCA, and what actually happened when they attended. Making the coverage of the assessment more explicit would help to manage customer's expectations, and in some cases, fears, around this stage of the process.

'They should have put it in the letter that you're not going for a physical, you're going for an interview, instead of [saying] you've got an appointment to go for a medical. You know, that's what makes you think you're going for a medical.'

(Customer age 35-44, WRAG, mental health conditions)

Some said they would also have liked more explanation about why they had to attend the medical, although some were simply displeased that they had to go for a medical at all. One had been receiving sickness benefits for many years and was 'flabbergasted' when asked to come and attend a medical for ESA. In contrast, some customers were reasonably content with the information that they had been given about the face-to-face WCA, either in the letter they had been sent, or at their initial WFI at Jobcentre Plus, and understood that they needed to attend as it was part of the process of applying for the benefit.

'I think it explained what to expect, what sort of things they would ask and things like that. The leaflet was good that you got with it.'

(Customer age 45-54, WRAG, musculo-skeletal condition)

There were also some examples of customers having looked for more information about the face-to-face WCA on the internet. They had learned that rather than being a physical assessment, it would mainly involve questions for the customer to answer.

Not all customers knew what to expect of the face-to-face WCA prior to attending, and some had not given much thought to what it would entail before they actually went to their appointment. Some had no particular expectations about what it would involve, and did not question this beyond the fact that they needed to attend their appointment to continue on ESA.

2.6 Customer experiences of the face-to-face WCA

2.6.1 Travel to the face-to-face WCA

Customers' travel times from home to the Medical Examination Centre (MEC) where the face-to-face WCAs were conducted in their area, ranged from 20 minutes to two hours. Most lived some distance away so they had to travel by car or use public transport. For some this was not problematic, although those without cars living in rural areas, and some customers in large cities, had to make their way to their appointment using two or three different buses. Some customers were able to get lifts with family members if the appointment was conveniently timed, although others said that although they had requested a time when they would be able to get a lift, they did not have much say over when their appointment would be, so they had to travel by bus.

Some customers, with particular difficulties in travelling, reported that they had requested a home visit rather than to have to travel to the MEC, but had been told that they had to attend in order for their claim to be processed, so that they could continue to receive benefits. This customer, who was in considerable pain, had failed to obtain any response to an explanation of his difficulties:

'It was hard for me to travel because I can't travel very far – even to my hospital. It's complete and utter agony. By the time I'd got home I could hardly move and I felt like saying to them, "Well why couldn't you have come to me?" I did explain to them that it was difficult for me to get around but it was as if it went in one ear and out of the other because I said, "Is there any way someone could come and see me?" but they just didn't want to know.... They didn't tell me I could have come by taxi and they would have paid for it so I went by bus in the end...it took me an hour and a half to get there.'

(Customer age 45-54, WRAG, musculo skeletal and systemic condition, 'other health condition', cardiovascular condition)

For those with mobility difficulties, travel issues had sometimes been compounded by the bad weather in the early months of 2010, with icy conditions making journeys much more difficult. Some customers with mental health difficulties also found travelling to the MEC difficult or distressing.

'I was a bit worried to be honest with you because of this condition and not wanting to be in crowded places...I was very uncomfortable and very nervous. If I could have had a lift there and a lift back it would have been better but the fact that I had to get the bus up there made it even worse because I don't drive you see.'

(Customer age 35-44, WRAG, mental health conditions)

There was considerable variation in whether customers had been advised in advance that their travel expenses to the face-to-face WCA would be refunded. Some customers had been advised in advance that they were able to take a taxi to and from the MEC, as it would be refunded in full afterwards, some found out only when they arrived at the MEC, while others were never told about this. There were also examples where the information regarding travel expenses provided was unclear to customers, resulting in them being out of pocket.

A number of customers argued that they would have found attending the face-to-face WCA considerably easier and less distressing if it had been carried out at a venue nearer to their home area, such as their usual Jobcentre Plus office.

2.6.2 Waiting times

Customers said that they generally did not have to wait long once they had arrived at the MEC. Some had been seen almost straightaway, while others had needed to wait for a short time. However, some customers reported that as appointments were running late, they had to wait for 30 to 45 minutes, and there were a few reports of having to wait for more than an hour.

2.6.3 Environment

Some customers said that they had been comfortable enough in the waiting room, particularly if they did not have to wait long for their appointment. Others had found the waiting areas to be 'stark', or 'bleak and intimidating', and those with mental health conditions often reported that this, together with having to sit with lots of other people in the waiting room, had exacerbated the stress of the situation for them. Some suggested that a few pictures on the walls or other 'human touches' would have helped to put them more at ease. A number of customers commented on the 'hard plastic chairs' which were uncomfortable to sit on for more than a few minutes, or were unhappy what they saw as intrusive levels of surveillance (CCTV and security guards). Other customers, however, compared the Atos Healthcare waiting area to their own GP or dentist's waiting room, suggesting that it was acceptable for its purpose.

In terms of the examination room, some customers were comfortable with the surroundings, even if they were less happy with the process itself, as this quote illustrates:

'The surroundings were fine, it's just a room with a desk, a computer and a doctor, it was nothing... The waiting room was clean and comfortable, that was fine. It's just what was occurring really.'

(Customer age 35-44, SG, cardiovascular condition, musculoskeletal conditions, mental health conditions)

However, others had found the room unpleasant; for example, they reported that it was cramped, or that it had made them feel as though they were *'under interrogation'*. One customer reported that the room in which his face-to-face WCA was held was not adequately soundproofed. As he could hear the conversation of the HCP and customer in the neighbouring room, he suspected that they could probably hear his own discussion, which was of an acutely sensitive nature, and this had troubled him.

2.6.4 The assessment

While not all of the customers interviewed had given much thought to what the face-to-face WCA would involve, many reported that they had been surprised at the content and coverage of the appointment when they attended. There appeared to be a widespread mismatch between customer expectations of the face-to-face WCA and their subsequent experiences. As discussed already, most had anticipated, and indeed would have preferred, more of a *'hands-on'* examination from a doctor (rather than another type of HCP), and fewer questions about how they felt and what they could do.

'They could start by examining you instead of asking you how you feel. You're there because they want you to go for a medical, but you're not getting a medical, you're just getting somebody who's talking to you, and was he a doctor?'

(Customer age 45-54, WRAG, respiratory conditions, musculo-skeletal condition, alcohol dependency)

Customers with mental health conditions also appeared to have expected some sort of diagnostic test administered by a doctor, rather than being asked questions about what they did in their everyday life and how they coped with particular situations.

'As for the mental state, I would have liked a doctor there, not to prove that I was depressed, because like she said, depression isn't really something that you can prove. But I would have liked some sort of questionnaire, like the doctor gives me, to say how I'm feeling and stuff like that.'

(Customer age 35-44, FFW, appealing decision, mental health conditions)

Some customers reported that some of the questions asked in the assessment had seemed strange or inappropriate. They did not understand why some of the questions were necessary, for example, asking if they had a partner, whether they could wash and dress themselves, and what they watched on television. Some found such questions rather disconcerting.

'The questions they were asking were: "what time do you get out of bed", "what do you do in the day", "do you watch much telly", "can you focus on the telly?" And it was just silly questions really. The amount of questions they were asking, it felt they were really trying to catch me out for some reason.'

(Customer age 35-44, WRAG, mental health conditions)

Some customers reported that issues which they saw as relevant and important, such as impending operations, had apparently been ignored in the face-to-face WCA. For example, one customer reported being asked repeatedly when he would be able to go back to work. As he was due to have open heart surgery the following week, with a reported six-month recovery period, he felt that such questions were ill-timed and inappropriate.

Customers with fluctuating conditions – including mental health conditions and certain physical conditions such as chronic fatigue syndrome – had also found many of the questions difficult to answer, as they had seemingly not been designed with these in mind:

‘Most people can do that [bend down] with chronic fatigue syndrome, but if you’re severely affected, you pay for that after an hour or even a day later.... Those questions were very orientated to physical illness and they just didn’t really capture my experience.’

(Customer age 18-24, found FFW and appealing decision, systemic condition)

There were also mixed views from customers regarding the manner and attitude of the HCP who conducted their face-to-face WCA. Some customers felt that they were not being believed, or that the HCP was not accurately recording what they were saying, but was instead concentrating only on the positive aspects reported, and not taking notice of the negative things being reported by the customer. In short, a number of customers believed that they were not being heard by the HCP, and they found this distressing.

‘I knew that if I failed they would stop my money and I thought that I wouldn’t fail it because I’ve had depression and Crohn’s Disease, but the woman wouldn’t listen to what I had to say, what bad things I had to say. Every time I mentioned a positive thing she was writing all the positives down and ignoring the negatives, which was quite annoying to be honest.’

(Customer age 18-24, FFW and appealing decision, systemic condition, mental health conditions, drug dependency)

Some customers said that they had been able to take a family member, friend or support worker into the face-to-face WCA with them, but there were also some reports that this had not been permitted, which customers found distressing.

Some customers said that there had been enough opportunity for them to put their views and experiences across, but others reported that the appointment had felt very rushed and that the HCP had tended to hurry through the questions, asking the next question before the customer had fully addressed the previous one. Customers who had made positive comments about the MEC staff also identified these feelings of time pressure, suggesting that, in some cases at least, it was the process, rather than the staff administering it, which was problematic.

‘They were very nice down there, they were lovely people and they’ve all got a job to do.... It was just question after question. You felt like you were trying to be caught out, that’s how I felt.’

(Customer age 35-44, WRAG, mental health conditions)

Turning to other issues with the process, there were isolated examples of customers who had been required to attend more than one face-to-face WCA because of IT problems which meant that case notes had been lost. There was also one report from a customer that a piece of paper with other customers’ names and details was in full view on the HCP’s desk during their assessment. This may have been a rare or isolated event, but any breach of customer confidentiality is still a cause for concern.

There were also some positive views from customers about their experience. Some reported that the HCPs were indeed professional in their manner and the way in which they conducted the appointment; that they gave adequate explanations, and were appropriately understanding of the customers' condition and circumstances.

'When I got there, before the medical even started, they explained everything; why I was there, who asked them to do it, and stuff like that. So in fairness to everyone there, they were really nice about it.'

(Customer age 45-54, WRAG, cardiovascular conditions, systemic condition)

Some customers had been told that they needed to attend the appointment they had been given, but on arrival, the HCP had immediately judged that their health was simply not good enough for them to be away from home. In these cases, the HCP made sure that the customer was able to get home as quickly and comfortably as possible, typically by terminating the appointment straight away, and by ensuring a taxi from the centre was called for the customer.

2.6.5 Customers' views of the HCPs

Some customers praised their HCP's manner and professionalism, or said that the HCP's manner put them at ease. This quote is typical of these views:

'I thought the interview went very well. The questions they asked were in-depth, you know what I mean, they were very thorough.... The way she looked at me and the way she was listening... you know, she was very good.'

(Customer age 35-44, WRAG, mental health condition)

However, others were unhappy with the HCP who had conducted their face-to-face WCA. Some customers with relatively rare or unusual conditions reported feeling that the HCP did not have enough specialist knowledge to ask appropriate questions to assess them. They also commented that there did not seem to be a way for the HCP to deviate from what appeared to be a standard procedure either in how the questions were asked, or the way in which responses were captured on the system.

Others complained that the manner of the HCP was *'impersonal'*, *'robotic'* or as though they were *'on autopilot'*. Some said that the manner and language used by the HCP they saw was strange or even slightly offensive. In some cases, where this was not the HCP's first language, a lack of fluency in English had led to questions being asked in a manner which seemed rather abrupt to the customer. Some customers even questioned whether their HCP's English language skills were of a sufficient standard to assess them properly, as this quote illustrates:

'When people can't communicate with you because of a language barrier I find it upsetting to say the least.'

(Customer age 45-54, WRAG, musculo-skeletal condition, systemic condition and mental health condition)

As stated earlier, many customers were expecting to see a doctor for the WCA, and some of those who saw a nurse were fundamentally unhappy about this. By contrast, other customers explained that they had no concerns about who had conducted the assessment, as long as they were appropriately trained, listened to them, and acted in a professional manner.

2.7 The use and value of other medical evidence for the face-to-face WCA

2.7.1 HCP perspectives

The amount of additional medical evidence available to HCPs doing the assessment varied greatly. In some cases, the assessor would have a substantial amount of other medical evidence, mostly from specialists, GPs and possibly previous assessments. However, it was reported by HCPs that they often did not have any additional information.

Some Atos Healthcare staff reported that GPs do not always respond to their requests for information, so although they have a statutory obligation to do so, information is often not provided. One HCP reported that GPs reports were provided in less than half of her cases. However, GPs reports were particularly well received because they tended to know the claimant so well. Some HCPs felt that would help to contextualise what they observed on a single appointment.

The provision of additional medical evidence was generally seen as beneficial to the assessment, where available. HCPs identified a number of benefits. Firstly, HCPs argued that a lack of access to medical information sometimes meant that customers were called to attend a face-to-face WCA when this was not appropriate, a situation they were keen to avoid if possible:

‘Obviously we don’t want to call people in that are unfit. And then if the GP doesn’t respond to us, we’ve got no evidence to not call them in. And it is distressing at times from a professional perspective to see some people being called in, because we know, when we meet them, that they shouldn’t be coming in.’

(Atos Healthcare HCP)

Secondly, in the case of a complex medical condition, some HCPs felt that additional medical evidence could help them in their functional assessment.

In addition, it was felt that greater access to medical evidence ahead of the face-to-face WCA might improve the quality of decision-making by providing a more rounded picture of the customer’s condition than was really possible in a one-off assessment:

‘It can be very difficult sometimes when you’re assessing somebody in a short space of time as to whether what they’re telling you and whether all your examination findings, whether they all tie together. It can be very difficult, and I think if you had some supporting evidence from a health practitioner, it would make your decision making a lot more robust.’

(Atos Healthcare HCP)

Overall, HCPs thought that the provision of additional medical evidence could be improved and a number of suggestions were made regarding this. One of these was to reinforce messages encouraging claimants to bring along evidence such as medical reports, referrals, copies of hospital letters, GPs reports and medicines/prescriptions with their names on. Another possible improvement would be the routine provision of GP reports (although some Atos Healthcare staff were conscious of trying not to over-burden GPs in this way).

However, although some HCPs said they would like more medical evidence, others felt that such evidence was not always necessarily applicable to the process of carrying out a functional assessment. Customers also reported that HCPs did not always take account of other medical evidence where this was provided.

2.7.2 Customer views and experiences

Some customers were surprised and concerned that the face-to-face WCA did not appear to include a thorough examination of their medication, even where they had been requested to bring these with them to the appointment. This quote is typical of these views:

'I took everything with me, my hand things, my neck brace, all my prescriptions, and these are all the tablets that doctors have told me I have to take, so I took everything. By the time I got it all up there for the doctor to see it was as if they've asked for all this but they don't want to know, it was as if the medication wasn't what they wanted to know about, whereas the medication to my way of thinking is part and parcel to help you get through your condition.'

(Customer age 45-54, WRAG, musculo skeletal and systemic conditions, 'other' health condition, cardiovascular condition)

Other customers had expected the HCP to seek other medical evidence from their GPs or specialist, but reported that this did not seem to have happened, as this quote illustrates:

'I thought that because I'd given them authorisation to speak to any one of my doctors or the surgeon or any one of them on the form; the various forms that I filled in. I just thought it was a waste of time...why don't they ring a professional so they can get the true story?'

(Customer age 55+, WRAG, injury, musculo-skeletal conditions)

Other customers were quite angry that the opinions of their doctors and specialists were not taken as sufficient evidence on which to award ESA, and that they had to go to an additional appointment to assess whether they were entitled to ESA or were in fact FFW:

'So I asked her [the Jobcentre Plus adviser] "Why do we need a medical?" Well, the government's saying the doctors are incompetent or corrupt, because their word's not good enough. The psychiatrist says I'm not fit, the surgeon says I'm not fit, the GP says I'm not fit, but the government is unhappy with this, they want to send me...'

(Customer age 45-54, WRAG, musculo-skeletal conditions, systemic condition, mental health condition)

2.8 Comparisons with the Personal Capability Assessment

Staff were asked whether they had any previous experience working with the IB client group and in particular, whether they had previously carried out PCAs used in the determination of eligibility for IB. Those who had previously worked with PCAs were asked what they felt were the main differences between the two assessments.

2.8.1 HCP perspectives

Some of the Atos Healthcare staff had experience of the PCA under IB. In general terms, the structure of the face-to-face WCA and PCA were reported to be quite similar where the key issues they look at are: condition history, medication, social and occupational history, a typical day, history of examinations.

There were, however, a number of differences identified between the WCA and the PCA. Overall, HCPs were aware that with ESA the emphasis has changed and now the WCA looks at what claimants can do, as well as what they cannot do, which was the focus of the PCAs. In terms of process, HCPs found that the WCA was more in-depth because more information is required to

justify the information discussed around function. Also, face-to-face WCAs tended to be longer, partly because they were more in-depth and partly because, as discussed already, assessors had a lot more information to discuss, ie the ESA50 form and any other medical evidence which had been supplied.

A key difference identified by HCP staff was the differences in the thresholds, with HCPs reporting that the threshold for qualification to benefit is higher in the WCA than the PCA, that the descriptors have become more tightly defined, (for instance, one example given was that someone with an injury to one upper limb now scores no points) and consequently, a claimant has to have significantly less function to score above the threshold. On the whole, HCPs thought this was a positive change, however, some also felt that perhaps the threshold had moved too far in the opposite direction and had become too high. As one put it:

'I personally think ESA is good, the theory behind it is excellent. However, as I said before, the pendulum has sort of swung a bit too far in the opposite direction. I think there are a group of people in the middle who would probably qualify for IB but wouldn't get ESA and is not particularly Fit for Work – they're just there and what can we do with these people?'

(Atos Healthcare HCP)

Atos Healthcare staff discussed some cases where they felt that the claimant was not in a position to work and would have benefited from a period on ESA, however, they did not score highly enough to reach the threshold. In these situations, Atos Healthcare staff suggested that there could be some flexibility in the system to allow them to place someone (perhaps temporarily) onto benefit and review the case.

'There isn't the option of exempting somebody (under ESA) and I think there were categories of severe ill health before on the PCA where you could just accept that they were disabled. Whereas you can't now and so the application of the non-functional descriptors virtually never apply now.'

(Atos Healthcare HCP)

Reassessment of existing IB customers for ESA

Thinking about the differences between the WCA and PCA, Atos Healthcare staff appeared to view the prospect of reassessing existing IB customers under the WCA as a considerable challenge. While there was general acknowledgement that this was a reasonable and worthwhile development, it was also seen as one which could generate a considerable amount of additional workload and different kinds of demands:

'You'll have people who've been on benefit for a much longer time [and] will have come under a different system, I suppose my worry is they'll come in with a different mental attitude to the examination and it will be more challenging. There's the potential that, A, lots of them are sicker, B, lots of them have been on benefit for a long time, but may be found fit under the new process. They're not going to be happy about it. And if you're looking at a WFHRA, lots of them have had three, four, five, possibly ten years of not working. And trying to look at their perceptions for work for the future when they feel that they will never be able to work again will make the WFHRA side of things challenging.'

(Atos Healthcare Service Manager)

Sensitivity to different health conditions

With regard to how the WCA varies from the PCA in terms of sensitivity to conditions, HCP staff noted some differences. On the whole, the WCA was viewed as an improvement on the PCA, as redundancies and overlap in the previous descriptors had been eliminated, and descriptors for some conditions improved. Conditions specifically mentioned as being better dealt with in the WCA included severe mental health conditions, learning difficulties, Asperger's Syndrome and some visual disorders.

However, it was reported that the WCA did not work so well with other conditions. Specific conditions mentioned here included fluctuating conditions, primarily mental health conditions. Some HCPs thought there may be an issue for claimants with mild to moderate depression who would find it difficult to score above the threshold, although in some cases they felt the person could have benefited from some time on the benefit and the extra support that would offer.

Another condition identified as being problematic in the WCA was multiple sclerosis (MS) and several HCPs said that claimants with MS were difficult to score above the 15-point threshold for entitlement to benefit, despite substantial difficulties with locomotion and limb co-ordination which meant that they felt they were not well enough to work. HCPs also thought that the WCA was not sensitive enough to cancer, particularly for people recovering from treatment, and some discussed cases where they would have advised that someone be awarded ESA but the thresholds did not allow for this.

'Well the one that springs to mind is people with cancer. The requirements in ESA are quite stringent and you find that you're presented with someone with breast cancer, unless they're undergoing treatment, it's quite difficult to write them in for the benefit. Although the legislation does allow us to take into account recovery from treatment, it's a bit of a grey area how long you should accept as being a recovery period from treatment. I think that has caused a certain degree of upset for the people affected.'

(Atos Healthcare HCP)

HCPs stated that they were seeing many more severely disabled claimants than they previously had in PCAs (under IB, fewer of these claimants would have been called for a face-to-face assessment) and some had found that some severe disabilities, such as generalised motor impairment due to degenerative conditions, were incompatible with the guidelines and descriptors, which made the assessments more difficult.

'I think the fact that we examine people with very significant disabilities that don't fit into the guidelines and descriptors that we work with. It's difficult, as a nurse, to see people that are quite unwell but with all the information that we've got, they don't fit into categories for ESA.'

(Atos Healthcare HCP)

Some HCPs also felt that the WCA dealt less well with customers with multiple conditions, as this quote illustrates:

'Some of the ones that we've been aware of were customers with multiple conditions, multiple physical conditions, all of which are mildly disabling but in combination are quite difficult.'

(Atos Healthcare HCP)

2.8.2 Customer perspectives

Some customers had previously experienced the face-to-face PCA, when they had claimed IB in the past, and they tended to think that the PCA was more appropriate for them, compared with their experience of the face-to-face WCA. This was mainly because they thought that the PCA had examined their health condition itself in far more detail than had been the case in the WCA. Some also commented on the detailed report which they had received after the PCA, which they had found useful and reassuring. There were some examples of customers having had a PCA in their own home, and who had also hoped to have a home visit for their WCA, but who were told that they needed to go to an MEC this time. After having been through the IB assessment process, it was clear that some customers had expectations which did not match their subsequent experiences of the ESA assessment process.

'I thought it was going to be a proper medical; it's them examining you to see what's wrong with you.... Well the first time [for the PCA] the doctor came out to me and he actually gave me a proper medical and was able to assess me sitting, me standing, me going up the stairs. He looked at that just to see what I can do, but this time they didn't even do that.'

(Customer age 45-54, WRAG, respiratory conditions, musculo-skeletal condition, alcohol dependency)

Regardless of whether they had experience of claiming IB or not, many customers questioned the lack of physical examination involved in the WCA, and the use of the questions that were asked instead, again suggesting a mismatch between customers' expectations of what the face-to-face WCA would involve, and its actual content.

2.9 WCA outcomes

Few customers remembered being told at the end of their face-to-face WCA about what would happen next, although some recalled receiving a letter soon afterwards advising them of the result of the WCA. Those who were found FFW following the WCA and, therefore, ineligible for ESA reported that the letter provided details of how many points they had been awarded. Some customers who had obtained sufficient points to qualify for ESA said that they had received a letter telling them this, but other customers reported that they did not receive a letter, and only realised that they had been awarded ESA when the amount of benefit which was paid into their bank account increased a few weeks later.

Customers who been found FFW following the WCA and, therefore, ineligible for ESA reported being shocked that their ESA payments had stopped without warning, as they did not recall receiving a letter from Jobcentre Plus advising them of this. Those who scored few or no points did not believe that the WCA was a fair assessment of their condition, or an accurate record of what they had said in their face-to-face WCA. As stated above, some customers believed that the HCP had concentrated on recording the positive points that had emerged, but had not taken on board the negative aspects that the customers had also reported at all, and so they had gained an unbalanced picture of customers' health and capabilities.

Customers who had been found FFW following the WCA also often believed that supporting medical evidence from GPs, psychiatrists and other doctors and specialists had not been taken into account in the final result of the WCA, and that had it been included, they would have been awarded sufficient points to receive ESA.

2.10 Appeals

2.10.1 HCP perspectives

HCPs, especially those with long experience of the IB system, were unsurprised by the high volume of customer appeals, since the threshold for benefit entitlement has changed quite considerably with the introduction of ESA. Some felt that there were individual cases which might merit the award of benefit but where they were unable to score the person highly enough against the descriptors, such as people with advanced MS, or acute depression. However, these cases appeared to be a minority. The overall tenor of their comments suggested a concern that appeal decisions tended to be too lenient, and were sometimes taking undue account of social factors.

This quote is typical of these views:

'I don't think sometimes they actually have hard and fast evidence to support overturning the decisions – they put people in the Support Group...for fairly minor conditions.'

(Atos Healthcare HCP)

An issue that came up frequently in interviews with HCPs was that there was no written rationale or justification for the points awarded against descriptors in the appeal, of the sort that HCPs must provide for the WCA, and this also tended to undermine their confidence in the validity of the decisions. Some HCP comments on this issue evinced a degree of frustration, as this example shows:

'They scored nothing at all...They go out, they walk the dog, they're looking after their children, they're going to the shops, they drive a car, and they've gone to appeal and won 15 points. We have no clue why they've got those 15 points, because there's no evidence that we've got why they would score any points at all.'

(Atos Healthcare HCP)

It was felt to be particularly invidious if a customer who had successfully appealed subsequently had to be seen by the same HCP for a WFHRA, as there was almost no possibility of positive engagement in this situation. While it was generally possible to avert this, HCPs reported that it was sometimes unavoidable in smaller or rural centres.

2.10.2 Customer perspectives

Some customers who had been awarded few or no points at the WCA, and had been declared FFW, had appealed the decision because they felt that it did not reflect their actual ability to work. Not all had been keen to appeal at first, as they did not think that an appeal would be likely to overturn the original decision. In some instances, Jobcentre Plus advisers had told customers of previous appeals in similar circumstances which had been successful, and this had persuaded customers that they too should appeal. There were also examples of Jobcentre Plus call centre staff advising customers to appeal their WCA decision.

'I phoned [the Jobcentre Plus adviser] up the following day, and he said, "Are you going to appeal against it?" I said, "Well, what's the point?" Basically because I can walk and talk and do all the things for myself, there's no point. He said, "I've seen people who've had no score, appealed against it, and got a great result". So I phoned up the ESA and asked how I went about appealing against it...while I'm appealing they'll still pay me until they reach a decision.'

(Customer age 35-44, FFW, appealing, mental health condition)

While most of the appeals were made by customers who were declared FFW, the research also found customers who were placed in the WRAG, who felt that they should have been allocated to the SG.

A few customers went to the Citizens Advice Bureau or other welfare and support organisations for advice and help with writing their appeal letter, or had found other professionals, such as a social worker, to help them with this. Others wrote their appeal letter themselves, as they thought it would be important for them to state their reasons for appealing, in their own words.

Customers rarely knew in advance what the appeal would involve, but while the general view was that writing the appeal letter had not been too onerous, many were surprised at how long it took for their appeal to be dealt with, and for a decision to be reached, as the process had generally taken at least six months. The waiting that was involved was reported to be very stressful for some customers, and some of those with mental health conditions commented that their condition had worsened during this time. Customers reported that the uncertainty while waiting was difficult for them to handle, and that they needed the outcome of the appeal in order to be able to take any positive steps, as prior to that they simply did not know what the future held for them.

‘Obviously, it was quite horrendous having the appeal hanging over my head for six months, quite a stressful time, especially with the depression side, it made it a lot worse.’

(Customer age 35-44, FFW, appealed and now in WRAG, cardiovascular condition, musculo-skeletal condition, mental health condition)

Customers did, however, appreciate the fact that their benefits continued while they were waiting for their appeal to be heard. However, there were examples of customers’ payments stopping while they were preparing their appeal, which put some in a very difficult financial position. For example, a customer said that she had appealed her WCA decision, but that Jobcentre Plus did not receive her appeal and so her money stopped without warning. She had since sent another appeal letter, but was waiting for her benefits to be reinstated. In the meantime she was struggling financially.

Customers’ experiences of the appeal hearing itself varied greatly; some had thought that the tribunal panel were not listening to them properly, but others reported positive experiences at the appeal hearing. Unsurprisingly, their views seemed to have been shaped by the result of the appeal, with those who had been unsuccessful at appeal feeling more negative about the whole process, than was the case for those who had won their appeal.

‘I had the tribunal at the end of January...here was a judge and a doctor on the appeal panel in the court, because it was actually a court, Tribunal Court, they gave me almost three times as many points as the [WCA] doctor did. They gave me time to explain, very, very professionally done, and I won the appeal and now I’m signed off work.’

(Customer age 38, FFW, appealed and now in WRAG, cardiovascular condition, musculo-skeletal condition, mental health condition)

3 Staff and customer experiences and views of the WFHRA

3.1 Introduction

This chapter explores customer and staff experiences and views of the Work-Focused Health-Related Assessment (WFHRA). At the time of this research, this assessment was carried out by a Healthcare Professional (HCP) who could be a doctor, nurse or physiotherapist. It was intended to explore customers' views about moving into work, their perceptions about their disabling condition, and identify workplace interventions that could facilitate their engagement in work. Both the customer and their Jobcentre Plus or Pathways to Work Provider adviser received a report of this assessment, for reference during Work-Focused Interviews (WFIs).

The WFHRA was originally carried out on the same day as the face-to-face Work Capability Assessment (WCA), immediately after it, meaning that all Employment and Support Allowance (ESA) customers attending a face-to-face WCA, regardless of their eventual claim outcome, were required to attend a WFHRA. However, these two assessments were subsequently decoupled, and only those in the Work-Related Activity Group (WRAG) were required to attend a second appointment for a WFHRA, at a later date. This was the situation at the time of the fieldwork for this study. Since then, the WFHRA has been suspended.

3.2 The timing of the WFHRA

3.2.1 Customer experiences

The timing of the WFHRA varied; it was typically reported to have been held about two months after the WCA, and after customers had attended three or four WFIs, but there were variations to this. In particular, when customer case notes had been lost, or in instances when benefits had been stopped and restarted, the WFHRA was delayed.

3.2.2 HCP experiences

Atos Healthcare staff reported that decoupling the face-to-face WCA and WFHRA had improved administrative efficiency considerably. Initially, when both parts of the assessment were being carried out on the same day, the appointments were estimated to last between 70 and 90 minutes, which made it difficult to organise scheduling and deal with non-attendance issues, and also meant that it was a long and taxing process for customers. It was also felt that it was more appropriate to limit the WFHRA to those in the WRAG, partly because it seemed unlikely that report would be used if someone was found Fit for Work (FFW), and also because of the risk of creating expectations that might not be met:

'I don't know about the ones who weren't going to get the benefit, and I wonder whether doing that actually raised expectations that they were going to be getting help, which never materialised. And I think that was almost a worry or enough to be a concern.'

(Atos Healthcare HCP)

Some HCPs also argued that customers might be more inclined to engage in a separate WFHRA, when their entitlement to benefit was already established, but others felt that allocation to the WRAG could have the opposite result, leading to a failure to engage, as this quote illustrates:

'I think once they've scored the points into the benefits stream, then they feel that that's it, they're sick and they can't work.'

(Atos Healthcare HCP)

Some other downsides to decoupling the face-to-face WCA and WFHRA were also identified, in particular that it was harder 'going in cold to do a WFHRA'. As one HCP commented:

'It's tough, because you haven't spent that time with the person, you haven't got...any of the rapport.'

(Atos Healthcare HCP)

Whereas doing them both on the same day, in addition to building rapport with the customer, it was noted that:

'You've got some factual stuff. Similarly, you've got knowledge of their health issues.'

(Atos Healthcare HCP)

3.3 The purpose of the WFHRA

3.3.1 HCP perspectives

When asked what they saw as the purpose of the WFHRA, HCPs tended to stress that it was intended to be positive, customer-led, future-oriented and focused on customer skills and interests. Several spoke of the process of 'planting the seed' of a future return to work or 'exploring avenues', rather than necessarily viewing employment as a short-term goal. The emphasis of individual HCPs varied quite considerably, with some seeing the WFHRA as very exploratory, while others saw it as quite focused on the types of adjustments which might be needed to help someone back to work, as in this example:

'It's meant to help people in the future, to get the right job for them, which is suitable for their condition. It's meant to pick up the points that can be adjusted to their workplace, maybe if they need adjustments to the workplace; to give them a medical opinion about their ability to work.'

(Atos Healthcare HCP)

Many HCPs found delivering the WFHRA quite challenging, and they had varied experiences of how they were received by customers, as this quote illustrates:

'The whole idea of going back to work is not something that has entered their frame of reference, and you have to be gently persistent in inviting their thoughts and ideas on a change which can be quite difficult. Often they don't really want to have to think about it. They may think, "No, that's in the future, I don't have to think about that now". I've had very rewarding WFHRAs. I've had some that were just so difficult that you think, "I'm not getting anywhere here at all", and there's no way in, and you just have to do your best really.'

(Atos Healthcare HCP)

Only one or two HCPs specifically identified the WFHRA as an aid to the adviser in carrying out WFIs, as in this quote:

'The purpose of the WFHRA is to really act as a bridge between the ESA interview and the personal adviser...it's an opportunity for a health practitioner to explore their ideas about their health, if there are any barriers to work and help them on their journey to the work focused interviews given by the personal adviser. So it's to really help the claimant on their journey and also to provide information to help the personal adviser to conduct their interviews.'

(Atos Healthcare HCP)

Some Atos Healthcare staff also felt that as that the WFHRA was being carried out later in the ESA assessment process, this could limit the potential benefit to the customer and duplicate what was covered in WFIs, as this quote illustrates.

'The only thing I will say is that very often, the WFI, is done before we actually get the chance to do the WFHRA here, so sometimes there's a bit of double handling that goes on.'

(Atos Healthcare Service Manager)

Some HCPs had also learnt from meetings with advisers that the WFHRA report was not being used in WFIs, and this had somewhat undermined their sense of its purpose and value.

3.3.2 Customer perspectives

Customers generally reported being surprised when they received a letter asking them to attend another appointment at the Medical Examination Centre (MEC); few remembered having been informed that this might happen. This quote was typical of these experiences:

'I'm thinking, "Well, what's this about?". It doesn't explain it on the letter why I had to go back, why the second interview was asked for, and as far as I was concerned I only had to go for the medical assessment. I didn't realise I had to go back again.... I didn't know it was to say when I could go back to work and that sort of thing. If it was explained to me that's what it was about then I would have been quite happy with that.'

(Customer age 45-54, WRAG, various musculo-skeletal conditions)

Others did have a vague recollection of having been told they might need to return to the medical centre, as this quote illustrates:

'I think actually someone did say something, that you might have to have a second interview, at some stage. But then the letter just came through the door; you've got to be here on this day.'

(Customer age 18-24, WRAG, cardiovascular condition)

Customers commonly reported that they had assumed the letter was a mistake, and some had rung up Atos Healthcare or mentioned the letter to Jobcentre Plus to confirm this. Instead, they had learned that they were expected to attend a second 'medical' appointment with Atos Healthcare.

'I was going to ignore it [the letter]. I thought they'd made a mistake or they sent this out again and I'd already been; I'd already done it.... It was just so lucky that I actually had an appointment with Jobcentre Plus and I mentioned that I had to go on this and I said; "Do you know what this is?" and she said "Oh you must go on that. If you don't, you'll have your money stopped".'

(Customer age 55+, WRAG, respiratory conditions, alcohol dependency)

Customers were often unclear about why they had to attend the WFHRA, having already had one face-to-face medical assessment for ESA. However, they generally assumed that the WFHRA would be similar to the face-to-face WCA, and based their expectations on what had happened during their first appointment at the MEC.

'I'd already been for a medical. I thought it'd probably be roughly the same. I think I had phoned up and said I'd already been for a medical, and they said yes, but this was a different kind, and that's when I realised what it was, that they were expecting me. I just thought they'd made a muck-up of it, because the day after I'd had my medical I did receive a letter saying it had been cancelled to a later date. And I thought, "But I've already been".'

(Customer age 35-44, WRAG, musculo-skeletal conditions)

Some customers said that receiving an invitation for what they assumed was a second medical appointment, was rather unnerving; they wondered if the decision from the first one was being checked or questioned in some way. Others had assumed that this was another step to 'sort out the fraudulent claims', and so were surprised when the WFHRA itself did not reflect this.

'You go once and they call you back a few weeks later and you don't know why because you've already been. I sort of did start panicking. In the letter it did state "don't worry, your claim is not affected", but you still can't help but wonder why they're doing it.'

(Customer age group 25-34, WRAG, musculo-skeletal conditions and mental health condition)

Those carrying out the WFHRA also confirmed that customers were generally ill-prepared, with little sense of why they had been asked to attend, a typical comment from an HCP being that '99 per cent of people that come in haven't a clue why they're here'. A commonly reported misconception among customers was that the WFHRA was 'a repeat medical'. Among those customers who did have some idea why they had been called in, HCPs felt that they generally tended to see this as an attempt to pressurise them into returning to work, as this quote illustrates:

'My feeling is that they think that we are there to try and push them back into employment somehow. That's the overall impression that I get.'

(Atos Healthcare HCP)

One HCP commented that she tended routinely to advise people at the face-to-face WCA about the possibility of being asked to attend a WFHRA, and encouraged them to prepare for this to maximise engagement:

'I do say to them at the end, "You may get called back for this work- and health-focused interview. And if you do get the letter to come back, try and get some thoughts around work, work-related activities, charity work, any courses that you might be interested in doing", so that they come prepared. Because nine times out of ten people come back and they just sit in front of you, they've given it no thought.'

(Atos Healthcare HCP)

Other HCPs, however, did not do this, recognising that only a minority of those seen would subsequently be allocated to the WRAG.

3.4 WFHRA discussions and the work focus

3.4.1 HCP perspectives

HCPs varied in the extent to which they felt comfortable discussing work in the WFHRA. Some identified this as an area where they felt competent and experienced, especially if they had previously worked in an occupational health context, whereas others admitted to some unease, making comments such as *'I don't like it'* or *'It doesn't sit well'*. HCPs pointed out that it was a large cultural change for them, as HCPs used to carrying out medical assessments, to start talking to customers about work, and some noted that the training had been helpful in addressing this:

'The training for doing the WFHRA was good because I think that the training actually helped break down some of one's own barriers, because for years we've been doing these sort of encounters but the word work, dirty word, you never mentioned that at all. It was a no-no.'

(Atos Healthcare HCP)

The absence of an actual job as the basis of an assessment could, however, make it challenging to create a tangible and objective focus for the WFHRA, as this comment reflects:

'It's difficult when you haven't got a particular employment to consider...if you are doing an occupational health medical, you're giving advice about a particular job and you can explore what they're doing in that job before you give the advice. But here, we're giving advice in general. So I think it's not easy, [and] may be perceived as not being that helpful.'

(Atos Healthcare HCP)

A lack of specific and local knowledge about the types of services which would be available to customers via Jobcentre Plus was also something which some HCPs identified as a limitation in terms of being able to advise customers about their options. This quote was typical of these quite widespread views:

'One of the things that I find most difficult about WFHRA is the fact that I don't know exactly what's available to them at the other end...one thing that I'm very careful about is I don't want to promise or give them false hope for something that's actually not available to them.'

(Atos Healthcare HCP)

Some Atos Healthcare staff argued that it was not necessary or ideal for the WFHRA to be conducted by HCPs, although the strength of these views, and the rationale underlying them, varied somewhat. At one end of the spectrum were those who were quite content to carry out the WFHRA, but did not feel that this required medical expertise, as illustrated by this quote:

'I have no problem with sitting down with them. I just don't necessarily think it needs to be a medically trained person that carries these things out – it could be done by a lay person.'

(Atos Healthcare HCP)

Others argued much more forcefully that the medical context and setting for the WFHRA could actively undermine its intended focus on employment, saying:

'It's not a medical.... Even though the WFHRA's not a medical, I think our presence medicalises it. And I think it should be completely non-medical.'

(Atos Healthcare HCP)

Another HCP simply argued that, given that the WFHRA could potentially be carried out by any lay person with suitable training, it was a waste of scarce resources to deploy medically trained staff on this task, especially in the context of the imminent reassessment of existing IB customers for ESA.

3.4.2 Customer perspectives

Some customers remembered that the content of the WFHRA was different to the face-to-face WCA, and that work, or training options were discussed with regard to what customers thought they needed to move closer to work.

'I wasn't over the moon. I thought, "Well, I've done it once". But the second one was more like "Would you consider in the near future going back to work, or would you consider taking some courses that would help you?". And it was more like that sort of stuff, like would I consider help, stuff like that.'

(Customer age 25-34, WRAG, systemic condition)

Some customers remembered having been aware in advance of the WFHRA appointment that it would have a different focus from the face-to-face WCA, and that work options would be discussed. However, they were sometimes surprised that the appointment mainly consisted of being asked more questions about what they thought they could do when they had been anticipating that the HCP would introduce more concrete suggestions and options to help them move towards work. This quote is illustrative of such views:

'They just asked me a lot of questions, what would help me get back to work quicker and it was a lot of them asking me really, rather than.... I thought it'd be more solutions. She did come up with a couple, I'm trying to think of the words that she was using.... the only suggestion she made was about – I don't know if it was doing volunteer work or placement, that might be the correct word for it – a placement to a part-time job and then it might lead to a full-time job.'

(Customer age 25-34, WRAG, cardiovascular condition, musculo-skeletal condition, mental health conditions)

In contrast to these experiences, some customers did not recall any work-related questions in the WFHRA, and did not remember the WFHRA content being any different from the face-to-face WCA. This had compounded their initial confusion about the purpose of a second appointment with Atos Healthcare.

'I just think that the second appointment was exactly the same as the first; the questions were a wee bit similar. I just think they could have looked at the questionnaire I'd done before and... got the information off there before asking me to go for another appointment. And I was only in there for five minutes... I thought, "What a waste of time".'

(Customer age 35-44, WRAG, musculo-skeletal conditions)

There were some instances of the WFHRA reportedly being more of a 'general chat' about the customer's health, hobbies, family and age, rather than work. This appeared to be when the HCP had decided at an early stage in the WFHRA that it would not be suitable to conduct an assessment with a strong work focus, given the customer's current health. Indeed, some customers who did not recall a work focus to the second assessment seemed grateful for a more general discussion; especially if they did not feel well enough to be talking about work options, as this quote illustrates.

'I just expected them to ask me all the kinds of questions they'd asked me before and my doctor has asked me, which she did, so it wasn't really a surprise, but it was more of a nice chat in the end. She was a nice lady too and obviously qualified in depression which was quite handy.'

(Customer age 35-44, WRAG, mental health conditions)

However, if there is little work focus to a WFHRA, this does call into question its purpose and intended outcomes, which are concerned with exploring and influencing attitudes towards work (see Chapter 1).

Customers gave varied reports about the length of the WFHRA, and the depth of questions included; this seemed to vary considerably from one individual to another, perhaps depending on the customer's circumstances, and on the approach of the HCP conducting the assessment. Some customers said that the WFHRA had been shorter than the WCA; for instance, there were reports of it lasting just five or ten minutes, while others remembered it being longer, lasting half an hour or more.

Having been through the WFHRA, many customers questioned the value and purpose of this second appointment, and the questions that were asked. One of the key reasons that customers tended to think the WFHRA had not been useful to them was that similar discussions had already been covered by advisers in their WFIs. This quote is typical of these views:

'I don't see the point of the second one, the second one is a total waste of time because you can go to see Pathways to Work, because that's what he's there for.'

(Customer age 35-44, WRAG, mental health conditions)

Other customers, although they had not personally found the WFHRA of value, could nonetheless appreciate that it might be beneficial to others; here too, however, this tended to be seen as a discussion that could take place at Jobcentre Plus, rather than in a medical setting:

'I don't think it was [useful or relevant] but then I don't want to be critical or judgemental. I don't think it was useful because those things could have been asked by someone in the Jobcentre and could have been more informal.'

(Customer age 25-34, WRAG, systemic condition)

There were also examples where the timing of the WFHRA seemed problematic. Some people were waiting for operations, or for injuries to heal, and once they had recovered sufficiently, they were intending to take up their previous trade or return to a job which was still open. They too said that the work-related questions in the WFHRA were not useful to them, as the timing felt inappropriate and the intervention was regarded as superfluous. This was a typical comment from this group of customers:

'Well it wasn't [useful] really. I'm nowhere ready for work, for a start, am I? And, just, I can find my own work. I always have in the past.'

(Customer age 45-54, WRAG, injury)

Some customers found the WFHRA a more pleasant experience than the face-to-face WCA. This generally appeared to be as a result of the manner of the HCPs who conducted their assessments; the extent to which customers felt listened to and believed.

3.5 WFHRA results and output

3.5.1 Customer views

Most customers who had attended a WFHRA had received a report of the results, generally within three to four weeks, although there was the occasional example of customers who reported that they had not received a report. Customers were often critical of the WFHRA output, on the grounds that they felt it was inaccurate; was not what they said and did not reflect the discussion in the assessment, or that it was too brief to say anything of use, or that it did not tell them anything new. Others were critical as they said it contained information of which they were already aware, and which had often already been covered in their WFIs.

'She's made certain recommendations which are absolutely nonsense. In my case she suggests that I'm going to be fit for work in 12 months time, nonsense, especially when I've told her I won't be and I've given her evidence that I won't be and she disregarded it.... My cardiologist has said I'm not fit to work again, Why not just accept that?'

(Customer age 55+, WRAG, cardiovascular condition)

Others were happy enough with the output, finding it to be an accurate reflection of the discussions they had had during the WFHRA itself. While some found it a useful record of the appointment itself, others reported that it had not provided them with any new information.

'Now these answers, they're basically what I said. So really, I don't see these answers as being assessed by her, you know, saying what she feels, but more what my answers were.'

(Customer age 55+, WRAG, respiratory conditions and alcohol dependency)

WFHRA reports were said to have rarely included original suggestions for the kind of work that customers could do in the future, given their health condition. Customers' own reports reflected this; many said that the WFHRA output had not made any firm recommendations for jobs that they might be able to do in the future, that they themselves had not raised in their WFHRAs. Some customers thought that this affirmed the fact that they were unfit for work in general but others would have liked more specific direction and guidance which provided information, options and suggestions beyond those of which they were already aware, for example, of alternative jobs or work areas that might now be suitable for them.

Some customers were upset by the inclusion of a statement on the WFHRA report that they could be expected to return to work within six months. Customers were inclined to see this as a definite requirement, rather than a possibility or aspiration, and often felt pressurised and stressed by this expectation.

'I think he said six months. And I'm saying, "you're putting a timescale on this but I'm not even sure what's happening". And it just goes to show, it's a few months now and that's just me getting medication sorted. I haven't even got anything else sorted.... I think it was a bit of pressure because I thought I'll have to try and get sorted for six months. And I think that's what's caused the depression a wee bit.'

(Customer age 35-44, WRAG, musculo-skeletal conditions)

3.5.2 HCP views

Several HCPs commented that there are legal restrictions as a result of the Data Protection Act which mean that the WFHRA output has to be couched in quite general terms, and they are aware that this can limit their usefulness for customers and advisers alike:

'We're not allowed to discuss conditions. We're not allowed to name people that support the client, so if the client was supported by their mother or their father or their son, we're not allowed to do that. We just have to say, another family member. So the reports can end up looking quite bland. We tell the customer that at the beginning of the examination so that they know that when this report comes through, they know why we've done that. And when we mention a physical condition or a mental health condition, instead of the diagnosis, they know why we've done that as well. Because otherwise they complain.... And the feedback we had from the Jobcentre Plus advisers is sometimes it would be more useful to have the diagnosis in there than just, "a physical health problem".'

(Atos Healthcare HCP)

At best, however, a WFHRA was seen as offering advisers a tool that gives them the confidence to push a customer slightly out of their comfort zone, in the knowledge that there are no risks to customers' health involved in doing so, as this HCP explained:

'It increases their comfort in putting people slightly out of their comfort zone if they know that medically that's going to be an okay thing to do. So a really good WFHRA can give them that confidence to do that because otherwise they worry about duty of care and all of that stuff because they're not medically trained. And it would be interesting to know how to get more of those more of the time.'

(Atos Healthcare HCP)

4 Customer and staff experiences of Work Focused Interviews

4.1 Introduction

This chapter explores customer views of Work Focused Interviews (WFIs), the experiences of advisers delivering them, and looks at the impact of the face-to-face Work Capability Assessment (WCA) and Work-Focused Health-Related Assessment (WFHRA) on the WFI process.

At the time of the research the intention was that all customers applying for Employment and Support Allowance (ESA) attended one WFI with a Jobcentre Plus adviser, before their face-to-face WCA, which was intended to take place at about week nine of their claim¹⁹.

Following their WCA outcome, customers in the Work-Related Activity Group (WRAG) were required to attend further WFIs to help them take steps towards preparing for work, for example considering suitable types of jobs, or discussing relevant training courses they could attend. Support Group (SG) customers could also attend WFIs on a voluntary basis.

In Provider-led Pathways to Work areas, after the initial WFI at Jobcentre Plus, further WFIs are delivered by organisations from the private and voluntary sectors, known as ‘providers’, on behalf of Jobcentre Plus. In other areas, Jobcentre Plus deliver all WFIs.

4.2 Overall experience and views of WFIs

4.2.1 Customer perspectives

Many customers reported that the WFIs had been very helpful, regardless of whether they were in a Jobcentre Plus or a Pathways to Work Provider²⁰ area. Many praised the advisers they had seen; customers reported that they had presented the options, and encouraged them to think about the steps they could take to move closer to the labour market, by working on their skills, confidence and on ways to manage their health conditions.

‘I was always determined to go back to work but without any support from the jobcentre, I wouldn’t have had any idea how and what to do. I think, especially when you’re out of work due to an illness, this kind of support they give you is absolutely vital and it gives you a boost, you are not useless now, you can still do your bit for society.... With them backing me up, pushing me, helping me, I’m even more convinced I’m going back to work.’

(Customer age 45-54, WRAG, systemic condition, musculo-skeletal condition, mental health conditions)

¹⁹ Customers who are terminally ill and claiming under Special Rules, or other severely ill customers, are exempted from the face-to-face WCA and placed directly in the SG.

²⁰ In Pathways to Work Provider areas, WFIs are delivered by organisations from the private and voluntary sectors, which have been contracted to do so by Jobcentre Plus. The organisations that carry out the programme are called ‘providers’. In these areas, a Jobcentre Plus adviser carries out the first interview. Local providers conduct the remaining five WFIs on their own premises.

However, customers particularly appreciated not feeling pushed by advisers into courses of action they did not feel well enough for.

*'They showed me that even with depression and anxiety I could go and do volunteer work, and things like that, to help build my self-esteem up, and it wasn't just down to going back to doing decorating, and being p***** off and bored again. They helped with the whole transition...they were fantastic.'*

(Customer age 18-24, found Fit for Work (FFW), mental health conditions)

Some customers reported that they had taken up training opportunities, or accepted places on Condition Management Programmes. Whether they had taken up such opportunities or not, customers generally reported that they felt more positive about the future as a result of having had WFIs with advisers, as they had been made aware of the range of options and support that were available to them, when they were ready. This quote is typical of these views:

'He's reassured me there's help out there when I feel in myself better to get that help. There is a lot of support off [adviser] because he said he can do my CV, he can look at my benefits, different things like that. He's very helpful at Pathways to Work, very, very helpful.'

(Customer age 35-44, WRAG, mental health conditions)

Not all customers were willing or able to have work-focused discussions in their WFIs. Customers going through appeals were reluctant to talk about work as they thought that doing so might make them less likely to win their appeal. Customers waiting for operations were similarly reluctant to talk about work until after these had been carried out. Some customers reported that advisers had delayed their WFIs while they were waiting for operations, and they appreciated this flexibility.

Those with drug and alcohol issues usually reported feeling unable to engage in meaningful and productive discussions about work in their WFIs with advisers, as they had more pressing issues which clearly needed to be dealt with before they would be in a position to move into work. Some of these customers also had secondary health conditions caused or made worse by their drug and alcohol use, which they felt were additional constraints to work.

4.2.2 Adviser perspectives

Advisers had a range of provision which they could offer to customers on ESA. Generally they would discuss the *Options* leaflet, which sets out the services available under Pathways to Work. Advisers could also refer customers onto a range of provision, one of the main ones being the Condition Management Programme, which provides one-to-one or group sessions to help customers improve their employability by managing health issues such as pain or mental health conditions.

Advisers reported that the outcome of the WCA would influence customers' motivation, primarily if they were found FFW. If customers decided to appeal, the WFIs would be dominated by discussions around the appeal. Customers would not be motivated to think about work or training and in fact were concerned that if they co-operated with the adviser this might jeopardise their chances in the appeal.

Advisers reported that most of the customers they saw for an initial WFI were subsequently being found FFW. In cases where customers were in the WRAG, advisers commented that some were quite ill, and others were undergoing treatment or waiting for an operation. In these cases, advisers reported that customers were not motivated to engage with their services. As noted above, in these cases, advisers would prefer to defer these customers until their condition had improved and they would, therefore, be more motivated to engage with them and get some positive outcomes from the process.

'When they [customers] are getting help from the NHS, from key workers, or whatever, there is actually a chance that, by the end of that six months, they're in a much better state and a much better position. If we can defer for four months, that means we've got an extra four months when we can roll them onto the programme, that we can use mandatory, you have to come and see us button, which is useful.'

(Jobcentre Plus adviser)

4.3 Impact of the WFHRA on WFIs

4.3.1 Customer perspectives

There were no clear reports of the WFHRA having made a difference to customers' motivation to find work, or to their future aspirations or focus. Some, like this customer, felt that it was entirely futile:

'It was just pointless. It didn't serve any purpose. It didn't change the benefits...the position I was in. It changed nothing.'

(Customer age 25-34, WRAG, drug and alcohol dependent, mental health condition)

Some of the customers with the poorest health reported that they had found the WFHRA a validating experience, as the Healthcare Professional (HCP) had confirmed that they were not in a position to be considering work, as in this example.

'He said, "I'm not going to torture you by making you jump through hoops. As a doctor I can plainly see you're unfit".'

(Customer age 45-54, WRAG, musculo-skeletal conditions, mental health conditions, 'other' health condition)

None of the customers interviewed recalled the WFHRA output being used by advisers in the WFIs. One of the customers reported that the HCP who had conducted her WFHRA had told her that in their view, the results would have little impact on the claim process or entitlement to benefit, which in turn made the customer question the purpose and value of the WFHRA:

'She [the HCP] was of the opinion, at least in that particular report, "there's a copy goes to me" she says and a copy goes to the Jobcentre and they'll file it away, but it doesn't ever go... it doesn't have bearing on whether you get any kind of benefit, the ESA or whatever. So to have it was of no consequence basically.'

(Customer age 55+, WRAG, cardiovascular condition)

Another customer reported that his Jobcentre Plus adviser had expressed a similar opinion on the extent to which the WFHRA output was used.

'I take it to the jobcentre interview, present it to [my adviser] and say "This is the second medical, I am not happy, I want some of this expunged from the record". She gives us a quick glance and says "To be honest with you, we don't bother with it".... It begs the question what is the purpose and point? And how many millions of pounds is it costing?'

(Customer age 45-54, WRAG, musculo-skeletal conditions, systemic condition, mental health condition)

Again, as the quote illustrates, this kind of attitude could undermine the customer's confidence in the overall value of the WFHRA.

4.3.2 Adviser perspectives

Advisers generally felt that the WFHRA was of limited value, because it tended to duplicate information which they had already obtained from the customer during the WFIs. In most cases, advisers did not feel that the content of the WFHRA added any extra information to what they were able to collect from the customer themselves and what was already in their action plans. Some advisers found the WFHRAs to be quite standardised and generic. A few advisers reported that the reports state more about what customers cannot do, rather than what they can do. From what they had heard about the WFHRA before it was introduced, advisers had generally expected it to contain information about what goals to set customers, but most found these to be lacking in the reports. The WFHRA was reported to be rarely mentioned in subsequent WFIs, and did not appear to be providing the kind of medical reassurance that HCPs anticipated.

'I don't really use them so to me it's quite limited about what they can do but, like I say, they're not always accurate anyway so I'm not really even looking at them.'

(Pathways provider adviser)

Advisers also reported that customers in many cases felt the WFHRA did not accurately reflect what they had spoken about in the assessment.

Several advisers made the point that the timing of the WFHRA, usually quite late into the sequence of WFIs, also tended to limit its potential value for them, even where the output was helpful. For instance, one said:

'If we got it early enough you could say, "Oh, you've said this. Can I ask you about that?". It would help with questions you could ask customers and how you move forward, but you don't get it early enough to do that.'

(Jobcentre Plus, adviser)

However, it is difficult to assess whether advisers would in fact make more use of the WFHRA if it was provided sooner, since this could only be established by experience.

5 Conclusions and policy implications

5.1 Introduction

This chapter draws together the findings of the research, and identifies some policy implications which flow from them. They should be read in the context of the scope of this research. As a qualitative study, this research cannot shed light on the incidence of particular experiences and views of the face-to-face Work Capability Assessment (WCA) and Work-Focused Health-Related Assessment (WFHRA), although the findings are not inconsistent with those of the customer survey²¹. Instead, its value lies in highlighting the range of issues which influence customer engagement and satisfaction with the assessment process, and the types of issues which staff delivering the assessment or using its outputs are encountering. The weighting of the customer sample towards those in the Work-Related Activity Group (WRAG), which was deliberate, in order to include views of the WFHRA, should be borne in mind, as claim outcome appears to be a key driver of customer views about the WCA²²; a sample which included more of those found Fit for Work (FFW) may have generated additional views and experiences.

5.2 Training for ESA

Healthcare Professionals (HCPs) and Provider employment advisers were very positive about the training and guidance they received about Employment and Support Allowance (ESA), and said that it had equipped them well for delivering the face-to-face WCA and WFHRA. Jobcentre Plus advisers on the other hand said that they received less face-to-face training than they would have liked, and some said they would value additional training in dealing with customers with severe mental health conditions.

5.3 The ESA50 form and overall process

Customers' views of the ESA50 form were mixed, some finding it straightforward while others found it long and unwieldy. Some would have liked to have been offered support and assistance, similar to that provided for Disability Living Allowance (DLA) claims, to ensure they completed it well enough to properly represent their case.

The face-to-face WCA was generally taking place at the intended time in the ESA assessment process at the time of the research, after the initial WFI. The WFHRA was happening slightly later than intended, often after the fourth Work Focused Interviews (WFI). However, the WCA decision was not always promptly available, and this could have an impact in limiting engagement in WFIs, with customers reluctant to discuss moving towards work until the outcome of their claim was known.

²¹ Barnes, H., Sissons, P. and Stevens, H. (2010). *Employment and Support Allowance: Findings from a face-to-face survey of customers*. DWP Research Report No. 707.

²² Ibid.

5.4 The face-to-face WCA

5.4.1 Customer expectations

Customer responses to the face-to-face WCA were varied. HCPs reported that some customers did not know what to expect, while others seemed to be very well prepared for the assessment. Advisers reported some negative responses from customers about the face-to-face WCA, including HCPs seeming unresponsive and not asking questions they felt were relevant to them if they had a mental health condition.

Some HCPs said that they would like extra medical evidence, particularly from GPs. Some also felt it would help if customers were able to provide some additional evidence themselves, although there were some contradictions here with customers saying when they took other medical evidence in with them it was not looked at by the HCP.

5.5 The face-to-face WCA

5.5.1 Customer expectations

There is an issue regarding managing customers' expectations about what the face-to-face WCA involves, as many had anticipated a physical examination or some kind of diagnostic test, regardless of their actual health condition. Some had not expected that the assessment would be carried out by anyone other than a doctor, and were unsatisfied if seen by a different type of HCP.

5.5.2 Travel and access issues

Some customers required more flexibility about the timing and location of face-to-face WCAs and WFHRAs. We found cases where it would have seemed more appropriate to carry out home visits than to require customers to travel to Medical Examination Centres (MECs), and/or where appointments could helpfully have been delayed until after operations. There was also a great deal of variation and inconsistency in the information customers were reportedly given about the travel expenses they could claim, leaving some making difficult and painful journeys, and some being out of pocket.

There were also reports that it had been very difficult to get through to Atos Healthcare call centres to change appointments, and that customer requests for home visits had sometimes been disregarded, as had reports of customers being too ill to attend the face-to-face WCA at that point in time. Similarly, there were reports of customers having to change hospital appointments to fit around Atos Healthcare appointments, when it would perhaps have been more appropriate for Atos Healthcare to be flexible.

5.5.3 Conduct of the face-to-face WCA

Some customers were happy with the way that the face-to-face WCA had been conducted, but many were not. Reasons for this included feeling that they were not being listened to or believed, that the appointment felt very rushed, and that the questions asked in the WCA were not sensitive enough to mental health conditions and other fluctuating or chronic conditions.

The manner and attitude of the HCP, as well as their ability to conduct the assessment in a flexible enough way to make it appropriate to each customer, was of paramount importance in shaping customers' experiences of the face-to-face WCA. This involves tailoring the approach taken in each WCA to suit each customer. Customers felt that listening to them, taking on board what they say, and adjusting the subsequent questioning accordingly were all important in ensuring that they felt

they are both heard, and treated as individuals, rather than simply being put through a pre-determined process, regardless of its suitability to their circumstances and their health. Some HCPs were praised for having done this, but other customers were very unhappy at the way that the HCPs had treated them.

Customers were often surprised and distressed because the medical evidence from their doctors or specialists, and the medication that they brought with them to the WCA appointment – often in response to specific instructions in the appointment letter – seemed to have been disregarded by the HCP conducting the assessment.

5.5.4 The WCA compared to the PCA

Staff who had previously worked under Incapacity Benefit (IB) recognised that the WCA was intentionally stricter than the Personal Capability Assessment (PCA) and that the threshold for benefit eligibility has risen significantly. However, in some cases, staff felt the WCA had gone too far the other way. Although overall, staff were very positive about the move to ESA, some HCPs felt they would like the option of temporarily scoring a customer above the threshold in the short term while they were either recovering from or waiting for an operation, undergoing treatment or experiencing severe mental health conditions. Some conditions, such as severe mental health conditions and some learning disabilities were noted to be better assessed by the WCA, but others such as cancer, fluctuating conditions, and multiple sclerosis (MS), were seen as harder to assess with the WCA.

Customers who had experienced a PCA on a previous claim tended to compare this favourably with the stricter WCA assessment. In part, this appears due to the greater emphasis on medical examination in the PCA, which better matched customer expectations of the assessment process.

Appeals

Customers who were found FFW had, on occasion, been encouraged by their personal adviser at Jobcentre Plus to appeal, because they felt that there was a reasonable prospect of the customer being allocated to the WRAG on appeal. Customers who had appealed reported finding this stressful, and were unwilling to consider activities which would move them towards work during this time, but they appreciated being able to remain on ESA while their appeal went through.

When discussing the issue of appeals, HCPs often felt the reason so many were decided in favour of the customer was that non-medical factors were being taken into account, although in the absence of a written rationale from the panel they had no way of substantiating this perception. It seems likely that providing additional feedback on successful appeals to HCPs could enhance confidence in the process, and might also improve the quality of initial assessments.

5.6 The WFHRA²³

5.6.1 HCP experiences and views

HCPs varied in the extent to which they felt comfortable discussing work in the WFHRA, and many felt ill-equipped to provide detailed advice on the range of provision available to customers. There also appeared to be a lack of a shared vision of the purpose of the WFHRA among advisers and HCPs. If it is to be reinstated, these issues would benefit from being discussed and resolved, to improve the use of the WFHRA and clearly delineate roles. For instance, if the HCP is to provide advice on employment provision, they will need more information on this, but a more appropriate role for the HCP may be to refer the customer back to the adviser, who can provide this type of information in the WFI.

²³ The WFHRA is currently suspended.

5.6.2 Customer expectations

Many customers had not been aware that they would need to return to Atos Healthcare for a second appointment until they received the letter inviting them. Even after it had been confirmed that they must attend, many still did not know what this appointment was for. It may be beneficial to provide more details in the WFHRA appointment letter to alert customers to some of the information that they have been missing, i.e. that although they had already been to a face-to-face WCA, they still needed to have a WFHRA. The difference in focus and purpose of the WFHRA could also usefully be spelled out in the letter, to prevent customers becoming confused and disillusioned.

Many customers found the WFHRA to have been a more pleasant experience than the face-to-face WCA. Again, the manner of HCPs in listening to customers and tailoring the appointment to their individual needs was important in shaping customers' views and feelings about the WFHRAs.

Not all customers remembered having any work-focused discussions in the WFHRA, and those who did said that they had not learned anything new as a result of these. An important reason for this is that most of the work-focused conversations that took place in the WFHRA had already happened in customers' WFIs with advisers. Some customers made the point that they preferred having conversations of this nature with their adviser at Jobcentre Plus or their provider.

There were no clear reports of the WFHRA having made a difference to customers' motivation to find work, or to their future aspirations or focus, although some of the customers with the poorest health reported that they had been supported by the HCP in their belief that they were too unwell to work. Although they had found this a validating experience, it does raise the issue of how well this matches the policy intention behind the WFHRA.

5.7 WFIs

5.7.1 Customer perspectives

Customers generally viewed WFIs as helpful, regardless of whether they were in a Jobcentre Plus or a Provider area. There was praise for advisers; customers reported that they had presented the options, and encouraged them to think about the steps they could take to move closer to the labour market, but without putting pressure on them to take action before they were well enough.

5.7.2 Adviser perspectives

Advisers were generally positive about the decision to delay WFIs until the outcome of the WCA was known. There were, however, concerns that with the delays in face-to-face WCAs, some customers could be left without support for a considerable amount of time, especially in cases where they were waiting for the outcome of an appeal.

Advisers said that the initial WFI tended to be dominated by the WCA, either discussing what will happen to customers when they go for their face-to-face WCA or discussing the outcome if a decision has been made. At the time of the research the WFHRA report appeared to form a minor part of the WFI process, typically being briefly discussed then filed. Advisers and customers reported that it was rarely mentioned in subsequent WFIs.

5.8 Policy implications

5.8.1 Overall process

It is clear from both this report and the report of the customer survey²⁴ that many customers would benefit from the provision of additional support in completing the ESA50, and that this may also have benefits for HCPs and Decision Makers who use the ESA50. It may be worth considering whether assistance with completing the ESA50 form should be routinely offered to customers, as part of the ESA claim process.

Equally, it is clear that customers would value increased information and an improved differentiation between face-to-face WCA and WFHRA in the information provided. This is also likely to improve attendance rates and levels of engagement with the process.

Flexibility and standards of customer service could be improved where customers need to change Atos Healthcare appointments; those with severe conditions or in the middle of treatment may need to defer appointments, or be offered a home visit. The rules about when assistance with travel is available should also be clearly explained and publicised, and customers provided with consistent information regarding their eligibility for travel expenses.

5.8.2 The face-to-face WCA

The provision of improved customer information which makes clear that the face-to-face WCA is a functional assessment – looking at what work the customer might be capable of, rather than their last job or occupation – and not a medical examination, would help to manage expectations and should improve customer satisfaction.

There appears to be a need for clearer protocols about the use of additional medical evidence. Where customers have been requested to bring medication or other evidence, HCPs should be aware of their sensitivities around this, and acknowledge it, ensuring the customer knows that they have noted this. It would also be helpful if customers' expectations could be better managed. For instance, it would be helpful if the section of the ESA50 which requests permission to contact the customer's GP indicated that this does not necessarily mean that they will be contacted. Customers would benefit from clear information on where to send any additional medical evidence they wish to submit, and how it will be used. Decision letters should also state which evidence has been taken into account in reaching a decision, for the sake of transparency.

The WCA is currently being reviewed, and it will be important that close attention is paid to the descriptors, particularly in assessing specific conditions or impairments which have been identified as difficult to assess, and where there are multiple or fluctuating conditions, to ensure they are treated appropriately in the assessment. A review of appeals decisions may also be helpful in defining thresholds. Some HCPs also felt that there would be some merit in being able to create a higher, but temporary score, to reflect improvements that would result from treatment outcomes or adjustment to a new condition or diagnosis. For instance, this might imply a greater degree of flexibility in scoring in cases where the HCP was setting a three-month prognosis date for a repeat face-to-face WCA.

²⁴ Barnes, H., Sissons, P. and Stevens, H. (2010). *Employment and Support Allowance: Findings from a face-to-face survey of customers*. DWP Research Report No. 707.

5.8.3 Decisions and appeals

As noted above, it would be helpful if decision letters included details of what evidence has been considered in reaching the decision. The wording of the letter as it stands also tends to undermine acceptance of the decision, and leave customers feeling that they are being told that they are not really ill; that they are not believed. Even if a customer does not meet the threshold for ESA, recognition that they still have a health condition might go some way to address this sense. However, it cannot be said whether this would definitely lead to a reduced appeal rate, since the substantive decision not to pay benefit would remain unchanged.

5.8.4 The WFHRA

At present the WFHRA is suspended. If it is reinstated, it is likely to require a much clearer shared understanding about the purpose of the WFHRA among advisers, HCPs and customers. There are a number of issues which would benefit from being addressed:

- **What type of intervention is the WFHRA?** The research provided some evidence that both advisers and customers would have welcomed more tangible, work-focused recommendations, drawing on occupational health expertise rather than having a more general discussion about work motivations, intentions and plans, and providing an indication of the available support options, which was seen to duplicate the WFIs in large part, and which some HCPs felt ill-equipped to deliver.
- **What is the purpose of the WFHRA**, in particular to what extent is it important that the WFHRA functions as a tool for the adviser to use during WFIs? This should determine the nature of the output provided; involving advisers in the design of the intended output might, therefore, be helpful. The purpose of the WFHRA also has implications for its timing. If it occurs too late in the sequence of WFIs, this is likely to limit its value to advisers. On the other hand, if it is intended primarily as an intervention that will benefit customers in a more general sense, then its timing is less crucial.
- **Who should carry out the WFHRA?** This relates to the earlier questions. To the extent that this is viewed as primarily a medical intervention, it will need to be a medically trained person, although the appropriate professional might be a work psychologist or another occupational health adviser. Conversely, if the WFHRA is focused on identifying and sourcing practical employment-related support, it may be better delivered by an adviser.
- **Who should have a WFHRA?** The boundaries between the WRAG and FFW groups are fairly fluid, and as the customer survey report has identified, there are many similarities in the characteristics and work barriers faced by these groups. With the reassessment of those on incapacity benefits and the introduction of the Work Programme, it may make sense for both groups to have a WFHRA. At the same time, it may conserve resources, and increase levels of customer engagement, if those with an existing job to return to are diverted away from the process.
- **How should the WFHRA be described and ‘branded’?** The research has identified the lack of clarity among customers about the differentiation between the face-to-face WCA and the WFHRA. The name of the WFHRA may require reconsideration to improve understanding of its purpose and the work focus. Customer understanding would also be facilitated by providing clear messages about the WFHRA, reinforced in the face-to-face WCA and WFIs.

5.8.5 Interaction with WFIs

Advisers welcomed the decision that WFIs could be deferred pending the outcome of the WCA, but noted that potentially this might mean that customers lacked support for work-related activity in the interim. Publicising the option of voluntary WFIs might help to address any needs arising from this change.

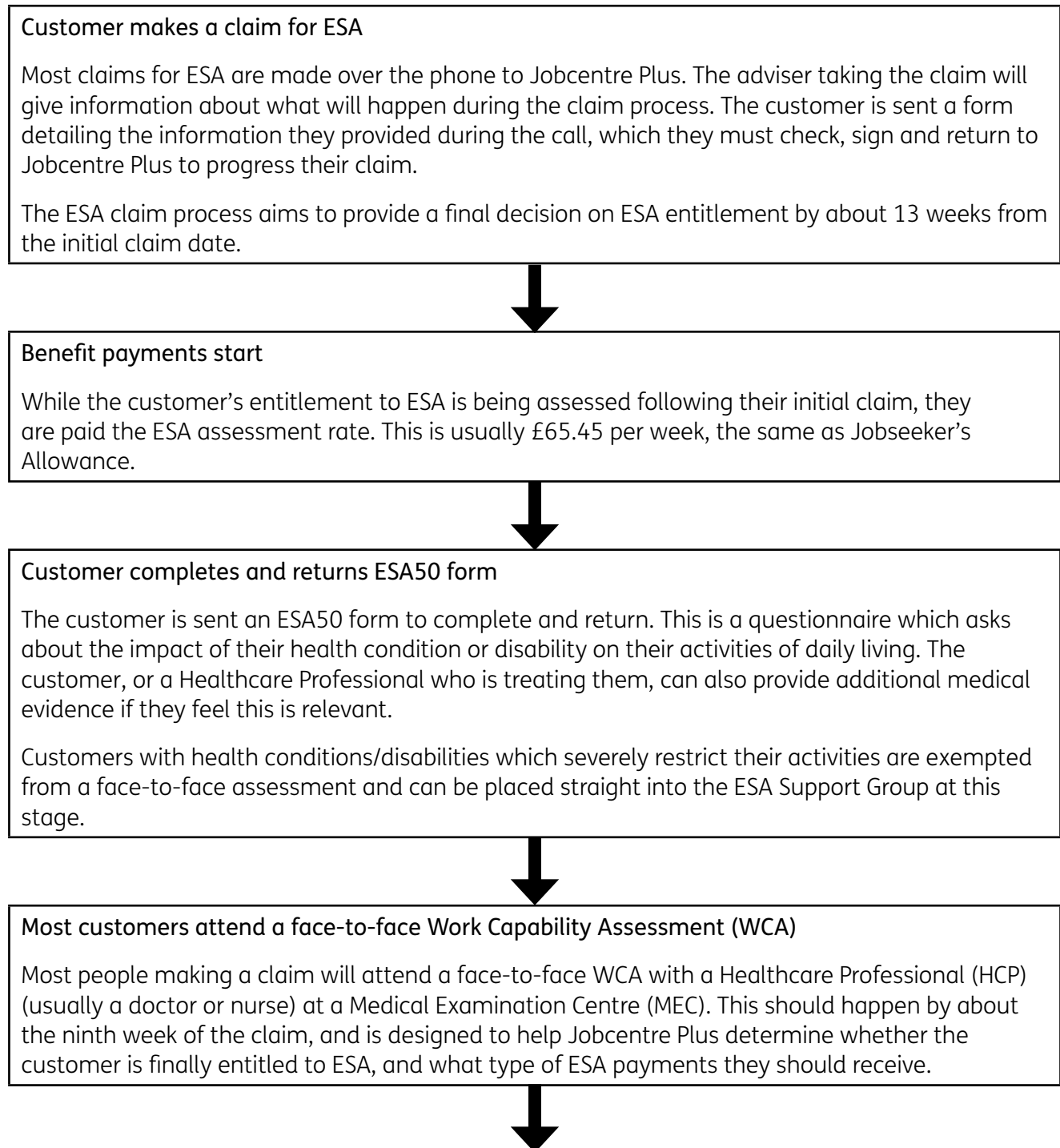
Advisers would also have welcomed more flexibility to waive WFIs until a more appropriate time (e.g. after recovery from operations, injuries etc.) and this would appear likely to improve levels of customer engagement. This is possible at the time of writing, with advisers free to defer WFIs pending treatment, and to carry out four WFIs at any points which seem appropriate over a year, but the staff interviewed for this study did not appear aware of this.

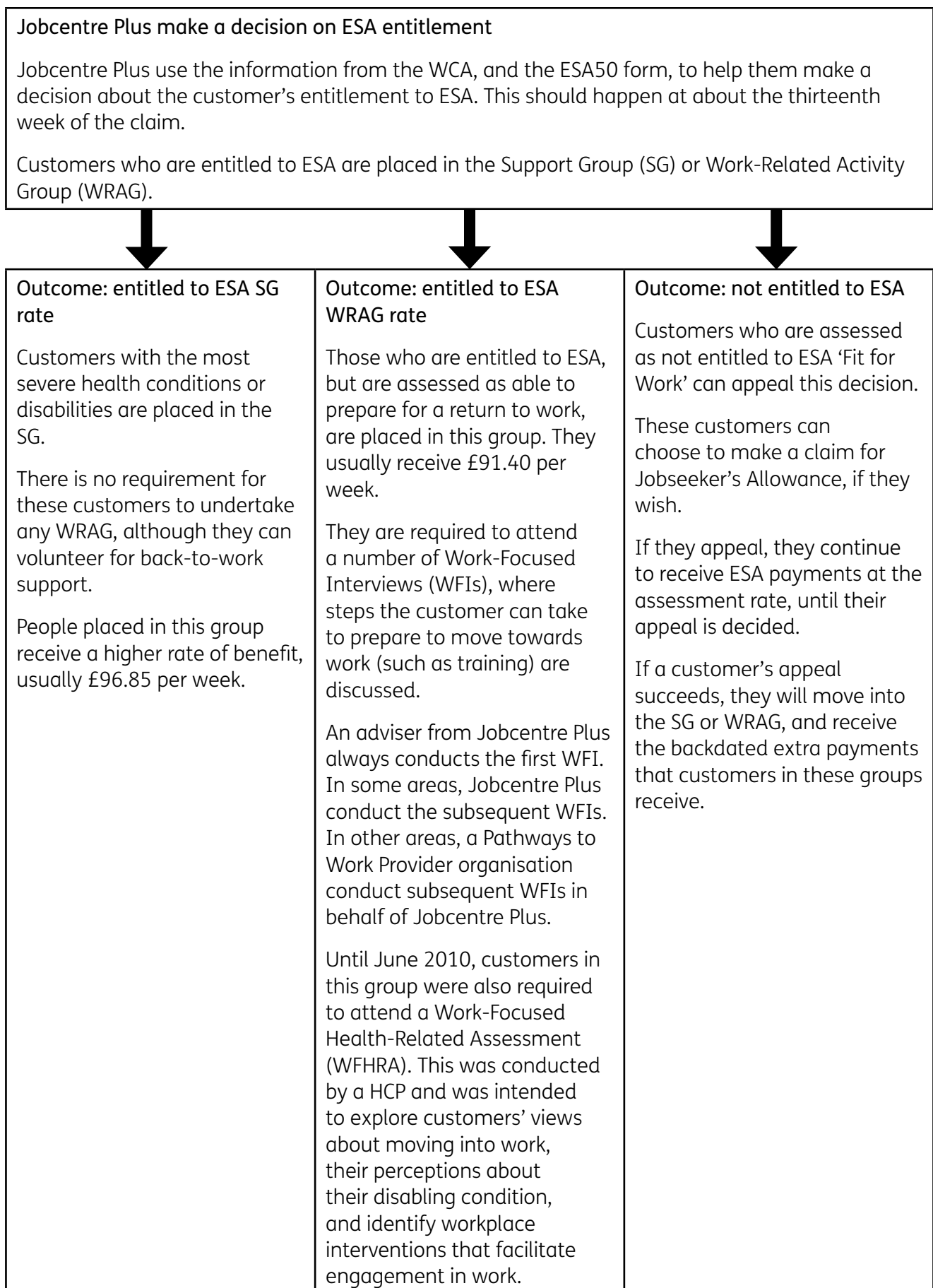
As noted above, the timing of the WFHRA, as well as its content, also has implications for the extent to which it can be expected to contribute to the WFI process.

Appendix A

ESA claim process

This diagram outlines the claim process for Employment and Support Allowance (ESA), for most customers.





Appendix B

Opt-out letter

June 2010

Project reference: 1505

Dear

I am writing from the Institute for Employment Studies (IES) to invite you to participate in some research. IES is an independent organisation that has been asked by the Department for Work and Pensions (DWP) to research people's experiences of claiming Employment and Support Allowance (ESA), in particular their experiences of the medical assessment process (this is formally known as the Work Capability Assessment and Work-Focused Health-Related Assessment) .

We need to know how well ESA is working for the people it was designed to help. We are contacting you because you have recently taken part in a medical assessment, and would like to invite you to help us with the research, by telling us about your experiences. This would involve being interviewed by one of the IES research team, either in your home or at a convenient local venue. The interview will last for up to an hour, and everyone who is interviewed will be given a **£20 High Street voucher** as a small token of thanks for their help. Your participation is entirely voluntary and **any benefits you receive will not be affected in any way**.

The interview would cover your experiences and views of having a medical assessment and, if applicable, your experiences of seeing a health professional in a second appointment to discuss your future hopes and expectations about work. Anything you say to the researcher will be strictly confidential; your name and personal details will not be passed on to any Government department or to anyone else.

Please do let us know if there is anything we can do to make it easier for you to take part. We are able to provide an interpreter if you wish to be interviewed in a language other than English. We can also arrange to meet any access needs you may have arising from a disability or health issue.

What happens now?

- If you are willing to take part in this research, you do not need to do anything. IES will contact you to ask a few questions and arrange a time and place for one of our researchers to speak to you in person.

I do hope that you will take part in this important research, as we would like to hear your views. But if you would rather not be involved, then please contact me on 020 7470 6117 (or email Helen.Barnes@employment-studies.co.uk or use the reply slip and prepaid envelope provided), and we will

not contact you again about this. You can also contact us on this number if you need assistance to take part or if you have any questions about the research.

If you would like to speak to the Department for Work and Pensions (DWP) about the research, the research manager for this project is Michael Kelly. He can be contacted by email at Michael.Kelly7@dwp.gsi.gov.uk, telephone on 0207 449 7643, or by post at DWP, 1st floor Caxton House, Tothill Street, London, SW1H 9NA.

With thanks and best wishes

Yours sincerely

A handwritten signature in black ink that reads "Helen Barnes". The signature is written in a cursive style with a large initial 'H'.

Helen Barnes
Principal Research Fellow

Appendix C

Discussion guides

Atos Healthcare Professional discussion guide²⁵

The aim of this set of interviews is to explore healthcare professionals' (HCPs):

- understanding of the purpose of both the Work Capability Assessment (WCA) and Work-Focused Health-Related Assessment (WFHRA);
- views on, and experiences of, delivering the WCA and WFHRA;
- views on how sensitive these assessments are, particularly for people with mental health and fluctuating conditions.

Introduction

Explain background to the research:

- The research on the WCA and WFHRA is being carried out by Institute for Employment Studies (IES) which is an independent research organisation, on behalf of the Department for Work and Pensions (DWP).
- This research is part of a wider study looking at how well the delivery of ESA is working. The main purpose of the interview is to gain their understanding of ESA, and their views and experiences of delivering it, in particular the medical assessment aspect of the process.
- Reassure about anonymity – no individuals will be identified or identifiable in the research report. All contact details and confidential research materials are stored in accordance with the Data Protection Act and DWP data transfer protocols (e.g. password protected files, secure file areas for designated research teams, anonymous alphanumeric identifiers for transcripts, etc.).
- Ask permission to record the interview. The recording will be transcribed and the resulting transcription is a confidential document which will only be seen by members of the research team. Recording helps to make sure there is a full and accurate record of what has been said, but if they feel very strongly about not being recorded, we can take notes instead.

Background

Aim: to gain information on the interviewee's professional background, role with Atos Healthcare, and previous experience of working with Incapacity Benefit (IB)/disability client group. Also, any training they have received to help them carry out their role.

²⁵ Adapted versions were used for Atos Healthcare Service Managers, and advisers, and can be made available on request.

- Could you tell me briefly about your professional background?
- Could you tell me a little about your job role?
 - Ask whether they are involved in assessing customers across the full range of health conditions. Which conditions are they involved in assessing?
 - Ask whether they deliver both the WCA and WFHRA.
 - Also ask whether they were involved in delivering both of these prior to their decoupling (i.e. these two assessments used to take place at the same time; they have subsequently been separated and take place at different times).
- How long have you worked with Atos? How much of your current working time does it account for?
- What, if any, was your previous experience of working with the IB client group?
 - Find out whether they were previously involved in carrying out the Personal Capability Assessment (PCA) used in the determination of eligibility for IB.
- What information did you receive about ESA prior to helping to deliver it? How useful was this? How could it have been improved?
- What information did you receive about the WCA/WFHRA prior to delivering them? How useful was this? How could it have been improved?
- What training, if any, did you receive to help you deliver the ESA? If yes, what did this involve? Did you receive any training around the WCA/WFHRA? If so, what did this involve? *Probe for whether or not (and how effectively) training covered changing the focus from what customers cannot do to what they can do.*
- What did you think of the training? How useful was it? Could it be improved, and if so, how?
- Is there any ongoing quality appraisal of WCA assessments? If yes, what issues does this raise? How have these issues been addressed, if at all? If no, how helpful do you feel such appraisal would be?
- Is there any ongoing quality appraisal of WFHRAs? If yes, what issues does this raise? How have these issues been addressed, if at all? If no, how helpful do you feel such appraisal would be?

Work Capability Assessment

Aim: to understand what the WCA involves, and whether this varies depending on the type of health condition (both in terms of medical diagnosis and its nature in particular, whether the severity of the condition fluctuates over time; and whether it is primarily a mental or physical condition). Also to understand how sensitive they feel the WCA process is in assessing fitness for work, and whether this varies with the type and nature of condition.

- What do you understand as the purpose of the WCA?
- How well do you think customers understand the purpose of the WCA?
 - Ask whether customers mention anything they have read about the WCA, and their understanding of it.

- do customers ask many questions about the WCA? If so, what is the nature of the questions asked?
- Can you take me through what a typical WCA involves?
 - ask whether this process and any questions asked vary according to: the nature and type of health condition. In particular, ask whether the process varies with medical diagnosis, with whether the condition is physical or mental in nature, and with whether or not the condition fluctuates over time.
- What information do you receive about the customer prior to conducting a WCA?
- How is this information used in the assessment process? How useful do you find this information? (Probe: how well-completed is ESA50, whether additional information, e.g. from GP or hospital specialist would be helpful?)
- How sensitive do you feel the process is in assessing customers' fitness for work?
 - ask whether they feel this varies according to the type and nature of the condition. Ask in particular about how sensitive the process is for customers with mental health conditions compared to physical health problems; and customers with fluctuating conditions.
- How well do the results of the WCA process reflect responses given by the customer to the ESA50? i.e. does the WCA process result in customers being disallowed who would have been allowed on the basis of their ESA50 or vice versa?

If previously involved in carrying out PCAs:

- What do you feel are the main differences between the WCA and PCA? What implications have these had, if any, do you think for the outcome of assessments? In what ways is the WCA an improvement on the PCA? Are there any areas in which it is not an improvement?
- How is a decision made on the case review date? Is there much variation?
 - How does it vary, if at all, with different types of health condition e.g. fluctuating compared to stable; mental compared to physical health problems?

All

- What do you feel the main issues have been in carrying out WCAs? How have these been addressed, if at all?
 - customer understanding of its purpose;
 - the information provided to customers prior to the assessment;
 - the timing of the WCA (in approximately week 9 of the claim);
 - the sensitivity of the assessment process (for different types of health condition);
 - setting a case review date.
- How might the assessment process be improved, if at all?
- As you may know, by the end of August 2009, three in ten (1,500 of 4,900) appeals heard on the 'Fit for Work' decision were decided in favour of the appellant. Have you received any feedback or updates on appeals? What do you feel may be the reasons behind the successful appeals?

Work-Focused Health-Related Assessment (WFHRA)

Aim: to understand what the WFHRA involves, its timing, and whether this varies according to the type and nature of the health condition of the customer. Also to understand how customers react to the WFHRA, and how it might be improved.

- What do you understand as the purpose of the WFHRA?
- How do you explain it to customers?
- How well do you think customers understand the purpose of the WFHRA before this?
 - Ask whether customers mention anything they have read about the WFHRA, and their understanding of it.
 - Do customers ask many questions about the WFHRA? If so, what is the nature of their questions?
- How well do you think customers understand the relationship between the WCA and the WFHRA? What do they understand as the link between the two?
- How is the WFHRA raised with customers? How do they respond to it?
- What does the WFHRA involve?
 - What do the questions cover?
 - How do you approach the issue of employment? How do people react to this, in your experience? How easy is it to broach the subject?
 - How comfortable are you giving advice on interventions to help customers back to work?
 - Do you approach the WFHRA differently from one customer to another (eg by type and nature of health condition or employment history)? Can you give me some examples of this?
 - Would there be any benefit in your view of additional WFHRAs? If so, how would this be beneficial? And for whom? For whom would it not be beneficial?
- Do you feel that the timing of the WFHRA has any implications for the potential benefit of the WFHRA to customers?
 - Ask what they feel the implications are, if any, for health conditions of different types and nature, such as mental health and fluctuating conditions.
 - Do customers who have attended a WFI ever mention this? What do they say about it?

If involved in conducting the WFHRA and WCA prior to their decoupling:

- What implications has separating the WFHRA from the WCA had, if any, from your perspective, as an HCP? Has this been an improvement for you? If so, how? If not, why not? And how do you think it has affected customers?

All

- What do you think have been the main challenges in carrying out WFHRAs? How have these been addressed, if at all?
- Thinking about both the process and the assessment itself, how well do you think the WFHRA is working? What are the issues for HCPs, for customers? How might the WFHRA be improved, if at all? Who would this benefit (e.g. customers, HCP)?
- How comfortable are you giving advice on interventions to help customers back to work?

Overall views on WCA/WFHRA

- Thinking about the WCA and WFHRA process as a whole, what has worked well? What has not worked so well?
- How could the process be improved, if at all?
- Is there anything you wanted to say that I haven't asked about?

Thank interviewee and close.

Customer interviews – WFHRA²⁶

- Introduction (for respondent): Explain a bit about the background to the research.
- The research is being done by IES which is an independent research organisation, on behalf of the DWP.
- This research is part of a wider project looking at how well the delivery of ESA is working. The aim of this particular interview is to specifically focus on the interviews you had with HCPs (such as a doctor, nurse or physiotherapist) about your ability to work and the steps that would help you prepare for work. We would like to try to understand your experiences of this process because talking to people who have used this service is one of the best ways to find out how it is working and what could be improved, so thank you for participating.
- Remind them the interview will take up to one hour, check this is ok. Remind them they will get a £20 voucher as a thank you at end – this will not affect their benefits in any way.
- Reassure about anonymity – no individuals will be identifiable in the report. All contact details and confidential materials are stored in accordance with the Data Protection Act.
- Do tell me if you need a break at any point or if there is anything you'd prefer not to answer.
- Ask permission to record the interview. The recording will be transcribed and the resulting transcription is a confidential document which will only be seen by members of the research team. Recording helps to make sure there is a full accurate record of what has been said, but if they feel very strongly about not being recorded, we can take notes instead.

Background

Firstly, I'd like to try and understand how you came to claim ESA.

- Could you explain the circumstances leading to your decision to make a claim? Probe:
 - Background to your ill health – how long have you been ill, was it sudden?
 - When last worked, type of work? Is this your usual work (type of work, hours)?
 - Were you claiming any other benefits at the time you claimed ESA? Which benefits? For how long?
 - Family situation (caring responsibilities/are others in household in work)?
- Could you tell me when you first registered your claim for ESA?

²⁶ An adapted version was used for customers who had attended a WCA but not a WFHRA, and can be made available on request.

- Do you currently claim any other benefits (e.g. Disability Living Allowance (DLA), housing, tax credits)?
 - Could I ask how old you are please?

ESA – customer’s understanding

Before we discuss any details I would just like to try to understand what has been involved in making your claim for ESA.

You completed and posted off the ESA paperwork to complete your claim. This normally comes as a part-completed claim form (called the ESA1) after you have claimed by phone, and then a longer medical form (called an ESA50 – interviewer to show copy) which is sent out by post for you to complete. Do you remember how long it took you to complete the paperwork and send it back? What happened then? *Probe:* Have you attended any assessments?

If not already mentioned say; Claiming ESA may involve a medical assessment and return to work advice. The medical assessment is called a ‘Work Capability Assessment’ and involves a face-to-face meeting with a doctor or a nurse at a Medical Examination Centre (MEC). The return to work advice is called a ‘Work-Focused Health-Related Assessment’. It involves a face-to-face meeting with a medical professional to discuss moving into work and to identify any support that may help you with this. The WFHRA is usually at a later date after the WCA.

- Have you heard these terms before? Can you tell me about how you came to hear them?
- Do you know if you have had a WCA and/or a WFHRA?

The WCA

I would now like to move on to talk about your WCA, this is the face-to-face appointment with a doctor or nurse at a medical assessment centre.

- Have you had a WCA or more than one WCA? Can you remember how long it was after you registered your claim for ESA that you had your first WCA?

(Note: if more than one WCA, ask questions in relation to most recent WCA, and explore any differences between that and first WCA).

Expectations

- Were you aware that you would be called for a WCA as part of your claim for ESA? How did you become aware of this?
- Could you describe to me what you thought the purpose of the WCA was?
- What did you expect the assessment would involve? What were these expectations based upon?
- Did you have any expectations about who would conduct your assessment? Doctor/nurse?
- What information were you given about the WCA? How useful was this? Did you seek any additional information? What did you want to know?
- What did you think the possible results or outcomes of the WCA might be? How did you find out about this (e.g. other people you know, health practitioner, Jobcentre Plus)? Can you tell me about what you expected to happen and why?
- How did you feel about the WCA before it took place? What could have been improved?

Arrangements, journey and arrival

- Could you now tell me about how your WCA was arranged? Probe for:
 - Method of contact.
 - Any difficulties with the appointment time offered/ease of rescheduling.
 - What could have been improved?
- Please tell me about how you travelled to the assessment. How did you find the journey? Did you think it reasonable to ask you to attend at that venue?
- What happened when you arrived? How long did you have to wait to be seen? How did you feel about this? How comfortable was the waiting area?

The Assessment

- Please could you now tell me about what happened during your WCA? Probe:
 - Who conducted the assessment? Doctor/nurse/physiotherapist? How did you feel about this?
 - What was the room like? Were you comfortable?
 - What was discussed? How did you feel about the questions? Did you expect other areas/aspects to be discussed – can you say what these are?
 - To what extent were you given the opportunity to put across your views and feelings?
 - How comfortable were you discussing health matters with the doctor/nurse?
 - How was your physical health examined? How did you feel about this?
 - How was your mental health examined? How did you feel about this?
 - How long did the assessment last?
 - How happy were you with how the medical professional conducted the WCA?

Results

- After your WCA what information were you given about what would happen next? Was this sufficient?
- Please could you talk me through what actually happened after your WCA. Probe:
 - When were you were made aware of the results? What were you feeling as you waited for your results to arrive?
 - How did you receive the results? How easy were they to understand?
 - Do you mind if I ask what were your results? What did this mean for you? Were the results what you expected?
 - Has the amount of benefit you receive changed since receiving your results?
- How well do you think the results reflect the assessment conducted by the doctor/nurse/physiotherapist? Do you feel the results reflect your condition and its impact on your ability to work (yes, not sure, no)? Why do you think this?
- How has the assessment affected your understanding of your health condition?

- How has it affected your beliefs about the possibility of returning to work? Were you encouraged to think about other types of work or jobs that you could do with the right support?
- What practical help might have been useful, ie discussion with someone who knows about employment matters?

Only ask those unhappy with their results:

- What did you do when you found out about your results? Probe:

- Did you appeal the results?
- How did you know about the right to appeal the decision?
- Did anyone help? (eg friend, CAB, law centre, health provider)
- How did you find the appeals process?
- What could be improved?

The WFHRA

I would now like to talk about your WFHRA, this is a meeting with a medical professional to discuss moving into work and to identify any support that may help you do this. The WFHRA is usually at a later date after the WCA.

Expectations

- Were you aware that you would be invited to attend a WFHRA as part of your claim for ESA? How did you become aware of this?
- What did you think the purpose of the WFHRA was, at this stage?
- What did you expect the assessment would involve? What were these expectations based upon?
- Did you have any expectations about who would conduct your assessment?
- Did you have any expectations as to what the outcome might be?
- What information were you given about the WFHRA? How useful was this? Did you seek any additional information? What did you want to know?
- How did you feel about the WFHRA before it took place? What could have been improved?

Arrangements/travel and arrival

- Now, please could you tell me about how your WFHRA was arranged? Probe:
 - Method of contact?
 - Any difficulties with the appointment time offered/ease of rescheduling?
 - What could have been improved?
- Where was your WFHRA held? Was it the same venue as your WCA? How did you travel to your WFHRA? How did you find the journey?
- How long after WCA was your WFHRA?
- What happened when you arrived? Probe: Waiting time. Did they feel this was reasonable? Was the waiting area comfortable?

The Assessment

- Please could you tell me about what happened during your WFHRA? Probe:
 - Who conducted the WFHRA? Doctor/nurse? Same person who conducted the WCA? Probe (if same person): What were the advantages/disadvantages of being seen by the same person who conducted the WCA?
 - What was the room like? Were you comfortable?
 - What was discussed? How did you feel about the questions? How did the doctor/nurse talk to you about work and the possibility of a return to work?
 - What effect did talking about work and the possibility of working in the future have on you? Overall, do you think you felt more or less positive about your chances of returning to work? Why was this?
 - How do you feel about this now, compared to at the time of the WFHRA? Can you tell me more about this?
 - Were any forms filled in? Did you see them? Did you help complete them?
 - Roughly, how long did the assessment last?

Results of the WFHRA

- After your WFHRA, what information were you given about what would happen next? Was this sufficient?
- Talk me through what happened after your WFHRA. Probe:
 - Were you sent a copy of your WFHRA report?
 - When did you receive a copy of the WFHRA report?
- Could you tell me what your WFHRA report said? Probe:
 - To what extent did the report give you new ideas or information about what might be possible now or in the future? Can you tell me what these were?
 - Did it suggest the amount or type of work you might be able to do?
 - Did it suggest when you might be able to return to work?
 - Did the report give any specific details of the steps you might take next?
 - Did it set an expectation that you would be discussing the findings with an adviser?
- What do you think about your WFHRA report? Probe:
 - How well do you think the results reflect your condition and its impact on your ability to work? Why do you think this?
 - To what extent did the report affect your confidence about returning to work? In what ways?
 - Do you feel that the report changed your motivation to return to work at all? In what way?
 - Was the report what you were expecting?
- Do you think your views regarding your health condition and its impact on your ability to work have changed as a result of the assessment or the report? Can you explain how?

- Do you think you understand your health condition better as a result of having the WFHRA? Has this changed your belief that you will be able to return to work?
- To what extent did the discussion help you think about other types of work or jobs that you could do with the right support?
- How do you think the assessment or report process could be improved to have a greater positive impact for you in terms of how you feel about your health condition and its impact on your ability to work? How could it be different?
- Do you know if anyone else was given a copy of your WFHRA? Who? Probe an adviser from Jobcentre Plus or Pathways to Work?

WFI

- Have you been invited to any interviews either with a Jobcentre Plus adviser, or a Pathways to Work adviser as part of the process of claiming ESA?
- What do you think is the purpose of these interviews?
- How many interviews have you attended? How long do they usually last?
- Who have the interviews been with? (Jobcentre Plus or Pathways to Work Provider). Do you always see the same adviser?
- Could you talk me through what happens during these interviews? Probe: What is discussed? Health, skills, job goals, employability, vacancies, benefit advice?
- Do you know if your adviser has referred to the results of your WFHRA in any of your interviews?
 - Can you tell me how they did this?
 - How did they discuss the issue of employment with you?
 - How did you feel about this?
- Do you think your views regarding your health condition and its impact on your ability to work have changed as a result of these interviews? Tell me about why you think this.
- What could be improved about these interviews?

Overall impact

- The idea of ESA is to help people with health conditions and disabilities to think about or begin moving back into work, where this is suitable for them. What do you think about this as an approach? (Explore reasons.)
- If there is no change in your health condition, do you feel that work may be a possibility for you in the future? Has this changed at all during the ESA process? Can you tell me about this? Explore any improvements in management of health, soft outcomes such as confidence and changes in the way they think about work.
- Was there anything else you wanted to say, that I haven't asked about?

Thank the interviewee, explain what happens to the interview material, pay incentive and close.

Appendix D

Coding frame

The coding frame is derived from the question areas in the discussion guide, and from additional themes that arise during the interviews and which are identified in the post-fieldwork debrief, or during coding interview material. The codes are used to carry out a thematic analysis of the material within individual transcripts and fieldnotes. The ‘families’ refer to subgroups, which can be used to analyse and check for inter-group differences, e.g. by area or age group.

Staff

Families

- Job role.
- Organisation.
- Area.

Codes

General

- Interviewee background and role.
- Training and preparation for Employment and Support Allowance (ESA).
- Targets and workload issues.
- Appeals.
- Access to Work.
- Condition Management.
- Support Group.
- Work-Related Activity Group (WRAG).
- Fit for Work (FFW) group.
- Customer population and issues.
- Conditions.
- ESA process.
- ESA system.
- Overall views of ESA.
- Information and publicity.
- Medical evidence.
- Incapacity Benefit (IB) migration.
- Uncoded elsewhere.

WCA

- Timing.
- Purpose.
- Content.
- Customer understanding and response.
- Impact on Work Focused Interviews (WFI).
- Comparisons with Personal Capability Assessment (PCA)
- Sensitivity/conditions
- ESA50 completion
- ESA50 value of
- Fail to attend (FTA)
- Any other issues and views

WFHRA

- Timing.
- Purpose.
- Content.
- Output.
- Customer understanding and response.
- Discussing work.
- FTA.
- Decoupling.
- Additional WFHRAs?
- Impact on WFI.
- Any other issues and views.

WFI

- Content.
- Timing.
- Issues.

5.22 Customers

Families

- Age group.
- Appeals.

- Complex cases.
- Area.
- Main condition – mental health.
- Main condition – physical condition.
- Multiple conditions.
- Previous IB claim.

5.23 Codes

General

- Health condition.
- Work history.
- Personal and family circumstances.
- Finances and debt.
- Future plans and work aspirations.

Process

- Initial awareness of ESA and decision to claim.
- ESA 50.
- FTA.
- Appeals.
- Problems/issues.

WCA

- Expectations/understanding.
- Timing and scheduling appointment.
- Travel.
- Waiting time and environment.
- Content.
- Healthcare Professional (HCP).
- Results.
- Feelings/emotions.
- General views positive.
- General views negative.

WFHRA

- Expectations/understanding.
- Timing and scheduling appointment.
- Content.
- HCP.
- Results.
- Feelings/emotions.
- General views positive.
- General views negative.

WFI

- Expectations/understanding.
- Timing and scheduling appointment.
- Content.
- PA.
- Jobcentre Plus compared to Pathways provider.
- General views positive.
- General views negative.

Additional

- Overall views on ESA.
- Suggestions/improvements.
- Uncoded elsewhere.

This report presents findings from qualitative research on the Work Capability Assessment (WCA) and Work-Focused Health-Related Assessment (WFHRA). The research was carried out in spring/summer 2010 and included Employment and Support Allowance customers, Jobcentre Plus and Pathways to Work Provider Personal Advisers, and Atos Healthcare staff working on these assessments.

The research explored customer and staff experiences and views of attending or conducting a face-to-face WCA and WFHRA, in particular whether they were being delivered as intended and possible improvements, whether the WCA and WFHRA seemed to influence customer views of work, and how the report of the WFHRA was being used in Work Focused Interviews.

If you would like to know more about DWP research, please contact:
Paul Noakes, Commercial Support and Knowledge Management Team,
Work and Welfare Central Analysis Division, 3rd Floor, Caxton House,
Tothill Street, London SW1H 9NA.
<http://research.dwp.gov.uk/asd/asd5/rrs-index.asp>

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