



House of Commons
Work and Pensions Committee

The role of incapacity benefit reassessment in helping claimants into employment

Sixth Report of Session 2010–12

Volume I

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The Work and Pensions Committee

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Contents

Report	<i>Page</i>
Summary	3
1 Introduction	5
Reassessment of incapacity benefit claimants	5
Outcomes of the reassessment	6
The inquiry	7
Our report	7
2 The Government’s policy objectives for the IB reassessment	9
Government aims	9
Claimant perceptions	10
Improving communication of the Government’s objectives	12
3 The Work Capability Assessment—claimants’ experience and Atos Healthcare	18
Design of the process	18
Claimants’ experiences of the process	19
The DWP contract with Atos Healthcare	26
4 The Work Capability Assessment—Reviews	31
The reviews of the WCA process	31
The future of the WCA	35
5 Decision-Making and Appeals	40
Decision-making	40
Reconsideration of decisions	42
Appeals	44
Recalling claimants for WCA after appeals	47
6 Reassessment outcomes	49
Outcomes	49
The impact of the decision to time-limit contribution-based ESA	50
Claims withdrawn before completing the assessment process	54
Tracking of claimants	55
7 Employment support for ESA claimants	57
Support under the Work Programme	57
Back-to-work support for customers moving onto ESA	59
Back-to-work support for customers found fit for work	59
8 Conclusion	64
Conclusions and recommendations	65

Formal Minutes	73
Witnesses	74
List of printed written evidence	74
List of additional written evidence	74
List of Reports from the Committee during the current Parliament	76

Summary

We support the Government's objectives for the incapacity benefit (IB) reassessment, of helping people with disabilities and long-term health conditions to move back into employment, while continuing to provide adequate support for people who have limited capability for work or are unable to work.

It is, however, clear from the evidence we received that the positive messages about the IB reassessment are not getting through to the public. The Government needs to be proactive in explaining its aims for the process and in emphasising the range of support which will be available to claimants. Care should be taken in the language used in all Government communications, and in the contacts Jobcentre Plus and Atos Healthcare have with claimants, to stress that being found fit for work is a positive outcome and should not be interpreted as "failing the test".

Media coverage of the reassessment is often irresponsible and inaccurate and we deplore the pejorative language which some sections of the press use when referring to benefit claimants. Portraying the reassessment of incapacity benefit claimants as some sort of scheme to "weed out benefit cheats" shows a fundamental misunderstanding of the Government's objectives.

It is widely accepted that the Work Capability Assessment (WCA) as introduced in 2008 was flawed. This has been borne out by the high number of appeals and the high success rate of appellants. It was also reflected in the amount of evidence from individuals which expressed grievances with the way they were treated during the process and the accuracy of the outcome.

The service provided by Atos Healthcare, which carries out the WCA, has often fallen below the standard claimants rightly expect. This has contributed significantly to the widely felt mistrust of the whole process. Welcome changes to the WCA have been made, mainly in response to the recommendations in Professor Malcolm Harrington's independent review, which we fully endorse. Further welcome changes to the process were made as a result of the reassessment trials in Aberdeen and Burnley. These changes have already improved communication between Jobcentre Plus and claimants and the service provided by Atos Healthcare.

The decision-making process is also showing signs of improvement, with more decisions on work capability being "got right the first time". The new measures introduced are likely to be resource-intensive, but it is important that the necessary funding is made available for their implementation nationwide, despite the pressures on DWP budgets, because accurate decisions will save the Government money through fewer appeals and greater efficiency in the process.

The Government has acknowledged that the WCA requires further refinements. We look forward to the outcome of Professor Harrington's second review which will focus on mental, intellectual and cognitive conditions and fluctuating conditions; improving the IT system; tracking outcomes of different claimant groups; and assessing whether the WCA could contribute more to establishing an individual's employment capability.

The ultimate success of this policy will be determined by whether the Government achieves its aim of helping people with disabilities and long-term health conditions into employment. The scale of the challenge should not be underestimated. It is vital that the reassessment process assesses claimants' employability and needs in the workplace accurately and that information from the assessment is directly linked to the Work Programme to ensure that the level of support provided matches the needs of the claimant. As the WCA is designed at the moment, there are concerns that this may not yet be the case. The Government needs to take steps to strengthen the link between the assessment process and employment support under the Work Programme.

1 Introduction

Reassessment of incapacity benefit claimants

1. Employment and Support Allowance (ESA) replaced incapacity benefits for people making new claims from October 2008. The introduction of ESA did not initially affect people already in receipt of incapacity benefits, but reassessment of existing claimants began in October 2010 with a trial in Aberdeen and Burnley. At the end of February 2011, Jobcentre Plus began a limited introductory phase, before moving to full national reassessment from April. 1.5 million existing claimants will be reassessed by 2014.¹

2. The Government has made clear that its objective in reassessing incapacity benefit claimants is to support long-term benefit claimants back into work, whilst continuing to provide appropriate support for those who are unable to work:

There are over 2.5 million people on incapacity benefits and Employment and Support Allowance. This is some 7% of the working age population at a cost to the taxpayer of around £13 billion a year. The Government recognises that many of these people, with the right support, could and indeed do want to work, but the current system does not give them that opportunity.²

We discuss the Government's objectives for the IB reassessment in the next chapter.

The Work Capability Assessment

3. To be eligible for ESA, a person must undergo a Work Capability Assessment (WCA). The assessment is carried out by Atos Healthcare on behalf of the Department for Work and Pensions (DWP) under a Medical Services Agreement which runs until 2015. The contract with Atos is discussed in Chapter 3.

4. DWP states that the WCA is “an independent functional assessment which focuses on the overall effects of a condition or impairment on the individual”. It “looks at a range of different activities related to physical, mental, cognitive and intellectual functions. It also assesses certain additional criteria that do not directly measure function (such as terminal illness) to determine capability for work”.³ Claimants score points against a series of functional descriptors which look at the impact of a health condition or disability on an individual's ability to carry out a range of everyday activities, involving such things as walking, reaching, speech, hearing, sight, memory and concentration. A claimant who accumulates 15 points is regarded as having a “limited capability for work” and may also have a “limited capability for work-related activity”.⁴

1 Ev 67, paras 1-2. Incapacity benefits include Incapacity Benefit, Severe Disablement Allowance and Income Support paid on the grounds of illness or disability.

2 Ev 67, paras 8-9

3 Ev 71, paras 50-51

4 DWP, *A Guide to Employment and Support Allowance – The Work Capability Assessment*, ESA214, June 2011, p 10; and Professor Malcolm Harrington, *An Independent Review of the WCA*, November 2010, Chapter 3 (The Harrington Review).

Changes to the WCA

5. In response to concerns raised about the effectiveness of the WCA, the previous Government announced its intention to undertake a DWP-led review of the WCA in December 2008.⁵ The findings of this internal review were published in March 2010 and changes to the WCA were recommended. These related to individuals: awaiting or in between courses of chemotherapy; receiving residential treatment for drug or alcohol misuse; and those with severe mental health conditions or communication difficulties. The review also recommended taking greater account of how an individual had adapted to their condition. The recommendations were accepted in full by the coalition Government and were implemented in Regulations in March 2011.⁶

6. In addition to the internal review, the Welfare Reform Act 2007 provided for an annual independent report on the WCA for the first five years of its operation. In June 2010, Professor Malcolm Harrington, an occupational health specialist, was appointed by the Secretary of State for Work and Pensions to carry out the first review. Professor Harrington's report was published in November 2010. The Government's response, published at the same time, fully supported the review's recommendations and pledged to implement them "over the coming months".⁷

7. The Minister for Employment, Rt Hon Chris Grayling MP, made clear to us that he accepted that, initially, the WCA had been a "flawed" process. He pointed out that the version of the WCA that was now in place, following the internal and Harrington Review changes, was different from the one experienced by new ESA claimants when the benefit was introduced in 2008.⁸ We explore the concerns expressed to us about the WCA, and the changes which have been implemented as a result of the reviews, in Chapters 3 and 4.

8. Professor Harrington has been reappointed to conduct a second independent review. This work will include looking in more detail at the assessment of mental health conditions and other fluctuating conditions and is likely to lead to further changes to the WCA.

Outcomes of the reassessment

9. There are three possible outcomes of the WCA for claimants:⁹

- They score less than 15 points and are assessed as fully fit to work. These claimants are not eligible for ESA but can claim Jobseeker's Allowance (JSA), with the accompanying responsibility to look for work.¹⁰
- They score 15 points in the WCA and are assessed as having limited capability for work at present but as being able to prepare for a return to work. They are placed

5 DWP, *Raising expectations and increasing support: reforming welfare for the future*, December 2008, para 5.15.

6 Ev 71

7 DWP, *Government response to Professor Malcolm Harrington's Independent Review of the Work Capability Assessment*, Cm 7977, November 2010, p 7.

8 Q 266

9 Harrington Review, Chapter 3, paras 2-4

10 JSA is currently £67.50 per week for a single person aged over 25.

in the Work Related Activity Group (WRAG) and are eligible to claim ESA (either contributory or income-related).¹¹

- They score 15 points and are assessed as having limited capability for work-related activity in addition to limited capability for work. These claimants are placed in the Support Group and are not expected to look for work.¹² Some claimants are placed in the Support Group without undergoing the WCA because of the severity of their condition.

10. Employment support will be provided to people moving off IB through the Work Programme, the unified welfare to work system, which the Government launched in June and on which we reported in May.¹³ We discuss employment support available to claimants in Chapter 7.

The inquiry

11. We first discussed the ESA migration with a range of organisations and individuals at a roundtable on disability in February. This was followed by a visit to Burnley, one of the two trial areas for the IB reassessment, where we met representatives of Jobcentre Plus and Atos and then held an open public meeting. It was clear from our discussions that there was a high degree of concern amongst claimants and their representatives about the reassessment process up till then. We therefore decided to conduct a formal inquiry into the migration process and issued a call for evidence.

12. We received 61 submissions of written evidence from individuals and a range of organisations. We also received many papers setting out individuals' personal experience of the reassessment process which provided us with very helpful background information. We held three oral evidence sessions with: Citizens Advice, Rethink, Professor Paul Gregg of Bristol University; the Careers Development Group (an employment provider); Atos Healthcare; Professor Malcolm Harrington; and Rt Hon Chris Grayling, Minister for Employment and DWP officials. We are grateful to everybody who contributed to our inquiry, particularly those who took the trouble to share their personal experiences with us.

Our report

13. This report looks at the reassessment process from two perspectives. The first is the Government's objectives for helping long-term disability benefit claimants back into work and how effectively they are being communicated to claimants and the wider public (Chapter 2); and the extent to which the Work Capability Assessment supports the process by providing an accurate assessment of a claimant's capability to work which is useful to employment providers (Chapters 4 and 7).

11 Both income-related and contributory ESA Basic Allowance is £67.50 per week. The work-related activity component is £26.75 per week. Income-related ESA is set at £105.95 per week for couples and lone parents.

12 The support component for both contributory and income-related ESA is £32.35 per week. This is payable in addition to the Basic Allowance. Additional premiums are payable in certain circumstances.

13 Work and Pensions Committee, Fourth Report of Session 2010-12, *Work Programme: providers and contracting arrangements*, HC 718.

14. The second strand looks at the process from the claimant's perspective. This includes their experience of the earlier version of the WCA process and the services provided by Atos (Chapter 3); the quality of decision-making by Jobcentre Plus and the appeals process (Chapter 5); and the outcomes of the reassessment process for claimants in terms of the benefit group to which they are allocated and the subsequent support available to them (Chapter 6).

2 The Government's policy objectives for the IB reassessment

Government aims

15. Professor Harrington's report highlights that ESA was launched under the previous Government in 2008 "as both an assessment for benefit entitlement and as the first, positive step back towards work for most people".¹⁴ The report also cites the substantial evidence of the "centrality of work to people's lives" and asserts that "previous assessments and benefit regimes lacked a focus on the positive effects of work and the interactions between recovery and work".¹⁵

16. The current Government's objectives for the IB reassessment are clear. The Minister for Employment told us that the aim is "identifying people who have the potential to return to work, and helping them to do so".¹⁶

17. The Minister explained the background to the Government's approach. In preparing its Green Paper on Welfare Reform in opposition, his party had identified a "huge gap" in terms of the 2.5 million people claiming incapacity benefits "that were just being left there. There was no real process of challenge to say 'Is there something better you can do with your life if we provide you with the right help and support to get back into work'".¹⁷ The Government believes that many of these people "could and indeed do want to work, but the current system does not give them that opportunity [...] People have been left on their own with no support or sense of when and how they might get back to work."¹⁸ The Minister also acknowledged that:

The majority of those who could return to work are people who are a long way away from the workplace, who have become detached from the world of work through that length of time on benefits, who probably no longer have the self-confidence to get back into the workplace, and who often think they do not have the ability to work.¹⁹

He emphasised that the reassessment is not a savings measure, "although if we succeed it will save money".²⁰

18. We support the Government's objectives of helping people with disabilities and long-term health conditions to move back into work, whilst continuing to provide adequate support for people who have limited capability for work or are unable to work. However, the scale of the challenge should not be underestimated and nor should

14 Harrington Review, Chapter 2, para 19

15 Harrington Review, Chapter 2, para 14 and 18

16 Q 247

17 Q 247

18 Ev 67, paras 8-9

19 Q 250

20 Q 247

the level of anxiety which currently surrounds the process. A suspicion persists that the only objective of the Government is to save money. The Government must be proactive in explaining its aims and spreading the positive messages about the benefits of work and the support which is available to find work, and in engaging employers. It is vital that the Government's objectives are firmly supported by the reassessment process, and by the WCA in particular, but at the moment we are not completely convinced that it does this. Our report focuses on the changes we would like to see to help ensure that this happens in practice.

Claimant perceptions

19. Unfortunately, the Government's positive messages are not necessarily getting through to claimants or the wider public. DWP's own research into claimants' views of the IB reassessment trials in Aberdeen and Burnley found that "some customers expressed a desire for more explanation of the overall rationale for reassessment [...] few customers saw reassessment as a means to help people access the support they needed to move back into work". The research paper goes on to say that "it was commonly believed that reassessment formed part of the Government's spending reductions" and "customers tended to believe that the sole purpose of the exercise was to reduce benefit expenditure". Only exceptionally did customers report having seen the reassessment portrayed in a positive light in the media.²¹

20. One witness, who works in a GP practice, suggested that, to address this misunderstanding, an additional sentence should be included in the letter informing claimants that they were not eligible for ESA to explain that:

[...] although some people have medical problems the Government wants to help as many as possible back into work suitable for them. Many people I see are angry at being assessed as having no problem, particularly when they have been getting IB and have had no change in circumstances. They don't understand it.²²

21. Professor Paul Gregg, who worked with the previous Government on designing employment support, believed that: "A lot of the messages that are coming out—and I think the Government is guilty of this—are creating a culture where the disabled community feels the primary function is about driving them off the benefits on to lower value, less-supportive type benefits".²³

22. Another witness argued that there was a contradiction in the Government's position:

On the one hand, they claim that ESA has been introduced because they know that those of us with health conditions and disabilities want to work; on the other hand, we are treated as malingerers or children who can't be trusted to engage in work-related activities without coercion, threats and financial sanctions. If the Government

21 DWP, *Trial incapacity benefits reassessment: customer and staff views and experiences*, Research Report No. 741, June 2011, pp10, 12 (DWP Research Report 741).

22 Ev w4 [Patricia Oakley]

23 Q 6

truly believed that most of us are responsible adults who are keen to work, they wouldn't impose on us such a punitive regime and such a draconian eligibility test.²⁴

Having followed our oral evidence sessions, she wrote again to say that, despite what had been said in our exchanges, many claimants did know what the purpose of the WCA and the reassessment process was but:

[...] we are worried because we know that there aren't enough jobs for able-bodied people, let alone for those with special employment needs. It is all very well to keep repeating the mantra that with the right support and encouragement people can move into work. Yes, in theory and in an ideal world. The reality is, however, that they are more likely to end up languishing on the dole or fall out of the system entirely.²⁵

23. As well as not necessarily understanding or sharing the Government's objectives, claimants are also anxious about the process. The DWP research reported that:

A number of claimants were anxious about the prospect of being assessed and concerned the assessment might not fairly assess their capabilities. Often believing that they had been "targeted", these customers tended to be pessimistic about their chances of being awarded ESA and fearful about the prospect of working.²⁶

24. Many of the individuals who submitted evidence spoke of their anxiety about the process. One woman stated that she had "heard several stories about people being treated unfairly, the reports being false and not representative of the claimant's needs or disabilities".²⁷ Another wrote: "As more and more news comes out about the functioning of the WCA, the two types of ESA, and people being sanctioned and losing benefits entirely I am becoming even more worried, and the worry is worsening my health."²⁸

25. Claimants also sometimes felt that being found fit for work in the WCA equated to being told that they did not have a health condition. Professor O'Donnell of Atos Healthcare agreed that this was an issue:

One thing that would make a difference would be if we could find a way of explaining to people that failure to be awarded ESA is not the same as being classed as a malingerer, someone who does not have a disability or someone who is not ill. I think we need to get that across very clearly.²⁹

This accords with the DWP research on the IB reassessment trials which found that people who received no points in the WCA "were particularly critical of the process because they

24 Ev w47 [Elina Rigler]

25 Ev w115 [Elina Rigler]

26 DWP Research Report 741, p 15

27 Ev w74 [Catherine Burns]

28 Ev w41 [Julia Cameron]

29 Q 143

felt that the notification letter was stating that they did not have any form of impairment or medical condition”.³⁰

26. Dr Bill Gunnyeon, the DWP Chief Medical Adviser, acknowledged that “one of the challenges we have with perceptions is that people think that, if they are considered fit for work, that means the assessment has concluded there is nothing wrong with them: that is a problem”. He believed that it was a question of changing people’s perceptions about the WCA so that they saw its purpose as being to try to “identify where somebody sits on this continuum, from being in work and fit for work to being a long way from work because of a health condition”. He also pointed out that “about 25% of people in work suffer from a long-term health condition. Of working age people as a whole with a long-term health condition, about 60% are in work.”³¹

Improving communication of the Government’s objectives

27. Given that the IB reassessment is being implemented over three years, it is important for DWP to ensure that it informs claimants about the reassessment at the point when it is most helpful for them and is likely to reassure them rather than increasing their anxiety. We discussed with witnesses what the most effective timing for informing people about the process might be. Jane Harris of Rethink pointed out that there were two communications processes going on: specific information for claimants and the general information in the media. She said that “some people do feel that they are getting a lot of communication but that they are never being given a date for an assessment [...] That seems to be causing quite a lot of anxiety”.³² The DWP research on the reassessment trials found that “general awareness of reassessment prior to receiving the notification letter was reasonably high”, although claimants’ understanding of why it was happening and what it would involve “tended to be quite basic”.³³ It should be borne in mind that some IB claimants will also be recipients of Disability Living Allowance, which is to be replaced by the Personal Independence Payment, for which a separate eligibility assessment will be necessary.

28. It is also important that claimants understand the objectives of the reassessment process from the outset. However, because Employment and Support Allowance has two purposes, to provide help to those who might be able to move into work and to provide an income replacement benefit for those who are unlikely ever to work again, the messages claimants receive can be confusing.

29. The initial letter which Jobcentre Plus sends to incapacity benefit claimants to inform them that they are to be reassessed says “We need to assess you for Employment and Support Allowance. This is a new benefit that helps people with an illness or disability move into work and provides people with the support they need.”³⁴ The leaflet which Jobcentre Plus (JCP) has issued on reassessment states that “moving people on to Employment and Support Allowance and Jobseeker’s Allowance will mean they get the

30 DWP Research Report 741, p 34

31 Q 272

32 Qq 3-4

33 DWP Research Report 741, p 9

34 DWP, Jobcentre Plus sample letter to claimants, IBM2591, January 2011.

right help and support to find work”.³⁵ Both of these imply that the purpose is to move everyone into work. It is not clear whether the “support” offered is in the form of help to get into work or the income replacement benefit which is paid to people who are not in work. In fact the word “support” means both and this may be why the impression has been given that the purpose of the WCA is to remove people’s benefit. It is also confusing in this context that the group not required to seek work is called the “Support Group”.

30. It may be that, as people become more familiar with the new benefit, this confusion may lessen and that evidence that the process works in practice may also contribute to ensuring that the positive messages are effectively communicated. The Minister believed that, as claimants went through the reassessment process and began to move into work, role models would be created and this would help to get the positive message across that the process was about supporting people who could work to find jobs.³⁶

31. The Government needs to develop its communications strategy for the IB reassessment in a way which ensures clarity and minimises anxiety. Providing claimants with the right level of information at the time that is appropriate for each individual forms an important part of this, bearing in mind that the reassessment process as a whole will last three years. It also requires the Government to be clearer about what the word “support” means in the context of Employment and Support Allowance. Currently it is used to describe employment support on the one hand and financial support through benefits for those who cannot work on the other. These two different meanings in the context of one benefit can be very confusing.

“Passing” or “failing” the WCA

32. One of the obstacles to ensuring that the positive messages get through to claimants is the use of language in the process. One of the particular concerns we have about the public response to the IB reassessment and the WCA is that claimants see themselves as “passing” the test if they are found to be unfit for work and they qualify for ESA, but as “failing” the test if they are assessed as being able to work. This ties in with the point made above, that if claimants “fail” the test and are found fit for work, they interpret this as meaning that DWP does not believe that they have a health condition or illness.

33. The difficulty of using the right language to describe the outcome of the WCA was borne out in oral evidence when Dr Gunnyeon of DWP referred to a claimant being “unsuccessful” in the WCA, meaning that they had been found fit for work. He acknowledged this inconsistency, saying “I think I have just demonstrated exactly why it is so difficult”.³⁷

34. The message which the Government sends to claimants involved in the reassessment process should be clear and simple: if the assessment process correctly finds someone fit for work, that is a successful and desirable outcome. However, we believe that the Government also needs to take greater steps to reassure claimants. It

35 DWP, Jobcentre Plus information leaflet, *Reassessment of incapacity benefits*.

36 Q 251

37 Qq 313-316

needs to explain that being found “fit for work” does not equate to denial or disbelief about the existence of an illness or health condition: rather the condition is acknowledged but its impact has been assessed as not being so serious as to prevent the person from returning to work at some point in the future.

35. We believe that the language currently used to describe the outcome of the WCA is a barrier to the Government’s objectives for the reassessment being properly communicated. The idea that a claimant has “failed” the assessment if they are found fully capable of work risks negating the positive messages which the Government is trying to convey. It needs to be addressed across the board and to include all communications between claimants and DWP staff, especially Jobcentre Plus staff who tell claimants the outcome of the process, and Atos Healthcare employees who may explain the process to claimants. We also believe that the communications need to explain clearly and at every stage of the process that, where someone is found not fit for work, they will be eligible to receive ESA at the support rate.

Media coverage

36. Another cause of concern for claimants was that media coverage of the IB reassessment had resulted in a very negative public perception of them. Some believed that the Government might be contributing to this negative portrayal. One witness believed that “When a daily tabloid trumpets that ‘75% of all claimants on disability benefit are scroungers’ it is surely only endorsing successive Governments’ public spin. Clearly Atos has deemed me a ‘scrounger’.”³⁸ Another told us: “We are not ‘work-shy scroungers’ as depicted so unpleasantly these days in the media—as a trustee of a local organisation of disabled people I know my concerns are felt by many others.”³⁹ A mother of a claimant told us that:

Many of the articles that are being printed in the papers are fairly negative and are painting people on benefits as being scroungers and people who want something for nothing. My son has become very distressed by the news articles which have added to his extreme stress and anxiety.⁴⁰

37. Nor is it just the tabloid press which presents a negative view of long-term incapacity benefit claimants. *The Times* published an article in April with the headline “Too fat, too drunk, or just too lazy to work—but not to claim their benefit”. The article said that official figures indicated that “more than 80,000 people are too fat or too dependent on alcohol or drugs to work” and that many of these people had been on incapacity benefits “for more than ten years”.⁴¹

38. Part of the problem is the way in which releases of official statistics about the reassessment process are covered in the media. DWP released initial findings from the Aberdeen and Burnley trials of the IB reassessment in February 2011. The DWP press

38 Ev w1 [John Heeps]

39 Ev w41 [Julia Cameron]

40 Ev w12 [Carole Rutherford]

41 *The Times*, 21 April 2011

release set out that 29.6% had been found fit for work; 31.3% had been placed in the Support Group; and 39% had been placed in the WRAG, explaining that “this means with the right help and support they can start the journey back to work”.⁴² This was headlined on the BBC website as “Incapacity benefit review suggests majority could work”.⁴³ The Daily Express used the headline “70% of Britons on incapacity benefits found to be fit for work”. The article itself did break this number down but said “Early results showed that 29.6% of claimants were found to be fit enough to get a job and support themselves rather than sponge off the taxpayer.”⁴⁴ A number of other newspapers were required by the Press Complaints Commission to publish corrections for suggesting that 70% of claimants had been found fit to work.⁴⁵

39. The Minister stressed that the Government had played no part in feeding media stories which referred to benefit claimants being “work-shy” or “scroungers”. There was a statutory requirement on the Department periodically to release official statistics. When publishing these figures, the Government had “one single consistent narrative, which is that there are people there with the potential to get back into work, and through the Work Programme there will be specialist help for them to do so. That is a message I stand by four square.”⁴⁶ The Government could not “control the editorial approach of the tabloids” and he was often “bemused” by the stories which ran, but he had had “a number of conversations with people in the media about the need for care in this area”.⁴⁷

40. Sections of the media routinely use pejorative language, such as “work-shy” or “scrounger”, when referring to incapacity benefit claimants. We strongly deprecate this and believe that it is irresponsible and inaccurate. The duty on the state to provide adequate support through the benefits system for people who are unable to work because of a serious health condition or illness is a fundamental principle of British society. Portraying the reassessment of incapacity benefit claimants as some sort of scheme to “weed out benefit cheats” shows a fundamental misunderstanding of the Government’s objectives.

41. Whilst fully accepting that the Government, and this Committee, have no role in determining the nature and content of media coverage, we believe that more care is needed in the way the Government engages with the media and in particular the way in which it releases and provides its commentary on official statistics on the IB reassessment. In the end, the media will choose its own angle, but the Government should take great care with the language it itself uses and take all possible steps to ensure that context is provided when information about IB claimants found fit for work is released, so that unhelpful and inaccurate stories can be shown to have no basis.

42 “Grayling: initial reassessments of those on IB in Aberdeen and Burnley show large numbers of claimants with the potential to return to work”, DWP press release, 10 February 2011.

43 BBC News online, 14 February 2011

44 *Daily Express*, 11 February 2011

45 See Press Complaints Commission website at www.pcc.org.uk and the Full Fact website at <http://fullfact.org>

46 Q 254

47 Q 256

Role of representative organisations

42. Non-governmental organisations (NGOs) which represent benefit claimants and people with disabilities play an important role in communicating Government policy to the public and in voicing the concerns of people affected by proposed changes. We welcome the contribution such organisations make, but some of the messages they give are not always easily reconciled. A number of NGOs made clear that they supported the principles behind the IB reassessment. Citizens Advice Scotland (CAS) told us: “It is important to note that CAS—and many groups that support people who live with disabilities across Scotland—support the principle that those who have a capability for work should be helped into suitable and sustainable employment.”⁴⁸ A joint submission from organisations working with people with mental health problems stated:

Our organisations understand the motivation for moving claimants off existing incapacity benefits (IB), which is seen as a “passive” benefit, onto Employment and Support Allowance (ESA), which is seen as a more “active benefit” [...] We welcome efforts to help people with mental health problems back to work, where appropriate and if done in a supportive and understanding manner.⁴⁹

However, the overwhelming message from representative organisations was that this was a flawed process. The joint submission cited above went on to state “we are concerned that the process will not be fair; will cause substantial distress; and will lead to many people receiving inadequate support and being subject to inappropriate and potentially harmful requirements”.⁵⁰

43. We put this apparent contradiction to two of the representative organisations, Citizens Advice and Rethink, when we took oral evidence from them. Jane Harris of Rethink told us that “in principle we support a lot of the ideas behind the Employment and Support Allowance, and certainly we think there are a lot of people with mental illness who may be able to work with the right support, who probably are not able to work at the moment”. However, “there are some really fundamental barriers to work that are not being addressed, the chief one being the stigma and discrimination that thousands of people with mental illness face when trying to find a job”. She welcomed the “very positive step forward” which the Equality Act represented in this respect but believed that “it has not solved that fundamental problem”. She drew a distinction between the short-term and long-term prospects of a claimant with a mental health problem being found fit for work:

[...] long term, with the right support, we think there are lots of people who could work. [...] The problem is there is a difference in thinking that somebody might need a couple of years in the Work-Related Activity Group, certain amounts of support and then they might be able to go back to work [...] There is a difference between that and concluding that, on the basis of a test, that across the sector people do not really think is particularly valid, somebody can therefore work tomorrow.⁵¹

48 Ev w28

49 Ev 91, para 1.1

50 *Ibid.*

51 Qq 2, 5

Sue Royston of Citizens Advice took a similar view:

We welcomed the Employment and Support Allowance. A lot of disabled people want to get back into work, and we welcomed the help and support it would give. We are not very happy about the way it is working. We feel the test is too crude a test, and there are also problems with the way the assessment is actually carried out in practice.⁵²

44. We put it to the Minister that organisations which represent people on benefits shared some of the responsibility for the negative attitude to the IB reassessment and for fuelling anxiety amongst claimants about the process. The Minister believed that these organisations were “in a slightly difficult position”. Some had been involved in the development of the WCA and in the various reviews, because it was important to have the benefit of their expertise. But at the same time the Minister recognised that “there is a lot of uncertainty out there, a lot of concern out there, and to some extent they have to voice that”.⁵³ However, he also pointed out that “one of the ironies” was that some of the organisations which had been critical of the reassessment were on the list of Work Programme sub-contractors who would be responsible for helping people coming off benefits to find jobs.⁵⁴

45. We agree with the Minister’s view that organisations which represent benefit claimants may sometimes face a conflict in being both advocates for the people they represent and key players in helping to design and implement the reassessment process. We believe that these organisations could contribute enormously to allaying the concerns about reassessment by giving equal weight to publicising the opportunities an effective assessment process could offer, and the back-to-work support available from Government, as they do to fulfilling their important role in raising legitimate concerns. We also consider that this would help reassure potential employers and thereby reduce the risk of stigma and discrimination.

52 Q 2

53 Q 252

54 Q 254

3 The Work Capability Assessment— claimants' experience and Atos Healthcare

46. In this chapter we look at claimants' expectations and experience of the Work Capability Assessment (WCA), and its design and delivery. We also discuss DWP's contract with Atos Healthcare, the private company which carries out the assessments.

Design of the process

47. The Welfare Reform Act 2007 legislated for the introduction of the WCA as the assessment for Employment and Support Allowance (ESA), which replaced Incapacity Benefits for new claimants in October 2008. We have described how it works and summarised the range of assessment outcomes in Chapter 1.

48. The assessment was developed by DWP officials, working in consultation with experts in the field and disability organisations.⁵⁵ As we have described, it is an assessment of the functional effect of an individual's health conditions and/or disabilities on their capacity to work—it is not a medical assessment of those conditions. It also assesses the extent to which an individual's conditions and/or impairments limit their capability to work by focusing on everyday functional activities, both physical and mental, cognitive and intellectual.⁵⁶

49. The physical activities assessed include: walking (“mobilising”) (with a stick or other aid if such aid is normally used); standing and sitting; manual dexterity; making self understood (through speaking, writing, typing, or other means normally used); understanding communication (by both verbal (such as hearing or lip reading) and non-verbal (such as reading 16 point print) means using any aid it is reasonable to expect them to use); navigation and maintaining safety (using a guide dog or other aid if normally used); continence; and remaining conscious during waking moments. The mental, cognitive and intellectual activities assessed are: learning tasks; awareness of everyday hazards; initiating and completing personal action; coping with change; getting about; coping with social engagement; and appropriateness of behaviour with other people.⁵⁷

50. The WCA assesses claimants' functional capability against “descriptors”, which describe the extent to which the person can undertake the particular activities. Claimants “score” up to 15 points against each descriptor if they have limited function in the activity described. For example, for the manual dexterity descriptor, a claimant will score 15 points if they:

- (a) cannot either (i) press a button, such as a telephone keypad or (ii) turn the pages of a book with either hand

55 DWP, *Explanatory Memorandum for the Social Security Advisory Committee: The Employment and Support Allowance (Limited Capability for Work and Limited Capability for Work-Related Activity) Amendment Regulations 2011*, August 2010.

56 Ev 71

57 DWP, *A Guide to Employment and Support Allowance – The Work Capability Assessment*, ESA214, June 2011, pp 17-23

[Or] (b) cannot pick up a £1 coin or equivalent with either hand.

9 points will be scored if the claimant:

(c) cannot use a pen or pencil to make a meaningful mark

[Or] (d) cannot use a suitable keyboard or mouse.⁵⁸

If none of the limitations under each of the descriptors applies to the claimant, they will score no points, will not qualify for ESA and will normally be advised by Jobcentre Plus to make a claim for JSA. A score of 15 points in any one activity qualifies a claimant for ESA. If a claimant does not score 15 points in any one activity, points scored in all activities are combined. A combined score of 15 points also qualifies a claimant for ESA.⁵⁹

51. The second part of the WCA assesses whether claimants qualifying for ESA should be placed in the Support Group, which is for those claimants whose conditions are considered to affect their function so severely that an expectation to engage in work-related activity would be unreasonable. This part of the assessment uses 25 descriptors under 16 headings which are similar to those described above. If a person satisfies at least one of the descriptors they will be placed in the Support Group and will not be mandated to begin preparing for or looking for work.⁶⁰

Claimants' experiences of the process

Atos call-centres

52. The first stage in the assessment process is that the claimant receives a letter telling them that their claim is to be reassessed as part of the IB/ESA migration. JCP then telephones the claimant to provide any necessary advice, and the claimant is sent the ESA50 medical questionnaire to complete and return. Atos Healthcare call-centre staff then telephone the claimant to make an appointment for a WCA at an assessment centre.⁶¹ All subsequent contact about the appointment time is via the call-centre: claimants are not able to contact the assessment centre directly.⁶²

53. Evidence suggests that many people have experienced problems with the call-centre service. In one extreme case it took 135 telephone calls to get through to Atos.⁶³ People we spoke to at our open meeting in Burnley told of similar experiences. Lisa Coleman of Atos acknowledged that the call-centres had experienced significant problems a year ago, which were due to technical problems. She assured us that Atos had since invested heavily in new technology to rectify the problems. This, together with the retraining of call-centre staff,

58 DWP, *A Guide to Employment and Support Allowance – The Work Capability Assessment*, ESA214, June 2011, p 19

59 *The Work Capability Assessment for Employment and Support Allowance*, SN/SP/5850, House of Commons Library, February 2011, p 7

60 DWP, *A Guide to Employment and Support Allowance – The Work Capability Assessment*, ESA214, June 2011, pp 24-26

61 Q 81

62 Qq 101-2

63 Ev w110 [Tom Greatrex MP]

had enabled Atos to reduce call waiting times to less than 30 seconds. Over 90% of first calls are now picked up.⁶⁴

54. Sue Royston from CAB suggested that claimants had found the appointment booking process inflexible and had found it difficult to arrange a convenient appointment time. She told us that Atos call-centre staff work to a rigid script and that claimants tend to be told, “You must come along because otherwise you might lose your benefit.”⁶⁵ Lisa Coleman from Atos told us that the arrangement of an appointment time was “a negotiation” between call-centre staff and the claimant. She said that if the appointment time offered was inconvenient for the claimant “an alternative appointment will be offered if there is a suitable one available”.⁶⁶

55. Atos acknowledged that its call-centres had experienced significant problems in the past. We welcome the assurance that this has been addressed to ensure that waiting times are significantly reduced and most calls are picked up first time. We expect call statistics to be maintained and published to demonstrate that progress is being made and sustained. However, claimants are still unable to contact the assessment centre they are due to attend directly, and we believe they should be able to do so, even if calls are routed through the call-centre.

Over-booking of appointments

56. Atos told us that it routinely overbooks appointments for the WCA by about 20% (although this varies between assessment centres). It does this because the non-attendance rate is as high as 30% in some areas.⁶⁷ We asked Atos whether this overbooking resulted in clients sometimes being turned away without being seen. Lisa Coleman told us:

It does happen. I am not going to say it does not. We do have a waiting time of less than 10 minutes, and we do try to manage within that time. But we also try to make sure the customers have the appropriate time within the assessment. So I am not saying it never happens because it does, which is why we have a target. And in those instances we will investigate why that happened, put remedial action in place where we can, and then try to work with the customer to offer an alternative appointment. But it does happen.⁶⁸

57. We asked the Department about its views on Atos’s overbooking policy. Karen Foulds confirmed that this policy of overbooking by 20% is based on the 30% non-attendance rate for new ESA claims. She stressed that the rate for non-attendance in the reassessment trial was much lower, at 9%, and that Atos “will be reviewing their policy on that basis”. However, she added that “the number of customers who have actually gone through the IB

64 Q 120

65 Q 41

66 Q 83

67 Q 104

68 Q 85

reassessment process is still very small in comparison to those that are going through ESA, and we have not seen that impact yet on the whole of ESA”.⁶⁹

58. Atos routinely overbooks WCA appointments by 20% on the basis of the non-attendance rate for new ESA claims, which was 30%. However, the non-attendance rate in the IB reassessment trials was much lower, at around 9%, although it is too soon to say whether this low rate seen in the trials will continue in the national roll-out. We recommend that Atos reviews its overbooking policy as a matter of urgency, to take account of this much higher attendance rate by IB claimants, to ensure that people are not turned away from assessment centres without being seen. Atos should also continue to monitor and adjust its overbooking policy as necessary.

“Failure to attend” and sanctioning

59. Sanctions are imposed by Jobcentre Plus on claimants who do not comply with the requirement to attend a WCA, known as “failure to attend”, in the same way as they are applied in other parts of the benefit system. Sanctions can include stopping benefit payments. Witnesses were concerned that claimants were being sanctioned for “failure to attend” their WCA when it was not, in fact, a failure on their part. Atos told us that they do not routinely follow up non-attendance with the claimant to establish the reasons for it; they pass the information about non-attendance back to JCP, whose role it is to establish the reason.⁷⁰

60. Oxford Welfare Rights believed that it was unlikely that significant numbers of people would wilfully not attend their WCA. It argued that sanctioning in these circumstances could have serious implications for claimants:

Whilst there is some protection within the “good cause” provision, in practice there are long delays in the determination of good cause by decision-makers. This means claimants are left without benefit for considerable periods. If good cause is not accepted there will be a further delay while a new claim for ESA (or JSA) is made and processed and a new date for a WCA is set. Frequently claimants in this situation are left reliant on Crisis Loans for income.

Its view was that JCP should make greater efforts to establish the reasons for non-attendance at WCA appointments and that sanctions should only be applied where failure to attend was wilful.⁷¹

61. DWP confirmed that sanctions can be applied to claimants for failure to attend a WCA but that people should only be sanctioned if JCP “considered there was no good cause for the person not attending”. Karen Foulds of JCP set out an example of where sanctions would not be applied:

[...] if we know that somebody’s got a mental health condition, then we would take that into account with good cause. We would do safeguarding visits to people’s

69 Qq 301 and 305

70 Qq 93-94

71 Ev w34

homes if they had not responded to either our telephone call, our letter, and had not attended the appointment. We put safeguards in place to ensure that, where there is a good reason why the person has not attended, or, in fact, they have not been able to engage with the process at all because they have not perhaps understood what is happening to them, we would put those measures in place.⁷²

62. Karen Foulds was clear that sanctioning of people who turned up for their WCA but were subsequently turned away without being seen “categorically should not happen”.⁷³ The Minister believed that it was a rare occurrence but that, where it had happened, it was “unacceptable” and that if it were found to be happening on a significant scale it would require “process changes”.⁷⁴

63. Instances have occurred where vulnerable claimants have had their benefit stopped as a sanction for non-attendance at a WCA appointment when the non-attendance arose because of administrative errors on the part of Atos or JCP, or because the claimant was too ill to attend but was unable to get in touch with Atos to inform them of this. We agree with the Minister that this is unacceptable. We recommend that DWP and Atos Healthcare jointly review the processes for recording non-attendance and change them where necessary to ensure that claimants are not sanctioned for “failure to attend” when the failure is on the part of Atos Healthcare and/or Jobcentre Plus.

64. Evidence from the trials of IB reassessment in Aberdeen and Burnley suggests that the reason for non-attendance at WCAs is rarely wilful non-compliance on the part of the claimant. The recent DWP research paper on the trials found that “there was very little evidence of active or deliberate non-cooperation”. It concluded that the reason for non-attendance was most often “general confusion and inability to cope with the process”. Others were unable to attend due to their fluctuating condition:

These customers had intended to go to the WCA and had generally planned for it; having a variable or unpredictable condition they stressed that the appointment had simply caught them on a “bad day”. These customers expressed a clear intention to attend their WCA appointment if at all possible.⁷⁵

65. Administrative error on the part of Atos or JCP was also sometimes to blame. The DWP paper reports that some customers who had their WCA appointment cancelled by Atos “were sometimes marked as having failed to attend this appointment. These customers were keen to comply with the process: all intended to attend their rescheduled appointment”.⁷⁶

66. We believe that Jobcentre Plus should be more proactive in establishing the reasons for non-attendance at WCAs, including by following up with a phone call as soon as is practical after an appointment has been missed.

72 Q 306

73 Q 307

74 Q 307

75 DWP Research Report 741, p 42

76 *Ibid.*

Atos assessment centres

67. Several witnesses complained about the inadequacy of Atos assessment centres in meeting specific needs arising from their health condition or disability. One witness, a wheelchair user, described his experience:

The building is an old office block on a busy road junction halfway up a very steep hill. It is not on any bus route and there is no parking of any sort. The nearest car park is about half a mile away. To gain access to the building you have to ring a door bell to be let in. The only problem is that the door is at the bottom of a flight of steep concrete steps with no ramp. My carer had to leave me on the pavement to let them know I was there and we were redirected to another door to enter the building. Once in the building my carer had to fight the wheelchair past various tables, chairs and plants, through three sets of doors and down a narrow corridor with two sharp turns. The really big problem though was when I had to enter the actual examination room. The doorway was so narrow my wheelchair would not actually fit through. Surely at least Atos should be made to make the buildings they use easily accessible to all.⁷⁷

At our public meeting in Burnley in March several people echoed this dissatisfaction and it was clear that this is not just an issue which affects wheelchair users. Cases were reported where reasonable adjustments to accommodate particular conditions were refused, such as a choice of chairs being offered, or lighting being adapted. People at the meeting told us that when they had made requests for adjustments they had been told that they were “asking for too much”.

68. DWP told us that the majority of assessment centres are on the ground floor and that, where centres are not located on the ground floor, “prior to a customer being called to an assessment, efforts are made to identify customers who may have problems in evacuating via the stairs during an emergency”. These customers are offered an appointment at the nearest ground floor centre or a home visit but: “Inevitably however, some customers in this category are not identified and still attend the centre.”⁷⁸

69. We asked Atos about the locations and accessibility of its assessment centres. Lisa Coleman told us that there are 148 assessment centres, 20 of which are owned by Atos. The remainder are provided by DWP and “usually co-located with the Jobcentre”. She also reported that:

We are [...] working closely with the Department on individual locations. There are about 27 of them where disabled access is okay, but in the event of a fire, there are potential issues around evacuation. We are working with the Department to make sure that we can either get ground floor accommodation, or put some form of evacuation plan in place with the landlords. This usually affects sites not on the ground floor.⁷⁹

77 Ev w75 [M Turner]

78 Ev 74, para 87

79 Q 108

Dr Gunnyeon of DWP said that Atos was “moving rapidly toward” having ground floor accessible centres suitable for the needs of “anyone with a disability”.⁸⁰ The Minister told us he was “amazed that this was not part of the original process three years ago”.⁸¹

70. Atos stated that people are asked if they need transport to the assessment centre and that taxis are provided “in some instances”. Claimants receive, with their WCA appointment letter, “very tuned travel instructions”, which explain the quickest route to the assessment centre via public transport. Atos also told us that people are not expected to travel more than 90 minutes by public transport to get to an assessment centre.⁸²

71. It is unacceptable that disabled people should be called to attend an assessment at a centre which is inappropriately located, inaccessible to them or where reasonable adjustments cannot be made to accommodate special requirements arising from their health condition. We note DWP’s assurance that Atos Healthcare is “moving rapidly toward” a situation where this is no longer the case. We request that, in response to this Report, the Government sets out progress towards this aim. This should include options for the relocation of assessment centres where necessary, increasing disabled access, and improvements to the mechanisms for ensuring a claimant’s needs are known to Atos Healthcare in advance of the WCA.

The assessment

72. Many witnesses highlighted concerns about the assessment process itself. Professor Paul Gregg of the University of Bristol believed that claimants go to the WCA expecting to “present information about their illness and be tested against their perception of that illness”. Instead, they experience what they perceive as a “tick-box” process. He described this as a “profound disconnect” between what claimants expect and what they actually experience.⁸³

73. This disconnect between claimant expectation and the reality of the experience is borne out by evidence we received from disability organisations and a number of individuals. Evidence from Citizens Advice Scotland sums up the typical concerns about the WCA that many witnesses have told us about:

- The WCA is often rushed, and can last just 20 minutes, leaving claimants with the impression that they have not been properly assessed.
- The yes/no format of the assessment is too narrow, leaving little opportunity for the client to explain their condition.
- The health care professionals often fail to listen or interact with the client, which can lead to mistakes and a failure to properly assess conditions.⁸⁴

80 Q 298

81 Q 298

82 Q 105

83 Q 12

84 Ev w29

74. One witness who wrote to us had a mental health condition and had experienced two WCAs. She felt she was prevented from explaining her circumstances more fully during the WCA: “I would have appreciated it if she [the Atos assessor] had taken her time more and let me put more time in to my answers so she could get a better picture.” She also expressed frustration at not being able to present documentary evidence to back up her answers.⁸⁵

75. The Minister stressed that these types of examples were of individual experiences of the WCA before recent improvements had been made. He told us that:

Almost nobody has experienced the system that we have put in place over the past few months, and we have learnt lessons from the trials in Burnley and Aberdeen, which have been put into place. We have learnt lessons and put in changes as a result of the Harrington Review. Any experience that you are hearing from individuals or recounted from pressure groups, unless they are from people in Burnley and Aberdeen going through the trials, will by definition have come from the previous system as new claimants for ESA—a system that I fully accept was flawed and that we sought to improve.⁸⁶

76. Most of the submissions we received from individuals were from claimants who were dissatisfied with the WCA process and who did not believe that they had been accurately assessed. The Minister asked us to bear in mind that much of the evidence submitted to us related to assessments carried out prior to implementation of the two sets of review recommendations and experience from the Aberdeen and Burnley trials. We fully acknowledge this fact. However, we believe that there is no room for complacency and we have identified a number of areas where further improvement is required.

The LiMA computer system

77. Atos healthcare professionals (HCPs) use a computer system, the Logic Integrated Medical Assessment (LiMA), to enter information as they go through an individual’s WCA. LiMA records the responses claimants give at the assessment and builds a final report for each claimant, which is then passed on to the JCP decision-maker (DM). LiMA helps the Atos assessor focus on particular descriptors and obtain and record evidence in a relatively short space of time. It uses stock phrases such as “can load washing machine (front loading)” that can be input into the system quickly.⁸⁷

78. DWP stated that LiMA was designed to “improve and ensure consistency and quality of the reports [...] It serves as a guide only and the healthcare professionals are required to use their own clinical judgement to justify the medical opinion contained in the medical report.”⁸⁸ However, many witnesses complained of an over-reliance on the part of Atos HCPs on the LiMA IT system and therefore a perceived lack of human contact in the

85 Ev w6 [Samantha Fulstow]

86 Q 266

87 Harrington Review, p 37

88 Ev 73

process. One person, a carer for a disabled relative, described Atos HCPs as “computer-driven operatives”; another individual, who had been through the WCA process twice, told us that “the whole thing is done via a computer program”.⁸⁹

79. In his first annual independent review of the WCA (considered in more detail below), Professor Harrington was critical of the LiMA computer system, calling it “not very intuitive”. He also found that Atos HCPs were over-reliant on the system, despite the existence of guidance that warns against this:

The Atos Training and Development handbook encourages their HCPs to use open questioning and not to rely on the LiMA system, but in evidence to this review, this seems to be uncommonly invoked in practice. It can, perhaps, be too easy for HCPs to use stock phrases generated by the LiMA system that do not necessarily capture the whole assessment or allow nuanced responses to be reflected.⁹⁰

80. Professor Harrington told us that there had been recent changes to the LiMA system to make it more intuitive and that there was now a free text paragraph for the HCP to fill in to allow more individualised information to be provided. He told us the system now “appears to be more responsive”.⁹¹ We saw how the latest version of the software worked in practice when we visited the Atos Medical Examination Centre in Marylebone, London in June to observe a mock-up of a WCA.

The DWP contract with Atos Healthcare

81. Atos Healthcare’s role is to carry out the Work Capability Assessments, scoring claimants against the descriptors in each activity, and then preparing a report. The report is then passed to a Jobcentre Plus decision-maker who decides on a claimant’s eligibility for ESA and, if they qualify, to which ESA group they should be assigned. We discuss the decision-making process in more detail in Chapter 5.

82. Atos Healthcare has held the DWP contract for medical services (the Medical Services Agreement) since 2005. It has therefore been responsible for all the WCAs that have taken place since ESA’s inception in October 2008.

83. The 2005 contract was for £100 million per annum, which includes “the total number of examinations undertaken across all benefits and also includes costs relating to written and verbal medical advice, fixed overheads, administrative costs, investment in new technology and other service improvements”. DWP has reported that the total amount paid to Atos Healthcare by DWP “for the scrutiny, face to face and work focused health related assessment reports” was £1.7 million for 2008–09 and £24.4 million in 2009–10. These figures do not include costs relating to fixed overheads, administrative costs, investment in new technology and other service improvements.⁹²

89 Ev w2 [Mrs M Bernard] and Ev w7 [Samantha Fulstow]

90 Harrington Review, p 37

91 Q 211

92 HC Deb, 9 February 2011, col 312w

84. Atos Healthcare’s contract with DWP was originally for seven years from 2005 and was therefore due to expire in 2012. DWP took the decision last year to extend it until 2015. When we asked the Minister why he took this decision he told us that it was because “it seemed to be a bad idea to try to change the supplier in the middle of the migration process”.⁹³ DWP told us that the contract extension was negotiated on the basis of Atos “delivering substantial savings against the current estimated cost of £100 million per annum”.⁹⁴

85. We were keen to find out how Atos Healthcare expected successfully to deliver an increasing number of WCAs during the IB/ESA migration process while simultaneously delivering cost savings to DWP. Lisa Coleman told us “we have reduced our prices to do that. Future savings are around making the process more efficient, looking at where we can make sure that we are using technology to support the end-to-end process, and that we are using the right people at the right point in time.”⁹⁵ The Minister said that savings were expected across all Government contracts and that the coalition Government had renegotiated all such contracts on this basis when it took office. Dr Gunnyeon of DWP told us:

It is reasonable to expect any organisation to look at how it can do things more efficiently, and certainly Atos have been doing that. There has also been a move to look at how we can use different healthcare professionals, and that is in keeping with what is happening across healthcare generally: for example, the use of more nurses to undertake assessments after appropriate training. That happens in different aspects of the NHS, where there is more responsibility being devolved to other healthcare professionals who have the right skills to do things, and that has an impact on costs as well. A number of things were part of that process.⁹⁶

Karen Foulds also pointed out that not all of the claimants coming to Atos as part of the IB/ESA migration process would constitute additional work for them: some IB claimants would have had a Personal Capability Assessment carried out by Atos as part of their IB claim.⁹⁷

86. We were aware of considerable public suspicion that payments to Atos Healthcare are made on the basis of the outcomes of WCAs. Some claimants clearly believe that Atos healthcare professionals (HCPs) are encouraged through targets within the DWP contract to find people fit for work. DWP has made clear that this is not the case: “the result of the assessment has no bearing on Atos Healthcare targets or remuneration”; and that the Medical Services Agreement “does not include any provisions either from the Department or from Atos Healthcare to incentivise health care professionals to find claimants undergoing the WCA fit for work”.⁹⁸ Lisa Coleman of Atos confirmed that, contractually,

93 Q 258

94 Letter from the Secretary of State to the Chair of the Committee, 28 September 2010, following up oral evidence taken on the work of the Department on 15 September 2010 at which the Atos contract was discussed. Printed in: Work and Pensions Committee, *Work of the Department for Work and Pensions*, Oral and Written Evidence, HC 468, Ev 23.

95 Q 192

96 Q 260

97 Q 261

98 Ev 72, para 65 and HC Deb 9 February 2011, col 334w

Atos is paid for the number of satisfactory assessments it completes, not on the basis of the results of those assessments.⁹⁹

Monitoring quality

87. We wanted to know what quality control procedures were in place in relation to the contract. Lisa Coleman told us that Atos was monitored by DWP on both the quality and timeliness of assessments and reports. She told us that Atos faced financial penalties if it did not meet the required standards.¹⁰⁰

88. DWP stated that Atos Healthcare have put in place several measures to ensure that “consistent, high quality, independent” assessments are provided to the Department:

- a rigorous selection process to recruit the best medical and non-medical staff—less than 15% of applicants who apply are successful;
- comprehensive training in disability assessment on joining for all doctors, nurses and physiotherapists plus on-going training to ensure skills and knowledge are up to date;
- a continual programme of internal and external audits to ensure high standards in medical assessments and reports are maintained; and
- strong performance management governance to enable high performance of all staff and to support their career development.¹⁰¹

89. The quality of Atos assessments is monitored in two ways. Firstly, Jobcentre Plus decision-makers must judge that the Atos report is of acceptable quality; if it is not it is sent back to be re-done at Atos’s own cost. Dr Gunnyeon, Chief Medical Adviser at DWP explained:

[...] the decision-maker needs to be able to have a report that shows why the recommendation of the healthcare professional is as it is. They have to be reassured that the points that have been allocated look right on the basis of the information that the claimant has provided and the assessment report itself. Clearly if the decision-maker cannot see why the recommendation is as it is, for example, if it looks as though points should have been scored on some descriptors where they have not, then that would not be acceptable, and the decision-maker would send that back.¹⁰²

DWP was not able to tell us in oral evidence what proportion of Atos reports had been sent back by JCP decision-makers but in subsequent written evidence informed us that this was only 0.22%.¹⁰³ Such a low percentage would seem to indicate that this aspect of DWP

99 Q 193

100 Q 194

101 Ev 73, para 74

102 Q 262

103 Ev 82

quality control over Atos's service is not functioning as it should. It also reinforces Professor Harrington's point, discussed in Chapter 5, that decision-makers rarely question the advice provided by Atos.

90. The second strand of quality control is Atos's internal audit of assessments, which DWP described as follows:

Each healthcare professional is subject to audit once they have completed their training until they have reached an acceptable standard, and they are then subject to random audit, so that we are continuing to check the quality. Those reports are graded either A, B, or C, and C are of an unacceptable standard. The proportion of Cs is very small, and remedial action is taken. The challenge is to try to have as many at grade-A standard as possible and to continue to look at that, and there are certain standards set.¹⁰⁴

Atos aims to audit each of its HCPs every six months.¹⁰⁵ If an HCP demonstrates persistent unsatisfactory performance, their approval to perform assessments can be revoked. Atos told us that five of its HCPs had had their approval revoked in the last six months. This is from a total of about 1,500 HCPs.¹⁰⁶

Atos Healthcare as the sole provider of the WCA

91. We asked the Minister whether it would have been better, from the outset, to have had two providers delivering the WCA in order to provide competition and to drive up performance. He told us that it "probably" would have been better and that other companies had been interested, but he reiterated that he thought it would have been unwise to change providers during the reassessment process.¹⁰⁷ The Minister defended Atos Healthcare, saying that although they "get a lot of grief", the quality of the service provided by Atos "has steadily improved as time has gone by".¹⁰⁸

92. We recognise that Atos Healthcare, as the sole provider of the Work Capability Assessment, takes the brunt of public criticism about the WCA. Some of this arises from the understandable anxiety which claimants feel about the process. We accept that considerable efforts have been made on the part of both Atos Healthcare and DWP to improve the quality of assessments. However, it is also clear that many claimants have not received the level of service from Atos which they can reasonably expect.

93. We remain concerned about whether there are sufficient levers within the DWP contract with Atos to ensure that Atos consistently gets the assessment right first time. We therefore recommend that, when the contract is re-let in 2015 and in future contracts for other medical assessments, DWP reviews the performance indicators, with significant financial penalties built in if standards are not met.

104 Q 263

105 Ev 74, para 79

106 Qq 147-148

107 Q 270

108 Q 269

94. We agree with the Minister that it would not have been practical to introduce a second provider for the IB reassessment but we believe that the Government should consider contracting a second provider to deliver the ongoing Work Capability Assessments for new ESA claims when the reassessment of existing claimants has been completed, in order to drive up performance through competition. We recommend that the Government publishes proposals, before the end of 2012, for how such a system of competition could work in practice.

4 The Work Capability Assessment— Reviews

The reviews of the WCA process

95. In this chapter we consider the impact of the recent reviews of the WCA and of the changes made in the trials of the reassessment process in Aberdeen and Burnley. As we have highlighted, the WCA is likely to be further amended as a result of Professor Harrington's second review, expected to be published at the end of this year.

The DWP-led internal review

96. The DWP internal review came to fairly positive conclusions on the accuracy of the WCA:

On the whole the expert group thought that cases assessed as being in the Work Related Activity Group were at the right level. A handful of these cases were considered ambiguous as it was not apparent if they should have been allocated to the support group or whether it was because the descriptors need modifying. The reverse was also true as there were a few cases allocated to the support group on the basis of the ESA50 without examination (with GP evidence) that one expert thought may have been more appropriately allocated to the Work Related Activity Group. The vast majority of cases allocated to the support group however were felt to have been appropriately evaluated. Crucially, all those cases where individuals scored below threshold were felt to be accurately assessed.¹⁰⁹

However, the review proposed a number of changes to the descriptors, with the aim of more accurately measuring an individual's capability for work and to reflect the use of aids and adaptations. Changes were also proposed to the scores allocated to limited function in certain activities. The review also recommended substantial simplification of some mental, intellectual and cognitive function descriptors and the reduction of the number of such descriptors from 10 to 7. The recommendations of the internal review came into force in March 2011.¹¹⁰

97. NAT, a charity which works with people living with HIV, told us that the internal review recommendations had been "consistently and strongly rejected by disability organisations, including those who had been consulted in the review process".¹¹¹ Sue Royston of CAB argued that changes to the mobility descriptors would inevitably result in more people being found fit for work.¹¹² Particular criticism has also been directed at the changes to the mental, intellectual and cognitive descriptors by some mental health organisations. Jane Harris of Rethink argued that they would result in some people with

¹⁰⁹ DWP, *Work Capability Assessment: Internal Review*, October 2009, p 15

¹¹⁰ The Employment and Support Allowance (Limited Capability for Work and Limited Capability for Work-Related Activity) Amendment Regulations 2011

¹¹¹ Ev w20, para 29

¹¹² Q 42

mental health problems, who ought be in the ESA Support Group, being found fit for work:

The descriptors still say that, if a claimant can set an alarm clock, feed themselves and manage life without daily aggression or needing almost constant supervision, or have some social contact of any kind, they will not go into the Support Group. It seems to me there are quite a lot of people who might need to be in the Support Group who would not fit those descriptors.¹¹³

98. The review team undertook further work “in response to representation from disability groups that some of the internal review recommendations had not adequately addressed their concerns”, leading to further changes set out in an addendum to the review report.¹¹⁴ For example, the word “exhaustion” was added to the descriptor for mobilising to recognise that: “an individual who has a fluctuating condition may have completed an activity but could not do so again due to a range of symptoms such as fatigue, which may not be considered discomfort”.¹¹⁵ Changes were also made in relation to cancer patients which:

[...] ensure the assessment makes greater provision for individuals awaiting or in between courses of chemotherapy, individuals receiving residential treatment for drug or alcohol misuse and those with severe mental health conditions or communication difficulties. They also ensure the assessment takes greater account of how an individual has adapted to their condition.¹¹⁶

99. Professor Gregg felt very strongly that the changes should have been tested in the trials in Aberdeen and Burnley, before being implemented nationally. He believed that the trials had provided an “absolute gift opportunity” to test the changes and found it “baffling” that implementation was not delayed to allow this.¹¹⁷ Professor Harrington would also have preferred the changes to the descriptors to have been delayed. He told us that he “had heard nothing but criticism of the changes” and had expressed his view to the Government that they should be delayed until after his independent review.¹¹⁸

100. The Minister acknowledged that an argument could have been made for delaying the introduction of the changes, but said he was keen to implement the changes as soon as possible because he believed they would have three important effects: allowing people who were between courses of chemotherapy to remain in the ESA Support Group; ensuring that more people with mental health problems went into the ESA Support Group; and ensuring assessments took proper account of aids and adaptations.¹¹⁹

113 Q 42

114 DWP, *Addendum: Work Capability Assessment Internal Review*, March 2010, p 3

115 DWP, *Addendum: Work Capability Assessment Internal Review*, March 2010, p 4

116 Ev 71, para 58

117 Q 47 and Ev 90

118 Qq 216-217

119 Q 286

The Harrington Review

101. As we have noted, the coalition Government invited Professor Malcolm Harrington, an occupational health specialist, to carry out the first independent review of the WCA, in accordance with the provisions of the Welfare Reform Act 2007. Professor Harrington's independent report was published in November 2010. He supported the evidence-based nature of the WCA and found that the system was not "broken or beyond repair" but believed that the WCA had significant failings:

There are clear and consistent criticisms of the whole system and much negativity surrounding the process. There is strong evidence that the system can be impersonal and mechanistic, that the process lacks transparency and that a lack of communication between the various parties involved contributes to poor decision making and a high rate of appeals.¹²⁰

102. The review made a number of recommendations aimed at improving the WCA process, including:

- Building more empathy into the process, with Jobcentre Plus managing and supporting the claimant. This includes speaking to them to explain the process, to explain their result and to explain the support that is available after the WCA;
- Improving transparency of the Atos assessment by ensuring each report contains a personalised summary of the Atos healthcare professional's recommendations; sending this summary to all claimants; and piloting the audio recording of Atos assessments;
- Accounting for the particular difficulties in assessing mental, intellectual and cognitive impairments by ensuring Atos employ "mental, intellectual and cognitive champions" in each Medical Examination Centre to spread best practice and build understanding of these disabilities;
- Empowering and investing in decision-makers so that they are able to take the right decision, can gather and use additional information appropriately and speak to claimants to explain their decision; and
- Better communication and feedback between Jobcentre Plus, Atos and the First-tier Tribunal to improve the quality of decision making on all sides.¹²¹

103. The Government issued an immediate response to the Harrington review at the same time as it was published in November 2010. It fully supported the review's recommendations and pledged to implement them "over the coming months".¹²²

104. Witnesses were very positive about the impact of the Harrington Review recommendations. They particularly welcomed the additional contact points between JCP

¹²⁰ Harrington Review, p 9

¹²¹ Harrington Review, p 7

¹²² DWP, *Government response to Professor Malcolm Harrington's Independent Review of the Work Capability Assessment*, Cm 7977, November 2010, p 7

and claimants put in place to respond to the recommendation that JCP should do more to manage and support claimants through the process.¹²³ However, some witnesses believed that further work remained to be done to improve the assessment process as a whole. Jane Harris of Rethink told us:

I think it would be naïve for any of us to think that any review or set of recommendations would be a total solution and that we will end up with the perfect system after that, but I do think Harrington does address some of the really fundamental problems and represents a massive step forward for the group of people we represent. The fact that there seems to have been support for the Harrington review from almost every quarter, from Government to most disability charities, just shows how comprehensive it has been despite its limited timeframe.¹²⁴

105. Professor Harrington expressed his broad satisfaction that DWP and Atos were making efforts to implement the recommendations of his first review:

I was very pleased that they accepted all the recommendations in the first place. Obviously I think some of the things should have been done faster than they are, but the DWP and Atos are big outfits in which to make some of these changes. Looking at all the recommendations that I have made, they have either been done or are in the process of being done. There are some modifications to some of them, but in essence there is not a single recommendation that they have shelved or they have ducked or they are obfuscating about what they are going to do.¹²⁵

Trials in Aberdeen and Burnley

106. Reassessment of Incapacity Benefit claimants was trialled in Burnley and Aberdeen from October 2010, ahead of the national rollout of the reassessment from April 2011. The trials involved 1,700 claimants, 850 in each area. DWP told us that the trial was designed to “provide early indicators about customer and staff reactions to the reassessment process, evaluate whether the communications were effective and to provide recommendations on how the process could be improved”.¹²⁶ The Minister told us that the Harrington Review and the trials in Aberdeen and Burnley had “fed off each other” and that Professor Harrington had spent time with the JCP teams in the trial areas, which had influenced his recommendations.¹²⁷

107. DWP believed that the trials had gone well:

The customer journey has been shown to be viable, with staff and customers reacting positively to the additional customer interventions. There was little adverse customer reaction and low levels of active non-compliance. Enquiries by telephone and in

123 See, for example, Q 22 [Jane Harris]

124 Q 46

125 Q 221

126 Ev 68, para 17

127 Q 283

person have been much lower than expected, suggesting that the communications provided to customers have effectively provided for their needs.¹²⁸

The claimant experience in the trial areas does appear to have improved. Evidence from DWP's research suggested that claimants found the additional contact from JCP helpful and reassuring.¹²⁹ Dr Gunnyeon told us that a lot of work had gone into better explaining the process to claimants and that Atos HCPs in the trial areas had reported that claimants had "much better understanding of why they were there, and what to expect".¹³⁰ Evidence from CAB backed this up: "Citizens Advice Bureaux in the trial area handled relatively few enquiries from anxious clients, suggesting that the telephoning of claimants at key stages in the journey was helpful and reassuring".¹³¹

108. However, the DWP research also found that JCP staff involved in the trials felt that the resource-intensive nature of adding in the extra contact points would be difficult to scale up for the national reassessment.¹³² The Minister was clear that, even in the context of reductions in DWP costs, which would include cuts to Jobcentre Plus, he wanted to push ahead with the new regime on a national basis and believed that it would save money in the long run:

I have been very clear in budget terms that this is something we have to do, but Professor Harrington in his report said specifically he believed in the end this would save money rather than cost money because of the impact it would have on the workings of the organisation and the effectiveness of the system.¹³³

109. We congratulate Jobcentre Plus on the improvements made to the claimant journey during the reassessment trials in Aberdeen and Burnley. However, we are concerned that the resource-intensive nature of the additional claimant contact, which has been added to the process following the Harrington Review and the reassessment trials, may be difficult to scale up to a national level in the context of public sector spending cuts. We welcome the Minister's commitment to ensuring that the improved system is implemented nationally and urge the Government to ensure that the necessary resources are made available to Jobcentre Plus, given that a more robust reassessment process is likely to save money in the long run.

The future of the WCA

The second independent review

110. Professor Harrington is continuing in his role as independent reviewer and will produce his second annual report at the end of 2011. He is currently reviewing, with the help of Mind, Mencap and the National Autistic Society, the WCA descriptors relating to

128 Ev 70, para 43

129 DWP Research Report 741, p 13

130 Q 266

131 Ev 86

132 DWP Research Report 741, p 14

133 Q 285

mental, intellectual and cognitive conditions and impairments. He will also consider how the descriptors can take better account of fluctuating conditions. He will examine the LiMA computer system “and how it can drive the right behaviours”. Importantly, he will also look at the outcomes for the different claimant groups: those found fit for work; the WRAG group; the Support Group; and those who do not complete a WCA.¹³⁴

Assessing employability

111. A number of submissions have questioned the suitability of the WCA to determine capability for work. Roy O’Shaughnessy from the Careers Development Group, a prime provider under the Work Programme, said “there is inconsistency when we are dealing with people who are supposedly work ready as to just how work ready they really are.”¹³⁵ Another provider, the Papworth Trust, highlighted that there “appears to be an underlying assumption that because someone has physically managed to arrive for an appointment, that they must be fit to work”.¹³⁶

112. The Department states that “as an independent assessment the WCA can help better determine an individual’s readiness for work. Other supporting evidence is considered alongside the WCA, where appropriate, to get the fullest picture.” It adds that the WCA was developed “to take account of the demands of the modern workplace, developments in medicine and our understanding of disability”.¹³⁷

113. One witness disagreed and argued that, having read the ESA Handbook for 2011, she was concerned that:

The criteria for being “fit for work” or “fit for work related activity” do not correlate with criteria of “fit to be employed”. The criteria only demonstrate that the claimant has an absolute minimum amount of functionality, and this bare minimum will not be acceptable to employers [...] those who are found “fit for work” or “fit for work related activity” are actually only being assessed to be working at a work station. Hence they are actually only being assessed as “fit for work, or work related activity that occurs at a work station”. Until the assessment criteria tests for ALL work types it is actually not a test for work, or employment.¹³⁸

114. When the WCA was first introduced, it included a final and separate component—the Work Focused Health-Related Assessment (WFHRA). This was mandatory for all claimants judged to have a limited capability for work who were not in the Support Group. It took place on the same day as the Atos assessment and was usually conducted by the same Atos HCP. It focused on what the claimant might be capable of doing and how their condition might be managed to help them find and stay in work. It sought the claimant’s views on returning to work, what difficulties they faced in this, what steps they thought

134 Harrington Review, p 66

135 Q 2

136 Ev w72, para 14

137 Ev 71, para 53

138 Ev w101, para 2.2 [Caroline Richardson]

they needed to take to move back into work, and tried to identify health-related or workplace interventions which might support them into work.¹³⁹

115. The WFHRA was suspended by the coalition Government for two years from July 2010. DWP said that the decision was taken in light of the introduction of the Work Programme and would “provide an opportunity for DWP to reconsider the WFHRA’s purpose and delivery” while also improving “the capacity to focus on and cope with the demands of the reassessment of existing benefit customers”.¹⁴⁰ Jane Harris from Rethink said it was “one of the disappointments” that the WFHRA has been discontinued.¹⁴¹ She suggested that there was:

[...] a gap between the policy definitions of limited capability for work and the descriptors; there is another gap between the descriptors and the actual Atos assessment; there is another gap between the Atos assessment and what the computer says. No wonder at the end of all that process somebody thinks, “Hang on a minute, I was just trying to claim a benefit because I do not think I can work due to an illness”.¹⁴²

The Minister stressed that the Government wanted to address:

[...] the situation where, in extremis, a Paralympic athlete with a university degree has no obligation to look for a job. Now that does not seem sensible to me. Equally, somebody who is blind or partially sighted who has been in work for 20 years who is made redundant would not theoretically have the obligation to look for a job.¹⁴³

Sue Royston of CAB made a similar point:

[...] somebody with a degree but with a serious impairment, their impairment will cause them less disadvantage compared with somebody who has no qualifications, no experience other than manual work—a less severe impairment will have more effect on their disadvantage in the workplace.¹⁴⁴

116. One witness believed that “many sick and disabled people will continue to be wrongly declared fit for work until the assessment process starts taking into account how an individual’s illness or disability affects their capability for work in the real world.”¹⁴⁵ The Muscular Dystrophy Campaign echoed this:

[...] the WCA currently fails to take into consideration real-life context—it does not measure the availability of accessible and appropriate work, only functionality for theoretical jobs, and does not recognise that for many disabled people who are able

139 *The Work Capability Assessment for Employment and Support Allowance*, SN/SP/5850, House of Commons Library, February 2011, para 2.4

140 *The Work Capability Assessment for Employment and Support Allowance*, SN/SP/5850, House of Commons Library, February 2011, para 2.4

141 Q 19

142 Q 40

143 Q 286

144 Q 51

145 Ev w46 [Elina Rigler]

to work, it can be almost impossible to find, obtain and retain employment, due to inaccessible workplaces, transport and employer attitudes.¹⁴⁶

Sue Royston from CAB argued that “there needs to be something more than descriptors; there needs to be some sort of real world test based on evidence of somebody’s actual level of disadvantage.”¹⁴⁷

117. When we put this to Professor Harrington, he told us that he is considering “whether there is another part of this assessment that looks at real world work”.¹⁴⁸ He explained that he had asked CAB to examine the feasibility of some kind of a “real world test”: “I want to have a seminar in the autumn, and involve the CBI as well, to sit down and discuss the real world test and whether it is a practical proposition. If so, then we introduce that as another tier in the assessment. If not, then at least we seriously looked at it.”¹⁴⁹ He conceded that “you could argue my remit does not extend to the business of how we are going to find jobs for these people. But I am going to bring them [employers] into this, and they want to be part of the process this year.”¹⁵⁰

118. ERSA, the umbrella organisation for employment service providers, suggested that:

The assessment should be more than simply assessing whether someone can work and should take into account the full range of employability factors including a customer’s barriers to work. These barriers include but are not limited to, literacy, numeracy, confidence and self-esteem. A sharing of this information with Work Programme providers could then help to inform their own diagnostic processes and aid their client segmentation.¹⁵¹

119. However, the Minister made clear that he was “absolutely unreservedly and implacably opposed” to a real world test. He argued that:

Either somebody is fit for work or they are not, and what I am not prepared to do is to countenance a situation where we are saying: “You are fit for work, but you should not be on JSA because there is high unemployment in your area.” I think that does a huge disservice to those people—some of whom have health problems—who are on JSA.¹⁵²

Dr Gunnyeon believed that there was “quite a lot of confusion around the issue of a real world test” and that what was in Professor Harrington’s mind was the importance of “the assessment correctly assessing whether people really are fit for work or not”.¹⁵³ The Minister emphasised that he had told Professor Harrington that the Government would:

146 Ev w55, para 8

147 Q 51

148 Q 236

149 Q 236

150 Q 79

151 Ev w110, para 5.2

152 Q 340

153 Q 342

[...] do everything we can to improve the process. It is just that that red line for me is we cannot create a point of discrimination to say that, because you are fit for work but you are on IB, somehow you should be treated differently to somebody who is fit for work but never was on IB.¹⁵⁴

120. We welcome the improvements to the WCA which have resulted from the Harrington Review and the lessons learned from the reassessment trials. However, we believe that the Government needs to do more to clarify whether the purpose of the WCA is to be an eligibility test for benefits or whether it is a diagnostic test to assess a person's ability to work. It is not yet clear whether it is quite achieving either of these effectively.

121. The Government decided to suspend the Work Focused Health-Related Assessment for two years without putting anything in its place. This separate component of the WCA focused on health-related or workplace interventions which might support claimants into work and would have been particularly useful for people moving off incapacity benefits. We welcome Professor Harrington's commitment to consider whether an additional assessment is needed to determine a claimant's suitability for work, and his engagement of employers in the process through the CBI.

122. Any new employability test must effectively link into the employment support available under the Work Programme. We recommend that Professor Harrington also includes Work Programme providers and sub-contractors in the work he is undertaking to try to design an assessment that identifies a claimant's workplace capabilities and needs.

5 Decision-Making and Appeals

Decision-making

123. The Department explains the decision-making process as follows:

The decision-making process starts when the decision-maker in Jobcentre Plus considers information from the ESA50 questionnaire, the WCA and any other relevant evidence provided. Where there is a discrepancy in the medical evidence, the decision-maker can seek advice from Atos Healthcare, our medical services provider, or ask the customer for clarification.

The decision-maker assesses this information and, following any discussion with the customer, decides whether or not the customer is entitled to ESA. The decision-maker issues a decision notice informing the customer of the outcome and whether or not they are entitled to ESA. If benefit is awarded, the notice specifies the amount of benefit and the date from which it is paid, and informs customers whether they will be placed in the Work Related Activity Group or the Support Group.¹⁵⁵

124. Professor Harrington drew attention to what he called the “decision gap”. He believed that Jobcentre Plus decision-makers (DMs) had the most important role in the WCA process but that many in reality rarely made decisions: instead they tended merely to “rubber-stamp” the advice received from Atos. Professor Harrington pointed out that the intended role of DMs was to make informed judgements based not only on the Atos WCA report but also on the whole “suite of information” provided to them, including: the original ESA50 questionnaire; additional information provided by the claimant; and any additional representations or case notes provided by the claimant’s own doctors. However, he found that DMs deviated from the Atos advice in only around 2% of cases.¹⁵⁶

125. Professor Harrington’s view was that:

[...] if there is more opportunity for the decision-maker to have a dialogue with the claimant, and to collect this additional information, there will be less disagreement between the claimant and the Department. It appears that even if you disagree with the outcome, you will accept a decision you do not like if you feel you have had a fair crack of the whip; that is called “procedural justice”, I think. At the moment a lot of people just do not feel they have had a fair crack of the whip.¹⁵⁷

The Minister stressed that:

[...] as a result of the Harrington Review, we have downgraded the role of the Atos-carried-out Work Capability Assessment in this process. [...] They [decision-makers] have been told very clearly that they should use the assessment as an important part of their decision-making, but not the only part, and that they should also be looking

155 Ev 75, para 98

156 Harrington Review, chapter 6

157 Q 230

at input from the evidence from a hospital consultant, for example, or a mental health specialist.¹⁵⁸

126. Witnesses felt that decision-making by JCP decision-makers had improved during the Aberdeen and Burnley trials. Rethink stressed that this was “a really positive step forward”.¹⁵⁹ CAB welcomed the fact that claimants were encouraged in the recent trials to send in medical evidence with their ESA50 forms. However, it is concerned, that “it is the claimant’s responsibility to produce such evidence. Some clients are unable to get such evidence because GPs frequently charge for the information. Someone receiving £65 a week for all their living expenses will not be able to pay £30 for a letter.”¹⁶⁰ Professor Harrington’s view was that it would better if doctors did not feel the need to charge for such reports or if the legislation could be changed in this respect.¹⁶¹

127. The DWP research on the reassessment trials found that the approach to decision-making and the proportion of WCA reports sent back for review varied substantially across the two trial sites. However, it concluded that the different approaches to decision-making were seen as resource-intensive in different ways:

[...] sending back WCA reports for review took up valuable time for HCPs and DMs and postponed a decision being made, but acquiring further medical evidence could also be time-consuming, particularly if this involved chasing GPs. Some staff involved in decision-making and reviewing cases expressed doubt that the processes used in the trial were workable or sustainable on a national level without additional staff resources.¹⁶²

128. Professor Harrington acknowledged that “it will cost more money possibly, because the decision-makers need to be trained up to do this.”¹⁶³ We asked DWP about this. Karen Foulds of JCP conceded that “for the changes that Harrington is wanting to the ESA journey, we are just at the very start of that and we are just starting to test some of that as part of a controlled national rollout”.¹⁶⁴ She suggested that “One of the things that makes this cost-effective and makes it affordable is that, if we get that evidence earlier, then we make the right decision earlier, and that is obviously better for the customer and more cost-effective for us as an organisation.”¹⁶⁵ So far, JCP “have not had to adjust [...] staffing.”¹⁶⁶

129. We welcome Professor Harrington’s central recommendation on the need to strengthen the role of Jobcentre Plus decision-makers in the reassessment process. There are signs that decision-making is already improving and this needs to be

158 Q 269

159 Q 11

160 Ev 88

161 Q 232

162 DWP Research Report 741, p 25

163 Q 79

164 Q 285

165 Q 284

166 Q 285

reinforced by ensuring that all the supporting information from the claimant is available to the decision-maker at the time the decision is made. To facilitate this, it is important to ensure that claimants are able to submit medical reports, but GP charges for this service put it beyond the reach of some claimants. We recommend that the Government considers how to address the problem of charges acting as a barrier to the full range of medical information being available to decision-makers.

130. We congratulate the Department for the marked improvements in the decision-making process achieved during the trials in Burnley and Aberdeen. However, DWP's own research suggests that this new approach is very resource-intensive and may not be sustainable in the national roll-out. Nevertheless, it should remain a priority for the Department to ensure that it gets the decision-making right first time. We agree with the Government's assessment that investing resources in the decision-making process will provide savings in the medium and long-term through reducing the costs in appeals. An improved decision-making process will also help to increase claimants' trust in the process and enhance their sense that "procedural justice" has been delivered by allowing their case to be properly presented.

Reconsideration of decisions

131. If a claimant is dissatisfied with the outcome of the IB reassessment, they can do any or all of the following:

- ask for an explanation;
- ask for a written statement of the reasons for the decision;
- ask for the decision to be looked at again to see if it can be changed, pointing out that there may be some facts they think have been overlooked, or that they may have more information which affects the decision; and
- appeal against the decision.¹⁶⁷

132. DWP explained how the reconsideration option worked:

[The customer] can ask for an explanation and for the decision to be reconsidered. If a customer appeals this will also trigger the reconsideration process, as the Department aims to put decisions right at the earliest opportunity. A decision-maker will telephone the customer to see if there is any additional evidence the customer wishes to be taken into account, re-examine the original decision in the light of the customer's representations or additional evidence, and decide if the decision should be changed; legally this is known as a revision. If the decision is changed, the customer has the right of appeal against the new decision. If an appealed decision is revised in favour of the customer, the appeal will lapse and action is discontinued.¹⁶⁸

133. Jobcentre Plus conducted a pilot in Wrexham aimed at reducing the number of decisions being taken to appeal. The new approach involved direct telephone contact with

¹⁶⁷ Ev 75

¹⁶⁸ Ev 76, para 105

ESA customers, the so-called Touchpoint 13, to explain how the decision had been arrived at and to identify any other information that might be relevant to the decision.¹⁶⁹ Professor Harrington believed that “it would be nice to think that what happened in Wrexham last year would apply nationally. Wrexham found that they were spending more money on doing this, but they were saving an enormous amount of money on not going through the appeal system.”¹⁷⁰ DWP told us that this new stage has now “been built into the incapacity benefits reassessment process”.¹⁷¹

134. Sue Royston from CAB suggested that “It is not in anybody’s interest—DWP’s, the taxpayer’s or clients’—that appeals go on when they do not need to go forward. We are really pleased with that, but we are concerned that there is a chance that Touchpoint 13 may be used to persuade people that there is no point in appealing.”¹⁷²

135. The Welfare Reform Bill 2011, currently going through Parliament, makes provision for the power to require consideration of revision before appeal. The Explanatory Notes to the Bill state:

Although the claimant (or other person) could ask initially for the decision to be reconsidered with a view to revision [...] in practice many people do not do so and make an appeal from the outset. In order to resolve more disputes with claimants through the internal reconsideration process before an appeal to the tribunal is made, [provisions in the Bill would] enable the Secretary of State to make regulations setting out the cases or circumstances in which an appeal can be made only when the Secretary of State has considered whether to revise the decision.¹⁷³

Sue Royston from CAB said “We do not like that at all”:

At present, when somebody puts in an appeal, DWP has to reconsider that decision, so the reconsideration is there [...] what is being proposed is imposing two time limits on the client. The reconsideration would be done; the client would get the decision; and then they would have to put in an appeal again. They would have two time limits to meet. That seems to me very wrong. It is putting the onus on clients to do the thing twice.¹⁷⁴

136. The Papworth Trust welcomed the Government’s plans to make better use of the reconsideration process but believed that, at present, the Government does not track the reconsideration process and the subsequent outcomes: “without this tracking, we are unable to draw any conclusions as to whether a fall in the appeal rate is as a result of more correct decisions in the first place, or that the reconsideration process is simply a shortened version of the appeal process.”¹⁷⁵ ERSA argued that “There needs to be an onus on Jobcentre Plus officials using the reconsideration process effectively, thereby minimising

169 Ev 76, para 107

170 Q 235

171 Ev 76, para 107

172 Q 63

173 Explanatory Notes to the Welfare Reform Bill [Bill 154 (2010-12) –EN]

174 Q 62

175 Ev w72, para 20

the number of decisions going to appeal.” It stressed that providers do not want to see a “revolving door” situation “where people are referred to the Work Programme only to appeal and then leave”.¹⁷⁶

137. We welcome Professor Harrington’s recommendation on making more effective use of the reconsideration process. The trials in Burnley and Aberdeen have shown that claimants find the additional contact with the Department, and the opportunity to present further evidence in support of their claim, helpful. This should help to address the problem identified by Professor Harrington of new information appearing at the tribunal stage that was not available earlier in the process. However, we also request that the Government put in place processes to track outcomes for cases which have been through the revision process in order to ascertain whether this is producing speedier and accurate final decisions, to avoid potential adverse consequences both for the claimant and for Work Programme providers.

Appeals

138. As set out above, a claimant can take their case to appeal either immediately after being informed of the decision or if they remain dissatisfied after reconsideration. Appeals are dealt with by the Tribunals Service which is funded by the Ministry of Justice. The Tribunal will consider the appeal and the evidence submitted by the claimant and the Secretary of State, as well as taking oral evidence at a hearing.¹⁷⁷

139. Detailed information on the number and outcome of appeals is available only for new ESA claims as very few reassessment cases have yet been heard. The table below shows the monthly figures from the introduction of ESA to August 2009. During that period, around 40% of new ESA claimants appealed their decision. The percentage of successful appeals was also relatively high.

¹⁷⁶ Ev w109, para 3.1

¹⁷⁷ Ev 76, paras 109-112

Table 1: WCA Appeals heard on “Fit for Work” Decision: ESA claims to August 2009/Appeals heard by end of June 2010

Month ESA claim started	Fit for work	Appeals heard (to date)	% Fit for Work with an appeal heard (to date)	Decision in favour of appellant	% Decision in favour of appellant
Oct 2008	3,600	1,400	39	600	40
Nov 2008	17,500	7,000	40	2,700	39
Dec 2008	15,100	6,200	41	2,500	40
Jan 2009	20,900	8,500	40	3,400	40
Feb 2009	19,700	7,600	38	3,100	40
Mar 2009	23,300	8,700	37	3,500	40
Apr 2009	21,700	7,500	35	3,100	41
May 2009	21,900	6,900	32	2,700	40
Jun 2009	22,600	6,300	28	2,500	40
Jul 2009	22,700	5,500	24	2,100	37
Aug 2009	20,300	4,100	20	1,500	37
Total	209,200	69,500	33	27,500	40

140. Our colleagues on the Justice Select Committee recently highlighted the increasing number of social security appeals which are dealt with by the Tribunals Service. The number rose from 242,800 in 2008–09 to 370,000 in 2009–10 and was expected to rise to an estimated 370,000 in 2010–11 and 436,000 in 2011–12, mainly as a result of the introduction of ESA. The report pointed out that, in 34% of cases in Quarter 2 of 2010–11, the decision was made in favour of the appellant (although not all of these were ESA cases). The Committee believed that this demonstrated “a significant volume of incorrect decision-making on behalf of those tasked by DWP to make decisions about benefits”. DWP has funded the additional costs arising from ESA appeals and allocated £1.3 million for 2008–09; £9 million for 2009–10; and an estimated £21.1 million for 2010–11.¹⁷⁸

141. Tom Greatrex MP also highlighted the high cost of appeals to the public purse in his evidence to us: “the cost of WCA appeals between 1 May and 30 September 2010 was estimated to be £22.15m. If this is taken over the whole year, the annual cost to the taxpayer of WCA related appeals is around £50m.”¹⁷⁹

142. A number of submissions expressed concern that the pressure on the Tribunals Service had resulted in a significant wait for claimants before their appeals are heard. The Department referred to data which shows that the average time taken to clear or dispose of a case stood at 21.8 weeks:

Both the Department and the Ministry of Justice recognise the importance of reducing the time taken to process appeals which has been mainly caused by the

¹⁷⁸ Justice Committee, Third Report of Session 2010–11, *Government’s proposed reform of legal aid*, HC 681-I, paras 53–60

¹⁷⁹ Ev w111, para 10. This estimate is based on a reply to a parliamentary question: see HC Deb 15 February 2011, col 758w. The latest estimate of the cost of a completed appeal in the first-tier tribunal, based on 2009–10 data, is £282: see HC Deb 29 June 2011, col 795w

introduction of ESA which resulted in a large number of appeals being received above original forecasts. As a result, tribunals capacity was not then in place.¹⁸⁰

The Minister acknowledged that:

[...] there is and there has been a big backlog for some very considerable time in the appeals service [...] there has been a reduction in that backlog and they are gearing up capacity wise quite substantially, so effectively the Tribunals Service will have doubled its capacity between 2009 and 2012 in part to deal with the extra people who are being assessed as a result of the migration.¹⁸¹

However, he also conceded that keeping up with the increase in caseload “is certainly a challenge”.¹⁸²

143. CAB suggested that the number of appeals was likely to increase again in the next few years because of:

- the IB reassessment process
- the time limit of one year for contribution-based ESA for those in the WRAG
- the introduction of a large financial difference between the Support Group and WRAG, when the Welfare Reform Bill is enacted
- the introduction of face to face assessments for PIP.¹⁸³

The recent DWP report on the IB reassessment trials agreed that it was unlikely that appeal numbers would decrease. It found that awareness of the possibility of making an appeal was very high among customers and that:

Both Jobcentre Plus staff and HCPs said they often told customers they could appeal as a means of deflecting negative attitudes towards reassessment. In the context of the face-to-face WCA, HCPs were sometimes trying to ensure co-operation from unwilling customers within the limited time available for the assessment, and had found that telling customers that they could appeal if they did not like the outcome was an effective way of achieving this. Customers reported that Jobcentre Plus staff had advised them to appeal because their outcome did not look “right”, and this was corroborated by staff feedback.¹⁸⁴

144. The Minister acknowledged that “it is likely that an awful lot of people will appeal”. He said “I do not think it is going to be possible to reduce the number of appeals that are actually lodged.” Instead the Department is aiming “to reduce the number of appeals that

180 Ev 77, para 119

181 Q 310

182 Q 312

183 Ev 88. PIP is the Personal Independence Payment, the new benefit which will replace Disability Living Allowance.

184 DWP Research Report 741, p 35

are successful, and that could be done by making sure we take much better decisions right the way through the process”.¹⁸⁵

145. Professor Harrington stressed that the focus of his recommendations on decision-making was that “the decision should be got right first time, leading to fewer people appealing and more confidence in the initial decision” which would help reduce the number of appeals and the appeals success rate.¹⁸⁶ The Minister also highlighted that:

One of the things Professor Harrington found was that evidence was emerging at the tribunal that Jobcentre Plus had never seen. So one of the things we are seeking to do after the decision is taken, if somebody comes back and says “I am not happy”, is to say to them at that point very clearly “You can give us further evidence to take into account”.¹⁸⁷

146. **The high number of appeals for new ESA claims is a cause of concern. The estimated cost to the public purse is £50 million per annum. The pressure on the Tribunals Service has also resulted in a significant delay for claimants before appeals are heard, causing stress and anxiety for claimants and their families.**

147. **We welcome the Minister’s commitment to improving decision-making to ensure that fewer cases are overturned at tribunal. However, as the Minister rightly acknowledged, the volume of reassessment cases means that it is unlikely that the number of cases going to appeal will decrease significantly in the next few years. We welcome the Government’s acknowledgment of the importance of reducing the time taken to process appeals and we recommend that the available resources are kept under regular review. The tribunal system must be adequately equipped both to address the backlog and to provide an ongoing, efficient appeals service.**

Recalling claimants for WCA after appeals

148. A joint submission by mental health organisations expressed their concerns that clients who had won their appeals were being reassessed through the WCA within a very short time of the appeal decision:

We have been in touch with a claimant who was initially declared “fit for work”, but overturned this verdict at appeal. He was sent an ESA50 form within months of the appeal being settled, and has now been called for a further medical assessment. This is causing him great distress and could potentially impact on his health [...].¹⁸⁸

A number of claimants told us of similar experiences.¹⁸⁹ One woman wrote that “Each time I fail a WCA and have to go through the appeals process it knocks me back further from my goal of being fit enough to find work in the future.”¹⁹⁰ Another said it is “appalling that

185 Q 308

186 Harrington Review, p 29

187 Q 308

188 Ev 94

189 Ev w4 [Dr Sarah Campbell]; Ev w5 [Samantha Fulstow]

190 Ev w6 [Samantha Fulstow]

people who've gone through the appeals process and have had their original WCA overturned, then have to go through it all again, in a matter of weeks or months.”¹⁹¹

149. Professor Harrington recommended that the lesson-learning process should be improved: “feedback from the First-tier Tribunal should be routinely shared with Jobcentre Plus staff and Atos healthcare professionals. As part of their professional development, Jobcentre Plus decision-makers should be encouraged to attend Tribunals.”¹⁹² A joint response by mental health organisations agreed that, at present, there was no systematic method for decision-makers to learn from the outcome of Appeals Tribunals.¹⁹³

150. We put to Jobcentre Plus the concern that DWP was not represented at appeals, which risked the tribunal only hearing one side of the case. Karen Foulds from JCP confirmed that they would now ensure that for the “appeals that are going through from the trial we are having presenting officers, as we call them, there, to see what impact that has”.¹⁹⁴

151. It is not acceptable that some claimants have to go through the entire assessment process again shortly after their appeal without any of the information from the appeal being passed on to JCP and Atos Healthcare. This is a waste of resources and causes unnecessary stress and anxiety for claimants and their families.

152. We agree with Professor Harrington that it is important for the outcome of appeals to be fed back into the WCA system effectively, to avoid unnecessary future appeals. We also believe that when cases do go to appeal, it is important that the DWP case is properly presented. We recommend that DWP review whether JCP presenting officers should attend more tribunal cases in order to ensure both that this happens, and that information is fed back from the appeals process, thus promoting more effective learning of lessons by JCP.

191 Ev w36 [Jaki Tean]

192 Harrington Review, chapter 7, para 22

193 Ev 94, para 5.4

194 Q 313

6 Reassessment outcomes

Outcomes

153. The Department published interim results from the reassessment trial on 1 April 2011. As of 22 March, 1,626 decisions on whether a customer's claim qualified for conversion to ESA had been made. Of these:

- 38% (616 individuals) were placed in the WRAG
- 30% (484 individuals) were placed in the Support Group
- 32% (526 individuals) were found fit for work and not entitled to ESA.¹⁹⁵

It should be noted that these figures do not take account of the outcome of appeals which, as we have discussed above, have previously had a 40% success rate.

154. The Papworth Trust pointed out that, at the start of the reassessment process, the Government had estimated that:

- 65% of claimants would be placed in the WRAG
- 20% would be placed in the Support Group
- 15% would be found fit for work.¹⁹⁶

The Government welcomed more people being found fit for work than it had originally estimated.¹⁹⁷ However, the Papworth Trust was concerned at how different the predictions were from the outturn:

We are concerned that vulnerable people are being wrongly assessed as fit for work, and what the legacy holds for those people subsequently placed onto Job Seekers Allowance (JSA) on reduced incomes and with less support to find employment. In our experience, simply reducing benefits does not help the hardest to reach to find work; instead tailored support is required to help them into employment.¹⁹⁸

155. Professor Harrington believed that the number found fit for work was “surprisingly high”.¹⁹⁹ However, he stressed that this was likely to change with improvements in decision-making:

I think one of the things that will happen—to the fit-for-work, the work-related activity group and the support group—if we get the decision right, meaning similar to the way in which the judges have changed it, is that you will probably find fewer

¹⁹⁵ Ev 78, para 122

¹⁹⁶ Ev w71, para 7

¹⁹⁷ “Grayling: initial reassessments of those on IB in Aberdeen and Burnley show large numbers of claimants with the potential to return to work”, DWP Press Release, 10 February 2011.

¹⁹⁸ Ev w71, para 9

¹⁹⁹ Q 218

people in the fit-for-work group and more in the WRAG, and possibly more in the support group because that is what is happening where the appeals are upheld by the judges. If, as I keep saying, the decision-makers have the same information available to them, at least in 40% of these cases, my suggestion is that they will probably come to the same conclusion [...].²⁰⁰

156. The Minister stressed that implementation of the Harrington changes and those resulting from the trials meant that “we genuinely do not know” what the outcomes were likely to be: “where we end up in terms of the final numbers will really only become apparent in a few months’ time”.²⁰¹ However, he also expected to see “a fairly consistent pattern all the way through the migration”.²⁰²

157. A number of submissions from individuals indicated a degree of suspicion about the consistent patterns in assessment outcomes. One witness said that:

[...] the drive to reform IB has led to implicit targets for caseload reduction, with expected savings of £1bn over five years, even though the Government denies that there are targets. [...] Any policy that starts with targets for reducing a benefit is not based on compassion or a desire to help, but on an attempt to save money.²⁰³

When we put these suggestions to the Minister, he made clear that: “I am not aware [...] of any attempt anywhere in Jobcentre Plus to impose any targets around the categorisation of this, and I would not tolerate it for a second if I discovered that was the case.”²⁰⁴ Karen Foulds from JCP added that “The only benchmark we have is a benchmark for the number of decisions that we would expect decision-makers to be able to deal with. So we have planning assumptions but not [for] any of the outcomes from them.”²⁰⁵

The impact of the decision to time-limit contribution-based ESA

158. There are two types of Employment and Support Allowance; contributory and income-related. Contributory ESA is paid if the claimant satisfies the national insurance (NI) conditions. This type of ESA is not means-tested, although it is possible to receive contributory ESA topped-up with income-related ESA. Income-related ESA is paid if the claimant passes the means test, which is based on household income and capital. There is no requirement to satisfy the NI conditions.²⁰⁶

159. In October, the Chancellor set out the intention to introduce a time limit of one year for those claiming contributory ESA who are placed in the WRAG. The change requires primary legislation and is included in the Welfare Reform Bill. Subject to Parliamentary approval, the proposals are that:

200 Q 219

201 Q 322

202 Q 332

203 Ev w81, para 12 [Rhydian Fon James]

204 Q 329

205 Q 330

206 CPAG, *Welfare benefits and tax credits handbook*, 2011/2012

- customers in receipt of incapacity benefits who are reassessed and qualify for contributory ESA before April 2012 will have their benefit time limited, with the 12-month period running from the point of conversion. As with existing claims, the period of time already spent on contributory ESA before April 2012 will be taken into account in calculating the 1 year period; and
- those who are in receipt of incapacity benefits and are reassessed and qualify for contributory ESA after April 2012 will also receive 12 months benefit from the point of conversion.²⁰⁷

160. In a written answer, DWP provided the following table which sets out the annual savings which it expects to arise from a range of time limits, including the 12 months proposed in the Bill.²⁰⁸

Table 2: Estimated savings arising from introducing time limits on contributory ESA

Scenario	Savings £ million			
	2011–12	2012–13	2013–14	2014–15
Welfare Reform Bill: 1 year time limit	0	400	800	1,100
6 month time limit	0	700	1,050	1,400
2 year time limit	0	150	350	650
3 year time limit	0	50	150	300
4 year time limit	0	0	50	100

The next table shows the estimated number of future recipients of contributory ESA in the Work Related Activity Group and Assessment Phase with and without time-limiting in force.²⁰⁹

Table 3: Estimated number of recipients of contributory ESA

Contributory ESA caseload in the WRAG/Assessment Phase	With time limiting in force	Without time limiting in force
2011–12	400,000	400,000
2012–13	350,000	600,000
2013–14	400,000	800,000
2014–15	350,000	900,000
2015–16	200,000	900,000

DWP also indicated that “it is estimated that in steady state, without time-limiting, around 77% of contributory ESA claimants in the WRAG or Assessment Phase would have duration of 12 months or more.”²¹⁰

207 Ev 78, para 126

208 HC Deb, 28 April 2011, 534W. The answer explained that “The savings include reductions to expenditure on contributory ESA net of expected costs to income-related ESA and other DWP administered benefits and are measured against a baseline forecast of the contributory ESA expenditure without time limiting.”

209 HC Deb, 3 May 2011, 722W. The answer explained that “Assessment Phase cases have been included as the legislation intends for them to be eligible for time-limiting if their duration on contributory ESA is 12 months or more. Figures have been rounded to the nearest 50,000 claimants and are based on Budget 2011 forecasts.”

210 HC Deb 3 May 2011, cols 723-4w

161. Citizens Advice Scotland highlighted that:

Around 700,000 people in the UK will be affected by the change by 2015–16—around 280,000 would lose entitlement to ESA after 12 months. [...] Research undertaken for the DWP found that 31% of claimants in the WRAG group did not expect to ever return to work. Assuming that the figures from the pilot in Aberdeen and Burnley apply to the rest of the country—30% fit for work; 39% placed in the WRAG group—then the [...] figures would suggest that 30% of claimants would be moved off sickness benefit after their assessment and a further 12% moved off ESA after 12 months.²¹¹

162. CAB is currently conducting a survey on its website, of people who are claiming contribution-based ESA in the WRAG group, and who have a partner who works, or who have savings over £16,000 (which would mean that they were ineligible for income-based ESA). It reports that:

One very clear message already coming through, is that people feel betrayed because, after working for many years and paying their contributions, the system will not help them when they need it. Some respondents with mental health problems express their feelings of hopelessness if their benefit stops, and some say that they will end their lives.²¹²

163. The Minister defended the proposal by stressing that the Government is applying to ESA the same principles that apply to JSA in terms of the contributory element:

We pay something back in recognition of the fact you have yourself paid in, but we only allow you to draw for a period of time. With ESA, regardless of your means, you can draw benefits indefinitely and regardless of your household income, and amongst the tough decisions we have had to take to deal with the deficit challenge that we face, one of them has been to say “We actually need to apply the same principle to ESA as we do to JSA”.²¹³

164. However, a number of witnesses argued that ESA claimants face a different situation compared to JSA claimants due to their health condition and employer discrimination against former claimants with long-term health conditions. NAT gave the example of how this might affect people with HIV:

Physical and mental health problems related to HIV do not come with a time limit [...] HIV remains a stigmatised condition in the UK, so people living with HIV still face social, as well as health-related, barriers to work. Research shows that unemployment among people living with HIV may be as high as 50%. One in five people living with HIV who are in work have experienced discrimination in either their previous or current job.²¹⁴

211 Ev w31, para 23

212 Ev 89

213 Q 333

214 Ev w19

165. The Middlesbrough Welfare Rights Unit argued that “Statistically disabled people remain out of work for longer than those that are able bodied, those that have been out of work for more than two years are statistically unlikely to find work unless they receive a substantial amount of help.”²¹⁵ A submission from an individual emphasised:

I understand why ministers think this will work. Evidence shows that those who are off work for more than a year are less likely to return to work at all. What no-one seems to consider is that those who stay off work for more than a year are likely to be those very people with the most severe long term conditions. [...] Very high percentages of those with long term conditions are being found capable of some work and therefore placed in the WRAG group, yet their conditions are often degenerative, painful, distressing and limiting.²¹⁶

166. The Careers Development Group, an employment provider, explained the possible impact of the time-limit on employment support under the Work Programme:

[The proposals] could lead to customers moving from the ESA Flow Work Programme customer group and into one of the JSA customer groups. This changes the payment received by the provider for the customer, which could potentially affect the level of support providers could offer the customer. In addition, many of the Pathways to Work customers the charity works with who have more complex health needs, for example those with multiple sclerosis, potentially need longer than one year to move into employment.²¹⁷

167. We asked the Minister what assessment the Department had made of the potential impact of the proposals on this group. He told us:

We expect around 40% of them to move straight to income-based ESA because of their financial circumstances. We expect around another 20% to receive some element of income-based ESA, and we expect another 40% not to require ESA at all.²¹⁸

In response to a parliamentary question on the proportion of ESA claimants placed in the WRAG who leave the benefit and move into work within a year, the Department responded that “The information requested on those leaving employment support allowance (ESA) and moving into work is not available.”²¹⁹ Nor does the Department appear to collect information on the numbers of new ESA claimants who were placed in the WRAG and the Support Group in specific months in 2009.²²⁰ However, DWP’s impact assessment suggests that a high proportion of claimants are currently on the benefit for longer than a year: “It is estimated that around 90 per cent of contributory ESA customers

215 Ev w49

216 Ev w100 [Susan Marsh]

217 Ev 85, para 33. Pathways to Work was a national back-to-work programme available to all incapacity benefit and ESA claimants. The programme ended in April 2011 and has been replaced by the Work Programme.

218 Q 335

219 HC Deb, 17 March 2011; Vol. 525, c. 572W

220 HC Deb, 26 April 2011; Vol. 527, c. 232W

of duration greater than 3 months and in the Work-Related Activity Group will be affected by a one-year time limit.”²²¹

168. **The Government’s argument for time-limiting contribution-based ESA to 12 months is a result of tough decisions about the budget deficit and also to put it on an equal footing with Jobseeker’s Allowance. It is true that the huge majority of JSA claimants move into employment within a year. However, we know that the JSA demographic of mainly young, male claimants with previous work experience is different to the ESA demographic, who may find it much harder to move into employment even though they may have done everything required of them to find work.**

169. **Nor does it appear that the Government has the data available to make an evidence-based decision on the appropriate length of time for which contributory ESA should be payable in order to support its objective of moving claimants into employment. We recommend that the Department conducts research on whether allowing former IB recipients to claim contributory ESA for more than 12 months would provide a more realistic timeframe for them to enter employment, taking account of the two years of employment support available through the Work Programme. The research should also include an assessment of the costs of such a change. The Government should adjust its policy accordingly if the need for change is borne out by the research.**

Claims withdrawn before completing the assessment process

170. The Papworth Trust states that it is “increasingly puzzled at the significant proportion (37%) of people who close their claim before the assessment process has ended.” It adds that it is “concerned about those who may have become frustrated by the system and simply given up, excluding themselves from appropriate support”.²²² Other witnesses were similarly unsure why the percentage of claims withdrawn before completion of the WCA was so high. Rethink said that there was no tracking of such claimants but that it was important to find out the reasons why people were dropping out:

The honest answer is that we just do not know. We have no research evidence on this; we do not have anybody tracking. I think it is very important that, because we do not know, we do not jump to conclusions about what is happening with those people. Certainly some of our members do tell us that they feel so ill and traumatised by the whole process that they do not feel able to go to the assessment, and that is why they drop out.²²³

CAB thought that one of the main reasons that people dropped their claim could simply be because their condition improved, but believed that tracking people was important.²²⁴

221 DWP Impact Assessment, *Time limit Contributory ESA to one year for those in the WRAG*, February 2011

222 Ev w71

223 Q 17

224 Q 16

171. The Minister agreed that this high withdrawal rate “is a concern” and “something that we are researching and will be researching”.²²⁵ He acknowledged that “we do need to be careful about this” and made clear that the process was “not about creating a situation where people just drop out of the system and disappear into obscure poverty”.²²⁶ DWP research carried out last year surveyed people who had made an initial claim for ESA in April to June 2009. This found that around a quarter (26%) at the baseline survey and 29% at the follow-up of the closed/withdrawn group had an unknown destination.²²⁷ DWP told us that it is conducting further research on the reasons why people end a claim for ESA, which will be available in July.²²⁸

172. We share the Minister’s concern about the high rate of claimants who withdraw from the assessment process before completion. It is important that the Government understands the reasons for this and gains a greater understanding of the destination of these people, to ensure that no one is left without appropriate support.

Tracking of claimants

173. Professor Paul Gregg argued that:

[...] it is clearly essential to track the progress of those denied access to the new benefit, especially among those previously claiming Incapacity Benefits, to study what is happening to them. Are they moving to JSA, getting jobs or suffering acute deprivation without any financial support? By tracking people according to what conditions they are presenting with, we can assess which conditions are not being picked up well, if groups fail to move into work. But again no such research or tracking is apparently being undertaken.²²⁹

174. The Department made the point that “Information on claimants’ destinations is particularly thin because it is presently too early in the process. For ESA claims the Department does not get reliable information about destinations until a few months after the decision.”²³⁰ However, Professor Gregg suggested that tracking of different categories of claimant could be achieved quite simply:

The DWP people who run the administrative system can or should be able to, with a little bit of a lag, tell you where people who have had decisions made around their ESA status are now in the welfare system. If you also go on to include whether they are in receipt of National Insurance payments and so on, which is available within the tracking system, you can see essentially whether somebody is working, you can see whether they are claiming other benefits or if they are just not within the system at all now—i.e. they are not in work or in benefits. It is not that hard; it would require an IT investment and some dedicated staff, but I feel there ought to be a

225 Q 324

226 Q 327

227 DWP, *Employment and Support Allowance: Findings from a follow-up survey with customers*, Research Report No. 745, 2011, p 36

228 Q 327

229 Ev 90

230 Ev 78, para 124

routine reporting system for people like Professor Harrington to be able to use to see where people have gone.

175. The Minister assured us that “we will do a lot of tracking”:

[claimants] who came from Incapacity Benefit are a discrete group within the Work Programme and so therefore we will certainly monitor very carefully what happens to them. We will understand if there are differences in the work placement rates between that group and others, how great those differences are and then we will carry out detailed research on a number of the groups post the WCA.²³¹

176. We strongly believe that the success of the IB reassessment is dependent on its effectiveness in helping people with disabilities and long-term health conditions into employment. In order to understand whether the assessment process is achieving this, the Government needs to track the destination of all claimants. We recommend that tracking includes categorising claimants on the basis of the health condition they presented with, to establish how different groups fare in terms of getting into sustained employment. It should also include recording the number of claimants who are initially allocated to the wrong group and have to be moved at a later date.

177. The trials in Aberdeen and Burnley would have provided an ideal opportunity to begin this form of tracking, from assessment to employment outcomes. We believe it is regrettable that steps were not taken to ensure tracking was in place for this first cohort. However, we believe that it is not too late to do this and recommend that the Government begins tracking outcomes for the reassessment trial cohort without further delay.

7 Employment support for ESA claimants

Support under the Work Programme

178. As we have set out, the Government's main objective for the IB reassessment is to help long-term claimants move back into work. In this chapter we will explore the employment support which is available to the various groups of claimants, based on their reassessment outcome.

179. Most of the employment support will be provided through the Government's new unified welfare-to-work scheme, the Work Programme, which was launched in June. We reported on the contracting arrangements under which the Work Programme will operate in May.²³² Employment support will be provided by prime providers from the private, public and voluntary sector. These providers will use the skills of a range of sub-contractors to ensure specialist support is available to the wide range of users.

Incentive structure for employment providers

180. Research from the Centre for Social and Economic Inclusion (Inclusion) predicts that a very large proportion (78%) of customers in the Work Programme in 2014 will have previously claimed ESA or IB.

181. The Work Programme has been designed to take account of the particular needs of claimants who have been through the IB reassessment process. Separate Work Programme entry points have been established for: JSA claimants who have been found fit for work under the ESA migration; those entitled to contributory ESA who are placed in the WRAG; those in the WRAG entitled to income-related ESA; and ESA claimants in the Support Group and IB claimants awaiting reassessment who volunteer for the Work Programme. Providers will be remunerated under a differential payments system, based on the benefit a user is claiming when they enter the Programme, which will mean that ex-IB claimants attract the highest level of funding.²³³

182. Professor Gregg argued that allocating claimants to the right benefit matters greatly in terms of the employment support available to them under the Work Programme.²³⁴ The Minister agreed that "it would not be right to reassess people and then say, 'Right; you are on your own'. It is all about making sure that there is proper specialist support available to help them into work." He emphasised that "the outcome price for the JSA ex-IB group is 50% higher, and [...] for those who are mandated from ESA onto the Work Programme, the tariff is almost £14,000 to get them into work. That is really important."²³⁵

183. The Papworth Trust supported the principles behind the Work Programme, that "with the right support, those people who are fit and able to work should have the necessary requirements placed on them to actively engage in work". However, it

232 Fourth Report of Session 2010-12, *Work Programme: providers and contracting arrangements*, HC 718

233 For more details see Fourth Report on Session 2010-12, HC 718, Chapter 4.

234 Ev 89-90

235 Q 340

emphasised the importance of getting the reassessment decision right: “for those people found wrongly fit for work under the WCA, they will receive a third to two-thirds less support to find and retain work under the Work Programme payment structure, which is extremely concerning.”²³⁶ The Careers Development Group echoed this view:

If WCA does not lead to the correct decision being made regarding a customer’s readiness for employment, prime providers may not be in the best position to provide the required level of support because of financial restrictions in the Work Programme payment structure.²³⁷

Advanced Personnel Management (APM), a private sector company which provides the Australian equivalent of the WCA, recommended that:

[...] referral pathways are separated from income determination decisions. This will help to ensure that customers are matched to the employment service provider that best meets their needs and to be able to commence with the most appropriate service provider with minimal delay.²³⁸

A4e, an employment provider, agreed that the Department should “maximise the opportunities that will be available through the Work Programme” by ensuring that eligibility for services was dependent “on need rather than benefit status”.²³⁹ A recent report by Inclusion also highlighted that the introduction of Universal Credit “will inevitably require a revised customer grouping system (as it will no longer be possible to base eligibility for the Work Programme on eligibility for different benefits once they are replaced)”.²⁴⁰

184. The measure of success of both the Work Programme and the IB reassessment will be the proportion of people helped to move from benefits into employment. Recent research suggests that a very large proportion of customers in the Work Programme by 2014 will have previously claimed ESA or IB. This highlights the challenge for the Work Programme and the need to ensure that the WCA is effective in allocating claimants to the differentiated groups within the Programme. Until the introduction of Universal Credit, claimants will be assigned to the groups within the Work Programme based on the benefit they are claiming. This reinforces the importance of ensuring that claimants are allocated to the correct benefit in the IB reassessment process.

185. It is too early to assess whether the current grouping and incentive structure under the Work Programme will be effective in leading to employment outcomes for former IB claimants. We reiterate the recommendation in our recent report on the Work Programme: that the Government keep the payment model under review and assess the outcome for participants within and between each client group. This review should be carried out by an independent panel and repeated on a regular basis.

236 Ev w72, para 22

237 Ev 84, para 30

238 Ev w108

239 Ev w68, para 8.3

240 Inclusion, *Opening up work for all: The role of assessment in the Work Programme*, June 2011, p 35

Back-to-work support for customers moving onto ESA

186. The Department states that the majority of ESA customers who want the more intensive support offered by the Work Programme will be able to access it as soon as they are placed in the WRAG or Support Group. Contributory ESA customers will be able to volunteer for the Work Programme and, if they wish, remain on the Programme after their contributory benefit has come to an end.²⁴¹

187. Most ESA customers in the WRAG who do not access the Work Programme will be expected to prepare for a return to work with support from Jobcentre Plus. The Department suggested that those with greater disability-related barriers to work may be referred to Work Choice, if mainstream support is not appropriate for them. Work Choice helps people with more severe disabilities or complex needs to prepare for work and to undertake supported employment, with the aim of progressing into unsupported employment where possible.²⁴² Subject to the passage of secondary legislation, from June 2011 JCP advisers will be able to require customers in the ESA WRAG, with some exceptions, to undertake work related activity to prepare for a return to work.²⁴³

188. Witnesses pointed out that some people with a limited life expectancy are placed in the WRAG. Sue Royston from CAB explained that:

[...] people who have a life limiting condition—say something where they have been given a prognosis of three or four years—are not put in the Support Group. They would go to a functional assessment. If their function was such that it was found that they had enough points, they would be in the Work-Related Group.²⁴⁴

189. We support the Government’s view that claimants in the WRAG should undertake work-related activity to prepare for a return to employment. However, it is important that decision-makers have discretion to apply exceptions to this requirement, where appropriate. One group of claimants which needs to be treated with sensitivity is those with a limited life expectancy. We recommend that decision-makers should be able to exercise discretion, on the basis of the claimant’s own medical questionnaire, to place these claimants in the Support Group, where appropriate.

Back-to-work support for customers found fit for work

190. The Government recognises that former incapacity benefits claimants who are found fit for work and choose to claim JSA may need extra support to find work compared to a typical JSA claimant, particularly at a time when unemployment remains high following the recession. Customers who move from incapacity benefits on to JSA will therefore be able to access the Work Programme from three months into their claim, “in recognition of the additional challenges that may be faced by jobseekers who have been away from the

241 Ev 78, para 129

242 Ev 78, para 130

243 Ev 78, para 132

244 Q 43

labour market for a long time”. They will also receive personalised support from Jobcentre Plus before their Work Programme referral.²⁴⁵

191. It should be borne in mind that, although a claimant may be found “fully fit for work” and moved on to JSA, they may still have scored 12 points in the WCA and have a health condition which continues to have a significant impact on them. In this respect, they will not be very different from someone who scored 15 points and was found to have a limited capability for work. There may also be claimants who have been found fit for work in the WCA while their GP is still signing them off work on the grounds of ill health.

192. The Department emphasised that, although customers on JSA must actively seek work and be available for work, the requirement may be tailored to individual circumstances, for example a limit of a certain number of hours, to take account of a health condition or caring responsibilities.²⁴⁶

Claimant engagement with providers

193. ERSAs highlighted its concern about the possible implications of claimants who are dissatisfied with the outcome of their reassessment entering the Work Programme:

The move from one type of benefit to another (potentially lower level benefit) will not be fully understood by the individual and this will mean that the first few sessions spent by the customer with a personal adviser on the Work Programme will need to concentrate on the implications of this benefit change. Many claimants will also feel aggrieved by the decision which will create additional pressures on advisers.²⁴⁷

The Papworth Trust agreed that “clients simply will not engage in employment programmes whilst they believe they have been placed on the wrong benefit”.²⁴⁸ This was echoed by the Careers Development Group: its experience of the Pathways to Work contract showed that, where customers believed they had not been allocated to the correct benefit, CDG had been required to provide “considerable additional support to overcome the resultant emotional issues encountered by customers”.²⁴⁹ Evidence from a number of individuals supported this view. One individual wrote:

I now fall into the category of those who need support in returning to work. Against all advice I am looking for a job because I feel very pressurised into doing so. Despite the fact that you are told in “work focused interviews” that you do not have to look for work if you are not ready, the underlying message is still the same, that you are a waste of resources because a doctor who cannot get a job in a normal practice or hospital has said you are fit to work.²⁵⁰

245 Ev 79, para 134

246 Ev 79, para 135

247 Ev w110, para 5.3

248 Ev w73, para 23

249 Ev 85, para 31

250 Ev w16 [Sarah Ross]

194. Inclusion found that “while the Work Capability Assessment can identify those who are ‘fit for work’, in many cases it will not give providers of welfare to work services and personal advisers the information they need to support everyone into employment”.²⁵¹ APM suggested that:

A greater amount of time needs to be allocated to the process to allow for maximum engagement of clients at this critical early stage. The additional time would be used to link clients to the appropriate employment service providers and source additional information from treating doctors and other medical professionals as required.²⁵²

ERSA highlighted the importance of joining up the WCA to the Work Programme:

The Government should consider (a) how information from the WCA can help providers in their delivery of the Work Programme; (b) how Jobcentre Plus can help communicate the changes to customers before referral to the Work Programme; and (c) consider the merits of a re-referral process.²⁵³

195. Evidence shows that the accurate assessment of disabled people’s employability and needs in the workplace is crucial in gaining their trust and engagement, and through this achieving employment outcomes. The Government should consider how information from the WCA can help Work Programme providers to identify the employability needs of customers.

Employer attitudes

196. A number of witnesses argued that the Department needed to recognise the additional barriers that people with disabilities face in returning to employment. Liz Sayce’s independent review for DWP of disability employment support referred to recent research which estimated that over 300,000 people move from work to incapacity benefits each year through ill health, when in some cases they could stay in work. She found that some employers were fearful of taking the “risk” of retaining or employing people with disabilities or health conditions.²⁵⁴

197. One individual agreed with the Department’s policy to “focus on people’s abilities, and not on their disabilities” but suggested that:

[...] there is a difference between what should be happening in an ideal world and what actually is happening. Unfortunately, we live in the kind of world where people with certain types of impairments are not employable in the mainstream job market; in particular, employers are generally not willing or able to accommodate the needs of those suffering from chronic, fluctuating illnesses [...] it is much easier to deal with an individual’s (supposed) deficiencies than to tackle socio-structural barriers,

251 Inclusion Press Release “Without the right assessment, guidance and support employment will remain closed for some, says think tank”, 9 June 2011 (for release of report on *Opening up work for all: The role of assessment in the Work Programme*).

252 Ev w108

253 Ev w109

254 DWP, *Getting in, staying in and getting on: disability employment support fit for the future*, A review to Government by Liz Sayce, Cm 8081, June 2011, p 80

make radical changes to working practices, or influence employers' attitudes, but social policy should be based on reality and not on wishful thinking.²⁵⁵

198. The Muscular Dystrophy Campaign's Trailblazers Young Campaigners Network is a group of young people with neuromuscular conditions campaigning for social inclusion for people with disabilities. Their report, *Right to Work*, found that there was a severe lack of appropriate employment opportunities for people with disabilities, who also faced a poor understanding of disability among employers.²⁵⁶ The Papworth Trust stated that its own experience showed that:

A major barrier for our clients is that employers often seek "ready-made" employees who are proficient in their role with minimum training, support, cost or perceived risk to the employer. Extra support or training is viewed as inconvenient, time consuming and costly.²⁵⁷

199. Roy O'Shaughnessy from the Careers Development Group suggested that "As long as there is a job fit and the person is accurately assessed that they can go into that opportunity, the employer is more than willing for that person to be considered." However, he also noted that:

[...] many of the mental health issues of individuals coming in make the employers more reluctant. Over the next 12 to 18 months, we will be tested quite heavily with our employers as to how we really are able to help those individuals coming off Incapacity Benefit and into the jobs that are available. That will probably be the biggest challenge for us and other organisations.²⁵⁸

Jane Harris from Rethink pointed out that:

One of the things that we did not think that Pathways addressed enough—and DWP's research on the experience of people with mental health conditions through Pathways suggests this—is that stigma is still a real issue. [...] We do think it is important that there are some attitudinal interventions as well as individual interventions. That is one of the fundamental issues. If the Work Programme is not going to repeat some of the mistakes of Pathways, it is essential that there are interventions to deal with that.²⁵⁹

200. Professor Gregg believed that "The onus is very much on the providers to be doing the kind of groundwork of relationship building with employers in order to get that trusted relationship: 'We believe this person can do the job and they can be taken on'." However, he added that "there are things that the Government can be doing about wider change of attitudes, [...] to get messages from employers out there to say that this is worth supporting, which individual providers cannot do, because they are too small".²⁶⁰

255 Ev w46 [Elina Rigler]

256 Ev w55, para 9

257 Ev w71, para 6

258 Q 77

259 Q 77

260 Q 77

201. In almost all of the discussion of the Government's plans, the emphasis is on getting the claimant ready to go back to work. However, the Government will only achieve this laudable aim if employers are willing to employ someone who might have been on incapacity benefit and out of work for some time and who might still have substantial health issues. This will require a great deal of co-operation and change of attitude from many employers. Providers of employment support have a crucial role to play in building relationships with employers so that they can gain trust and an understanding of the challenges and benefits of employing former benefit claimants. However, it is also the Government's responsibility to engage in changing attitudes and spreading good practice amongst employers. The Government must pay as much attention to this side of the "back to work" equation as it does to getting the claimant "work ready".

8 Conclusion

202. The Government's aim of helping people with disabilities and long-term health conditions into employment is laudable but the scale of the challenge should not be underestimated. We know that a very large proportion of people who will be in the Work Programme will have previously claimed incapacity benefits or Employment and Support Allowance. For the Government to succeed in its objectives for the reassessment and the Work Programme it is therefore critical that it effectively links up the findings of the Work Capability Assessment with the support available under the Work Programme.

203. It is important for claimants, Work Programme providers and the overall efficiency of the system that the decision on whether an individual is fit for and capable of work is accurate the first time it is made. Our central conclusion is that the assessment process, as it is designed at the moment, does not accurately assess claimants' employability and needs in the workplace.

204. The current approach of using the benefit claimed as a proxy for the needs of a client is not sufficient in determining appropriate employment support. It is also the cause of much of the confusion and anxiety amongst claimants who do not understand whether the WCA is for the purpose of determining eligibility for a benefit or capability for work. At the moment, by trying to do a bit of both, it is not achieving either effectively.

205. The Government and Work Programme providers will need to communicate effectively and regularly about whether the WCA is accurately assessing employability. This information can then be used to inform the levels of support for future Work Programme contracts and will support the introduction of the Universal Credit in due course.

Conclusions and recommendations

The Government's policy objectives for the IB reassessment

1. We support the Government's objectives of helping people with disabilities and long-term health conditions to move back into work, whilst continuing to provide adequate support for people who have limited capability for work or are unable to work. However, the scale of the challenge should not be underestimated and nor should the level of anxiety which currently surrounds the process. A suspicion persists that the only objective of the Government is to save money. The Government must be proactive in explaining its aims and spreading the positive messages about the benefits of work and the support which is available to find work, and in engaging employers. It is vital that the Government's objectives are firmly supported by the reassessment process, and by the WCA in particular, but at the moment we are not completely convinced that it does this. Our report focuses on the changes we would like to see to help ensure that this happens in practice. (Paragraph 18)

Improving communication of the Government's objectives

2. The Government needs to develop its communications strategy for the IB reassessment in a way which ensures clarity and minimises anxiety. Providing claimants with the right level of information at the time that is appropriate for each individual forms an important part of this, bearing in mind that the reassessment process as a whole will last three years. It also requires the Government to be clearer about what the word "support" means in the context of Employment and Support Allowance. Currently it is used to describe employment support on the one hand and financial support through benefits for those who cannot work on the other. These two different meanings in the context of one benefit can be very confusing. (Paragraph 31)
3. The message which the Government sends to claimants involved in the reassessment process should be clear and simple: if the assessment process correctly finds someone fit for work, that is a successful and desirable outcome. However, we believe that the Government also needs to take greater steps to reassure claimants. It needs to explain that being found "fit for work" does not equate to denial or disbelief about the existence of an illness or health condition: rather the condition is acknowledged but its impact has been assessed as not being so serious as to prevent the person from returning to work at some point in the future. (Paragraph 34)
4. We believe that the language currently used to describe the outcome of the WCA is a barrier to the Government's objectives for the reassessment being properly communicated. The idea that a claimant has "failed" the assessment if they are found fully capable of work risks negating the positive messages which the Government is trying to convey. It needs to be addressed across the board and to include all communications between claimants and DWP staff, especially Jobcentre Plus staff who tell claimants the outcome of the process, and Atos Healthcare employees who may explain the process to claimants. We also believe that the communications need

to explain clearly and at every stage of the process that, where someone is found not fit for work, they will be eligible to receive ESA at the support rate. (Paragraph 35)

Media coverage

5. Sections of the media routinely use pejorative language, such as “work-shy” or “scrounger”, when referring to incapacity benefit claimants. We strongly deprecate this and believe that it is irresponsible and inaccurate. The duty on the state to provide adequate support through the benefits system for people who are unable to work because of a serious health condition or illness is a fundamental principle of British society. Portraying the reassessment of incapacity benefit claimants as some sort of scheme to “weed out benefit cheats” shows a fundamental misunderstanding of the Government’s objectives. (Paragraph 40)
6. Whilst fully accepting that the Government, and this Committee, have no role in determining the nature and content of media coverage, we believe that more care is needed in the way the Government engages with the media and in particular the way in which it releases and provides its commentary on official statistics on the IB reassessment. In the end, the media will choose its own angle, but the Government should take great care with the language it itself uses and take all possible steps to ensure that context is provided when information about IB claimants found fit for work is released, so that unhelpful and inaccurate stories can be shown to have no basis. (Paragraph 41)

Role of representative organisations

7. We agree with the Minister’s view that organisations which represent benefit claimants may sometimes face a conflict in being both advocates for the people they represent and key players in helping to design and implement the reassessment process. We believe that these organisations could contribute enormously to allaying the concerns about reassessment by giving equal weight to publicising the opportunities an effective assessment process could offer, and the back-to-work support available from Government, as they do to fulfilling their important role in raising legitimate concerns. We also consider that this would help reassure potential employers and thereby reduce the risk of stigma and discrimination. (Paragraph 45)

The Work Capability Assessment—claimants’ experience and Atos Healthcare

8. Atos acknowledged that its call-centres had experienced significant problems in the past. We welcome the assurance that this has been addressed to ensure that waiting times are significantly reduced and most calls are picked up first time. We expect call statistics to be maintained and published to demonstrate that progress is being made and sustained. However, claimants are still unable to contact the assessment centre they are due to attend directly, and we believe they should be able to do so, even if calls are routed through the call-centre. (Paragraph 55)
9. Atos routinely overbooks WCA appointments by 20% on the basis of the non-attendance rate for new ESA claims, which was 30%. However, the non-attendance

rate in the IB reassessment trials was much lower, at around 9%, although it is too soon to say whether this low rate seen in the trials will continue in the national roll-out. We recommend that Atos reviews its overbooking policy as a matter of urgency, to take account of this much higher attendance rate by IB claimants, to ensure that people are not turned away from assessment centres without being seen. Atos should also continue to monitor and adjust its overbooking policy as necessary. (Paragraph 58)

10. Instances have occurred where vulnerable claimants have had their benefit stopped as a sanction for non-attendance at a WCA appointment when the non-attendance arose because of administrative errors on the part of Atos or JCP, or because the claimant was too ill to attend but was unable to get in touch with Atos to inform them of this. We agree with the Minister that this is unacceptable. We recommend that DWP and Atos Healthcare jointly review the processes for recording non-attendance and change them where necessary to ensure that claimants are not sanctioned for “failure to attend” when the failure is on the part of Atos Healthcare and/or Jobcentre Plus. (Paragraph 63)
11. We believe that Jobcentre Plus should be more proactive in establishing the reasons for non-attendance at WCAs, including by following up with a phone call as soon as is practical after an appointment has been missed. (Paragraph 66)
12. It is unacceptable that disabled people should be called to attend an assessment at a centre which is inappropriately located, inaccessible to them or where reasonable adjustments cannot be made to accommodate special requirements arising from their health condition. We note DWP’s assurance that Atos Healthcare is “moving rapidly toward” a situation where this is no longer the case. We request that, in response to this Report, the Government sets out progress towards this aim. This should include options for the relocation of assessment centres where necessary, increasing disabled access, and improvements to the mechanisms for ensuring a claimant’s needs are known to Atos Healthcare in advance of the WCA. (Paragraph 71)
13. Most of the submissions we received from individuals were from claimants who were dissatisfied with the WCA process and who did not believe that they had been accurately assessed. The Minister asked us to bear in mind that much of the evidence submitted to us related to assessments carried out prior to implementation of the two sets of review recommendations and experience from the Aberdeen and Burnley trials. We fully acknowledge this fact. However, we believe that there is no room for complacency and we have identified a number of areas where further improvement is required. (Paragraph 76)

DWP contract with Atos Healthcare

14. We recognise that Atos Healthcare, as the sole provider of the Work Capability Assessment, takes the brunt of public criticism about the WCA. Some of this arises from the understandable anxiety which claimants feel about the process. We accept that considerable efforts have been made on the part of both Atos Healthcare and DWP to improve the quality of assessments. However, it is also clear that many

claimants have not received the level of service from Atos which they can reasonably expect. (Paragraph 92)

15. We remain concerned about whether there are sufficient levers within the DWP contract with Atos to ensure that Atos consistently gets the assessment right first time. We therefore recommend that, when the contract is re-let in 2015 and in future contracts for other medical assessments, DWP reviews the performance indicators, with significant financial penalties built in if standards are not met. (Paragraph 93)
16. We agree with the Minister that it would not have been practical to introduce a second provider for the IB reassessment but we believe that the Government should consider contracting a second provider to deliver the ongoing Work Capability Assessments for new ESA claims when the reassessment of existing claimants has been completed, in order to drive up performance through competition. We recommend that the Government publishes proposals, before the end of 2012, for how such a system of competition could work in practice. (Paragraph 94)

The Work Capability Assessment—Reviews

17. We congratulate Jobcentre Plus on the improvements made to the claimant journey during the reassessment trials in Aberdeen and Burnley. However, we are concerned that the resource-intensive nature of the additional claimant contact, which has been added to the process following the Harrington Review and the reassessment trials, may be difficult to scale up to a national level in the context of public sector spending cuts. We welcome the Minister's commitment to ensuring that the improved system is implemented nationally and urge the Government to ensure that the necessary resources are made available to Jobcentre Plus, given that a more robust reassessment process is likely to save money in the long run. (Paragraph 109)

Future of the WCA

18. We welcome the improvements to the WCA which have resulted from the Harrington Review and the lessons learned from the reassessment trials. However, we believe that the Government needs to do more to clarify whether the purpose of the WCA is to be an eligibility test for benefits or whether it is a diagnostic test to assess a person's ability to work. It is not yet clear whether it is quite achieving either of these effectively. (Paragraph 120)
19. The Government decided to suspend the Work Focused Health-Related Assessment for two years without putting anything in its place. This separate component of the WCA focused on health-related or workplace interventions which might support claimants into work and would have been particularly useful for people moving off incapacity benefits. We welcome Professor Harrington's commitment to consider whether an additional assessment is needed to determine a claimant's suitability for work, and his engagement of employers in the process through the CBI. (Paragraph 121)
20. Any new employability test must effectively link into the employment support available under the Work Programme. We recommend that Professor Harrington

also includes Work Programme providers and sub-contractors in the work he is undertaking to try to design an assessment that identifies a claimant's workplace capabilities and needs. (Paragraph 122)

Decision-Making

21. We welcome Professor Harrington's central recommendation on the need to strengthen the role of Jobcentre Plus decision-makers in the reassessment process. There are signs that decision-making is already improving and this needs to be reinforced by ensuring that all the supporting information from the claimant is available to the decision-maker at the time the decision is made. To facilitate this, it is important to ensure that claimants are able to submit medical reports, but GP charges for this service put it beyond the reach of some claimants. We recommend that the Government considers how to address the problem of charges acting as a barrier to the full range of medical information being available to decision-makers. (Paragraph 129)
22. We congratulate the Department for the marked improvements in the decision-making process achieved during the trials in Burnley and Aberdeen. However, DWP's own research suggests that this new approach is very resource-intensive and may not be sustainable in the national roll-out. Nevertheless, it should remain a priority for the Department to ensure that it gets the decision-making right first time. We agree with the Government's assessment that investing resources in the decision-making process will provide savings in the medium and long-term through reducing the costs in appeals. An improved decision-making process will also help to increase claimants' trust in the process and enhance their sense that "procedural justice" has been delivered by allowing their case to be properly presented. (Paragraph 130)
23. We welcome Professor Harrington's recommendation on making more effective use of the reconsideration process. The trials in Burnley and Aberdeen have shown that claimants find the additional contact with the Department, and the opportunity to present further evidence in support of their claim, helpful. This should help to address the problem identified by Professor Harrington of new information appearing at the tribunal stage that was not available earlier in the process. However, we also request that the Government put in place processes to track outcomes for cases which have been through the revision process in order to ascertain whether this is producing speedier and accurate final decisions, to avoid potential adverse consequences both for the claimant and for Work Programme providers. (Paragraph 137)

Appeals

24. The high number of appeals for new ESA claims is a cause of concern. The estimated cost to the public purse is £50 million per annum. The pressure on the Tribunals Service has also resulted in a significant delay for claimants before appeals are heard, causing stress and anxiety for claimants and their families. (Paragraph 146)
25. We welcome the Minister's commitment to improving decision-making to ensure that fewer cases are overturned at tribunal. However, as the Minister rightly

acknowledged, the volume of reassessment cases means that it is unlikely that the number of cases going to appeal will decrease significantly in the next few years. We welcome the Government's acknowledgment of the importance of reducing the time taken to process appeals and we recommend that the available resources are kept under regular review. The tribunal system must be adequately equipped both to address the backlog and to provide an ongoing, efficient appeals service. (Paragraph 147)

26. It is not acceptable that some claimants have to go through the entire assessment process again shortly after their appeal without any of the information from the appeal being passed on to JCP and Atos Healthcare. This is a waste of resources and causes unnecessary stress and anxiety for claimants and their families. (Paragraph 151)
27. We agree with Professor Harrington that it is important for the outcome of appeals to be fed back into the WCA system effectively, to avoid unnecessary future appeals. We also believe that when cases do go to appeal, it is important that the DWP case is properly presented. We recommend that DWP review whether JCP presenting officers should attend more tribunal cases in order to ensure both that this happens, and that information is fed back from the appeals process, thus promoting more effective learning of lessons by JCP. (Paragraph 152)

Reassessment outcomes

28. The Government's argument for time-limiting contributory-based ESA to 12 months is a result of tough decisions about the budget deficit and also to put it on an equal footing with Jobseeker's Allowance. It is true that the huge majority of JSA claimants move into employment within a year. However, we know that the JSA demographic of mainly young, male claimants with previous work experience is different to the ESA demographic, who may find it much harder to move into employment even though they may have done everything required of them to find work. (Paragraph 168)
29. Nor does it appear that the Government has the data available to make an evidence-based decision on the appropriate length of time for which contributory ESA should be payable in order to support its objective of moving claimants into employment. We recommend that the Department conducts research on whether allowing former IB recipients to claim contributory ESA for more than 12 months would provide a more realistic timeframe for them to enter employment, taking account of the two years of employment support available through the Work Programme. The research should also include an assessment of the costs of such a change. The Government should adjust its policy accordingly if the need for change is borne out by the research. (Paragraph 169)
30. We share the Minister's concern about the high rate of claimants who withdraw from the assessment process before completion. It is important that the Government understands the reasons for this and gains a greater understanding of the destination of these people, to ensure that no one is left without appropriate support. (Paragraph 172)

Tracking of claimants

31. We strongly believe that the success of the IB reassessment is dependent on its effectiveness in helping people with disabilities and long-term health conditions into employment. In order to understand whether the assessment process is achieving this, the Government needs to track the destination of all claimants. We recommend that tracking includes categorising claimants on the basis of the health condition they presented with, to establish how different groups fare in terms of getting into sustained employment. It should also include recording the number of claimants who are initially allocated to the wrong group and have to be moved at a later date. (Paragraph 176)
32. The trials in Aberdeen and Burnley would have provided an ideal opportunity to begin this form of tracking, from assessment to employment outcomes. We believe it is regrettable that steps were not taken to ensure tracking was in place for this first cohort. However, we believe that it is not too late to do this and recommend that the Government begins tracking outcomes for the reassessment trial cohort without further delay. (Paragraph 177)

Employment support for ESA claimants

33. The measure of success of both the Work Programme and the IB reassessment will be the proportion of people helped to move from benefits into employment. Recent research suggests that a very large proportion of customers in the Work Programme by 2014 will have previously claimed ESA or IB. This highlights the challenge for the Work Programme and the need to ensure that the WCA is effective in allocating claimants to the differentiated groups within the Programme. Until the introduction of Universal Credit, claimants will be assigned to the groups within the Work Programme based on the benefit they are claiming. This reinforces the importance of ensuring that claimants are allocated to the correct benefit in the IB reassessment process. (Paragraph 184)
34. It is too early to assess whether the current grouping and incentive structure under the Work Programme will be effective in leading to employment outcomes for former IB claimants. We reiterate the recommendation in our recent report on the Work Programme: that the Government keep the payment model under review and assess the outcome for participants within and between each client group. This review should be carried out by an independent panel and repeated on a regular basis. (Paragraph 185)
35. We support the Government's view that claimants in the WRAG should undertake work-related activity to prepare for a return to employment. However, it is important that decision-makers have discretion to apply exceptions to this requirement, where appropriate. One group of claimants which needs to be treated with sensitivity is those with a limited life expectancy. We recommend that decision-makers should be able to exercise discretion, on the basis of the claimant's own medical questionnaire, to place these claimants in the Support Group, where appropriate. (Paragraph 189)

36. Evidence shows that the accurate assessment of disabled people's employability and needs in the workplace is crucial in gaining their trust and engagement, and through this achieving employment outcomes. The Government should consider how information from the WCA can help Work Programme providers to identify the employability needs of customers. (Paragraph 195)
37. In almost all of the discussion of the Government's plans, the emphasis is on getting the claimant ready to go back to work. However, the Government will only achieve this laudable aim if employers are willing to employ someone who might have been on incapacity benefit and out of work for some time and who might still have substantial health issues. This will require a great deal of co-operation and change of attitude from many employers. Providers of employment support have a crucial role to play in building relationships with employers so that they can gain trust and an understanding of the challenges and benefits of employing former benefit claimants. However, it is also the Government's responsibility to engage in changing attitudes and spreading good practice amongst employers. The Government must pay as much attention to this side of the "back to work" equation as it does to getting the claimant "work ready". (Paragraph 201)

Formal Minutes

Wednesday 13 July 2011

Members present:

Dame Anne Begg, in the Chair

Debbie Abrahams
Harriett Baldwin
Andrew Bingham
Karen Bradley

Kate Green
Mr Oliver Heald
Glenda Jackson
Teresa Pearce

Draft Report (*The role of incapacity benefit reassessment in helping claimants into employment*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 205 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Sixth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for printing with the Report (together with written evidence reported and ordered to be published on 27 April and 8 June 2011).

[Adjourned till Wednesday 7 September at 9.15am.]

Witnesses

Wednesday 4 May 2011

Page

Sue Royston, Social Policy Officer for Sickness and Disability Benefits, Citizens Advice, **Roy O'Shaughnessy**, Chief Executive, Careers Development Group, **Jane Harris**, Associate Director of Communications and Campaigns, Rethink, and **Professor Paul Gregg**, Department of Economics, University of Bristol.

Ev 1

Wednesday 18 May 2011

Lisa Coleman, General Manager, DWP, Medical Services, **Dr Laura Crawford**, Clinical Director, and **Professor Michael O'Donnell**, Chief Medical Officer, Atos Healthcare.

Ev 21

Professor Malcolm Harrington

Ev 36

Wednesday 8 June 2011

Rt Hon Chris Grayling MP, Minister for Employment, **Karen Foulds**, IB/IS to ESA Migration Project Manager, Jobcentre Plus, **Dr Bill Gunnyeon**, Director for Health, Work and Wellbeing, Chief Medical Advisor and Chief Scientist, Department for Work and Pensions.

Ev 44

List of printed written evidence

1	Department for Work and Pensions	Ev 67; Ev 82
2	Careers Development Group	Ev 82
3	Citizens Advice	Ev 86
4	Professor Paul Gregg	Ev 89
5	Joint response from mental health sector: Centre for Mental Health, Hafal, Mind, Rethink, the Royal College of Psychiatrists and Scottish Association for Mental Health	Ev 90

List of additional written evidence

(published in Volume II on the Committee's website www.parliament.uk/workpencom)

6	John Heeps	Ev w1
7	Mrs M Bernard	Ev w2
8	Mr S Gibbons	Ev w3
9	Dr Sarah Campbell	Ev w3

10	Patricia Oakley	Ev w4
11	Peter Higginson	Ev w4
12	Samantha Fulstow	Ev w5
13	Helena Cairns	Ev w7
14	North West Mental Health Welfare Rights Group	Ev w8
15	Carole Rutherford	Ev w12
16	Lynn Wyatt-Buchanan	Ev w14
17	Sarah Ross	Ev w16
18	Allerdale Multiple Sclerosis Society	Ev w16
19	NAT	Ev w17
20	Low Incomes Tax Reform Group	Ev w21
21	Royal National Institute of Blind People	Ev w24
22	Citizens Advice Scotland	Ev w28
23	Oxford Welfare Rights	Ev w32
24	Jaki Tean	Ev w36
25	Anne May	Ev w38
26	CarerWatch	Ev w38
27	Julia Cameron	Ev w40
28	ACT NOW	Ev w41
29	Elina Rigler	Ev w45; Ev w114
30	Middlesbrough Council Welfare Rights Unit	Ev w48
31	Steve Punter	Ev w50
32	Advice Services Coventry	Ev w52
33	Muscular Dystrophy Campaign	Ev w54
34	Zechariah Richardson	Ev w56
35	Darren Thomas	Ev w57
36	David Gillon	Ev w59
37	Law Centre Northern Ireland (LCNI)	Ev w62
38	Age UK	Ev w64
39	A4e	Ev w65
40	Patricia Williams	Ev w69
41	Penny Meade	Ev w69
42	Papworth Trust	Ev w70
43	Catherine Burns	Ev w74
44	M Turner	Ev w75
45	Steve Turner	Ev w76
46	Eleanor Wakeling	Ev w77
47	Advice Network on behalf of Advice Centres for Avon (ACFA)	Ev w78
48	Rhydian Fon James	Ev w80
49	Mindfulness Programme	Ev w84
50	Stockton CAB	Ev w87
51	Action for ME	Ev w91
52	Disability Alliance	Ev w94
53	Mental Health Resistance Network and Mad Pride UK	Ev w96
54	Valerie Crane	Ev w98

55	Heather Price	Ev w99
56	Susan Marsh	Ev w99
57	Caroline Richardson	Ev w101
58	RSI Action	Ev w104
59	Advanced Personal Management UK	Ev w107
60	Employment Related Services Association	Ev w109
61	Tom Greatrex MP	Ev w110
62	Equality 2025	Ev w111
63	Independent Resource Centre Clydebank	Ev w113

List of Reports from the Committee during the current Parliament

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2010–12

First Report	Youth Unemployment and the Future Jobs Fund	HC472 (HC844)
Second Report	Changes to Housing Benefit announced in the June 2010 Budget	HC469 (HC845)
Third Report	Appointment of the Chair of the Social Security Advisory Committee	HC 904
Fourth Report	Work Programme: providers and contracting arrangements	HC 718 (HC1439)
Fifth Report	The Government's proposed child maintenance reforms	HC 1047

Oral evidence

Taken before the Work and Pensions Committee

on Wednesday 4 May 2011

Members present:

Dame Anne Begg (Chair)

Harriett Baldwin
Andrew Bingham
Karen Bradley
Kate Green

Mr Oliver Heald
Glenda Jackson
Teresa Pearce

Examination of Witnesses

Witnesses: **Sue Royston**, Social Policy Officer responsible for Sickness and Disability Benefits, Citizens Advice Bureau, **Roy O'Shaughnessy**, Chief Executive, Careers Development Group, **Jane Harris**, Associate Director of Communications and Campaigns, Rethink, and **Professor Paul Gregg**, Department of Economics, University of Bristol, gave evidence.

Q1 Chair: Thanks very much to everyone for coming along this morning. We are slightly thin on this side, because the House did not finally rise until 5am this morning. I think some of my Labour colleagues were tucked up in bed well before that time, but unfortunately the Government side was expected to be there until the early hours. These are our brand new up-to-date modern, family friendly hours, but it was a Finance Bill so we cannot guillotine it and we certainly cannot programme it. Hopefully more colleagues will arrive as they get themselves together this morning, but that does not distract from the fact that this is the first evidence session for a very important inquiry for us into the migration from Incapacity Benefit to Employment and Support Allowance. Could I just get you perhaps to introduce yourselves, starting with you, Sue, just for the record?

Sue Royston: Yes. I am Sue Royston; I am Social Policy Officer for Sickness and Disability Benefits at Citizens Advice.

Jane Harris: I am Jane Harris; I am Associate Director at Rethink Mental Illness, which is the largest voluntary sector provider of mental health services and a membership charity with 10,000 members.

Roy O'Shaughnessy: I am Roy O'Shaughnessy and I am the Chief Executive of the Careers Development Group, which is a charity that competes commercially with the large commercial providers but reinvests our net profits back into the community, and we were successful on the Work Programme.

Professor Gregg: My name is Paul Gregg; I am a Professor of Economics from the University of Bristol. I undertook the review for the DWP that designed the employment support and conditionality package associated with what is now known as the Work-Related Activity programme of the ESA.

Chair: Thanks very much.

Harriett Baldwin: That reminds me: I should declare my interest as Vice Chair of The Social Investment Business, which has some investments in some firms that are on the Work Programme.

Q2 Chair: Thanks very much for coming along this morning. We have very detailed questions about the

migration, but perhaps we could start by just getting very briefly your overview of how well you think the Employment and Support Allowance has been working up to now as a new benefit. Bear in mind the more detailed things we will tease out from you later on, just in overall terms, is the Employment and Support Allowance fit for purpose? Has it been doing the job that the last Government envisaged when it was introduced? Do you have any overview of that? Again perhaps, Sue, can we begin with you?

Sue Royston: We welcomed the Employment and Support Allowance. A lot of disabled people want to get back into work, and we welcomed the help and support it would give. We are not very happy about the way it is working. We feel the test is too crude a test, and there are also problems with the way the assessment is actually carried out in practice. We also have great concerns about the new even tougher descriptors that are being brought in. I think that is a summary of how we feel about it.

Jane Harris: Similarly, in principle we support a lot of the ideas behind the Employment and Support Allowance, and certainly we think there are a lot of people with mental illness who may be able to work with the right support, who probably are not able to work at the moment. In practical terms, mental health has not really been in the mainstream of the policy in the way we would have liked it to be, and that is seen right from the beginning of the assessment process, where we do not think the Atos assessments are really conducted with the right level of knowledge about mental illness, right through to the support under Pathways, where even DWP's own research says that advisers do not feel confident in dealing with mental health claimants in the way that they do with other claimants.

There is a more fundamental question. Even if you get some of the operation of the benefit right, there are some really fundamental barriers to work that are not being addressed, the chief one being the stigma and discrimination that thousands of people with mental illness face when trying to find a job. We are certainly very pleased that the Equality Act has changed that in some ways, and that people now do not have to

4 May 2011 Sue Royston, Roy O'Shaughnessy, Jane Harris and Professor Paul Gregg

declare their disability when they are applying for a job. That is a very positive step forward but, while that is a step forward, it has not solved that fundamental problem.

Roy O'Shaughnessy: CDG only deals with the customer once they have already been assessed, and so we will be limiting our remarks to that as we go forward, but we would say there is inconsistency when we are dealing with people who are supposedly work ready as to just how work ready they really are. A lot of times it relates to the comments that were just made about what the level of ability really is. Overall, we are comfortable that the process is moving forward and are confident that, over the next year or two as the Work Programme kicks off, as we feed this information back to organisations that are represented here today, we will be able to refine that process.

Professor Gregg: My main interest is also employment, because I engaged with the DWP about that. I have some fairly detailed comments that I will make in due course, but I would like to start by expressing a discontent with the way in which the new test and system has been assessed, validated and refined, and the lack of follow-up with people who have been displaced, if you like, off ESA in order to find out what is happening to them. There is a sizable gap between JSA and ESA in terms of the regimes and the ability of people to comply with them. There is a severe risk we are creating a hole in the social safety net, and yet we do not have an adequate system of checking to follow people through, either within the WPLS¹ system or through case studies, to find out what is really happening with people after they have been denied access to ESA. This is deeply troubling to me.

Chair: We will have some questions on that, as we go. We will start with some questions on communications.

Q3 Kate Green: Thank you for coming in this morning. As you know, the Government is aiming to reassess around 1.5 million people between now and 2014 who are currently in receipt of Incapacity Benefit, and I want to ask a couple of questions about the way in which these changes have been communicated to Incapacity Benefit claimants. I wonder if you could say something about your experience of the Department's communication with claimants, both in terms of the reassessment that they will have to undergo and the changes in benefits that will follow.

Sue Royston: We worked quite closely with DWP on how the reassessment would work and the process, and we have talked to the CABs in the Burnley area, and our feedback is that they have not had many problems; they have not had lots of people coming in saying, "I do not understand this. What is happening?" As far as we are aware, for most people, the system of phoning people first and telling people at each stage has worked in terms of explaining the system. Interestingly, we have had more comments from other CABs, where people are coming in because they are worried about what is going to happen because they

have not been in the assessment area, than we have from Burnley itself.

However, there are a couple of things that we are more worried about. We did have feedback from one person who did not have a telephone and, right from the beginning, we said we were most concerned about the people who do not have a telephone, because they are more likely to be the vulnerable people who really need the help. The only help that was offered on the letter was to ring an 0845 number. He rang the 0845 number and got the switchboard, who did not know anything about it. It went to a virtual call centre and they knew nothing about what was happening. We are worried about the minority who do not have a telephone. For the majority who have gone through, as far as we can see, the actual process has been fine, but I do think DWP needs to look urgently at how they support the really vulnerable. We are not sure as yet, going back to what Professor Gregg said, whether there are some people who have just dropped out of the system as a result of being vulnerable. We also have some concerns about what DWP calls Touchpoint 13, but I think you will probably get on to that question later in the process.

Jane Harris: Similarly, we would echo what Sue has said about people who do not have access to telephones. I guess there is an extra dimension about this for people who have severe mental illnesses, like schizophrenia or other forms of psychosis, who might be hearing voices, and therefore using a telephone at some point is literally impossible. I do not think necessarily that that has been thought through in as much detail as it might have been. We would agree that, in general, the process seems to have been positive from the limited feedback we had from Aberdeen and Burnley, but we have two detailed concerns about it.

Firstly, it seems that some people do feel that they are getting a lot of communication but that they are never being given a date for an assessment. People seem to be getting quite a lot of envelopes through the post, but then not actually knowing when they are going to have to go to the assessment. That seems to be causing quite a lot of anxiety. I think we have to recognise that anxiety for any of us is not very pleasant and stress is not very pleasant, but for somebody with a mental illness that can actually cause illness. There is evidence from around the world about the links between stress and anxiety, and relapses of conditions like schizophrenia and bipolar disorder. It could be a trigger that could land someone back in hospital, in some cases, and so that needs to be thought about a bit more. Similarly on the Touchpoint 13 issue, again we have had limited feedback but what we have is slightly worrying because people seem to be given quite mixed messages about Touchpoint 13. People are told they might not be found eligible for ESA and, therefore, asked whether they want to move on to JSA. People seem to be getting quite confusing messages about whether they should appeal or should not appeal, and seem to be steered into not appealing because they will not get any benefit in the meantime. We think that needs to be investigated more.

¹ Work and Pensions Longitudinal Study—see also Q 49

4 May 2011 Sue Royston, Roy O'Shaughnessy, Jane Harris and Professor Paul Gregg

Q4 Kate Green: Given that we are going to be in a situation where not everybody will be tested until 2014, what is the right time to communicate, taking your point, Jane, about people needing to have a date?

Jane Harris: There are two communications processes going on, aren't there? There is the communication specifically to claimants who are going through this. I suppose there are three. There are communications to people just to let them know this will happen at any other time. Then there is also communication through the mass media, and I think that is what is really causing the concern here. In a way, it feels that the Government is playing it two ways. On the one hand, people are saying they agree with the Harrington Review; the testing needs to be made fairer and more efficient. A press release came out from DWP just last month saying they know clearly now that the vast majority of new claimants are in fact able to return to work, on the basis of a test that even Government is saying is not as fair or efficient as it should be. That is the bit of the system that really is not working and is undermining the good work that is being done with claimants who are going through the process.

Q5 Mr Heald: In all my time in Parliament, your charity has argued that many people with mental health problems could work. You have had campaigns complaining that only 7% of people with severe mental illness get the chance. Is it not true that, in a way, you are guilty of what you were saying that DWP was guilty of? What you are saying about this new programme, which is designed to help people with mental illness back into work, is you are concerned the process will not be fair, will cause substantial distress, will lead to people receiving inadequate support and being subject to inappropriate and potentially harmful requirements. What you are saying to people out there in your constituency, people who trust you because you are the leading charity in the field, is "Steer well clear. This is not for you." This is a once-in-a-generation opportunity to really change things and to give people with mental health problems a better deal in the work sphere. Do you really think you are doing the right thing?

Jane Harris: The distinction here is between the short term and the long term. Long term, with the right support, we think there are lots of people who could work.

Mr Heald: But it is now, isn't it?

Jane Harris: The problem is there is a difference in thinking that somebody might need a couple of years in the Work-Related Activity Group, certain amounts of support and then they might be able to go back to work, and indeed that they might need to get NHS treatments that they have not previously been offered. There is a difference between that and concluding that, on the basis of a test that across the sector people do not really think is particularly valid, somebody can therefore work tomorrow.

Q6 Mr Heald: Your message to employers is it is really hard and difficult to employ somebody with mental health problems. It takes years to get them in there.

Jane Harris: I do not think that is true.

Mr Heald: That is what you just said.

Jane Harris: No, it is going to depend on the individual. Some people will need that support for a while, and they will need support while they are in work. The problem with some employers at the moment is that they do not always feel confident that somebody will get that ongoing support. As a charity, we ourselves employ almost one in four people with mental illness, so we know that it is possible to employ people but with that right support. We cannot make conclusions about what is possible in the absence of talking about what support is there.

Professor Gregg: There are three big employment issues here, and it is really important to try to get clear which ones we are trying to talk about when having these discussions. The first and possibly smallest, although we do not really know, is whether the process of transition is causing problems—particularly, as we have just heard, for mental health problems. That is the anxiety and the stress. The gap between JSA and ESA in terms of requirements and activities means that there are groups that are falling out of the system and not receiving any support at all. The second issue is the divide between ESA and JSA. The levels of engagement, support and conditionality in those two regimes are profoundly different. The kind of resource that a provider such as these guys can offer to a person through JSA is around £3,500. That is their kind of fee; it is that order of magnitude. If they are coming through ESA, it is of the order of £14,000. The level of support and engagement is profoundly different, so getting that boundary right is essential for trying to work out how to help people—to enable that regime to engage people and get them back to work.

The third issue, and this one has been referred to and is very important, is that the process of helping people back to work when they have substantial illnesses and disabilities requires some positive engagement from their side, which is the point that you are referring to. It is imperative that we try to build a regime based within a degree of trust here, rather than one inherently built around confrontation. A lot of the messages that are coming out—and I think the Government is guilty of this—are creating a culture where disabled community feels the primary function is about driving them off the benefits on to lower value, less-supportive type benefits, and is destroying the potential to create a trust environment. I am deeply concerned that the Work-Related Activity programme, which is for those who need significant help, requires positive engagement from individuals who are participating, but they are not going to be in the mindset to engage because of the messages and regime shift that is going on here. It is imperative that this process of transition does not undermine the ability of the Work-Related Activity programme to work, and ultimately that process could result in less employment rather than more. That is a serious risk.

Q7 Glenda Jackson: If I could take you back to the issue about anxiety, it is coming from three different sources, not least what the Government is saying. I follow on from what Professor Gregg has said. One

4 May 2011 Sue Royston, Roy O'Shaughnessy, Jane Harris and Professor Paul Gregg

of the most recent announcements by Government was that however many hundreds of thousands of people—I cannot remember—were discovered to be fit for work, their problems were they were obese or either drug- or alcohol-dependent. Again the subliminal message coming out is that the majority of people who are claiming benefits are in fact fit for work. There is that element of anxiety, which goes across the board, I think. On the specific one of the brown envelopes coming through the door, do the people who send those brown envelopes know beforehand the illness or disability that the recipient is suffering from, or is this just a general kind of computer spewing out these letters to everybody on the benefit system? Do we know?

Jane Harris: I am not entirely sure about that. As far as I know, no, but I think it would depend—if somebody had only had a PCA² in the past, possibly not, but I would want to go away and check that to be sure.

Q8 Glenda Jackson: Who would be the gatekeeper to ensure that that level of anxiety could be reduced? Is it Jobcentre Plus? Is it the people who are actually handling the benefit claims now?

Jane Harris: I think it would be Jobcentre Plus.

Chair: The initial letter that goes out would be exactly the same to everyone regardless. It is not until further down the line—

Glenda Jackson: It would be tailored to an individual.

Q9 Kate Green: Just a couple of other things: one of the things I have heard a number of disabled people talk about in the context of testing suggests to me that there is confusion between the Work Capability Assessment and the forthcoming assessment for Personal Independence Payment, a replacement for Disability Living Allowance. Have you any comments from a communications perspective about how, given that we do not even know yet what the PIP test is going to look like, we can best offer reassurance to customers to make sure that that communication suggests a streamlined and smooth process?

Sue Royston: When people come into CAB, we frequently hear that people do not actually know what benefits they are on. They are confused, because people talk about sickness benefits and disability benefits. You will sometimes find that somebody has been living just on DLA because they did not know they were entitled. They thought that was the benefit that was meant to help them live, and they did not know there was any other benefit. I think it is a huge task. Perhaps some letters could set out the joint parts of it in the same letter, mentioning both parts and what is going to happen, rather than getting separate letters at different times—anything that could join things together so people understand clearly.

We have also asked, for some time, for a statement that tells the person exactly what benefits they are receiving—all the benefits. It should not be impossible with computers to do this: to join all the entitlements together and put them all on the same piece of paper,

and also have the basic conditions of entitlement. “These benefits are based on these things. If any of these things change, you need to tell us.” It should be one piece of paper because, as you said, people get thousands of letters through the post; it is very confusing, especially if people have difficulty reading, just having letter after letter with these. They do not know which ones they are meant to keep. Having one letter that states clearly all the benefits they are on and which benefit is going to be changed to which, and “keep this one piece of paper”, is very important. Perhaps even make it a different colour so that it was clearly able to be picked out.

Q10 Kate Green: You have been quite positive in your comments on the way in which telephone support has been built into the rollout in Burnley and in Aberdeen. In general, do you think that there will be sufficient easy access to information and advice from the Department, and to independent advice and advocacy if people need it?

Sue Royston: It is a concern. Bureaus are very busy. We see a lot of people; we give advice to a lot of people who find it very difficult interacting with the benefits system and find it difficult to read the letters to contact people. Some people find it very difficult to make phone calls and cannot cope with phone calls.³ We are obviously very concerned about the cutback in funding legal aid, because a lot of the benefit specialists with Bureaus are legally aided; their funding comes from legal aid and so, if you take that out, you take the specialist out of the Bureau, and the specialist is the backup to the volunteers, in terms of the advice that the volunteers are giving. Yes, we are concerned about the advice that will be given.

Roy O'Shaughnessy: I would just throw in there that, from a Work Programme perspective—and as you know the Work Programme only starts from 1 June, but it is meant to be a black-box approach—certainly the approach that CDG has taken on this is that if somebody has already been through the assessment, is having issues or is confused when they come into us, our advisers will have a set mechanism for assisting those individuals in coming to terms with that. Over the next two to four quarters, I suspect that will be tested out across the country in different ways, depending on the success that the providers have in dealing with that.

We have also initiated our expert volunteer initiative for all of the areas that we are working with—and made it available to every provider in the UK—where any individual can have a one-to-one mentor to assist them in the journey. I know that does not directly relate to today's debate, but in the sense of innovation and the process of going forward, many of us—and not just us a charity but many of the other providers—are looking to answer those questions, because we need accurate assessments when people come in as to whether they are work ready. I take your point completely about the mixed messages. Part of our mission is to reduce long-term unemployment. It is better to work than not if you are capable of working.

² Personal Capability Assessment (the assessment used for Incapacity Benefit Claimants)

³ Note by witness: However I was talking about the process but it is a very different issue if people need advice about a decision they believe is wrong.

4 May 2011 Sue Royston, Roy O'Shaughnessy, Jane Harris and Professor Paul Gregg

What we do not want to do is get somebody into a job and, two or three weeks later, they are out of it because they were not properly assessed, trained and serviced, because then they have even more barriers to overcome than before.

Having said all of that, I do believe this is a proportional issue. More and more of the people who we see coming in are work-ready. They might have barriers to overcome, but the barriers within the two years of the Work Programme and the following year of service are not the same. The only point that I would make here is that I think we are all aware of the challenges and issues, and it is more how we join up between JCP, the assessors and the providers. I think we have an amazing opportunity with the Work Programme to figure out what is right and wrong, and as long as there is a quick mechanism for correcting where it is wrong, at least the information will be on the table.

Q11 Kate Green: How important has the Jobcentre Plus phoning and sticking with the customer at different decision points been in improving the process?

Jane Harris: From Aberdeen and Burnley, it has looked like possibly there is more reflection on decisions. Some of the data I have seen come out does suggest there is more reflection at some points about whether the right decision is being made by Atos. That is a really positive step forward. Ultimately we are talking about a claimant group of millions of people, with many different health conditions, with many disabilities and many experiences of work. It is going to be a complicated thing to try to get the decision right in all of those different cases. Anything that builds in more reflection points and the more people who look at these reports and think whether they really add up and fit, the better the decisions we are going to get in the end. Aberdeen and Burnley have suggested that building in more of those decision points is a positive thing.

To come back to the issue about the advice and availability of that, one of the findings from the early work on Pathways was that people were really disappointed that advisers in Jobcentre Pluses could not give them benefits advice. It feels that people are looking for more of a one-stop-shop solution that can tell them everything about benefits, their ability to work and the support available to them. In going back to the point about people feeling some element of control in this process, if that was what people are asking for and feel would support them through this, maybe we should be looking more to join up advice-giving and the Jobcentre Plus process.

Q12 Teresa Pearce: I was interested in what Professor Gregg said about the buy-in of the individual and how that is really important. I think that is true. One of my perceptions, and I do not know whether this is accurate or not—the media has not helped this—is that when people are written to about going to a Work Capability Assessment, they think they are going for a medical; they think they are going for a test. How can we change that perception that they are not going for a medical, they are not going

for a test; they are going to be assessed to see what help they need? Do you think my view there is right? That is my perception from the people whom I have spoken to. That is what they say and this is where it comes out, “Oh, they did not speak to my doctor,” and all that, because they think it is a medical. The media reports will say so many hundred thousand found fit for work, but it is not “fit for work”; it is capable of some work. Am I right to be concerned about that and can we do anything?

Professor Gregg: I think you are right that one of the big anguishes that we continually hear about is that people think they are going there with an ability to present information about their illness and be tested against their perception of that illness, whereas what they actually get is a fairly stylised tick-box representation through the Atos process. That does not mean Atos is doing it wrong; it just means there is a profound disconnect between what people are expecting and what they ultimately get. They then do not feel that they have had a chance or opportunity to put their case in the process. They view that as the medical assessment, but their medical situation was not tested. Part of it is information, but I also think some of the Harrington proposals about allowing people to feed back information to the decision maker rather than just through the Atos process will help in that, if people feel there is an opportunity for them to present information where they feel that the Atos process has not fully captured their situation. Signalling there is a chance or opportunity they will have to present information, where they feel the assessment, the descriptors, has not captured their condition appropriately, will help them go through the process without feeling a profound disconnect between what they have and what they expected.

Q13 Teresa Pearce: If at that very initial stage there is that barrier to trust then we are starting on the wrong foot, aren't we?

Jane Harris: Some of this might just be to do with the language. Terms like “Work Capability Assessment” do not necessarily mean very much to the man on the street. The way that you have just described the process is probably more akin to what the Jobcentre Plus letter should say than technical words that may need to be in there somewhere, because they are in the legislation. It does feel like sometimes DWP could do a better job of translating quite technical policy legislative language into language that people understand. The thing is: if DWP does not do that, the media will and people will do that themselves. That will possibly lead to more misunderstandings.

Q14 Chair: Can I just ask if you know, because we are talking about communications here, whether the word “medical” is used in the letters going out? We talk about Atos assessors being medical assessors. People talk about going for this medical test. Is that word actually used? I have a feeling that, in the DWP's written evidence to us, they continue to use the word “medical”. As long as that word is constantly being used, then that reinforces this as a medical and not a Work Capability Assessment. It is a functional

4 May 2011 Sue Royston, Roy O'Shaughnessy, Jane Harris and Professor Paul Gregg

test because we know that but in people's minds it is different.

Sue Royston: Sorry, I am not sure. Sometimes it is called a "medical assessment" and sometimes it is called an "assessment", but I am not sure exactly.

Chair: Maybe it is for us to look at the actual stuff that is going out.

Q15 Andrew Bingham: You have sort of answered the question I was going to ask about whether the customers understand the purpose of the process. Do you have any views or information on why a proportion of people close the claim before they get to the end of the assessment period? I am picking up on Teresa's question.

Sue Royston: If you are employed, you get statutory sick pay for the first 28 weeks and then you would claim ESA, but if you are either self-employed or if you are not working, then as soon as you are ill, your only option is to claim ESA. You would go to your doctor and get a sick note. Most illnesses from work are short illnesses. If you have a bad dose of flu, if you need to have a stay in hospital, if you have shingles, if you have any short-term illness, you are likely to claim ESA for less than 13 weeks. When you claim ESA originally, it will be about 13 weeks before you go for the assessment. Anybody who gets better between nought and 13 weeks will stop claiming.

Q16 Andrew Bingham: Do you think a significant proportion of this 37% are taken up due to those circumstances?

Sue Royston: I think it is just straightforwardly that people are getting better, but they have a sick note for a certain length of time. I do very strongly agree with Professor Gregg that there should be, as we have been asking and asking for, some tracking in the system, because there may be some people who are just dropping out of the system because they cannot cope with it. I think DWP ought to know how many of those people cannot cope with it, so there ought to be some tracking to see rather than us second-guessing what this 37% is made up of.

Q17 Chair: Do we know what the comparative figure was for IB claimants? How many started an IB claim but did not see it through?

Sue Royston: I am sorry, I do not know that.

Chair: That is surely the comparison. Your analysis is about people getting better, but there is nothing else for them to claim. That would show up in those figures.

Sue Royston: Yes, it would.

Jane Harris: The honest answer is that we just do not know. We have no research evidence on this; we do not have anybody tracking. I think it is very important that, because we do not know, we do not jump to conclusions about what is happening with those people. Certainly some of our members do tell us that they feel so ill and traumatised by the whole process that they do not feel able to go to the assessment, and that is why they drop out. My guess is that is the minority of people. I would not want to say that is the majority, because we do not know, but it is absolutely

imperative that we do not jump to conclusions about what this figure means when we do not have any data.

Q18 Andrew Bingham: Do you think the media are jumping to conclusions on those figures?

Jane Harris: To be honest, I think the media often jump to conclusions, and that is a problem with every Government and also for charities trying to get an accurate picture out there. I do think sometimes some of the things coming out of DWP at the moment possibly push towards those conclusions as well. A better balance could be struck than is currently being struck in the messages from Government.

Q19 Harriett Baldwin: Going back to communications, I wanted to specifically ask about people with mental health conditions, and so probably most of these questions are for Rethink, but feel free to chip in with comments. Out of the 1.5 million people on Incapacity Benefit, is there an estimate out there of how many of those people would be presenting only with mental health conditions?

Jane Harris: I think the figure is around 40% of people who just have a mental health condition. Once it goes to people who have other conditions as well, it goes above 50%, but Professor Gregg might have more detailed answers than that. The thing is that, at the moment, the figures conflate mental health issues, learning disabilities and autism. All of those things are all put together, so even within that 40% figure there is a real variation in people's experiences and therefore what kind of support they might need to get back to work. One of the disappointments is that the WFHRA, which used to be in place to try to look at what support people might need, has been discontinued, and that perhaps would help people like Roy's organisation, which is then trying to plan what support people in that group would need. More work could be done on the data side, so we did just have a bit more of a detailed picture of what groups of people we are talking about.

Q20 Harriett Baldwin: From your knowledge, you think it is about 600,000 out of the 1.5 million.

Jane Harris: Yes, I think it is the largest group. That and back pain or musculoskeletal disorders compete for which is the largest group within that.

Q21 Harriett Baldwin: You have spoken about the communication in the Burnley and Aberdeen trials, and how it has added in a lot more telephone contact. The Department has told us that 68% of their initial outbound phone calls have been successful. You mentioned that the claimants with mental health issues have a particularly low ownership of telephones.

Jane Harris: It is not people with mental health conditions as a whole. The people I am specifically talking about are people with psychosis, who are a small group of people within the claimant group of people with mental health conditions. It usually about 1% or 2% of the population who have psychosis, but within this claimant group you would expect it to be a bit higher than that. I have never seen absolutely detailed figures that tell us exactly what that is. It stands to reason that, if somebody is hearing voices

4 May 2011 Sue Royston, Roy O'Shaughnessy, Jane Harris and Professor Paul Gregg

and having hallucinations, it is much harder to use the telephone than it would be for anybody else.

Q22 Harriett Baldwin: But generally speaking, adding in that telephone contact point or the additional telephone contact has been helpful?

Jane Harris: Absolutely.

Q23 Harriett Baldwin: How would you recommend that communication is done with that group of people perhaps where telephone is not the best method?

Jane Harris: I think it is true that there is probably a minority of people with mental illness who many public sector agencies find it difficult to communicate with. In the NHS, different teams have been put in place, like Assertive Outreach, which do home visits and go and meet people in cafes, as well as doing phone calls, where that has not worked. There are probably some lessons to be learnt from how the NHS talks to that group of people. Often people in that group would be put in the larger group of seldom seen, seldom heard groups within the policy framework, which suggests they are just difficult to communicate with, full stop. The real issue is that there is very much a one-size-fits-all approach to a lot of the communications within Jobcentre Plus. Looking at what data Jobcentre Plus could gather before they communicate with somebody to tailor that communication is a very positive idea.

Q24 Harriett Baldwin: If the Chair will permit me one last question, in your written evidence you said that people were very anxious, because they know this is coming, but they just do not know when between now and 2014 they will start on that journey. I am just wondering if you would recommend any further communication now to that group of people saying, "Over the next three years, you will be contacted and this will be happening."

Jane Harris: Absolutely. I think in our written evidence we suggested that there could be some kind of timetable that is published. I do not know whether that could go area by area to tell people roughly when, depending on where they live, they might have an assessment. Certainly I think charities like Rethink would be a good way to try to get some of that information out to claimants. As far as I know, we have not been contacted by DWP to try to engage in that process. Absolutely we want to keep people out of hospital without any undue stress, and so anything that we can do to reassure people about what is happening and give them information that will help towards that, we will do.

Q25 Chair: The Department would say in response to that that they do not want to worry people unnecessarily, when in fact the assessment could be anything up to two years away. I know as an MP from Aberdeen that everybody on IB on Aberdeen thought they were getting a letter and then started to worry when they did not get a letter, because there were only 820 out of the whole of the northeast of Scotland. That in itself created a real problem. How do you balance out these two different problems?

Jane Harris: While that is absolutely true, the problem is the media messaging that is going on is out there. It is not in anybody's control absolutely, but it is there and it is worrying people. We cannot act as though it is better to have a vacuum, a void of information, because there already is all this pressure causing people anxiety, so we need to be doing something proactive in order to balance that.

Q26 Chair: Does the Department or Jobcentre Plus do any kind of liaison with CPNs⁴, because a lot of the group that you were talking about, Jane, will be in the system somewhere and possibly have their own CPN? Does data protection prevent that route to getting engagement with the customer?

Jane Harris: There are data protection problems. They do suggest a complete disjoint between what the DWP is doing and what the NHS is doing. Joining up that would be very positive for everybody. This is part of the idea of not having a one-size-fits-all approach, and trying to create one point of contact for somebody to go to. One of the other things that has come up in the Pathways evidence is that people often get very different messages from people supporting them in the NHS compared with people supporting them at Jobcentre Plus. If you are in the middle of all that, and you are being told different things by your GP, your CPN, Jobcentre Plus adviser and maybe a condition management programme, no wonder people feel confused about what is best for them to do to sustain their health and to get back in terms of employment.

Q27 Chair: If you have a diagnosis for paranoia, it is even worse.

Jane Harris: Exactly.

Chair: Andrew has some more questions on the customer experience.

Q28 Andrew Bingham: The Department has said there are 30 assessment locations not on the ground floor. Obviously this point has been raised about the staff, so have you have any evidence, any experience or any thoughts about what customers' views are of the centres and the staff particularly?

Sue Royston: Our evidence is varied on the venues. We have not had strong complaints about accessibility, we have had some feedback on the ambience. Certainly some people have said that it has felt as if the assumption was that they were trying it on. One small example that somebody gave was—she did not have a child with her, but there were children in the waiting room—pointing out that there were no toys for the children, and she was told, "We do not provide toys; they would be stolen," which gives a feeling of mistrust as you are going into the process. We have a lot of evidence about the attitudes of the staff and the reports themselves. Do you want to come on to that now?

Q29 Andrew Bingham: I would be interested for you to expand there. The thing I would be interested in is whether the people who come to you are people who have been told they are fit for work or people put

⁴ Community Psychiatric Nurses

4 May 2011 Sue Royston, Roy O'Shaughnessy, Jane Harris and Professor Paul Gregg

back on the ESA. I am just wondering what people's reaction is. Is it because the result they have had has upset them and they have taken it from there?

Sue Royston: No. Obviously we see more people where it has gone wrong, but people will come to us for help with filling in their questionnaire or they will be with us because of some other problem and have asked about it, or will have come to us initially because they have never claimed benefits before and have no idea. They have suddenly become seriously ill and have no idea what benefits they can claim. We will see people before the process.

We have had problems about the assessments for many years and a lot of evidence about that. When we have given evidence, we have always been told it is a tiny minority. "Yes, there are problems; we do not disbelieve what you are saying, but it is a tiny minority." Our advisers tell us this is not so, but, quite clearly from the amount of evidence, we see a systemic problem, so we have set up a survey where we are asking advisers to ask any client they see before they have had a medical to take part in the survey, and then ask for a medical report afterwards, go through and see how accurate the history is that the adviser has taken. We have now got some evidence of problems in the accuracy of the reports from people who are quite definitely across the board, the people who took part in the survey are from all three groups and split in proportions roughly similar to the proportions in the WCA.

Q30 Andrew Bingham: Once the assessment is done, do you think that the customers understand the outcome and the basis of the outcome? Do you think that is transparent enough or do you think it is cloaked in secrecy, and you are not sure why they have got to that outcome?

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

Roy O'Shaughnessy: Could I just add very briefly to that? Once again, this is from the point of view of people coming to us who are supposedly job-ready, and then are very confused about why they should be job-ready and go through the process and, as we have noted in our evidence, we help them in dealing with that. In my company, I see every complaint that comes in. With 33,000 customers a year, even if you are doing very well you are going to have complaints coming in. A lot of times, the difference between getting a satisfactory and quick result is having the appropriate decision maker there at the time. Looking at all the different information in preparation for

today, a large part of this is a problem with customer service, in the sense of a quick feedback process and mechanism. What our advisers tell us is that most of the time the problem is that they can very quickly assess that this person is not work-ready, but the process then of going around and getting that corrected is very cumbersome, and that is what causes the confusion and this feeling of a complete lack of empathy and that you are in a system bigger than you are. Actually, the corrective actions for that are relatively simple, and it does not mean that it is systemic across the process. If you have six people out of 500 who are not job ready, that is still a huge problem for those six. It is building in an empathetic customer service basis for when it goes wrong, rather than assuming it will always go right.

Q31 Karen Bradley: Just very quickly to clarify, have any of the experiences you have been talking about come from the pilot schemes in Aberdeen or Burnley, or are they all from before or outside of that?

Sue Royston: It is not from before that; it is ongoing. We did not get a great deal of evidence in, although the evidence we had from our bureaux was that the problems with the assessments in Burnley were more or less the same as the problems we are seeing nationally.

Q32 Karen Bradley: I recognise it is a very small sample in Aberdeen and Burnley, but I just want to see if there is any difference at all between the pilots and the ongoing issues.

Sue Royston: In terms of the assessment process, I do not think we saw any difference.

Roy O'Shaughnessy: The only thing I would add to that is that under Pathways to Work the complaints have definitely lessened over the last six to nine months compared with two years ago. The number of critical cases, where you wonder how it could have possibly happened that the person is coming in ready for work, has decreased.

Q33 Chair: The figures that the Department published last week, which referred to October 2008 to August 2010, include the group of people who would have gone through the initial assessment when there were serious problems, and lots of people were being found fit for work when clearly they were not. Those figures are a bit misleading in that respect.

Sue Royston: I think I would want to come in and say we are still seeing very serious problems. We would not like people to go away with the idea that there were not still serious problems with this evidence.

Q34 Glenda Jackson: My supplementary on that is, from the very beginning, you defined a system that has been certainly current in my constituency ever since I was first elected, and I have seen no diminution in those arguments. Are you essentially saying that the assessment system has not fundamentally changed—that it is still creating the same kinds of problems?

Sue Royston: Yes. A lot of people have been pushing for the decision makers to be more central and to take extra medical evidence. The Department has taken that on board, and that is the one difference we are

4 May 2011 Sue Royston, Roy O'Shaughnessy, Jane Harris and Professor Paul Gregg

seeing, I must say. We are seeing more reconsiderations, because medical evidence is sent in, but that is patchy. I am still talking to advisers in some parts of the country who are saying, "No, we are still having to go to appeal."

Q35 Glenda Jackson: It leaves the individual in a kind of limbo, doesn't it, because a reassessment has to take place and that brings its own anxieties with it?
Sue Royston: Yes, absolutely.

Q36 Glenda Jackson: There has been no fundamental change as far as I see and as far as you see. If I could simply go to Mr O'Shaughnessy, when you were saying that you have seen some of the major blocks that existed in Pathways diminish, can you put your finger on how that has come about? What has changed in that?

Roy O'Shaughnessy: This is only in one tiny segment of the country; that is the first part of the consideration. Secondly—and I checked with the advisers yesterday just to make sure I was completely current on this, as to where we are—being able to get telephone response information has improved dramatically, and being able to get a sympathetic ear to at least hear why the individual really thinks their case is wrong has improved in this part of the country. The biggest frustration we were hearing from our advisers previously—six, nine, 12 months ago—was it was almost impossible to get phone connects, contacts, information, speak to a live voice and agree on a process. You could talk to your JCP adviser and they would be, "Yes, you are completely right. It sounds like this person should not be working," but it is the process for actually helping that individual go through. I did qualify my remarks by saying it was a small segment we are talking about, but definitely in the sense of a listening ear being better in the sense of that process, in the area we are in, that has improved.

Q37 Glenda Jackson: Essentially, I am paraphrasing but I would put it down as the shift has been that the applicant is not someone who is trying to put one over on the person who is assessing what they are doing. To go back to the point that has been running, one of the essential parts of this whole scheme is that the individual must be treated as an individual and with respect, not as someone who is trying to put one over on the rest of us hard workers, which essentially is the subliminal message that the Government is giving out.

Professor Gregg: To likewise paraphrase, the process of information flows between the claimant and the bureaucracy has definitely improved in the last few months in follow-up. There are still issues about the descriptors and how that relates to their health conditions, but the administrative process has definitely improved. Still one of the problems around the appeals process is that people do not realise they are appealing on the descriptors rather than making a general appeal on how they can possibly be deemed fit for work. The appeals process centres on the descriptors, and there is still a problem there in that people do not quite know what they are appealing against when they are making their appeal unless they

are getting professional support, but we are still in the zone that the descriptors are still a fundamental issue.

Glenda Jackson: I am simply going on the anecdotal evidence from within my own constituency. In a surprising number of cases, the people who are actually doing the assessment, going through the descriptors, have no kind of human contact at all. They are in the same room, but a number of times people have said to me "All they did was look at the computer." That is the issue, it seems to me: that there seems to be a complete separation between what is the desired outcome. In many instances, people have said to me, "They do not want me to get back into work. They want to prove that I could, because their basic consideration is that I am trying to swindle out." That is something I think that is being run.

Chair: Kate, did you not have another question on the WCA customer experience?

Q38 Kate Green: I did, yes. I wanted to know very specifically if you have had any feedback from people you have worked with about how they feel about being able to take someone with them to the assessment, and whether it is clear whether they can or not.

Sue Royston: Our feedback is that they obviously should be able to take someone with them, but at times they are told that they cannot. At times the person is told that they cannot come in or cannot say anything, when actually it should be clear that the person should go in and should be able to say things. It is patchy.

Q39 Kate Green: Do you happen to know if the letter that tells them to come in for reassessment specifically says whether they can bring someone with them?

Sue Royston: I am sorry; I do not know.

Q40 Chair: Does it say whether they can ask for a copy of their assessment?

Jane Harris: I have seen letters where people have been told they can bring somebody with them, but I do not think it is put in a necessarily very encouraging way—"allowed" but not necessarily "encouraged". If I just could come back to the point I wanted to make before, it was really from Mr Bingham's point about how people feel about the decisions that are made, this does really point to a fundamental issue, which is that we have these words that are in the legislation and in the policy about limited capability for work and limited capability for work-related activity, but it does not seem there is this really clear link between those concepts and the descriptors.

Because we have these very vague ideas about limited capability for work and work-related activity, it feels like there is constant interpretation through the system about what that means, which is why people feel confused. They think, "Wait a minute, this is a benefit that is meant to help people who are unable to work," but I do not think we have had a very clear debate about who it is that we really think has limited capability for work. Who is it who we think has limited capability for work-related activity? Without a bit more national direction on which groups of people

4 May 2011 Sue Royston, Roy O'Shaughnessy, Jane Harris and Professor Paul Gregg

can be reasonably expected to work and which groups of people can be reasonably expected to do something towards work, you will get constant interpretation at different levels of the system.

There is a gap between the policy definitions of limited capability for work and the descriptors; there is another gap between the descriptors and the actual Atos assessment; there is another gap between the Atos assessment and what the computer says. No wonder at the end of all that process somebody thinks, "Hang on a minute, I was just trying to claim a benefit because I do not think I can work due to an illness." That interpretation happens at all stages in the system. When you look from one end to the other, you start to think how these two things relate.

Q41 Chair: We were going to come on to questions about the reviews, and I am going to bring Oliver in in a minute. Just to clarify, because we are still talking about communications, I had assumed that for people who were being called in for an Atos assessment, there would be a standard letter used across the country, but, from what you are saying, it would appear that each assessment centre has its own letter, because some letters say they can bring someone with them and others do not. Some of these may be questions we need to ask Atos. Obviously what you are saying is that the communication that Atos itself sends out, rather than JCP but Atos themselves sends out to claimants, is perhaps not as clear and as helpful. We got the sense in Burnley that Jobcentre Plus was actually bending over backwards to try to get the communication right.

Jane Harris: The reason I said that I have seen letters like that is I do not want to claim to have seen every single letter that Atos or Jobcentre Plus has ever put out. That probably is a question for Jobcentre Plus and Atos, as to whether they always send the same thing, because it is hard for us to know.

Sue Royston: The problems with communication with Atos is that, once they have sent a letter, the claimant then has to make a phone call to Atos to make an appointment for the assessment. We have found that very rigid and have seen real problems there, where people are ringing up. It is clearly not appropriate that they go to an assessment at a certain time, but because the person just has a script, they will tend to be told, "You must come along because otherwise you might lose your benefit." At one extreme end, we had a psychiatric nurse ring up because the person was compulsorily detained in a psychiatric hospital. They rang up to say, "Surely you don't want..." to be told, "Well, the benefits could stop if you do not." This person had been sectioned but had to go to the assessment. Now that was clearly ludicrous and was clearly a mistake; they were not meant to; they would be exempt from the assessment. We have found a real problem with that phone line.

Chair: We have quite a lot of evidence now. I in fact had a constituent who had turned up twice and could not be seen because they had too many people turning up, and then got up a letter saying she was being sanctioned because she had not turned up to her assessments, when she had. Anyway, on to the reviews and the Work Capability Assessment, Oliver.

Q42 Mr Heald: Starting off, a question for CAB and Rethink. On the internal review, we are told by the Department that, "Recognising ongoing concerns of specialist disability groups, further detailed work was undertaken," which was "published as an addendum to the report." The Department go on to say that the changes that they made "ensure the assessment makes greater provision for individuals awaiting or on chemotherapy, individuals receiving residential treatment for drug or alcohol misuse and those with severe mental health conditions or communication difficulties. They also ensure the assessment takes greater account of how an individual has adapted to their condition." Chris Grayling has said that the overall effect in mental health is that more claimants would be placed in the Support Group. I am just wondering what your take is on that.

Sue Royston: There are some parts of the internal review that we welcome. DWP's assessment is that 1% more people of all those people assessed will go into the Support Group. However, their assessment also says that 9%⁵ more people will be found fit for work, and it is the 9% more who are found fit for work who we are concerned about, because already we are seeing a lot of people being found fit for work who should not be found fit for work. Our problem is that the internal review only looked at descriptors, and the whole premise of it is that it is a theoretical test based on adaptations that are theoretically possible for a theoretical person, if you purely look at descriptors and nothing else. The obvious example is that now there will not be any descriptors for bending and virtually nobody will qualify under the sitting and standing, because that is being made a either/or question. Basically if people have physical problems, general physical problems with mobility, they are going to have to qualify under walking, and just under walking, in the new descriptors. That is a large part of why 9% more people will be found fit for work.

For some people, that may be fine. On the one hand, this descriptor will fit for, say, a young man who has a degree, has done desk work all his life and who hurts his leg. It may well be that, if he can walk more than 50 metres, he can still work. On the other hand, it also has to fit somebody who has worked for 40 years doing manual work, has had perhaps a heart attack and is found to have heart disease and severe emphysema. The basic descriptor he is going to qualify under is how far he can walk. If he can walk 60 or 70 metres, he is going to be very restricted in his life. His opportunities to work will be very limited, but he is being tested on the same test as the young man with the degree, so that was our main problem with the internal review: it just looks at descriptors.

Jane Harris: It is interesting to hear that. I have not heard that from Chris Grayling before, that people with mental health problems or people with severe mental illness will be more likely to go into the Support Group. With the internal review, it has

⁵ DWP's estimate is actually 5% (see written evidence from DWP, para 60). CAB's own assessment puts the figure at 9% (for an explanation, see CAB's response to the SSAC Consultation on the Employment and Support Allowance (Limited Capability for Work and Limited Capability for Work-Related Activity) Amendment Regulations 2011, available on the CAB website at www.citizensadvice.org.uk)

4 May 2011 Sue Royston, Roy O'Shaughnessy, Jane Harris and Professor Paul Gregg

reduced some of the descriptors both for the Support Group and for the Work-Related Activity Group on the basis of mental illness. The descriptors still say that, if a claimant can set an alarm clock, feed themselves and manage life without daily aggression or needing almost constant supervision, or have some social contact of any kind, they will not go into the Support Group. It seems to me there are quite a lot of people who might need to be in the Support Group who would not fit those descriptors. You could come up with all kinds of scenarios, but you could imagine somebody who has just been released from hospital, is under a crisis team perhaps; they would not be given constant supervision. A crisis team might be visiting them daily to assess their mood and assess whether they are suicidal, for example. That person might be able to set an alarm clock for themselves and feed themselves, but they might still be experiencing really devastating hallucinations, really devastating voices, and might not be able to leave the house.

Even on the basis of the internal review, we still think the descriptors do not really reflect the real world, as Sue said, but also probably are still too restrictive. There was a fundamental problem with how the internal review was done, because not only was it done at a theoretical level, it did not even look at appeals data. Even if you are working just on a theoretical level and not actually meeting these claimants, appeals data is one of the best ways that you can tell what is happening. I accept there may be elements of the internal review that are very positive, like the issues around chemotherapy, but it does seem very odd that, because there were some elements that were positive, the whole thing was accepted. Plenty of Ministers through the ages have accepted some parts of internal reviews and not others. It does not seem a very good reason to accept the whole lot.

Q43 Mr Heald: I will come on to you with the next question, if that is okay, Professor Gregg. Just continuing with this, and then I will bring Professor Gregg in in a minute, this is not the full review process, because Professor Harrington's review is the main review. Do you believe that the implementation of his recommendations will fully address the weaknesses of the current system?

Sue Royston: No. We very much welcome Professor Harrington's report, but I do not think Professor Harrington himself—and I do not want to put words into his mouth—would feel it did. He made some very useful and important recommendations, but that was a fairly short review; he was not appointed until, I think, September. He is doing a more thorough review this year, and we hope that he will address a number of issues that we think are very important, which have not been addressed at all. Do you want me to go through them?

Mr Heald: Yes.

Sue Royston: When somebody is assessed, the first thing that happens is there is a look-through of all the evidence to see whether they should be in the Support Group. There are a number of reasons why you should be in the Support Group. Obviously one is if you are terminally ill, but terminally ill counts as if you are likely to die within six months. One of the things that

astounds people, once they see people in this situation, is people who have a life-limiting condition—say something where they have been given a prognosis of three or four years—are not put in the Support Group. They would go to a functional assessment. If their function was such that it was found that they had enough points, they would be in the Work-Related Group.

There is one condition where, at the end of that, if they still have not qualified for the Work-Related Group, then if they have a life-threatening illness that cannot be controlled, they are put in the Work-Related Group. I do not think there has been too much attention in the past about that, because some of them have got into the Work-Related Group, but now that the Work-Related Group is going to be limited to one year, there is a great concern about that. The example given in the doctors' guidance of who would qualify for this life-threatening illness is somebody with motor neurone disease. Now, I understand that the life expectancy for the most common form of motor neurone disease is usually two to five years, so you are going to have the position where somebody gets a year's benefit in the Work-Related Group and their condition is getting steadily worse, but unless they have a very severe impairment, then the idea is they have had enough time in the Work-Related Group that they should be able to go out and look for work. We do not think that makes any sense at all.

We certainly think that anybody who has a condition where you have a life expectancy of less than five years should automatically be put in the Support Group. That would address some of the really awful cases we have seen. We had somebody with breast cancer who then developed bone cancer. She went for a functional assessment, and we find the Atos reports are not very accurate but this was an inaccurate report in a different direction. Halfway through, not surprisingly she said, "I get a bit low at times." From that point, the report was exaggerating what she said. When she looked at the report, she said it was "exaggerated". It was clear that the nurse who was seeing her felt there was no way this person should be found fit for work, and so she was found not fit for work on the basis of depression, even though she was not suffering from clinical depression at all. We are very concerned about that group.

There are three other things I would very quickly say. The ESA assessment, part of that ringing up the helpline, is very mechanistic. We have seen people being asked to go to an assessment at an entirely inappropriate time. We had an example of somebody who had had bowel cancer, who had seemed to recover a bit and then became seriously ill again. The Bureau said he looked really ill, but he could walk more than 60 or 70 metres and so he was found fit for work. Two months later, the doctor said, "Your cancer has returned. You are terminally ill." He was put straight into the Support Group at that point, but DWP would not change the decision that two months ago he was fit for work. We are not talking about trivial investigations but serious investigations for a life-threatening condition. What is the point in paying for an Atos assessment? Just wait and put them temporarily in the Work-Related Activity Group with

4 May 2011 Sue Royston, Roy O'Shaughnessy, Jane Harris and Professor Paul Gregg

no conditionality; let them claim the benefit until you know the result of the investigations, and that is the point to decide which group they should be in.

Q44 Glenda Jackson: Can I just ask whether the decider in that kind of situation would be the medical evidence coming from outside? Would it be the individual's doctor, clinician?

Sue Royston: You are talking about the five years.

Glenda Jackson: Yes.

Sue Royston: Doctors find it difficult enough to say a person has six months to live. I do not think we would want doctors having to say, in this particular case, he has five years to live. I am not a medic, but I do not think it is beyond the bounds of reason that doctors could draw up a list of conditions and levels of conditions, of which for instance motor neurone disease would be one, where if somebody has the condition, their prognosis is not very good.

Q45 Glenda Jackson: The reason I ask that is I have a constituency case of a woman like the one you mentioned. After a recent diagnosis, she has refused to accept any more chemotherapy. She is going down what I would call a more holistic approach. Everything stopped; just everything has stopped because of that, and it is how one can set in the system a means whereby the individual does not have to go through that humiliating process, without having doctors feeling that they are issuing death warrants, which is not what they are about. I just wondered what the most effective way of saying that is.

Sue Royston: I think it would have to be condition based.

Q46 Glenda Jackson: The existing evidence of longevity in these cases should be the decider.

Sue Royston: Yes, I think insurance companies manage it.

Jane Harris: I just wanted to come in on the point about the Harrington review. I think it would be naïve for any of us to think that any review or set of recommendations would be a total solution and that we will end up with the perfect system after that, but I do think Harrington does address some of the really fundamental problems and represents a massive step forward for the group of people we represent. The fact that there seems to have been support for the Harrington review from almost every quarter, from Government to most disability charities, just shows how comprehensive it has been despite its limited timeframe.

The two main issues that Harrington really suggests improvements in for us are the issues with self-reporting. One of the problems is that people with some severe mental health conditions lack insight. Sometimes part of the diagnostic procedure is to check that somebody lacks insight into their condition. If somebody is then having to self-report and conclusions are being made on the basis of self-reporting, that just does not seem to work. There was one person who wrote a comment on our website saying, "I have extreme difficulty in talking about my mental ill-health to professionals trying to help me, let alone to a complete stranger at an impersonal

assessment." That is not just one comment; that is repeated across the board. The recommendations Harrington made about looking at more medical evidence would really help. Possibly on that Harrington does not go far enough, because in some instances it is still up to the individual to find that evidence themselves, rather than Atos or Jobcentre Plus trying to get that evidence forward.

Just another comment from one of our members: he said, "I do not have the strength now to organise further medical evidence to help me through this, because my illness means I have become paranoid about what they think about my appearance when they are talking to me. I seriously cannot see me leaving the house for this medical when, in my anxious episodes, I have to venture out in the early morning when it is dark to buy food to avoid looking at my body. Tesco is too much for me some days and I go without a meal." Somebody in that situation probably is not going to have the strength or the resources to go round and get all of the reports from their GP, from the CPNs, from psychiatrists to put forward. In that instance, Harrington is not the total answer, but it is absolutely a step forward, so at least when evidence is submitted it is looked at more seriously.

The other point that Harrington really addresses is the issue of Atos staff having much more knowledge of mental health. The idea that we will have mental health champions in all of these centres would be a massive step forward. It would really help. That is why we are so concerned that, while that is going to be such a positive step forward, there will be thousands of people going through the reassessment process before that is put in place. It does seem a real rush to be starting this process of migration before that is put in place.

Q47 Mr Heald: Chris Grayling says it is going to be in place from the beginning of the migration. Professor Gregg, you said that the trials in Burnley and Aberdeen should have been delayed to test run the new regime. Why do you think that? Also, do you mean to delay them just for these changes we were talking about, like the mental health champions, or do you mean delay it for a year almost because of the annual review?

Professor Gregg: The point I wanted to come in on, and it is to the question you have asked, is that we have a new regime—we have Harrington; we have the new descriptors, which you have mentioned—which is now going live, essentially untested. The mood music suggests everybody is saying that Harrington is a big improvement, but at no stage, as we have gone through this, do we try new systems in the field before rolling them out nationally. I felt that Burnley and Aberdeen were the absolute gift opportunity to run the new system to check that the new descriptor changes were working to fix the problems that were perceived and, in a sense, provide the information to say whether this was in need of further change or had solved the problem. Inherent throughout this process is the problem that we have not done enough to monitor and check the process at each iteration. I suspect we are going to have new iterations, which you are alluding to, but after each iteration we should do our utmost to

4 May 2011 Sue Royston, Roy O'Shaughnessy, Jane Harris and Professor Paul Gregg

check that it is fixing the problem that it is trying to fix before it goes national.

I felt we should have delayed Burnley. That starting point is that it was a shame Harrington was so late; it would have been nice if Harrington was around in time for Burnley and Aberdeen. Given it was not, and given that the internal review was not complete, I felt that the Burnley and Aberdeen process should have been delayed so we could have tested the new regime in reality.

Q48 Mr Heald: If I challenge you just a touch on that, when we went to Burnley, they said to us, "Look, this is what the existing scheme has been for people who are making new applications. What we are doing here is different." They did show us some things they were doing that were based on Harrington, such as the extra phone calls, looking at the medical evidence and having that review process available. It does seem to have paid some dividends.

Professor Gregg: I agree and the fact that DWP responded to try to get a lot of Harrington's proposals in a sense before they were public—a lot of this process was done when they were in the thought process rather than the formal process—is good news and was well done. The descriptors of course were not under that system, and so the new descriptors are being introduced in a sense to try to fix problems that were deemed to be with the old ones. We are now going live with those new descriptors without having any process of checking that they have fixed the problems and not created new ones, which is the kind of message coming out of here.

Just to finish on that particular point, I am unhappy at the lack of other informational sources that are potentially useful to be collected to tell the story to Committees such as yours, which is the WPLS system, the appeals system, where people are going once they leave the system and the conditions that are being overturned. The WPLS system can also tell you which conditions people were presenting with that they then go on to go into JSA with and not go into work, etc. We have had no systematic attempt to follow people. Again I thought Burnley and Aberdeen were a gift opportunity to track people who are not getting on to ESA or getting into the Work-Related Activity Group, and finding out what is happening to them. Are they moving into work? Are their conditions getting worse? Are they getting on to JSA? What is the story around this? We can gather the kind of information that will inform Harrington 2. There just has not been enough informational collection going on at each stage. Each stage of reform has been implemented without being tried in practice, and I feel that, given the vulnerability of the group that we are talking about, this is not good enough.

Q49 Chair: You used an acronym, WPLS.

Professor Gregg: Sorry, the administrative system within DWP that tracks where people are and what benefits they are on, so you can see whether somebody has moved from Incapacity Benefit to Jobseeker's Allowance or lone parent benefits, whatever benefits they are on. It is administrative; I have forgotten what it actually stands for.

Chair: I am conscious of the time. We have lots more questions and lots more areas to cover. I suspect quite a lot of it has been covered already, so can I make an appeal—this is more to my own colleagues—to concentrate on the things we have not said up until now. We are looking at decision making, which has been a large part of a lot of what we have already covered this morning, but Teresa has some questions on that.

Q50 Teresa Pearce: We have heard a lot about the descriptors. Just a basic question: who originally designed the descriptors? Was it Atos or was it DWP?

Professor Gregg: It was DWP—a team of medics commissioned from DWP.

Q51 Teresa Pearce: It appears to me one of the things about the descriptors is, as with targets, people started to work to the targets. It seems like we are trying to fit the people to the descriptors, rather than fit the descriptors to the people. I just wondered how accurate you felt those descriptors were and are, with the changes that are going to be, in actually assessing customers' needs.

Sue Royston: We have suggested that there should be a real-world test underlying it—for the sort of person that I described, the functional descriptor for the man who has done manual work for 40 years and got emphysema and for the young man. The same descriptor cannot describe both. The Government justifies somebody being on ESA rather than JSA on the basis that they are likely to be out of work longer because they are more disadvantaged in the workplace and likely to need more support and help. That seems to be a sensible suggestion. In that case, it should look at what somebody's disadvantage is. Certainly our advisers tell us that there are a lot of other factors that matter in terms of whether or not it is feasible for you to get a job than just your level of impairment.

There is a lot of evidence from academics about disadvantage and who is disadvantaged. For instance, somebody with a degree but with a serious impairment, their impairment will cause them less disadvantage compared with somebody who has no qualifications, no experience other than manual work—a less severe impairment will have more effect on their disadvantage in the workplace. There is work that could measure this level of disadvantage, and Professor Harrington has recognised that and asked Citizens Advice to write a report, because we suggested it last year, on how we would see a real world test functioning. We do think that there needs to be something more than descriptors; there needs to be some sort of real-world test based on evidence of somebody's actual level of disadvantage.

Q52 Chair: Sue, can I just ask if what you are describing is what we would call an employability test?

Sue Royston: Yes.

Q53 Chair: Although this is a work-related test, there is no test for whether the person can work.

Sue Royston: Yes, absolutely.

4 May 2011 Sue Royston, Roy O'Shaughnessy, Jane Harris and Professor Paul Gregg

Jane Harris: I think we would endorse absolutely all of that. We were on one of the consultative groups that worked on the original WCA descriptors, but not on the main group, and I have to say that it did not always seem that there was a real link between what evidence there was on whether somebody would get back to work and what actually ended up in the descriptors. I do not think it would be that easy to go through those descriptors and say this is because of this study that found this is a key factor in determining whether somebody goes back to work.

In the internal review that DWP did, they did say they were only looking at capability; they were not looking at employability. It seems to me that those two concepts are not entirely separate. It is hard to judge whether somebody will ever be capable of work without looking in some ways at the real world and whether somebody might be employable. I think there is this complete distortion between this idea of fitness for work and what the descriptors say. The other area where there is another slight distortion is between what the descriptors say and what the computerised system, LiMA, which Atos uses, uses as evidence for the descriptors or against the descriptors. We were shown during that consultative group process a demo of LiMA, but we were never able to see the protocols that work behind the scenes to determine whether something is evidence of a descriptor or not. That is all done completely shrouded in secrecy in the back end of a computer. Again, Atos told us that they did absolutely keep that up to date and it was based on the best evidence but, given this test is determining where public money goes, who is supported or not, the secrecy of that process probably does not seem quite right.

Roy O'Shaughnessy: Could I just add, when you talk about employability against capability, I asked our business managers in the centres dealing with the customers how long it took for them to recognise that the individual was not able to work. They have the appointment to come in; they come in; they sit down with the adviser. It is within the first 10 to 15 minutes. We have already noted in our evidence we are talking about a small group here. The vast majority of individuals coming in are capable, once we help them overcome their barriers, to go on. For the kind of individual who is being embarrassed, set back and things like that, it is not like it takes two or three weeks in our centre. You would think that there should be one other filter level to protect those individuals from the embarrassment and the humiliation of coming into the process, because it is not rocket science as to why these individuals cannot work, the ones who we are seeing coming into the centres.

Q54 Chair: Is that not because it is based on a gut instinct rather than anything that is formulaic, which is what the computer does?

Roy O'Shaughnessy: I think it is that real-life part that we were just talking about. In other words, our advisers are dealing with hundreds and hundreds of people every day. Very quickly, when you ask whether it is more instinctive or something like that, it is making that connection with the individual to say to them, "Look, even if you are so afraid that you cannot

run the copy machine and that is why you do not want to work, we can help you overcome that." Sometimes it is as simple as that with the people who have these regular barriers. The ones we are talking about here today have much more complex issues and needs, but those are absolutely obvious to anyone who is dealing with people coming in day in, day out, and that is where there is a little bit of a disconnect on the small proportion where you have a doctor or a nurse looking, when they do not have that daily experience. If there was one other level of filter into this process, maybe it is that experienced advisers from our centres rotate in there, because we would far rather help an individual know in advance that they are not qualified.

Q55 Mr Heald: I was going to ask you this. One of my great worries is that, if you have somebody with an intermittent condition, say a mental health condition like health anxiety, you could see them one day and they would be thinking they were about to die, and you would think that person is completely unemployable. But they get their treatment, they are with a counsellor and, three weeks later, you would think they were a fine, upstanding employee. How do you judge it? If you have a test of the sort you are talking about, is it not rather subjective?

Professor Gregg: Could I have a go at answering that, because it kind of answers the point I wanted to make? There are two issues here that are solvable. One is whether the descriptors are right and whether the process of measuring those descriptors is right, which we can have a look at. I am sure Harrington will come back to that.

The second is whether there is a way of triggering a more in-depth assessment for people where there may be serious reasons to think that they are falling into this group of severe but not captured. That is what they do in the States. In the States, where somebody presents and says they have health-related problems, they effectively have a two-stage process. They have something akin to what we have, which tries to measure some basic employability capability, and then they have a much more detailed medical conditional assessment for the small minority, where medics who understand the conditions actually go in to try to avoid the cases we are hearing more about—the bonkers ones, where somebody was about to die but still passed the test. What we need is sort of a triggering device, and it could be by the decision maker, who receives information from the claimant to say what their circumstances are, and says, "I cannot make a decision here, because I can see the conflict between the two? Can this go through a more detailed assessment from a medic?" It is not costly, because we are talking small minorities, but it will avoid this rough justice.

Mr Heald: That is the idea of a mental health champion—that you will have an expert.

Q56 Harriett Baldwin: In addition to mental health issues, there is this topic around terminal illnesses and how difficult it is for the medical profession to predict with any certainty how long someone's life expectancy is. You only have to think of al-Megrahi; that is nearly two years now. There are degenerative

4 May 2011 Sue Royston, Roy O'Shaughnessy, Jane Harris and Professor Paul Gregg

diseases where you know your outlook is poor but you are able to work fine, but then you might suddenly go into a rapid period of deterioration. Is there a process where the decision making can be reviewed, when there are those changes in circumstances? Can you opt in for a further assessment?

Sue Royston: If you are in the Work-Related Activity Group (WRAG), you can at any time ask for the decision to be reviewed to go into the Support Group. In practice, up till now there have not been that many appeals from people wanting to go from the Work-Related Group to the Support Group, but I think you are going to see a huge increase in appeals now, because obviously you have two new factors being proposed. One is limiting to one year the contribution base of those in the Work-Related Group, and the other is the fact that the Welfare Reform Bill proposes that the money that used to go in the Severe Disability Premium will now go to those in the Support Group, so people in the Support Group will get a great deal more money if what is proposed in the Welfare Reform Bill goes through, so you are going to see a huge number of more appeals to go from one group to the other, I think.

Q57 Chair: If somebody has been on the WRAG for over a year, and so has lost their contributory ESA and is reassessed for the Support Group, do they get the contributory element back?

Sue Royston: We do not know that. I suspect they are going to have to ask for a review at the end of that year. If their condition has not worsened, they are going to have to think, when they get the original decision, whether they want to appeal, because the grounds for a review would be about your condition having worsened, I would think. I think it is going to cause confusion.

Q58 Teresa Pearce: One of the things that people said when we went to Burnley was that, in their assessment, there was no notice taken of what their GP said, because it is not a medical. Going forward, what do you think the role of the GP should be? Do you think there is a role and, if there is, what should it be?

Sue Royston: A lot of this is about your medical condition. There are a lot of parts of it where the medical condition is very important, and we feel it is vital that what is known in somebody's medical records is known by the decision maker, because decision makers are making judgments. The Atos assessors are giving judgments based on what they think of the medical condition, and so it is not a medical, but it is not entirely divorced. You have to have a physical or mental condition in order to apply in the first place. It is not just about what you can do; it is also about your physical and mental condition.

One thing I wanted to come back to is about decision making. We are really pleased you can now present medical evidence for people and that will be taken on board. We are very concerned that that is the responsibility of the person at the moment. It is good that DWP are accepting it, but a lot of GPs charge about £30 for a report. If you are getting £65 a week and you have to pay a GP for £30 to get a report, I

can see a two-tier system developing, where you have a much better chance of being on ESA if you can afford to get a report from your consultant. What we are seeing are reports that are making judgments about someone's medical condition, where there may be loads of reports from a consultant psychiatrist or a consultant neurologist. It makes no sense whatsoever if that is in the medical records for that not to be taken account of.

It strikes me there are three things here: there is the evidence from the client about the way their condition affects them; there is the evidence about what the medical condition is and the level of severity of it; and there is a need for some independent confirmation that that level of condition is likely to produce that level of impairment. I do not think the system with Atos is necessarily providing the best way of finding that out, and there would be other ways that you could more accurately produce a result about what the person can actually do.

Q59 Chair: I am going to move on. I know there is one more question, but we are really beginning to run out of time. I have a couple of questions about the appeals process. The Minister intervened on me in the Chamber when I suggested that the appeals process was maybe taking quite a long time, and said that it should take 17 weeks. Is 17 weeks what you are finding?

Sue Royston: It is variable. We are still seeing people who are waiting over a year, but we are seeing people who are being seen in less time. We tend to have a backlog, so I would not like to say exactly, but I think it is variable.

Q60 Chair: Is it getting longer as more and more people appeal, and 44% of those appeals are found on behalf of the claimant?

Sue Royston: An effort has been made, and in some parts of the country it has been quite successful, where there is strong medical evidence and it is clear that it is the wrong decision. DWP is talking with Atos and looking at the cases, so some are being reconsidered. In some parts of the country, that is getting rid of some appeals that were clearly going to be successful, but in other parts of the country we have heard that system is not working at all and they are hardly reconsidering any.

Q61 Chair: I know from my experience in Aberdeen that certainly there is a reconsideration before the appeals stage has been built into the migration process, which seemed to be missing. Perhaps Professor Gregg can answer: when you have 44% of appeals being upheld, what does that say about the original assessment?

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

4 May 2011 Sue Royston, Roy O'Shaughnessy, Jane Harris and Professor Paul Gregg

and you sort of said it yourself, that we do need a filter device to try to reduce that flow into the appeals process. There should be a review system put in place. That review often should involve some assessment by a medical expert outside, an independent medical expert, to see whether this should go forward, which is what I was trying to allude to before. We need another trigger threshold to try to pick up cases that are flowing through the Capability Assessment but are heavily likely to be overturned at appeal process. Harrington has started that process. I still think there is more that we could do to try to build in a filter device before we get in there, because it is very costly and slow to go through this kind of process. The very slowness of it tends to inhibit the process of trying to engage people back to work, which impacts on Roy's part of the system.

Q62 Chair: Clause 99 of the Welfare Reform Bill makes a provision to enable the Secretary of State to lay regulations to the effect that an appeal can be made "only when the Secretary of State has considered whether to revise the decision". Will that be that filter? Will that operate as a filter? That puts in a mediation level before the appeal.

Sue Royston: Can I answer that? We do not like that at all. At present, when somebody puts in an appeal, DWP has to reconsider that decision, so the reconsideration is there. Now we have argued and argued that that reconsideration should be a serious reconsideration. What we saw up until very recently is you would send an appeal in and, within the two days, you would get a decision back that it had been reconsidered. That reconsideration by DWP was basically a rubber-stamping of what had gone before. We saw very few properly reconsidered. DWP has taken that on board, particularly in the Burnley pilot, and there are signs that they have made a definite decision to properly reconsider, and Touchpoint 13—

Q63 Chair: Could you explain what Touchpoint 13 is?

Sue Royston: Yes, sorry. If the decision maker looks at the evidence from Atos and other evidence that she is holding at that time, and decides that the likelihood is she is going to find the person fit for work, rather than sending out a letter with the decision, the decision maker will ring the client and talk through it—these are the reasons, these are the descriptors, these are the reasons why—and ask them if they are happy with that bit or if they agree with that bit. If they disagree, would they have any other evidence? The idea is, if there is other evidence, to get it at that stage rather than the appeals stage.

We have some concerns about Touchpoint 13, but we are also very happy that they are at least making a serious effort at that stage to get evidence. It is not in anybody's interest—DWP's, the taxpayer's or clients'—that appeals go on when they do not need to go forward. We are really pleased with that, but we are concerned that there is a chance that Touchpoint 13 may be used to persuade people that there is no point in appealing. There are dangers but there are signs they have reconsidered more. There is a reconsideration stage. It should be there; it is

important it is there, provided it is done properly and DWP take time to look at it. A lot of our advisers say that by the time they have evidence, it is too late; the reconsideration has been done and DWP will not pull back the decision. They say, "Oh, you will just have to go to appeal."

We want that reconsideration done properly, but what is being proposed is imposing two time limits on the client. The reconsideration would be done; the client would get the decision; and then they would have to put in an appeal again. They would have two time limits to meet. That seems to me very wrong. It is putting the onus on clients to do the thing twice. We have lots of evidence that there are problems with meeting one time limit and that people do not appeal because they missed the time limit. To put two time limits in the way of people is going to cause problems for Bureaux, because when we at the last minute have to fit people in because of time limits, we are now going to have to fit them in twice because of time limits. We think it is a very bad thing. There should be a proper reconsideration.

Q64 Chair: One of the other things somebody raised when we had a meeting in Burnley was that they had gone through the appeal process, and eventually, months or up to a year later, it was found in their favour, and then within a couple of months they had another appointment to be reassessed for another WCA. How can that possibly happen, especially if they have ended up in the Support Group?

Sue Royston: The problem is that the decision legally is about the time that the decision was made. The tribunal is not making a decision about whether the person is fit for work then; they are making a decision about whether the decision maker was right a year ago to find the person fit for work. Because it is a decision about a year ago, in a sense it is time for the person's new review. I can see that is a problem, because the tribunal may be faced with somebody who has got better and says, "Yes, I am fit for work now and quite happy about that, but I was not fit for work a year ago and you should have paid me until I was fit for work." I can see there is a problem, but I think it could be done, rather than sending somebody for reassessment, simply by writing to their doctor and saying, "Has this person's condition changed?" If this person's condition has got worse or stayed the same, then I do not believe there is an argument for putting them through the whole anxiety of that process all over again. I can see the need for it, but I do think it should be done without a whole assessment, unless that is really necessary.

Chair: I am going to move on to questions about the Employment and Support Allowance, and how that is working.

Q65 Glenda Jackson: Thanks very much. Professor Gregg, you have said in your written evidence that, in effect, you have designed the Work-Related Activity Group. Has it been implemented as you wished it or was it simply rejected out of hand? What happened to it?

Professor Gregg: Essentially it has become embodied in the Work Programme. When I was proposing it, the

4 May 2011 Sue Royston, Roy O'Shaughnessy, Jane Harris and Professor Paul Gregg

idea was to try to do pilots ahead of a full introduction of what were called multi-client group contracts, where providers would have people from unemployment benefits, lone parent benefits and sickness benefits under joint contracts. The idea was that they would be pilots, and essentially that was scrapped and it has been rolled into the Work Programme, so the Work Programme is implementing my proposals under the Work-Related Activity programme, and for people like Roy here, it will be in our duty to try to make that system work. Fundamentally, the system that I designed is in place and embodied within the Work Programme.

The issue that was not taken forward, which I would like to raise, is the funding system for support. What the Government has done is taken a sort of three-band system. You have a low, middle and high support payment to the providers, in order to get people back to work, and there is always a risk, particularly for the group we are talking about here with such huge diversity of conditions, that there are those who are going to be relatively easy and those who are going to be relatively hard and costly to try to move back to work. There is a clear incentive for providers to work with the easy and low cost, and park the rest. A point I tried to make earlier is that that divide then between JSA and ESA, which essentially puts people on the low to the highest cost of those three tiers, becomes increasingly crucial as to what support they have. Likewise, the groups we are talking about here, who might be migrated over off ESA on to other benefits, may well also be parked, because they are going to present the significant problems, but these guys (the providers of employment services) do not have the resources to meet those kinds of problems.

What I was proposing then and would still advocate is that we should be looking at what is sometimes called an escalator model, which is that the payment rises the more successful the provider is. If they get the easy ones back, they get a low premium. As they start towards the higher end of the business, the harder to help, the price rises, so they have a continuous incentive to work towards the more severe cases, rather than this kind of banding system.

Q66 Glenda Jackson: We have taken evidence on this, the issue of creaming and parking, and there is contrary evidence to your escalator, where in fact it was not the hardest that brought the bigger payments; in effect, it was the easiest. You also raised the issue of tracking. There have already been answers on the issue of tracking, as far as people in the system are concerned. How would you do it? Who would be the best people to track this? Does it require an independent review?

Professor Gregg: The DWP people who run the administrative system can or should be able to, with a little bit of a lag, tell you where people who have had decisions made around their ESA status are now in the welfare system. If you also go on to include whether they are in receipt of National Insurance payments and so on, which is available within the tracking system, you can see essentially whether somebody is working, you can see whether they are claiming other benefits or if they are just not within

the system at all now—i.e. they are not in work or in benefits. It is not that hard; it would require an IT investment and some dedicated staff, but I feel there ought to be a routine reporting system for people like Professor Harrington to be able to use to see where people have gone.

Further to that, you can also tell what problem they were presenting with. You can see, when they were presenting to ESA, whether they had mental health reasons, back problems or what have you, so you can in a sense get a descriptor of which conditions are seeing people returning to work and it all looks pretty fine, and which conditions they are not and are either disappearing or sticking on other benefits, hence the areas of which the descriptors might be refined, because we have evidence that groups are not being well categorised at the moment. It is not that hard a process. The IT structures are already there; they just have to be used for this particular process.

Q67 Glenda Jackson: Is that correct? You are talking about people in work, people being out of work, people claiming benefits. You are looking at several departments of state having to integrate, when they are already not integrated. In many instances, there are not even effective computer systems within their own existing remit of responsibility. Is it that easy really?

Professor Gregg: DWP and HMRC are integrated in this respect.

Q68 Glenda Jackson: You could have fooled me, when I look at some of the Working Families tax credits cases.

Professor Gregg: Decisions? Yes, well that is in a sense why they were integrated. It was the tax credit process that drove that computerised integration. In a sense, the informational flow, you are right; there may be cases where it goes wrong, but the core informational flow of National Insurance contributions, tax credit payments and benefit receipts is there and could be used.

Q69 Glenda Jackson: If this tracking system is not put in place—and I still disagree with you that it is as easy a process as you are attempting to paint—what happens to those people who do fall through?

Professor Gregg: At the moment, we do not know; they are not tracked. It would seem imperative to me that we do have some attempt to follow the people who are displaced from Incapacity Benefits on the transition to ESA, even if it is in a case study-type approach. I thought Burnley and Aberdeen were a gift for this: a few thousand people being followed up, their medical records being checked. Are they moving into work? What else is happening in their lives, with homelessness, etc, being monitored? We can get a sense of where people are going. Is it working for some groups and not others? Does that lead us to look at further processes? It is not clear to me that it is still too late for Burnley and Aberdeen.

Q70 Chair: I was going to ask: surely it is not too late? They have that cohort. In fact, a number of them still have not gone through the full process because

4 May 2011 Sue Royston, Roy O'Shaughnessy, Jane Harris and Professor Paul Gregg

they are now in the appeals, so they have not got a final determination. A lot of the unhappiness with the process still has not come out yet, because they have not got that final determination.

Professor Gregg: Commissioning takes a bit of time, the commissioning of that kind of follow-up work, but it would still be possible, I would have thought, in six to nine months, to have somebody working on contacting people and finding, if you like, their story. It would be nicer if it was real time, so you were doing it while it was going on, but we should at least be able to check what has happened to those people six to nine months on from now, so a year or so on from their decisions, and find out how many went through the appeals process, what happened to those people who were unsuccessful there and where they have got to now. It is still doable.

If we are not willing to do it for that cohort, can we set up a new cohort? There are attractions for trying to do it for a new cohort, because we have new descriptors. We have a slightly different regime now; perhaps we should be trying to do it for that new regime. Can we find a cohort of people who are going through it in the months of, say, September and October this year, who are going through that process, and track a proportion of those to find out what has happened to them? I feel it is really out of order that we are not making an attempt to try to find out what is happening to people where there is a serious risk that it could be going wrong for them. It is not that expensive. This is regular research. It can be done to track people for a year or two afterwards.

Q71 Glenda Jackson: I appreciate all that. I am trying to dig out how someone has fallen through the net. I share your fear that they disappear. How would that happen? At the moment, if I am looking at other areas where people come and say, "We want to claim this benefit," and you say to them, "No, you do not qualify," what are the lack of qualifications that are inherent in the new system that is going to be introduced that could affect people who will effectively disappear from the system and be left absolutely destitute? What are they? Is it just the year for one sort of claimant? I am trying to get my finger on how people can disappear in that way.

Sue Royston: If somebody is on means-tested ESA, they would qualify if they applied for means-tested JSA, although the worry is that some people simply cannot cope with the signing-on. We have for instance seen people who have lived on their DLA, because they just could not cope with it. That is one way they could disappear out of the system. It is much easier to disappear out of the system if you are on contribution-based ESA, because you only have a maximum of six months contribution-based JSA. Of course now, if you are in the Work-Related Group, you are only going to have a year of contribution based ESA.

It depends what you mean; obviously they are not going to be destitute in the sense that, if they literally had no money, they would be entitled to the means-tested benefit instead, but we will see a lot of people in great financial difficulty because they have perhaps been earning a good salary; their finances are

based on that; they suddenly get ill; their salary drops, and then, after a year, they do not get anything at all. Perhaps, if they have been the main breadwinner, earning £600 a week, they go down to £91 and then lose it all. They will just be dependent on their partner's salary.

Q72 Glenda Jackson: This is the area for which you say, after a year, they have nothing at all. I am trying to home in on that. You are telling us that there are absolutely no other means by which they could turn to the state and say, "In my much reduced circumstances, there is no support that you can give me." There is no other benefit that they could conceivably claim.

Sue Royston: It depends on their position. If they have more than £16,000 in savings, there would be literally no other thing. At the moment, if they have a partner who is working for 30 hours a week, they could claim tax credits, but if the partner only has a job for 20 hours a week, if they were in rented accommodation, they could claim housing benefit. All of these things might top up to some extent. If they for instance had a mortgage and their partner was earning so that they were outside of the income-related benefits, there would be nothing they could claim. There are lots of different complicated situations, but there are certainly some people who would get no benefit at all.

Q73 Glenda Jackson: Have you considered how one could avoid that, given the existing legislation? Are we stuck in that at the moment? I am opening this to all of you, in a sense.

Jane Harris: Could I just point out another scenario in which people end up with nothing? We run a national advice service that gives benefits advice specifically to people who have severe mental illnesses. Certainly one situation that we have found arises over the years is that people end up in a situation where their carers are basically subsidising them. This is particularly a problem where somebody lacks insight into their own condition, and therefore does not feel that they are ill, so therefore does not feel that they are entitled to claim benefit. We had one case where, for over a decade, a carer who was themselves quite elderly and living on a very low income was paying for their son's living expenses. One way to avoid that is by really raising awareness of this process called appointeeship, where if somebody is so ill that they cannot claim benefits, somebody else can do it on their behalf. As far as we know, this is not really integrated into DWP's systems, and that does seem to us to be one way that you could at least avoid the problem for that small group of people. It would not deal with all the scenarios that Sue has just outlined.

Q74 Glenda Jackson: It is a terribly complicated process. I have a constituency case exactly on that; it is incredibly complicated.

Jane Harris: Absolutely, and it could be made simpler.

Professor Gregg: I would just add one thing. Universal Credit offers an opportunity here but also a risk. At the moment, the rules around conditionality

4 May 2011 Sue Royston, Roy O'Shaughnessy, Jane Harris and Professor Paul Gregg

and JSA apply to JSA, not to your tax credits and your housing benefit. Under Universal Credit, the risk is that all of these benefits may be put at risk by not fulfilling the conditions to be ready and available for work, if you are not eligible for ESA. You can see why it offers lots of potential here; you have the potential for a universal safety net, but the conditionality attached to that universal safety net may create situations where all benefits disappear, rather than just those that that conditionality currently applies to. There are serious risks of people falling—the minority, very small numbers—right through the system, ending up homeless, etc. We need to be seriously monitoring if we are creating a great hole in the middle of our social safety net here.

Q75 Glenda Jackson: Is it your view that it is the tracking system that is the best monitoring method?

Professor Gregg: We need a tracking system to see how big a problem we have and if we have a serious problem. We have to start that process to try to see how big a problem we have. It may be it is not there.

Q76 Glenda Jackson: Would you see that the gateway that is still existing in Burnley might be the—

Professor Gregg: That is a great place to start. The numbers are going to be fairly small there, so you may not pick up all of the cases, but we do need something to try to follow a group of people to see whether we have people who are completely disappearing out of the system.

Chair: I am going to move on to the last thing on the Work Programme, but we did find when we were taking evidence on the Work Programme that Ministers continued to talk about the existing benefits and not what they will become when we go into Universal Credit, because there is obviously the different conditionality and different benefits. That is a reminder of the problem that we have found. I do not think Ministers themselves have got their heads around exactly what is going to happen.

Q77 Karen Bradley: We have covered an awful lot of the issues that we had on the Work Programme throughout the evidence, so all I wanted to try to draw out from you is if you have made any assessment of employers' attitude to employing people with long-term health conditions, where you saw the Work Programme helping those people, and any suggestions you might have for the Department on that.

Roy O'Shaughnessy: I can kick off on that one. I think there has been incredible progress over the last several years, where employers really are willing to give the benefit of the doubt to organisations like ours and others about reviewing applications from people who might not normally fit strict criteria. Whether or not you have a mental condition, that is an overall view. Where it moves to next is that a lot of those jobs are entry-level jobs, and many times individuals are having to take jobs that are not their ideal. For example, many of the 50-plus candidates who are coming into our centres now would love to do a gardening job or something like that, rather than a Tesco job. We are trying to encourage it as a stepping

stone to the next step; over 12 to 16 months, we can probably move in that direction.

What the employers have a great reluctance with, which is a really complex part of all of this when we recommend a person, is whether a person can do the job. If you have somebody with mental issues or something like that, the bias is not against the individual but about whether they can really do the 16 hours, 18 hours or 24 hours. They are the same worries we would have in employing people. As long as there is a job fit and the person is accurately assessed that they can go into that opportunity, the employer is more than willing for that person to be considered. What our advisers are telling us—and once again I did a quick reality check of this yesterday—is that many of the mental health issues of individuals coming in make the employers more reluctant. Over the next 12 to 18 months, we will be tested quite heavily with our employers as to how we really are able to help those individuals coming off Incapacity Benefit and into the jobs that are available. That will probably be the biggest challenge for us and other organisations.

We will just have to wait and see, because we have the customers for 24 months and let's say we find them a job in the 23rd month, and then we have 12 months working with them specifically. We really have a three-year window here to shape this. We expect that those coming off Incapacity Benefit will be a smaller group in the first six months than in a year from now, but we will know, quarter by quarter, how successful we are being with employers in placing them, but we see it as a challenge.

Jane Harris: I am really glad you raised that point because, as I said at the beginning, one of the things that we did not think that Pathways addressed enough—and I think that DWP's research on the experience of people with mental health conditions through Pathways suggests this—is that stigma is still a real issue. We in partnership with Mind have been running a campaign called Time to Change, which has been very well evaluated, which shows that those kinds of national-level interventions can change people's attitudes, both employers and colleagues, to whether people with mental health conditions can do these kinds of jobs. We do think it is important that there are some attitudinal interventions as well as individual interventions. That is one of the fundamental issues. If the Work Programme is not going to repeat some of the mistakes of Pathways, it is essential that there are interventions to deal with that. The other area we have not touched on at all yet is the issue of the NHS because, frankly, if somebody cannot work because of a mental health condition, it does not matter what you do to change employers' attitudes, it does not matter what sort of job-related support you give them—whether with job search or improving their skills—if they are not getting health treatment to deal with their health condition, they are not going to get back to work. We are in a situation where the NHS still is not really providing NICE⁶-approved treatments for mental health conditions anywhere near like standard. The number

⁶ National Institute for Health and Clinical Excellence

4 May 2011 Sue Royston, Roy O'Shaughnessy, Jane Harris and Professor Paul Gregg

of people who get talking therapies is still often the minority, rather than the majority.

Under Pathways, some of that mental health-related support sort of happened by the back door. You had condition management programmes that were using DWP money to provide what were basically self-management-type interventions, which maybe in the past you would have thought should have been provided by the NHS. It is not clear to us exactly how those kinds of interventions, particularly talking therapies, will happen through the Work Programme. When you look at the list of providers, there are not that many people, even at the subcontractor level, who have the kind of mental health expertise that would enable them to provide those kinds of treatments. It is also not clear how the NHS will provide that at the same time as they are going through efficiency savings of £15 billion to £20 billion. Until that fundamental part of the jigsaw is fixed, we can put lots of money into the Work Programme, into that job support, and lots of money into changing employers' attitudes, and you still will end up with millions of people out of work.

Professor Gregg: There is a regular argument presented that the kinds of ideas that I was presenting on the whole of ESA are going to be flawed because they are not tackling the problem of the employers' attitudes to taking people on, and hence the jobs will never be there. I feel this is unjust on the Government, and Roy said it, in the sense that the providers are paid to help people back to work. They will only be paid if they engage with employers and get them as part of the process. The onus is very much on the providers to be doing the kind of groundwork of relationship building with employers in order to get that trusted relationship: "We believe this person can do the job and they can be taken on." In a sense, the employer engagement has been devolved, if you like, to the providers by the Work Programme. That is very positive.

I would also echo that there are things that the Government can be doing about wider change of attitudes, which we have heard about: corporate social responsibility ideas and the Time to Change kind of campaigns. There is potential to try to change attitudes towards stigma. The biggest thing that does change employers' attitudes is other employers. If you can get other employers standing up and saying, "These are decent workers: they stay; they are productive," that is what really counts. I do feel there is wider stuff the

Government could do to get messages from employers out there to say that this is worth supporting, which individual providers cannot do, because they are too small.

Chair: I think everybody has asked everything they can.

Q78 Glenda Jackson: Can I just sneak in one more? Sneaking in on the issue of the employers, I am not saying that this is a major raft of stuff that is coming to me in my constituency, but I am getting people who are claiming that they are being exploited. They are sent off; they do two weeks filling shelves and then they do not get a job or an interview. Is this something you are seeing growing? In the late 1970s and early 1980s we had employers exploiting unemployment in that way.

Roy O'Shaughnessy: No. I would say no on that. I would say that we have very long-term relationships with our employers. If there were employers who were doing that, they would not continue working with us. Secondly, under the Work Programme, unless you keep people in work 13 weeks, 26 weeks on, there is no financial incentive whatsoever for just placing people in short-term employment. If somebody does leave after 11 weeks and then gets another job and things like that, it counts, but the system penalises against just putting individuals into very short-term employment. Certainly if there was any kind of exploitation, that employer would not last, not only for us as a charity but for a large number of the groups.

Chair: Thanks very much for coming along. The message from today is all of this is predicated on accurate assessments. If we cannot get the assessments accurate, then people will be on the wrong benefit and they will not get the help that they need to get to fulfil all of our expectations that people, given the right support, can work. I think we will take what you said, Professor Gregg, with regard to tracking as being absolutely crucial in all of this. Until we do that, we do not know whether people are being accurately assessed. It has been incredibly useful. Sorry we went on a bit longer than we should have done, but that just reflects on the importance of the subject and also the vast number of questions we still have, and have not answered. I thank you for your written evidence, which will be relevant as well. Thanks very much this morning for coming along.

Wednesday 18 May 2011

Members present:

Dame Anne Begg (Chair)

Harriett Baldwin
Andrew Bingham
Karen Bradley
Kate Green
Oliver Heald

Glenda Jackson
Brandon Lewis
Stephen Lloyd
Teresa Pearce

Examination of Witnesses

Witnesses: **Lisa Coleman**, General Manager, DWP Medical Services, **Dr Laura Crawford**, Clinical Director, and **Professor Michael O'Donnell**, Chief Medical Officer, Atos Healthcare, gave evidence.

Q79 Chair: Thanks very much for coming along this morning. This is our second evidence session of our inquiry into the migration from Incapacity Benefit onto Employment Support Allowance. As an inquiry we have probably received more individual submissions than is normal for a Select Committee. Many of these submissions obviously give individual experiences, but there are common threads that run through the evidence we have taken. So our questions this morning will try to help us understand from your point of view, the customer journey. We know how it is meant to work, but obviously quite a number of the submissions we received point to things that perhaps have not worked as well as they might, or have not worked at all. So can I just ask you first of all to introduce yourselves for the record?

Dr Crawford: My name is Laura Crawford, and I am the Clinical Director within Atos Healthcare responsible for the medical aspects of our work on the Medical Services Contract with DWP.

Lisa Coleman: I am Lisa Coleman; I am the General Manager for Atos Healthcare, responsible for the end-to-end service delivery into the Department.

Professor O'Donnell: I am Michael O'Donnell. I am the Chief Medical Officer of Atos Healthcare. I am responsible for Oversight of Professional Standards and Clinical Governance in both our Occupational Health and Medical Services side.

Q80 Chair: I will start with the appointments process because that is the first contact that the claimant or the client has. Do you prefer to call them claimants or clients?

Lisa Coleman: It tends to be claimants or customers, but we prefer customers.

Q81 Chair: I understand that after Jobcentre Plus has made the initial contact with the claimant about the assessment, Atos contacts them by phone to arrange an appointment for the Work Capabilities Assessment. That appointment is then confirmed in writing. Do your call centre staff have the necessary training and knowledge to respond to the questions that inevitably the claimant might have about the process? Are they able to answer all the questions that a claimant might have about accessibility and all other questions that may arise at that particular time?

Lisa Coleman: We train our contact centre agents and ensure they understand the process that Atos

Healthcare operates and have in-depth knowledge around the Medical Assessment Centres that the customer will attend. We find that we get queries into the contact centre that are not necessarily about the service that we deliver, and they could be about the benefit process itself. We do not train our contact centre agents in the end-to-end benefit process. So for example, if a customer rings up and asks where their claim is, we make sure that we can direct them to the right BDC¹, and we have set up a customer query helpline in the centre. We do not want to leave a customer waiting, or actually not signpost them to the correct route. We have a separate customer query line to deal with questions that are not related to the booking of the appointment or the environment the appointment will be held in. We work with the Department to make sure calls are directed appropriately.

Q82 Chair: Do the call centre staff work to a fairly rigid script?

Lisa Coleman: It is a script. We do make sure we have contact centre scripts to make sure that we go through all of the right information, and that we are providing information about the assessment and the process that will operate once they attend the assessment centre. But we also allow the contact agents to provide additional advice, if they can, about the actual appointment system, but never about the benefit process system. Their primary purpose is to book appointments.

Q83 Chair: Anybody who has used a telephone system to book an appointment will know that usually the computer generates when the next appointment will be, and that is what is offered. If that appointment is unsuitable, is there a negotiation that can happen down the phone to arrange a different time? For some people with some disabilities, it can take them some time in the morning—I know myself it can take a long time to get going—and a nine o'clock appointment is just not suitable.

Lisa Coleman: Absolutely. The most important thing for the contact centre agent is to book an appointment that someone is able to attend. We do have a failure to attend rate and we do recognise that the contact centre agent can be very useful in ensuring that somebody can attend an appointment. It is a

¹ Benefit Delivery Centre

18 May 2011 Lisa Coleman, Dr Laura Crawford and Professor Michael O'Donnell

negotiation; they will ask if the appointment time is available for them and whether that is okay. If someone says they cannot do that, then an alternative appointment will be offered if there is a suitable one available. So there is a negotiation between both parties.

Q84 Chair: How often is it the case that someone turns up to an appointment, is left waiting for some hours and then is sent away because it has not been possible for them to be seen?

Lisa Coleman: The customer service that we deliver is measured, and it is one of the key criteria. We have a target of never sending more than 1% of our customers home unseen, and we do meet that target. There are times—for example bad weather or high failure to attend rates, or we actually have everybody attend, because we have to operate an over-booking policy due to the failure to attend rate—when that does mean we do sometimes have to send people home, but we do meet our customers sent home unseen target of less than 1%.

Q85 Chair: My constituent went in twice, had to wait a number of hours, and was sent home. Then her benefit was sanctioned for non-attendance. Is that unusual? Was she just unfortunate?

Lisa Coleman: It does happen. I am not going to say it does not. We do have a waiting time of less than 10 minutes, and we do try to manage within that time. But we also try to make sure the customers have the appropriate time within the assessment. So I am not saying it never happens because it does, which is why we have a target. And in those instances we will investigate why that happened, put remedial action in place where we can, and then try to work with the customer to offer an alternative appointment. But it does happen.

Q86 Chair: But it happened twice to the same customer, and then the information that she had turned up did not make it to the Jobcentre Plus, and therefore she was sanctioned. That is one constituent; we have got quite a number of those kinds of complaints. We also got a lot of complaints that people were left sitting for a long time. You mentioned that you expect a level of non-appearance and therefore you overbook. Those of us who fly a lot know what it feels like if you are the one that gets bumped. But by the very nature of your client group, these are the most vulnerable people. Some of the very vulnerable ones will be assessed, quite rightly, as being in the Support Group and are still in your assessment centres. Sometimes very ill people will be left waiting.

Lisa Coleman: I accept what you are saying. As a service we do not want to have anybody waiting where we can help it. We do overbook, but what we have tried to do if we think we have to manage the systems differently is enhance our training around session management with our local receptionists, because they are the key people within our service to ensure those sessions are managed appropriately. We do have people who turn up late or slightly early for their appointments, and the receptionist is key in

managing that environment within the MEC². But it does happen, and when it does we investigate and try to put remedial actions in place.

Q87 Chair: You have accepted that customers will have to wait in some instances, so what does your waiting room look like? Do you have a variety of chairs? Is it possible for someone to lie down if they need to? There might be some customers there with their children. Is all of that catered for in the waiting rooms? Because that is not what have been told by many of the people who have given evidence.

Lisa Coleman: We have standard facilities, which are documented and agreed with the Department. Within those standards we make sure we have things such as variable height adjustable chairs and that there are alternatives for people to sit on chairs of different heights.

Dr Crawford: I have experienced instances myself with somebody who was more comfortable lying down, and in that case it would be a matter of talking to the receptionist. Not all examination or assessment rooms would be in use all day, so we would try to find somewhere for them to lie down more comfortably. If someone is very uncomfortable, that is where the receptionist is very important in trying to have them seen slightly more quickly than someone who is more comfortable waiting.

Q88 Chair: Being seen more quickly is also very relevant to somebody who suffers from anxiety. When they phone up for their appointment, do the people who are working their way through the booking system know what might be the underlying problem for the individual so that they can tag that a person has quite profound mental health problems? Somebody might be agoraphobic and might have difficulty in rooms full of people.

Dr Crawford: There are two or three ways we would manage that. We go through what we call a pre-board check, which is where the healthcare professional looks at all the cases before they are called into assessment to see whether somebody meets the criteria for the Support Group beforehand. They have the opportunity to mark the case if they recognise that someone is particularly vulnerable and would need special circumstances to help them when they come to an assessment, and those do not go into the routine telephone booking queue. Those are handled separately, and the person handling that call knows exactly what those special needs might be, so there is a more personalised booking service.

In terms of the regular booking service, when someone rings in and interacts with the call handler, part of the script is to ask the customer if they have special needs. Quite often we find that someone with anxiety will say they find it hard to get to the centre and that they dislike sitting in a room full of people. On those occasions we tend to offer them an appointment at the beginning of either the morning or the afternoon session so that they are the first appointments to be taken.

² Medical Examination Centre

18 May 2011 Lisa Coleman, Dr Laura Crawford and Professor Michael O'Donnell

Q89 Chair: A psychiatric community nurse in my constituency, who phoned up on behalf of one of her patients to say that a 9.30 appointment was not suitable, was still sent a 9.30 appointment. Is that unusual?

Lisa Coleman: One of the challenges that we have within the contact centre and we are seeing more of is third parties contacting the contact centre that are not necessarily noted as appointees, and I am conscious that sometimes can be an issue. We need to make sure that we are arranging the appointment with the individual concerned. If somebody contacts us that might be a third party that is not down in the system as an appointee, we ask them to contact the Department and make sure that they are allocated as an appointee. But if the customer is with them at the time, we ask them to negotiate on their behalf. I know we have instances where we cannot rearrange appointments without having that system and that protection for the customer involved.

Q90 Chair: But very often customers are told when they phone in that they cannot take anyone with them. We know that is not the case, but that has come through in our evidence. Or they are discouraged from taking someone with them. How do they know who their appointee is?

Lisa Coleman: The feedback that people are discouraged to bring companions with them really concerns me. In all of our scripts, both at our contact centre and in the literature that we send out in the AL1³, we encourage them to bring companions along with them. So the fact that those messages are out there is really quite concerning, because we think it is very important that people have a companion with them. Through all of our interaction, we encourage that. Would you like to mention the role of the companions at the assessment?

Dr Crawford: Particularly in people with mental health problems, I personally as an HCP⁴ find it very beneficial if someone has a companion with them that knows about their condition. It can help the customer relax, and helps contribute to the consultation. I know my colleagues feel similarly. Having read some of the evidence, we have made it very clear in the updated communications for IB reassessment that a companion is very welcome to join them, not just at the assessment centre, but within the assessment itself if they feel that is appropriate.

Q91 Chair: Again, we have had lots of evidence where the companion was told that they were not allowed to speak or be in the room, and all of those kinds of things. How clear is that made? Can someone turn up and, when that happens, show the letter, and say, "I have got this letter from Atos Healthcare that says this person can come in with me"?

Dr Crawford: It is in the letter, yes⁵.

³ The AL1 is the appointment letter sent out to the customer

⁴ Healthcare Professional, the person who carries out the assessment

⁵ Information on companions is given on an inserted leaflet included with the appointment letter sent to the customer

Q92 Glenda Jackson: I am intrigued in the use of the word "failure" to attend, which implies that it is the fault of the customer. And yet you have detailed, and indeed the Chair has given direct evidence, of where that is not always the case. Who chose that word? There are sanctions for the individual on the level of failure and repeated failure. Is that your choice of word or has it come from somewhere else? It seems grossly unfair to me.

Lisa Coleman: The choice of the word "failure" could also be interchanged with "did not attend". Within our business we use "did not attend". We know in the Department that the use of the word "failure" to attend in wider benefits is just a recognised term. It is a term I have always known; I do not know whether, Laura, you know the history of the term?

Dr Crawford: I do not.

Q93 Glenda Jackson: The point I am attempting to make and clearly did not is that the definition of an appointment not being made by virtue of being defined as a "failure to attend" implies an unwillingness on the part of the applicant. In many instances, as we have had direct evidence, that is not the case; the fault may well be your call centre.

Lisa Coleman: We want to make sure that we do not put anybody in difficult situations because of that, and we do have safeguards that we operate with the Department. So for whatever reason somebody has not attended an appointment, we then update the system and feed that information back through to the Department.

Q94 Chair: Do you call the person back and find out why they have not attended?

Lisa Coleman: In some instances the local team could do that, but it is not standard practice.

Q95 Chair: But you do not do that? I know some hospitals now send texts out to remind people to come. If you have got somebody with a mental health problem and a chaotic life, appointments are not easy for them. They might remember the routine signing on at Jobcentre Plus, but they will not necessarily remember an appointment out of the blue. If you sent a text, would that help to cut down on your no-show rate?

Lisa Coleman: We have done reminder texts and reminder calls as pilots previously, but we have not seen a significant change in the behaviour around the attendance rates. It is something that we have considered for the future. But as to whether we actually call people on the day to remind them, no, we do not.

Q96 Chair: If a constituent of mine does not turn up to an appointment at my surgery on a Friday I get worried, and I phone to find out what has happened. Sometimes it is just because they have forgotten, but I would always try to contact them, and these are not disabled people—just ordinary constituents. But you do not do that.

Lisa Coleman: We do not do that as standard practice, no.

Q97 Chair: Is it something you should be thinking about?

Lisa Coleman: I certainly think it is something we could consider with the Department in future, yes.

Q98 Glenda Jackson: How long is the process of you passing the information along? You said if it is not the fault of the individual, you will look at that and pass that information along.

Lisa Coleman: We enter that information directly into the MSRS⁶, which is available to the decision makers on the day that it is input. We also wait as often customers ring into the contact centre to say they are unable to attend on the day, and in those instances we will rearrange an appointment for them, so that does not class as somebody not attending. So we could have had contact from the contact centre to say the customer will not be attending until things change in their condition or it is just not appropriate, and we will always rearrange an appointment for them. That is not in any way, shape or form classed as a non-attendance at the appointment. In the instances where that has not happened and we have not had an "unable to attend", we will update the system, and then the Department will contact the individual to find out why and what happened. And if there is a valid reason that has been accepted by the Department, they will come back to us and we will rearrange an appointment.

Q99 Glenda Jackson: But I have had constituency cases where a sanction has been imposed upon an individual because of a failure, which was not on their part, to attend in some instances the initial appointment. I am not talking about a pattern of non-attendance, which you could justifiably consider to be the fault of the individual. I am talking about the decision making process by the call centres, the inability to make appointments, and those sanctions being imposed.

Lisa Coleman: I clearly cannot comment on any individual cases. If we get cases referred to us where that issue has occurred and it is something to do with the Atos service, then we will investigate and find out if remedial action needs to be taken, and deal with that through that route.

Q100 Glenda Jackson: And what is the timescale for that usually?

Lisa Coleman: For the investigation? If we have had a complaint to do with the service, we deal with that in less than 20 days.

Glenda Jackson: 20 days? It is a long time to be without money.

Q101 Chair: Do they phone up the actual assessment centre direct? Do they have the assessment centre number, or is just the call centre?

Lisa Coleman: No, they deal with the call centre.

Q102 Chair: So if they are running late or something has happened that morning, they cannot speak to a real person at the reception desk; they can only deal with the call centre?

Lisa Coleman: The contact is through the contact centre. We deal with that through the contact centre.

Chair: So it is very impersonal as well.

Q103 Andrew Bingham: Taking you back to the over-booking, what level of failure to attend/no show, call it what you will, do you get? I don't expect an instant figure off the top of your head. I am just trying to get a feel for the size of the problem.

Lisa Coleman: Nationally we get an average of about 30%.

Andrew Bingham: 30% fail to turn up? 30%? Strewth.

Q104 Stephen Lloyd: And you do not have a system that calls them back? I find that fascinating. That is incredibly high. In commercial terms, immediately I would say to people, "Right, I want some sort of call back system because that is unacceptably high." I find that astonishing.

Lisa Coleman: Okay, so we get 30%. So to resolve the question of how we overbook, we overbook to about 120%, but there are great regional differences in the attendance behaviours that we see. So we look at the patterns of attendance we see at a particular assessment centre, and decide what booking policy we need to put in place and how to deal with that appropriately.

Q105 Harriett Baldwin: Do you ask people if they have the means to travel to the centre? I represent a rural area where it can be quite hard on public transport. Do you ask people that question when they are making the appointment?

Lisa Coleman: We ask them if they need additional transport and we offer taxis in some instances. People are never asked to travel more than 90 minutes by public transport. And in addition, in the appointment letter we provide very tuned travel instructions using the Transport Direct system. It explains how they can get to the assessment centre using public transport to get from A to B.

Q106 Glenda Jackson: Do you have regional call centres or is there just one call centre?

Lisa Coleman: We have two call centres within the service, one in Cardiff and one in Newcastle. But for a customer ringing in, it is absolutely independent. Customers are just given one contact number.

Q107 Glenda Jackson: But there is very little local knowledge as well.

Lisa Coleman: No, there is an awful lot of local knowledge. We provide all our contact centre agents with knowledge of the assessment centres the customer needs to attend, so if somebody does have a question around the assessment centres, agents are fully trained and briefed and they have that knowledge available to them.

Q108 Glenda Jackson: We have evidence of people presenting to assessment centres that are not accessible to people with certain disabilities. Is that just a one-off? What happens?

⁶ Medical Services Referral System

18 May 2011 Lisa Coleman, Dr Laura Crawford and Professor Michael O'Donnell

Lisa Coleman: We have a total of 148 assessment centres. Of those, there are about 20 casual hires⁷ and about 128 permanent assessment centres, 20 of which belong to Atos Healthcare. The rest are provided by the Department and are usually co-located with the Jobcentre. We are conscious that there have been some issues around the instructions for people arriving at the assessment centres, so we have reviewed all the maps and strengthened the directions. We are also working closely with the Department on individual locations. There are about 27 of them where disabled access is okay, but in the event of a fire, there are potential issues around evacuation. We are working with the Department to make sure that we can either get ground floor accommodation, or put some form of evacuation plan in place with the landlords. This usually affects sites not on the ground floor. 27 sites are not on the ground floor, and a lift is needed to facilitate evacuation. So all of them have got appropriate access, but we do have issues in some centres around evacuation.

Q109 Andrew Bingham: You must have enormous logistical problems in dealing with the 30% no-show rate. Consequently you do the over-booking because of the 30%. Then consequently you have people like Anne's constituent. Is there anything that you can do to reduce that number, such as the texting arrangement? As I say, the consequence of the 30% must give you great difficulty. I know my local GP practice sends a text the day before. Have you thought of looking at that?

Lisa Coleman: Yes, certainly. We have a regular review with the Department around service improvements. We have previously piloted actual reminder calls the day before to customers. We have done that in Wales, Scotland and other regions.

Q110 Andrew Bingham: Has that reduced it?

Lisa Coleman: It did not have the kind of effect that you would expect in terms of attendance rates.

Dr Crawford: My perception from doing it in some of the sites that I used to work at in Scotland was the people who answered the reminder calls tended to be the people who were coming anyway. The ones we were not able to make contact with were the ones who often do not attend.

Q111 Andrew Bingham: So the people who do not show are making life difficult for those that do. That is my take on it.

Dr Crawford: Yes, absolutely.

Q112 Chair: If you are not phoning them back, you are not tracking what the reasons are for the no shows so that you can tackle it and address the issue?

Lisa Coleman: It is important to stress that we do work closely with the Department on that. The Department do contact people through their processes who have not attended for an appointment to establish why that has happened. And in the event that there is a genuine reason, they are referred back to us and we

then progress them back through the appointment system.

Q113 Chair: Could it be that the whole thought of the assessment process means that when someone wakes up that morning they are so anxious and ill because they know that it is the day of their Atos assessment? Could that be part of the reason?

Dr Crawford: I think coming for any assessment will cause anxiety for a lot of people, particularly people with mental health problems. We are very keen to ensure that, as early as possible, the expectations of someone coming for an assessment are managed so they understand what the purpose of the assessment is and where it sits in the process. And we try to allay their fears in the communications as early as possible.

Q114 Teresa Pearce: Is the call centre number an 0845 number?

Lisa Coleman: It is an 0800 number, so it is free from landlines and some mobiles.

Q115 Teresa Pearce: But not all mobiles. A lot of my constituents, particularly the group you are interfacing with, have pay-as-you-go mobiles. And if they have no credit or very little credit it can be very expensive when they ring out. Is there any way that they can be given a local number?

Chair: I think the 03 number as well would be cheaper.

Lisa Coleman: It is certainly something we could look at.

Teresa Pearce: Maybe there could be negotiation with the mobile companies.

Q116 Glenda Jackson: Presumably when the initial contact is made for an appointment, the person making that contact has the information. Jobcentre Plus issues an extremely lengthy questionnaire, which the individual has to fill in. Do your call centre staff know the illness, the disability, be it mental or physical, that the individual they are calling suffers from?

Lisa Coleman: Atos send the questionnaire out as part of the service we deliver. Once that is returned to Atos it is scrutinised by a healthcare professional, as Laura explained. At that point, if special needs are identified or adaptive care needs to be put in place, then that can be sent through to the contact centre. Those cases are then manually scheduled, so they are done by a resource team rather than through the contact centre. The contact centre agents do not have knowledge or visibility of the actual conditions the customer is suffering from.

Q117 Glenda Jackson: So in a sense that knowledge is irrelevant to the call centre staff.

Lisa Coleman: The primary role of the call centre is to book and negotiate a suitable appointment for the customer. Their function is to make sure that there is an appointment that is suitable for the customer—that they can arrive for and that they all have the necessary information around the assessment. They also set expectations to the customer of what is going to

⁷ Casual Hire sites are those which are used on an ad hoc basis, usually in a more remote locations.

18 May 2011 Lisa Coleman, Dr Laura Crawford and Professor Michael O'Donnell

happen, and strengthening the message that a companion can be taken with them.

Q118 Glenda Jackson: But how far down the clock is a call centre individual prepared to go when someone keeps saying, "No, I cannot manage that time"? Are the customers expected to give a reason as to why, and are those reasons valid as far as you are concerned?

Lisa Coleman: The most important thing for us is that somebody attends for an assessment. We want people to attend. The fact that we have a poor attendance rate causes us logistical difficulties, so it is important that we use the contact centres to negotiate the right appointment. If we get to the point where we cannot negotiate an appointment, then we can arrange a call back and say, "Can we talk to you again; what else can we do?" But their role and the function of the call centre agents is to arrange an appointment for them.

Q119 Kate Green: In the initial booking and the over-booking, do you block book or do you give people individual timed appointments?

Lisa Coleman: We give people individual timed appointments.

Q120 Kate Green: You have one number for the contact centre, but we have had a report from a parliamentary colleague who called to make an inquiry on behalf of a constituent, and he had to ring 135 times. Would that be calling your main contact centre number or do you use different numbers at different stages in the process?

Lisa Coleman: I do recall the issue that we had there. It is realistic to say we had some significant problems in the contact centre service around 12 months ago. That meant that we had an awful lot of inbound calls coming that we were not expecting, and we were flooded with the level of contact that was being made, which we were not prepared for. In the last 12 months we have invested heavily in the technology. We have changed the technology around the contact centre and the dialling solution. We have retrained our contact centre agents, and I am pleased to say now that the actual wait time for anyone ringing into our main contact centre is less than 30 seconds. And we are now picking up the first calls of over 90% of the customers.

Q121 Kate Green: And all calls would be made to your main contact centre at any point in the process.

Lisa Coleman: Yes, they still go through. We can do call-routing, so if somebody wants to book an appointment or has a query they can go in different directions. We have a very limited choice at the front that allows calls to be directed, but we have addressed the issues that we did have around people contacting the contact centre.

Q122 Kate Green: You say it is important to get someone to attend an appointment. Is your contract or your payment basis dependent on whether or not people attend?

Lisa Coleman: We are paid by output, so we are paid by the number of assessments that we do. However,

there is often a view that we are paid by the results of those assessments.

Kate Green: No, I am not asking about that; I am asking about attendance at the moment. We will come to that.

Lisa Coleman: We are paid by the number of reports that we generate.

Q123 Kate Green: Number of people you see, yes. How many times do you allow someone to fail to attend an appointment? Could they do this again and again and again, or is there a point at which you tell DWP again that they have not attended?

Lisa Coleman: We do have a process that is agreed with the Department where people are allowed to miss two appointments. There is a process for people ringing up and saying that. The Department decides whether they did not attend for valid and just reasons. That is done by the decision maker, not by Atos, and then those cases come back through. We do work with the Department to monitor where there may be people looping back through the system, because it is important that we understand why that happens.

Q124 Kate Green: And what is your staff turnover in your contact centres?

Lisa Coleman: It is 10%, which is very low for a contact centre, and that helps us keep that local knowledge.

Q125 Oliver Heald: Organisations that represent disabled people have been arguing for a generation that they should be given the chance to work, and given help to get into work. To what extent do you see this enthusiasm to work? "If I can get through the Work Capability Assessment, I will get help to get into work." Do you see any sign of that sort of enthusiasm in your centres?

Lisa Coleman: I am going to pass you to Laura, because she actually does assessments.

Dr Crawford: People come at various stages within the period of their disability, and a lot of people that we see would genuinely like to be able to do some work, and would like to have the support they need to get to work. Certainly some of the people that we saw through the IB Reassessment Trial welcomed this opportunity—people who had been on Incapacity Benefit for many years. When we explained to them the purpose of the new assessment and some of the areas they can go to in terms of support to look towards working, that was certainly welcomed by a number of the people we saw on the trial.

Q126 Oliver Heald: There has been quite a bit of criticism of the Work Capability Assessment. Do you think that is partly because you get less money if you are looking for work than you do if you are on Incapacity Benefit?

Dr Crawford: It is obviously difficult to talk about the financial side of things; it would be a natural reaction. I think sometimes people are coming into the Work Capability Assessment and not understanding the process, being cautious of the potential outcome, potentially not knowing what support is available to

18 May 2011 Lisa Coleman, Dr Laura Crawford and Professor Michael O'Donnell

them were they to end up in one of the particular groups.

Q127 Oliver Heald: The Work Capability Assessment is really a functional thing; it is to decide whether somebody can actually do any work. Yet some of the evidence we have seen from the DWP talks about a medical assessment and medical reports. Do you think there is some confusion about this? Certainly in Australia they make it very clear that this is not about what your diagnosis is; it is about whether you can do particular things.

Lisa Coleman: Do you want to comment on that first, Mike?

Professor O'Donnell I think this is always a very difficult area. It is clearly a functional assessment, but it has a medical component. I think the term "medical" is used partly because some people with certain conditions will require some form of medical examination. For instance if someone comes in with asthma, it would be usual for us to perform a peak flow assessment. If someone comes in with problems with mobility, a brief examination can sometimes help in those circumstances. So a medical examination can form part of the assessment, but not always.

The other point is that healthcare practitioners in general are trained to talk to people about sensitive or difficult problems, and to my mind the term "medical" in those circumstances provides some reassurance to people that they are dealing with people who have some level of understanding of the sorts of things they will be talking about and how such information should be handled.

Q128 Oliver Heald: I think a lot of people come along to the assessments thinking it will be their opportunity to present their information about their condition. Then they go through a process that does not allow them to do that. Do you think that some change is required?

Professor O'Donnell Can I answer that? I question whether people are not allowed to do that actually. I think the whole ethos of our assessment is to enable people to present their point of view to the person they are talking to, and for that person to record that and pass it on appropriately.

Q129 Oliver Heald: It would be great if it was like that, but we hear a lot of evidence that it is just a mechanistic thing. They are on the computer and just asking the questions that are on the computer. It is just not like that.

Professor O'Donnell I think computers form part of everyday medical practice now. You can argue that that might be unfortunate, but we do recognise that when we have people using computers there is a tendency for people to focus on the computer or what they are typing and appear not to be giving attention. We devote a lot of time to training our staff not to do that, and we do get positive feedback about our assessments. The trouble is one negative experience will get more publicity than a positive experience.

Q130 Oliver Heald: To what extent do you think your advisors are explaining to people what the

process is and how it works? There seems to be a lot of misunderstanding out there.

Dr Crawford: I recognise what you are saying. I often find someone will arrive at the assessment still unsure as to what they are doing there. And I agree sometimes that the phrase "medical assessment" can be misunderstood by people who think it might be conventionally what happens when they go to a hospital or see their GP, and they are having a barrage of tests. So I think we need to think very carefully about the wording and further explanation. Certainly when people arrive at an assessment, the first thing that we ask our HCPs to do, and it is some soft skill training that we have developed and enhanced, is to explore with them how much they already understand. Obviously you are not going to repeat it to them if they know exactly why they are there. But with people who are new, more time needs to be spent explaining. So we do get a real variety.

Q131 Oliver Heald: You understand that, if you are challenging somebody's diagnosis, it is deeply offensive to them. If they have been diagnosed by a consultant and you are there suggesting that they have not got the condition they have, that is deeply offensive. But that is not really what this assessment is about. It is not about whether you have a particular condition or not; it is about what you can do in the workplace. That is really the misunderstanding that is there, isn't it?

Dr Crawford: I think so. But we would never challenge a medical diagnosis that has been made by another professional. What we would do is look at that impact on their ability to function in a number of tasks, particularly work focused. But I think we can do more work to try to explain to people in advance the differences between our assessment and what might someone might conventionally find if they went to hospital or see their GP.

Q132 Glenda Jackson: You have spoken of the training of the health professionals, and you touched on softer approaches, so clearly these kinds of things have come back to you that have not been there before. What is the desired outcome as far as the assessors are concerned? Is there one?

Dr Crawford: The desired outcome is to do a robust, consistent assessment that accurately reflects the function of an individual in relation to the work tasks and the specific descriptors that are set down in the Government policy and legislation. And to ensure that it has been a successful consultation with the individual.

Q133 Glenda Jackson: Robust in the sense that they are fit for work?

Dr Crawford: Absolutely not. We do not take any part in the decision-making process regarding which group they go into in terms of fitness for work. Our role is to give an accurate reflection of the level of function, which is one of the pieces of evidence a decision maker will use in coming to their decision about fitness for work.

18 May 2011 Lisa Coleman, Dr Laura Crawford and Professor Michael O'Donnell

Q134 Brandon Lewis: We can all recognise how difficult is it to shift a perception that sticks in the public or a client's psyche. I have had residents who have come to me in surgeries who clearly do not understand the difference between what they are medically diagnosed as and what Atos is there to do. What more can be done, either by yourselves or outside bodies, for example DWP, to help educate and explain the difference between the two so that you get away from this disappointment or worse with a client, who is coming in expecting one thing but actually is there for something very different. What more can be done to educate people around the difference between the two assessments?

Dr Crawford: If I can start, I think particularly with IB reassessment and that large customer group who were on Incapacity Benefit and are now coming into a more work-focused type of assessment, we are looking at an external engagement strategy. We worked with the Department already to go and visit some of the special interest groups to talk to them about our role in the process and the purpose of our assessment. And some of those groups who have very wide membership and very extensive links with some of the disabled people are an ideal opportunity for us to reach a large number of people quickly. That is certainly one area I would highlight.

Lisa Coleman: And the messages within the communications products that go out, the work that we have done around the customer insight and the feedback that we get. Also there is our complaints process. It is a raft of information that we use to help us focus our attentions to make sure that people do understand what is going to happen when they arrive at the assessment. Fundamentally we want to deliver a really good service, and it is disappointing when we hear the stories that we hear. That is not what we are there to do, and not what we care about. So there are lots of sources of information that help us decide where to take action, both in terms of the work that we do with the Department, the interaction with the welfare groups, the direct feedback that we get from the customers and you on exactly the types of issues that we are seeing. So then we can focus the changes that we make, but a lot of it is about getting the communication at the right time to the right level in order to set people's expectations. If those expectations are not set up front, by the time somebody has arrived at the assessment centre it is too late. At that point you are managing somebody's expectations as opposed to making sure they fully understand what will happen when they arrive.

Q135 Chair: You said that Atos does not make recommendations as to which group the client will go into, yet we have in our brief a chart that was given in reply to a written answer, it appeared in Hansard, where the columns are: "WRAG based on Atos recommendation" and the numbers; "additional people placed in WRAG at reconsideration by JCP DM"; and then "Support Group based on Atos recommendation" numbers; and "additional people moved". This would suggest that it is Atos that are making the recommendations to the DWP. It goes to a decision maker, but Professor Harrington found that

generally the decision maker went with the Atos recommendations. So there must have been a recommendation for the decision maker to make a decision on.

Dr Crawford: The recommendation being the score on the descriptors, and whether that would meet the threshold or not. So I would accept that.

Q136 Chair: But the score would be 15, so anybody who gets 15 will go on ESA. But then who makes the decision as to whether they are in the WRAG or in the Support Group?

Dr Crawford: We would also make a recommendation regarding the Support Group if we felt somebody made that criteria, and we would justify for the decision maker why we felt that that particular group was appropriate.

Q137 Chair: But that is very mechanistic and computer generated.

Dr Crawford: It is not actually. The healthcare professional is at the centre of that, and often the early part of the history will enable the healthcare professional, if the customer has been called for assessment at all, to identify from the history that they may meet the Support Group criteria. In those circumstances they can completely short-cut completing the full assessment and just provide advice specifically on the Support Group that they would meet the criteria for.

Q138 Chair: Do you have figures of the number of people who do not get the 15 points on the initial assessment? These are people that any health professional looking at them would know that they should get the 15 points, but it is just the mechanistic nature of the points and therefore the recommendation would be that these are people who should be on the Support Group.

Dr Crawford: We would have figures on the number of people within our assessments who reach 15 points.

Q139 Chair: But I thinking of someone who does not reach 15 points, but ends up in the Support Group. There are people that do not get 15 points that end up on ESA, and people who do not get 15 points who end up in the support group simply because of the problems of getting 15 points. Somebody with a terminal cancer might not score anything on the initial criteria.

Dr Crawford: Someone with a terminal cancer with a life expectancy of less than six months would be put directly into the Support Group.

Q140 Chair: But they would not necessarily score 15 points.

Dr Crawford: No, but they would go directly into the Support Group. There is a special criterion for terminal illness.

Q141 Chair: But if they are going to live for some months then they score nothing.

Dr Crawford: The six months is in line with all the other welfare benefits in terms of the criteria.

18 May 2011 Lisa Coleman, Dr Laura Crawford and Professor Michael O'Donnell

Q142 Stephen Lloyd: I have a number of precise questions, which I will ask in a minute. But first, it is not exaggeration that, for x number of people in the UK who are currently going through this process, Atos is feared or loathed in equal terms. Fairly or unfairly, that is a statement of fact. Short of being able to pass every single person who comes through, which obviously is not feasible or appropriate, with your experience—Lisa particularly, because you have been involved in this for a long time, but your colleagues as well—if you had one thing that you could do that you think could potentially transform the attitude and the fear and loathing of a lot of people with disabilities and their families and friends have towards Atos, what would that be?

Lisa Coleman: A lot of the fear and the misunderstanding is because people do not have the right expectations about what is going to happen at the assessment and not understanding the role that Atos play within the end-to-end process—that the information we provide is only part of the overall decision-making process. And if we can set people's expectations, as we have talked about a number of times, at the earliest possibility, that will allow us to try to reduce some of the stress and anxiety that people feel when they come through our assessment centre doors.

Dr Crawford: It would help if there was recognition of how proactively we work both with the Department and people who have carried out reviews into employment support, such as Professor Harrington. We are looking to work with them to continue to improve, refine and evolve the assessment and our role in it so that people can see that we are always looking to improve and change to ensure that disabled people get the support that they need, and get access to the right benefits.

Q143 Stephen Lloyd: Michael, you are fairly new at this, so to speak. You have come from the outside. You have been a medic for many years; you have dealt with many people with disabilities. Tell the Select Committee the one thing that you think would make the difference.

Professor O'Donnell : One thing that would make a difference would be if we could find a way of explaining to people that failure to be awarded ESA is not the same as being classed as a malingeringer, someone who does not have a disability or someone who is not ill. I think we need to get that across very clearly. That is the real problem. I think the whole ethos of this process is to support them back into work and to provide them with the wherewithal to help them back in when they have had difficulty because of health problems and other disabilities. We need to make that very clear.

Stephen Lloyd: I think that is a very good point, both from Atos's perspective and perhaps for some of the politicians as well.

Q144 Oliver Heald: Could I come in on that? I have worked in the past giving welfare rights advice and free legal advice to people with disabilities and other claimants. If somebody is classed as able to work, all one's instincts are to appeal to try to get more benefit.

The whole ethos is to get people as much money as possible. Do you think there is a cultural change required to persuade people that to get into work and to have that opportunity to be in the workplace is a much better thing than just getting benefits? That is of course the truth.

Professor O'Donnell : I am anxious not to stray into policy areas here. I think that when you talk to the working population, such as through my background in occupational medicine, you meet many people who have difficulties with work who want to work. Many people drift into incapacity having gone off sick with back pain or depression, and over a period of time they end up stuck there. And it really is very challenging for people to think that they can move away from that. So I think people really need to understand the message that we are here to support them. This is all about support; it is not the way it is described in some of the newspapers.

Q145 Stephen Lloyd: On that basis, and it is a very important point, does the new Customer Charter that Atos has apparently put together reflect any of the things that Professor O'Donnell is saying? In the sense that it is not only a Customer Charter about improving your service and your empathy with the clients that come to see you, but is there anything within the Customer Charter or within the senior management—you, Lisa—about Atos playing a role in communicating clearer and much louder, or influencing the DWP or the Government to communicate much louder and clearer, about what this capability assessment is and how it is not necessarily about failure but about moving into work.

Lisa Coleman: Absolutely, and we really do welcome a benefit that focuses on what people can do rather than what they cannot do. We wholeheartedly support that. We do recognise that people with health conditions and the most disabled people can make their way back into work with the right support and encouragement. If you talk to any of our healthcare professionals, and I am sure you will when you see the mock assessment when you visit, you will see that for yourselves. That ethos is actually there; we do support the policy intent, and we try to drive that out in all of our interactions. We do not always get it wholly right, and we learn from that and we try to apply that learning back into our service. But we fully support the objectives and the intent of the policy.

Q146 Stephen Lloyd: I hear what you say and I agree with it. Though we all understand some people are very anxious and they may not necessarily be completely accurate in reflecting back to us as MPs and politicians the overall reality, against that we all—650 MPs—would have perceived a considerable number of fearful, disabled people going through the whole WCA process. My point behind that is that I am not convinced, Lisa, that ethos, belief and that determination—the glass half-full, positive aspect of this Work Capability Assessment—has got down to your advisors—the people that do the assessments. I do not believe it has because we are hearing too many fearful people to say every single one of them must be delusional or on the defensive. I am not convinced.

So what I would like to hear is not what you are trying to do or what you want to do; I would be interested to hear what specific actions Atos will be taking over the next few months to push that message down very hard.

Lisa Coleman: I will ask Laura to tell you about the training that we do with our practitioners, and how we cover off those elements.

Dr Crawford: If I start off with the practical training, I would like to mention the update training that we have just delivered to all of our healthcare professionals for the new assessments—the revised WCA that we are using for new claims and for the IB Reassessment Group. The healthcare professionals—I did my own training a couple of weeks ago—really welcomed the revision of the descriptors that talks much more about work place and work focused tasks. And I think they felt that would enable their engagement with the customer group to be much more focused on how someone might manage, or could be supported to manage, in a workplace rather than with some of the more day-to-day tasks that used to appear in the descriptor.

I think they also felt that the new descriptors had somewhat simplified some of the areas of the function, particularly making it easier to assess people with mental health problems in relation to the difficulties they may have with work or getting to work. It enables them to discuss much more clearly the impact of the health condition, particularly areas that customers are concerned about, such as fatigability, the ability to repeatedly do a task. That is much more well recognised in the new descriptors. So that is very clearly covered in the training, and it has led to the start of a change of focus with the new assessments.

Q147 Stephen Lloyd: One last question on that around measurement. Obviously Atos is an organisation that is all about measurement. By the same token, you have an audit system in place to monitor the performance of your own healthcare professionals. How many of your staff have been identified as failing in the last 12 months, or having enough points against them that show that they have not performed up to the level that you require?

Dr Crawford: I will start with the extreme end of the wedge, if I may. I just picked out the figures from the last six months. Over the last six months we revoked or unapproved five HCPs from doing the work because of performance issues.

Q148 Stephen Lloyd: How many HCPs do you have?

Dr Crawford: We have about 1,500 in total, and that includes those who work for us on a sessional basis as well as those directly employed. So we asked for the approval from the Secretary of State to carry out the assessments to be removed from those five people. Because we very actively manage, another six or seven HCPs left us with mutual agreement because they were heading down the route of realising that this kind of work was not for them. Beyond that, what we tend to do is very actively manage people, so rather than wait until they have a 'C' score, or a "not fit for purpose" score on their assessment, where they have

minor issues identified we will tend to work with them very actively to bring them up to our standard.

Q149 Stephen Lloyd: Within that do you have a support mechanism for the HCPs? Because this is a very challenging job. They are going to be potentially transforming people's lives, and in this instance the lives of the people they are transforming do not feel they are going to be transformed for the better, though I believe hopefully many will. So it is a challenging job for the HCPs. Do you have a support mechanism?

Dr Crawford: We do. Each group of 10 HCPs have a clinical lead or mentor, who engages with them every week formally or informally and provides them with positive feedback, support, and where necessary will work through any issues with them. All our nurse HCPs have clinical supervision, which is a more reflective feedback and learning session, which is in line with the NMC⁸ relicensing requirements. So both their performance leads, their mentors, and their reflective learning and clinical supervision.

Q150 Glenda Jackson: If I can take you back to the assessment in a workplace as opposed to the initial assessment, can the assessors answer the questions of the individual, or do they tell them they are checking to see if they can use a telephone or sit at a computer. How does the workplace element introduce itself? I have seen no sign of it.

Dr Crawford: Most of the people that we see for assessment are currently not in work. So during the assessment we explore the last job they did, the problems they had with it and the reason they had to leave. And obviously most of our history talks about how they manage from day to day, what sort of things do they struggle with, what is a good day, what is a bad day, how often do they struggle? And we can translate that function into the new descriptors, which tend to reflect the sort of tasks one might encounter at a workplace. So it is not directly asking them if they can stand at a workstation; it is finding out about the sort of things that they are struggling with, and maybe that they struggled with before they left work. That enables us to assimilate both the clinical and the functional information, and choose the most appropriate descriptor in that case.

Q151 Glenda Jackson: You may not be able to answer this, but there has been overwhelming anecdotal evidence—I think to the Committee and certainly within my own constituency casebook—that the individual feels that the assessor is regarding them as somehow attempting to avoid work. This may simply be because the Government of the day has been assiduous in attempting to present every benefit claimant as actually being workshy. Do you think that has affected your assessors in any way, because they sense that there is a conflict between the two? It is very palpable in the evidence the Committee and I have received.

Dr Crawford: I certainly do not believe that this is the case from working with the HCPs and from training with them. However, I recognise what you are saying, and the fact that it does come up in some of

⁸ Nursing and Midwifery Council

18 May 2011 Lisa Coleman, Dr Laura Crawford and Professor Michael O'Donnell

the press. One of the things that we have done in the new soft skills training that I alluded to was invite a couple of the special interest groups that we work with, Rethink and the Scottish Association for Mental Health, to participate in that training, which we formed into a DVD. Part of that is an introduction around the perceptions and the feelings of the customer group when they come for an assessment to enable our HCPs to reflect on that, and to consider how someone might feel and might perceive the purpose of the assessment.

Q152 Glenda Jackson: Do you monitor your HCPs post that re-training?

Dr Crawford: We do, so as well as auditing the report, which does not tell you about the interaction between an HCP and a customer, we look very closely both at our customer satisfaction stats, but in particular any feedback, any complaints, any communications from individual customers. And every one of them is recorded in terms of the area that they felt an HCP did not meet the standards they would expect, and that leads us to potentially take an HCP back to a stage in our training where we would go back to supervise them, review their assessments, sit in, record them, let them do some assessments with a role-player, so that we can look at how their empathic and communication skills are working, and support them further if necessary.

Q153 Glenda Jackson: Is that applied to the sessional assessors?

Dr Crawford: It applies to all HCPs who work for us, employed or sessional.

Q154 Glenda Jackson: Is there any payment by results for them?

Dr Crawford: No.

Q155 Chair: How easy is it for one of your customers to make a complaint?

Lisa Coleman: There are two routes: they can either contact us by telephone—we have a manned telephone service—or they can write to us.

Q156 Chair: But presumably the telephone number they have got is the call centre.

Lisa Coleman: No, there is a separate phone number for the complaints service, which is actually on the Customer Charter and in our booklets that we send out.

Q157 Chair: But it is not in the letter they get. With all due respect, many people do not look at a Customer Charter or very often do not read the booklets. You read the letter that is addressed to them.

Lisa Coleman: It is not on the actual letter, but it is within the insert that goes in that gives them all the information about the assessment and how they can register any dissatisfaction.

Q158 Chair: Do you think it is easy for them? If they have had a bad experience are they encouraged? Because obviously customer complaints are important for you in terms of customer feedback.

Lisa Coleman: I welcome it because it is the way we can actually get the learning, and we can find out what we need to do with the service. I believe we get a representative amount of complaints for the service that we offer.

Q159 Chair: I worry that they are not coming to you because they have had such a bad experience, so they come to all of us. Do you get many MPs' letters?

Lisa Coleman: We get both complaints and we get official correspondence, or we get feedback from local offices, so we do see the letters that come through to you. They often land directly on my desk, so I do see them as well.

Q160 Teresa Pearce: Earlier you said your satisfaction levels with customers is 90%. That is a random sample of about 30,000 people a year, isn't it?

Lisa Coleman: We have a target of around 90%. Overall for March we were at 89.2%, which is about the average. It covers both the HCP, the reception, the contact centre interaction, and we do a sample of—I will just get my figures for you. Sorry, I do have them in front of me.

Q161 Teresa Pearce: The market research company that you have that contacts those customers, it is about 30,000 to 31,000.

Lisa Coleman: Yes, it is a random sample.

Q162 Teresa Pearce: What percentage of your customers is 31,000, roughly?

Lisa Coleman: We do about 1 million assessments a year.

Q163 Teresa Pearce: So that is quite a small sample.

Lisa Coleman: But that is over the quarter, so we get a return rate on that of about 40%.

Q164 Teresa Pearce: What I am trying to get at is these people that the market research company contacts will be the easiest-to-contact people, or people who will answer the phone.

Lisa Coleman: No, not necessarily. They do a sample of both people that attended and people who did not attend as well.

Q165 Teresa Pearce: But for a market research company to contact these people, they must be people who answer the phone, and have a phone.

Lisa Coleman: They do it by mail shot as well. So the return rate we get is standard.

Q166 Teresa Pearce: So it is 90% of a small sample.

Lisa Coleman: It is 40% response rate of the sample that we take, yes.

Q167 Teresa Pearce: Earlier you said you were very keen to say that you are not paid by results, which is a misconception that people had; you are paid per assessment. So my concern is, if you are paid per assessment as a business model, it does not matter if you get them right or wrong. And there has been evidence that says that 39% of the decisions that are made are overturned. So what feedback do you get

the 39% that are overturned to see why that happened or if there is a common denominator? What sort of work do you do on that?

Lisa Coleman: We have worked very closely recently around the appeals service, and the changes that have gone into the appeals service, looking at the taskforce to actually build much closer links between our HCPs and the JCP decision makers that work with us, to make sure that we get the feedback. We find that there is also a lot of additional evidence that can be provided either post the assessment or actually at the appeal stage that can result in a different decision being made. So we have worked very closely with the Department to look at ensuring that we gather any evidence as early as possible that allows the right decision to be made, so that they do not have to be changed. And we are particularly looking at the reconsideration process. Laura, do you want to add anything to that one?

Dr Crawford: The key for us is ensuring that as much as possible we see any evidence and information that a customer has as early as possible in the process, because that will allow us to include that in our consideration when we are sending our assessment report back to the decision makers, and not having to look back later on and find that someone had some information or has submitted some further information that might have made us operate differently.

Q168 Teresa Pearce: Are you confident that the recommendations that have come forward for changes in the process will reduce that 39% of overturning decisions? Do you think it will help?

Dr Crawford: I think it will because more of the information that is available will be considered up front, both within Jobcentre Plus and when they ask us, as they often do, to interpret further evidence. I think the most important thing is the revised descriptors and the policy and the policy intent within Jobcentre Plus. It is certainly well trained within our organisation. So it is really important that at all parts of the process, including the appeal, the policy and the understanding of the descriptors and the policy intent, are followed so that we get consistent outcomes.

Q169 Teresa Pearce: So how was the computer based system devised? Was that devised by you or the DWP?

Dr Crawford: It was devised by us working with the Department as a tool to enable the HCPs to accurately and comprehensively record all the information, and make sure that we do not miss anything out, and ensure that all of that information is structured in a consistent way.

Q170 Teresa Pearce: One of the complaints that we do get is people feel like they are being processed rather than dealt with and talked to. I went as a friend with a family member to one of these assessments, and he has a very complicated eye condition and visual impairment. But because the question is asked in a certain way, the honest answer to them meant he did not get any points. It was, "Can you see this?" Yes, he can, but he cannot see it like everybody else

can. So how can you make something that is a question and answer, tick box-type computer programme fit a complicated condition?

Dr Crawford: The questions are not within the programme. The questions are an area that we would train the HCPs to explore in a typical day. There is no tick box in the programme. What is entered is an amount of information. One of the things I would highlight is, with the revised descriptors, you recognise these different disabilities and the way people have adjusted to them. So I do think the new descriptors, particularly around things like navigation, would recognise not just an issue with what people can see, but the breadth of their vision distortion. So all those things will be explored by the HCP in terms of how people are functioning.

Q171 Glenda Jackson: This additional information or evidence, does it come after the assessment or before? Where does it come from?

Dr Crawford: It comes at any point in the process. Thinking particularly about information that the customer might provide, the communications that go to the customer have been revised recently. That was just March, so I cannot see much change yet, but it is inviting them to present their evidence as early as possible. That may go straight to Jobcentre Plus and then would come to us. They may bring it with them on the day of assessment, at which point we will take it, copy it and insert it in the file so it is also available to the decision maker. Or it may come afterwards, in which case the decision maker will get it directly, and may ask us to interpret some of the medical information.

Q172 Glenda Jackson: But evidence of what? Is this exclusively medical evidence?

Dr Crawford: It may be oral evidence from a decision maker talking on the phone to a customer. They may then come up with something that they forgot to say, or some more information, and that would be transcribed by the decision maker. But in terms of our context, it would be medical evidence and medical information. People often bring copies of reports or appointments with them.

Q173 Glenda Jackson: And having looked at that evidence, either slightly before or at the assessment, how long is the process before the individual knows whether they have got the relevant number of points or not?

Dr Crawford: That would be the communication they have with the decision maker at Jobcentre Plus.

Q174 Glenda Jackson: But have you got any idea of how long that process is? You are looking at an increasing number of people.

Lisa Coleman: I do not know exactly how many days after an assessment the average time to decision is.

Q175 Glenda Jackson: Well how long does it take you to pass that on?

Lisa Coleman: We provide our report, in the majority of cases, on the day, unless we take that to one side to be audited, and then it will usually be 24 hours

18 May 2011 Lisa Coleman, Dr Laura Crawford and Professor Michael O'Donnell

after. So once we have provided our report, then that is available to the decision maker with all of the other evidence that may be available to make that decision. I do not have the stats on the time duration of that period.

Q176 Chair: Does the client get something to take away with them to say how they have done on the day? Because by the time it gets to appeal, clearly the error was the inputting data on the computer. Does the client get to look at the computer screen, because that is common practice in DWP offices now, to make sure that those kind of input errors are picked up at a very early stage.

Lisa Coleman: We do not provide a report at the point of time of the customer leaving. That is provided back to the decision maker.

Q177 Chair: One of the big fears, and it was a common theme through all the evidence we got, was the mechanistic nature, the computer-based nature. I think a lot of your clients feel they are in the *Little Britain* sketch, where it says, "The computer says no." The computer says no and they cannot get past it. That was a very common theme. Do you recognise that as a frustration of many of your customers?

Dr Crawford: I recognise it in communications from customers, but that is not how it operates it all. The HCP is in charge all through the process, and is entering all of the information. It is hard to describe the interaction in an oral session, so I am pleased that you have asked to come along and see a mock assessment with an HCP using it. I hope that it will all become clear having seen that.

Q178 Chair: A young lady with autism was involved in a roundtable discussion we had. When she went for assessment and tried to hand over an explanation about autism, that was refused by the person doing the assessment. From what you are saying, of the multiple examples we have got, is that because these were at an early stage of you doing these assessments and that would not happen now? Or is still the sort of thing that would happen, because you were saying that people can hand over their evidence, but we have lots of examples of people who were not allowed to hand over their evidence.

Dr Crawford: I obviously do not know about the specific circumstance, but it is reinforced within the training of the HCPs. Within LiMA⁹ we have an area that asks if people have brought evidence and whether it has been entered. So there is a reminder to enter evidence. The post-training scenarios we now have include what to do when someone brings evidence with them on the day of the assessment, and that should be considered, copied and entered onto the form.

Q179 Glenda Jackson: Is the individual told before that they may bring additional evidence?

Dr Crawford: Yes.

Q180 Glenda Jackson: And are they given any indication of what that additional evidence could be? There are many people who would not know what additional evidence was, because they are not absolutely clear what you are looking at.

Dr Crawford: That is something we are currently working on with the Department: thinking about and clarifying the types of things that would be useful to us and to them. I recognise what you are saying about knowing what is evidence and what is useful. It is something us and the Department have recognised.

Q181 Kate Green: Can you tell us a bit about how the processes changed following the DWP's internal review of the descriptors, and whether you agree with their assessment that that will mean an increase of around 5% of clients being found fit for work?

Dr Crawford: We have just recently trained our HCPs in the revised WCA descriptors following the Department-led review last year. I do not feel we are well placed to comment at all on the Department's research on potential change in rate. If it helps, I can offer you anecdotal information from the HCPs, having been trained about what they feel. The first thing is that they particularly welcome the change around people awaiting chemotherapy within the next six months. In the past we were not able to place them into the Support Group. We are now, and I think that is a clear benefit for an area where both the Department and the HCPs were uncomfortable. So the change in legislation to permit that is very welcomed. There is also a feeling amongst the HCP group that some of the more severe mental health conditions will fit better with the Support Group criteria, which I think was also part of the Department's intent in the change in policy. In terms of the descriptors, very few of the HCPs have done enough of the new assessments yet to get a really good feel for the pattern. Again, feeling the descriptors are easier to interpret, the explicit recognition of fatigability, safe repeatability of actions and fluctuations are also very much welcomed by them as a group.

Q182 Kate Green: Would you have preferred to have trialled those new descriptors before you were required to operate them in the context of the national rollout?

Dr Crawford: It is a relatively new benefit, and it is going to evolve and refine over time. I recognise that a review is planned each year. Obviously there is the Department-led review, but then the annual review that Professor Harrington has been involved in. I think some clear improvements have come out of that for the disabled person in terms of supporting and assessing them, and I think it is particularly important that some of the ones around the Support Group and chemotherapy are implemented early so that people have the benefit of those.

Q183 Kate Green: You have obviously begun to implement the recommendations of the first Harrington Review. Can you tell us how you are getting along with that, and how many have been implemented and whether it is the case across the whole country?

⁹ Logic-integrated Medical Assessment, the IT system used by Atos

18 May 2011 Lisa Coleman, Dr Laura Crawford and Professor Michael O'Donnell

Dr Crawford: The Customer Charter has been implemented nationally. The pilot of the recording of assessments has taken place in a Newcastle Medical Services Centre. The outcome of that is currently being reported, and the report will be done during June, so that pilot is complete now bar the outcome report. The personalised summary will be implemented nationally on 6 June for all new claims and IB reassessment claims. Our HCPs are undergoing further training on writing up the personalised summary as we speak. Tranche one of the mental health champions have been implemented, so that is now a national service.

Q184 Kate Green: When you say tranche one, how many is that? What does that mean?

Dr Crawford: We are training them in three groups. We have 14 in place now. We will be up to 45 by the end of May, and we estimate we will have about 60 by July. But we are already providing the national advice service, so the mental health champions are providing support to our HCPs. So HCPs working in all of our assessment centres, and carrying out home visits, can access support from a mental health champion every day to help with individual cases or to talk through issues. The mental health champions will be visiting each of our MECs at least once a month. They are also starting to lead some of our learning sets, and getting involved with some of our new HCPs or those undergoing remedial training, to provide some specialist mental health advice.

Q185 Kate Green: What qualifications do the mental health champions have? Are they mental health experts?

Dr Crawford: Yes. They are all experts so they all have more expertise in the field than a standard HCP. So in the group that we have trained already, the nurses within that group are dual-trained Registered Mental Nurses as well as Registered General Nurses. And all the doctors that we have selected in that first group, the champions' champions, have all worked within a psychiatric setting for at least six months or more post their general medical and psychiatric training.

Q186 Kate Green: One thing that surprised me when we visited Burnley was to learn that, although you have obviously frontline assessors from a range of health professions, the view of Atos appeared to be that because they had gone through a generic training, anybody could assess any client. And given that some people are physiotherapists by profession and are assessing potentially mental health claimants, I was quite surprised that would offer sufficient comfort and credibility to clients. I wonder whether you could comment on that, and whether that is correct, and whether the mental health champion is your answer to that.

Professor O'Donnell: It is correct that we feel that you do not have to be trained in a specific area of medical practice to perform these assessments. With regard to mental health, it is well recognised that most people who attend their general practice for other than common everyday problems will have some sort of

mental health problem associated with whatever health problem they are presenting with, if not the main problem. So all doctors are trained really in dealing with mental health, and should have some understanding of this. We also should recognise that basically it is part of nursing to be able to recognise mental health problems in your patients, and it is part of physiotherapy to recognise when psycho-social barriers may be obstructing recovery, for instance. So to that extent every healthcare practitioner has a basis of understanding of some level of psychiatric function.

We are performing a functional evaluation, so we are actually training people in the art of interviewing people and bringing out how their illness is affecting the way they live, and applying that to how they work. It is our view that really this is no different from what doctors and healthcare practitioners do in everyday life, it is something that all people learn. It is different, but it is based on what they have learnt in their basic training, and what they do in practice before they join Atos.

Q187 Kate Green: And yet there has been some scepticism, for example from advocacy groups, about the ability of non-expert professionals, albeit having gone through the training you describe, being able properly to assess conditions like autism. I wonder what assessment you are making of improvements in that kind of identification of conditions as a result of the creation of the mental health champions.

Dr Crawford: Remember that we are not diagnosing conditions; we are there to find out the way that a condition or a group of conditions impact on someone's ability to function. So the key skills that we need to have are communication, comprehension, the ability to evaluate perhaps a lack of cognitive function in someone with potentially an autistic spectrum disorder. So the evaluation is not of someone's skills in diagnosis, but the skills in being able to accurately assess and reflect someone's mental, cognitive or behavioural function. I think you are right to say the mental health champions will be a support in that, and one of the things I am keen to see is how, as we evolve through the period of the mental health champions, they are used potentially in a more proactive way with people's desire to learn more and more rather than in terms of somebody wanting to run past a specific case with them. So I think that support and education is what I want to see. How will it even further improve the skills in handling those cases?

Q188 Kate Green: How will you measure that impact?

Dr Crawford: We will do it in a number of ways. We will do it through our audit processes obviously, but also through the clinical supervision sessions that we have with our nurse HCPs, where they look at and discuss cases with the senior facilitator. So we then have feedback from the facilitators on the level of discussion, the articulation of the discussion, and any concerns that the HCPs have raised through that session.

18 May 2011 Lisa Coleman, Dr Laura Crawford and Professor Michael O'Donnell

Q189 Harriett Baldwin: It is clear in the written evidence that people who suffer from mental health problems are particularly worried about the fact that they know this assessment is coming down the line. I wondered whether you were therefore planning to perhaps prioritise that or perhaps let them know when they might expect to be assessed.

Dr Crawford: I think that is around the way the cases and IB reassessments are passed through to us. The Department for Work and Pensions will start off the IB reassessment process, and the cases will come through to us. It is only at that point we will make the assessment.

Q190 Harriett Baldwin: Obviously the number of assessments that you will be doing will go up to 11,000 a week this month. I just wondered if you had completely finished the recruiting process in terms of the staff that you will need.

Lisa Coleman: Recruitment within Atos Healthcare is an ongoing task that I do not think will ever end, to be truthful. We do have an attrition rate, we do have practitioners that leave us, so regardless of whether or not we have got the right requirement to deliver this volume, we will also be recruiting on an ongoing basis. It is a permanent state. We have worked very, very closely with the Department. We were able to do an assessment of the volume of practitioners that we would need very early in the process, and we kicked off that recruitment process back in early 2010. We are monitored very closely by the Department on how we are doing against our recruitment plans. We do have some hotspots regionally; the South East is a particularly difficult recruitment area for us. But we also work with the Department to make sure that we have contingency plans to be able to deal with the additional volume.

The thing to also point out is that we have had a drop in IB volumes, so we are offsetting some of that with existing practitioners, and we have got about 100 additional ones that we needed to recruit. We are well on with those plans, but it will continue to go on throughout the whole reassessment process. We have got the ones we need to start the process. We are already processing the output, so it will be very early days, but we do monitor any hotspots in terms of recruitment, etc, very closely

Q191 Harriett Baldwin: DWP have told us that they have extended your contract to 2017 and have asked you to deliver substantial savings against the current cost of about £100 million a year.

Lisa Coleman: The contract is actually extended to 2015. I would like to say it was 2017, but it is 2015. The negotiations that we did around the contract extension were actually part of our original contract, which we went through in open tender; we were awarded that contract with the opportunity to extend for the period that has now been extended. In terms of the savings that we have delivered, we reduced our prices by a certain percentage, and on top of that there are a number of service improvements that were working on with the Department over a period of time to deliver further improvements to the cost to the Department.

Q192 Harriett Baldwin: But how does the requirement to achieve savings fit in with the requirement to now scale up the level of activity?

Lisa Coleman: The requirement to take the savings is directly against Atos Origin, so we have reduced our prices to do that. Future savings are around making the process more efficient, looking at where we can make sure that we are using technology to support the end-to-end process, and that we are using the right people at the right point in time. It is a combination of factors.

Q193 Harriett Baldwin: So it is the number of assessments that you carry out that affects what you are paid, and it is not related in any way to the outcome of the assessment.

Lisa Coleman: Absolutely.

Q194 Harriett Baldwin: Are there any other indicators that DWP uses to monitor your performance that could affect the level of payment that you receive?

Lisa Coleman: We are monitored on the turnaround times, so we are making sure that we are providing the reports back in a timely manner, and at the right quality, as Laura has outlined. We are also ensuring that our customer service and our customer satisfaction is to the right level, and that we are doing the right amount of audit and that the reports are accurate. So we are monitored on a range of things. In the event that we do not deliver against those services there are financial penalties that we incur. They do not affect the output price of the actual report that we deliver, but we do experience financial penalties if we are not delivering to the right service.

Q195 Harriett Baldwin: And if you do better than those, do you get financial rewards?

Lisa Coleman: No.

Q196 Harriett Baldwin: So there is a maximum that you can be paid.

Lisa Coleman: The number of outputs that we are expected to do is contractual, and the price that we will be paid for that output is contractual as well.

Q197 Chair: Are there financial penalties if you get the decision wrong, based on the appeals and the decisions that are overturned?

Lisa Coleman: We are rewarded on the output of the report. We do not get a penalty against the decision because that is not something that we influence. We are only a part of the overall end-to-end decision-making process. We provide one element of the evidence.

Q198 Chair: That adds to the suspicion that you are a private company, you are driven by a profit motive, and the incentive is to get the assessments done, but not necessarily to get the assessments right. What is your response to that allegation?

Lisa Coleman: I find that very disheartening. We are very closely monitored in terms of the quality of our outputs from the Department. We have very stringent quality criteria that we set down, as I hope we have

18 May 2011 Lisa Coleman, Dr Laura Crawford and Professor Michael O'Donnell

explained. In the event that we do not have practitioners that meet the right quality, we do get rid of them. That is the way that we operate our business. So it is wrong for anyone to think that we would be incentivised that way.

Q199 Stephen Lloyd: I appreciate that, Lisa, but I am sure you appreciate that where around 40% of your findings are overturned on appeal, perhaps the DWP might revisit the business model and penalise the company if so many are overturned on appeal. 40% is very high.

Lisa Coleman: I think it is really important that you understand why things change at appeal. And as we have talked about, often it is because there is additional medical evidence that may not have been available to us at the point of doing the report. We work very closely with the Department on what we can do to improve the appeals process, and make sure that anything that we contribute towards the overall decision-making process is robust and to the standards that they require.

Q200 Glenda Jackson: You have spoken of having to take on more staff, and you have already highlighted the ongoing training that you are engaged with for existing staff. Are these training programmes cost free? How will it be possible with a reduced budget to improve and expand training? Is there going to be a reduction in the amount of time taken for an assessment? Looking at the evidence, on average it is 45 minutes per assessment. You are going to have 1.5

million more people to assess over the years. Is there going to be a reduction in that timescale?

Lisa Coleman: There is absolutely no intention, through any of the service improvements that we want to make, to reduce the quality of the practitioners that we use or to change the training. It is critical to us that we get the training right up front to ensure we get the quality of the reports at the back end. There is no intention to do that. The actual time to do an assessment was adjusted upwards as part of our view of what would happen under IB reassessment. We have a view that people will come to us with a nervousness. We want to recognise that, so the average assessment duration, and it is an average assessment duration, we use in terms of capacity planning, but often those assessments can be shorter or significantly longer. And certainly through the trial we saw that a number of those assessments were significantly longer than the average that we have used on previous benefits for capacity planning. But there is absolutely no intention to reduce the time that we give people to perform the assessment.

Chair: We will have to stop because we are well over time now. We have lots of other questions I am sure we could have asked. Can I thank you for coming along this morning? If we have got other questions we might write to you. I know that we are getting the paperwork to show what the customer gets. Thank you for your attendance this morning. It was extremely important for us to hear from you as part of this inquiry. And I will ask you to move; we have now got our next session with Professor Harrington.

Examination of Witness

Witness: **Professor Malcolm Harrington**, gave evidence.

Chair: Thank you very much for coming along this morning, Professor Harrington. I saw you in the audience, so I know that you have heard all of that session, and apologies for keeping you waiting. Perhaps the fact you have heard that session might help speed through some of the questions that we have, because obviously there is a mismatch between what Atos, as a company, claim that they are trying to achieve and what the real life experience has been of some of their customers.

Q201 Glenda Jackson: During your review, was there full cooperation with you from DWP, Atos Healthcare and the Tribunal Service? Were they absolutely open and cooperative.

Professor Harrington: Yes, they were. I was an independent, coming in from outside, and a couple of people from the DWP were assigned to me who then became independent by working with me. And I had a scrutiny group that oversaw what I did and challenged some of the thoughts that came through. But in terms of the cooperation that I had I didn't find anyone that was obstructive.

Q202 Glenda Jackson: So it was fully open and cooperative, and there were no blocks set in your way during that review process?

Professor Harrington: None that I was aware of.

Q203 Glenda Jackson: The DWP provides you with secretarial support and an office. Is it adequate to your needs, or could it be better?

Professor Harrington: I think it is. The number of people who worked with me on the first year, and the first year started somewhat later, because I was not appointed until July. The number of people who then worked with me varied with the amount of work that I had. In the end I had about four or five people. At the moment I have two, because the workload does not warrant more than that in terms of the Department's involvement. But they have been very cooperative. I do not have any difficulty in getting done what I want to do.

Q204 Glenda Jackson: It was a pretty fast review time though, wasn't it?

Professor Harrington: Unconscionably so, yes.

Q205 Glenda Jackson: You say "unconscionably"; that leads me to ask whether you could have done with more support or was it just more time?

Professor Harrington: We decided that we had to do with the time that was available. There was a number

18 May 2011 Professor Malcolm Harrington

of reasons why the appointment was delayed, not least the General Election. So I did not actually start working until July, but I felt the responsibility still was to produce a report by the end of the year. So I looked for things that I thought could be done now—somebody described it as a “quick fix”, which I do not particularly like—to change the system, and things that were going to take longer, a little more thought, consideration and research, which would be part of the Year Two programme. So I ended up with a set of recommendations that were things to be done now, and things to be looked at in Year Two, and hopefully completed in Year Two.

Q206 Glenda Jackson: There has been a great deal of criticism of the Government introducing certain aspects in their policies. The argument that we have heard is that you were not given sufficient time to conduct a thorough review before these changes were introduced. Do you share that criticism?

Professor Harrington: Firstly, it is a political decision, not a decision by an independent reviewer. My personal view is that, as this review is meant to take place for five years whoever does it, whatever changes the Government may choose to make in the course of running this particular part of the scheme will become part of that review process in due course in any case.

Q207 Glenda Jackson: Obviously, you must have made it clear to the Government that it was a very tight timescale that you were working under.

Professor Harrington: Yes, I did.

Q208 Glenda Jackson: But have you always felt that you are entirely independent, that your views—those that arose out of your review—are entirely yours?

Professor Harrington: Yes.

Q209 Glenda Jackson: There has been no kind of pushing behind you or blowing down your neck to get a move on?

Professor Harrington: In some ways some Ministers actually wanted me to go faster, but my scrutiny group also strengthened my arm on a couple of occasions when I was going to say something in one of the early drafts of the final report. I said, “I think we could go that far,” and they said, “No, you can go much further than that, strengthen it up, do more.” And that gave me a greater leverage when it came to talking to senior officials because I had my scrutiny group behind me.

Q210 Karen Bradley: On the process itself, you describe the Atos computer system as “not very intuitive” and not one that allowed “nuanced responses to be reflected.” Are you aware of what steps are now being taken to ensure that the Atos healthcare professionals do not rely on the computer system too heavily?

Professor Harrington: There are two aspects to that. One is that they have changed the IT programme, not only to include the free text paragraph, but also to make it more intuitive. I have seen that programme in action; it was demonstrated to me, and I quite like that, and I am going to arrange a series of seminars

this year where on a screen a number of people who deal with me—some of the charities and other groups—can attend that meeting and go through the programme; it is very difficult even if you are allowed into an assessment, which I was, being medically qualified, to peer round at the way the screen was. And I want this screen up there so that people can see. I want to know whether in fact the LiMA IT drives the assessment, or whether the individual can drive the IT. That is one of the calls for evidence I will have for this year. I thought to improve the quality of the response to that call for evidence, it would be a good idea if as many people as possible, from various groups with which I deal, could have a chance for an hour to do that. And Atos are laying on three of those sessions. I was going to offer the same facility to your people, but I believe that has already been arranged elsewhere, so you will have the same sort of demonstration. That is one aspect of it. There was another aspect to your question.

Q211 Karen Bradley: It is not very intuitive in allowing “nuanced responses to be reflected”. I think what you are saying is that it is now allowing nuanced responses.

Professor Harrington: It appears to be more responsive. The one thing I wanted to get across quite clearly, having listened to the first part of this, is that, in my view, the Atos assessment, if I may call it that, is merely one part of the whole process of assessing this individual and their work capability. And it is one piece of evidence that the decision-maker has to collect, as well as corroborative evidence, other evidence that the individual gathers from their healthcare advisor of their choice, and what they themselves may say. And then in my view, if in fact all that evidence is gathered together, the decision-maker should then do what their job implies they should do, which is make a decision. What they are doing now is rubber-stamping an Atos assessment.

Q212 Karen Bradley: On that point, it has been suggested that there is a slight oddity here, in that the healthcare professional is carrying out the Work Capability Assessment, but the unqualified—in terms of health—Jobcentre Plus decision-maker is the one who makes the decision. Do you see an anomaly with that?

Professor Harrington: I don’t have a problem with that. The predecessor to the decision-maker was an adjudicating officer, who had immense powers in the old days, and was not answerable to the Secretary of State even, and was always a layperson. It has always been a layperson who does that final adjudication. I am saying an intelligent human being, collecting that information that the Atos assessment is part of, should be able to come to the right decision. If they are looking at the same information that judges are looking at, they can make that decision and not have to go to appeal, for those cases where the appeal is upheld on the basis of additional information. I want to get around that particular problem.

Q213 Karen Bradley: So you want to address the fact that additional information is sometimes brought

into the appeal process which does not appear to have been taken into account during the decision-making process.

Professor Harrington: Sometimes it is evident that they do not look at these things. Other times it is the length of time that has passed from the decision to go to appeal to actually appealing before a judge. So other events have happened in that claimant's life that will provide additional information. But there is lots of evidence, from what I saw in the first year, that a lot of this additional evidence was not being effectively looked at. If you are going to put the decision-maker back at the centre of this process as the driver, and as the repository of all the information who is then making a decision, I think we will get a more accurate and effective assessment, and there should be less appeals.

Q214 Karen Bradley: Going back to the WCA process itself, do you think that 45 minutes is sufficient time to carry out a work capability assessment?

Professor Harrington: I think some could be carried out in less time, which will allow for some more complicated cases to take even more time. Where I have gone to see assessments done, it is clear that the individuals doing these assessments do work on the basis that some are shorter and some are longer, and they are perfectly prepared to go past an hour if it is a complicated case. You hope that in the course of the day you will have something that is a little simpler so you will not overrun your time, because you have a certain number of assessments to do in a day. But I do not think they stick rigidly to the 45 minutes.

Q215 Karen Bradley: Just a final point that is not so much about the process as about the terminology that is used: we have talked about "passing" a working capability assessment as if that means that you are not fit for work, and therefore you have passed the assessment. Do you have any views about whether the terminology could be looked at to perhaps help people to understand that this is to assess what work they are capable of doing rather than whether they are eligible for benefits.

Professor Harrington: You are absolutely right, people say they have failed the test, meaning they were declared fit for work, and that has become common parlance. It's a very difficult one to unravel. I know that when I was up in Wrexham looking at the way in which they were piloting some of these things last year, the phone call they were making—immediately before the person got the letter that said they had failed the test—was to say, "I thought I'd phone you up and tell you you've been found fit for work,"—that's the good news—"Now let me tell you how the Department is going to help you get back into work." And so it is turned into a very positive thing rather than, "Oh, dear, my benefit's going to be cut," which is the message a lot of people have. And it should be the other way round. "We think you are capable of some work. Now we have to help you find it."

Q216 Chair: The internal review has been implemented. What is your view of the changes to the descriptors?

Professor Harrington: I have heard nothing but criticism of the changes to the descriptors, admittedly from the groups who represent those particular people with those particular disabilities. I was not part of the internal review—it was effectively finished before I started work—so I did not include it as part of my assessment.

Q217 Chair: Would the Government not have been better off holding off implementing any changes to the descriptors until they had heard your review of descriptors, which you are undertaking now, I understand. But to change the descriptors now and then potentially have to change them again in a year's time in light of your findings, do you think that is the wrong decision?

Professor Harrington: It was made clear to me that they were going to go ahead and publish the review and implement the changes to the descriptors. I think the Department knew that I would have preferred it if they had left it until we had a more considered view of what my review was going to do in the first year and into the second year. But that wasn't the way it was.

Q218 Chair: We have got figures from the trial in Aberdeen and Burnley of the proportions that will end up in the fully-fit-for-work group, the WRAG group and the support group, and it looks like around 29% or 30% have been found fully fit for work. From your own instinct of the client group, do you think that is about right?

Professor Harrington: I have no idea, and I don't think anybody wondered what this percentage was going to be before they started. I think it is surprisingly high, but then I think—this is anecdotal, from what I heard when I was in Aberdeen—that for a lot of people, being found fit for work after having nobody take any notice of them for a decade was actually a positive thing rather than a negative thing. They felt they had just been shelved and nobody cared, and now somebody's gone back and said, "Actually, I wonder whether you could do some work. What do you think about that?" It has not all been people saying, "Shock horror, I can't possibly go back to work, I haven't worked for 15 years"; there is a positive element to this. And if that works for those people then that is terrific, because by and large work is good for you.

Q219 Chair: I don't think any of us here would dispute that. I think that that's right. A lot of the issue about the policy is whether the work is there and they can get the work. But I asked the question about your instinct about the balance of the proportion because the DWP's own estimate is that the changes resulting from the internal review will result in 5% more people being found capable of work. So that's actually putting the figures even higher than the figure you say is surprisingly high.

Professor Harrington: The supporters of the various charities would say that is because they have raised

18 May 2011 Professor Malcolm Harrington

the bar and made it more difficult to be other than fit for work. I don't know whether that is true. I don't know enough about the changes in the descriptors to say whether that would happen. I think one of the things that will happen—to the fit-for-work, the Work-Related Activity Group (WRAG) and the Support Group—if we get the decision right, meaning similar to the way in which the judges have changed it, is that you will probably find fewer people in the fit-for-work group and more in the WRAG, and possibly more in the Support Group because that is what is happening where the appeals are upheld by the judges. If, as I keep saying, the decision-makers have the same information available to them, at least in 40% of these cases, my suggestion is that they will probably come to the same conclusion; I don't think anyone in the Department is uncomfortable about that. We want to get it right rather than get it right after a long delay and a lot of expense.

Q220 Chair: Of course the 29% figure is the pre-appeals figure, and of those who appeal, somewhere between 30% and 40% are winning their appeal, so the actual proportion could be quite different.

Professor Harrington: I would like to get this decision right first time at DWP level without having recourse to the judiciary.

Q221 Chair: Your own recommendations on your first year work programme have been well received both by the groups that work in the field and by the Government. Are you happy about the way that those recommendations have been implemented?

Professor Harrington: I was very pleased that they accepted all the recommendations in the first place. Obviously I think some of the things should have been done faster than they are, but the DWP and Atos are big outfits in which to make some of these changes. Looking at all the recommendations that I have made, they have either been done or are in the process of being done. There are some modifications to some of them, but in essence there is not a single recommendation that they have shelved or they have ducked or they are obfuscating about what they are going to do.

Q222 Chair: But the big changes will be the descriptors, and you are still working on that. Do you have any indication of when you might finish that work?

Professor Harrington: Yes, perhaps I can just explain what I have arranged to do this time with a number of the descriptors. It was put to me by a number of charities that they did not really feel they had had a fair crack of the whip in terms of the way in which the decisions were made on the previous ones. They sat on the groups but they felt their view was not taken. Others say that they were heard but their view was not taken because it was not the appropriate decision to come to. I said to Mind and Mencap and the National Autistic Society, "Go away and come up with different descriptors, and I will establish a scrutiny group of experts to oversee that, and by an iterative process hopefully come up with an agreed form that you and the scrutineers agree, which will

then be put to the Department." That is where the mental health and learning disability descriptor position is now. It is with the Department. I expect the Department will go back through the iterative process with this group again, and I think we may come up with some improvements in those descriptors. The same thing is being done, but at an earlier stage, with fluctuating conditions, and we have a range of charities looking at that, related to Parkinson's, AIDS, ME, MS, arthritis, Crohn's and colitis to decide whether we need to look at fluctuation. Because the problem with the Atos assessment, according to some, is that it is potentially looked at as a snapshot rather than how the person is in the round. And people with fluctuating conditions, you can say by definition, if they have turned up to an assessment centre, it is a good day.

Q223 Chair: But if there is a problem with the existing descriptors, and the Government has already begun the national roll-out of the migration, is there not a mismatch that actually by the time what you are doing at present is implemented, then a large number of people will have gone through a flawed system. By definition it must be a flawed system if you are looking to try and improve it, particularly for those more difficult conditions. Is it unfortunate that the Government has not delayed the national roll-out until we can actually get the descriptors right so that the people who are going through the process think it is a fair process?

Professor Harrington: I cannot guarantee they are going to get the descriptors right in any case now; it is a process of improvement. The WCA, as it was, was not snatched out of the air, it was a development of previous assessment systems. It is not as though you can just throw it away because it does not work. It does work, it just does not work as well as it might.

Q224 Chair: But Professor Paul Gregg, who was very much instrumental in the whole concept behind assessing people as fit for work, has been very, very critical, and said that at the moment the WCA is not fit for purpose. Do you share that view?

Professor Harrington: No. I have discussed it with him, and he put forward a number of suggestions about how we ought to look at the fate of people. I read the evidence that he presented to you a couple of weeks ago. We are doing some research to look at the fate of people at various stages: the ones who start the process but drop out, the ones who are possibly borderline between fit for work and WRAG, and WRAG and Support, to see whether we got that decision right. So these pieces of research are going to be started this year. Some of it hopefully will be finished this year too.

Q225 Chair: Do you have any sense of what the position was under the old Incapacity Benefit? We just put down a written question asking the dropout rates of claimants on Incapacity Benefit who didn't complete their claim, because that is obviously an important comparator to the ESA; perhaps those are the numbers that used to drop out of IB claims. I do not know. Do you have any sense of that?

 18 May 2011 Professor Malcolm Harrington

Professor Harrington: No, I don't.

Q226 Andrew Bingham: You talked about the fate of claimants. Do you have enough information to enable you to analyse different types of claimants where the WCA may be working or it may not be?

Professor Harrington: You mean in terms of the appeals?

Andrew Bingham: No, the whole WCA process.

Professor Harrington: We did look a bit at what the diagnoses was associated with people going through various phases, and it seemed to be mental health and learning disabilities were particularly high on the list of the ones that went through this process rather than some of the more straightforward physical conditions. But we also tried to look at why these appeals were upheld. The headline figure that everybody comes up with is that 40% of them were because the judges had more information than was available or used by the decision-makers. And hopefully that will not happen any more. I would like the judges just to deal with the difficult cases that the decision-makers were in two minds about. I have been talking to the judges about how we can have a better relationship, connection and communication between the decision-makers and the judges, because at the moment the decision-makers do not know what the reason is for an appeal being upheld.

Q227 Andrew Bingham: Can I just interrupt you there on that specific point? Do the decision-makers go to make representation to the judge at the appeal themselves?

Professor Harrington: Very rarely.

Q228 Andrew Bingham: They do not go at all? So the judges are actually there looking at effectively one side of the argument.

Professor Harrington: The judges would like them to be there. In the old days apparently more of them did turn up to these things. I think they do not turn up now because of the sheer volume of work, and what that would entail in terms of their time to appear. There are people who write the appeals inside the Department, who are skilled at writing appeals, but in the vast majority of cases they do not actually turn up on the day.

Q229 Andrew Bingham: And do you think that if the decision-makers were to go it would make a difference on the result of the appeals? Do you think the result of the appeals may be artificially high because there is only representation from one side?

Professor Harrington: It might be. If we were restricting this to the difficult cases, first of all there would be fewer and there may be more opportunity and more time available for these people to turn up and discuss the cases. There will always be the difficulty that sometimes there will be a difference of opinion. I just want to get around the business of people looking at the same volume of data, and I assume that they ought to be able to come to the same decision. You would save the individual claimant a lot of trouble and angst caused by waiting around to appear before a judge, which a lot of people find

extremely distressing, physically and mentally. I would like to get around that too.

Q230 Andrew Bingham: On the appeal issue, which does interest me, what are the main reasons that people do appeal? Are there any specific points?

Professor Harrington: They usually appeal because they disagree with the number of points they have been awarded or the way in which the Atos assessment has described their problem. That may be because they just don't like the results and therefore complain about it. That is obviously a possibility. I think if there is more opportunity for the decision-maker to have a dialogue with the claimant, and to collect this additional information, there will be less disagreement between the claimant and the Department. It appears that even if you disagree with the outcome, you will accept a decision you do not like if you feel you have had a fair crack of the whip; that is called "procedural justice", I think. At the moment a lot of people just do not feel they have had a fair crack of the whip. They have not been handled well by the Department, they have had a computer-based assessment they do not like, and then they get a decision they do not like. So they appeal. This has changed, but there was a sense that inside the Department—the Atos assessment was accepted in 98% of cases, before I started—that people had a the knee jerk reaction to go to appeal if they did not like it. The reaction is now to have the case reconsidered, go through all the information and check it all out again, before going to an appeal. I think that will make a difference to the number of people who go to appeal, but also the customer satisfaction, if I can use that term.

Q231 Chair: When doctors write reports for people who are going through the WCA, do they understand the process of what the WCA is, or do they understand if they are writing a report for appeal that it is not actually just a medical assessment, but it is a functional assessment?

Professor Harrington: I don't think people do, no. I think people think it is a medical. I think the clients think it is a medical, and I think a number of the healthcare professionals who are asked for additional information probably think that. The difficulty is—I think Dr O'Donnell hinted at this as well—that because it is a functional assessment rather than a diagnostic assessment, it is not something that doctors necessarily do as part of their normal daily life. You would have to brief them that you do not just want, in this report, a diagnosis but also like a feel for how capable the individual is. A lot of general practitioners do not want to do that because they think it flies in the face of the sort of individual they are and the relationship they have with their patient. They are now becoming an advocate of work capability rather than just the patient's carer. I think that is a difficult one for them.

Q232 Chair: I can say that that is true, because my brother's a GP and he asked exactly that question of me. When I started to explain what he needed to do, he said "But that's not my job. I can just say what I

18 May 2011 Professor Malcolm Harrington

think in medical terms.” Sometimes getting another medical report might cost the client money, £50 or more. Is that a complaint that has been put to you?

Professor Harrington: Yes, Citizens Advice put that to me very clearly, as they put it to you in their evidence to you a couple of weeks ago. It is a difficult one to get around because it would be nice if the doctors did not charge for these reports, or that this was a particular type of legislation for which doctors were not allowed to charge for the reports. I cannot see the Department paying £30 or £50 per report, it is a big expense. I very rarely charged for reports when I wrote them; maybe I was just able to get away with it, I was never a GP. I was writing them from the point of view of a hospital consultant or something; I just wrote them because they needed to be written.

I don't know how you get around that. It is a serious reason why people will not go for that, they cannot afford to pay that sort of money. I don't know whether it is in the power of the law-makers—you—to change it so that this is a particular benefit for which reports should be provided.

Chair: There is a Health Bill being discussed at the moment.

Q233 Kate Green: What will your priorities be for your second review?

Professor Harrington: The priorities were to make sure the recommendations of the first year were implemented, and I think that is happening. The more difficult and time-consuming things about looking at the descriptors is working quite well at the moment. And Citizens Advice are looking at the real world test, whether that is a feasible one for me. And Macmillan are looking to see whether the chemotherapy wording is correct. And then we have got those bits of research looking at the fate of people. There are a number of things that are coming along. Have I discovered anything really major that is going to occupy the reviewers' time for Year Three and Four? Not at the moment. I wonder if there is a point at which you stop tinkering with the system to see whether it works under the new arrangement, or do you constantly go on trying to improve bits, which means changing bits of descriptors, which means changing legislation again, which causes confusion for people who have to interpret that, the Atos Healthcare professionals and the DWP. I do not know; but I think by the end of Year Two most of the things I wanted to achieve will either have been done or be close to completion in Year Three.

Q234 Kate Green: Do you believe that that will help to address the mistrust of the process, and will you be measuring that as one of your success measures?

Professor Harrington: Yes, I hope it will get round some of the mistrust because there is a lot of anger out there about the current system, some of it justified, some of it perhaps not justified. We have got to change the image of this as well. And if we can make it clear that in all contacts with the client, whether it is the DWP phoning up right at the start with a phone call, they change the language of their phone calls, they change the language of the letters, that the decision-maker is in touch with these individuals, that the Atos

Healthcare people have their Customer Charter that works—if all of that happens and people really feel that somebody is caring about them, and that has already happened in Aberdeen; people were saying to me—I don't know whether you heard that Chair—“Thank you for phoning me up; it's very nice of you to phone me.” That is a very simple thing in a way, but if it changes people's attitude that this process is supposed to give you the right benefit or the right support to get back into work, then that should be to the benefit of everybody. It is not trying to catch people out.

Q235 Kate Green: One of the things that I was very interested in was this additional contact that has been put in place as a result of your first report. And I asked Jobcentre Plus about the resource intensive nature of being able to do that. But I think what you are saying is that it has been a very important part of ensuring that we improve the process from where we started a couple of years ago.

Professor Harrington: I think it has. It was first trialled a bit in Wrexham, when I went up there last year, and they were actually doing some of this before the recommendations came in. They had worked out there was a better system, and so I added to that. What I hear now, going around the various places, is that it is making a difference, people are responding to that, and that's very important. The problem about that is that it will cost more money possibly, because the decision-makers need to be trained up to do this. The other people who make the phone calls need to spend more time. It would be nice to think that what happened in Wrexham last year would apply nationally. Wrexham found that they were spending more money on doing this, but they were saving an enormous amount of money on not going through the appeal system. Whether that comes out of the same budget I don't know, but as a taxpayer I am not so bothered about that. If it ended up by costing less and you had more customer satisfaction, that would be good.

Q236 Kate Green: The work-focused health-related assessment has been on a two-year suspension while we move from the IB into the Work Capability Assessment, or ESA and the new Work Programme. Would you support its reintroduction, or do you think there is a more effective way of achieving its aims to help the long-term Incapacity Benefit claimants back to work?

Professor Harrington: I don't know. What I think is being mooted now, which we are seriously looking at this year, is whether there is another part of this assessment that looks at real world work? In other words, “Could you get a job in this particular part of the country?” “Actually in this part of the country, with your disabilities, there are not many jobs that you could do”, that sort of thing. There are models that we could look at, the Americans have done something similar, the Australians have. The purpose of giving the Citizens Advice Bureau the first stab at this one is to go away and ask if it is feasible. I want to have a seminar in the autumn, and involve the CBI as well, to sit down and discuss the real world test and whether

 18 May 2011 Professor Malcolm Harrington

it is a practical proposition. If so, then we introduce that as another tier in the assessment. If not, then at least we seriously looked at it.

Q237 Kate Green: So do you think that the descriptors might need to be amended so that they reflect the type of work in the real world that the person might be capable of, or are you saying it would be a separate and additional process?

Professor Harrington: I think it might be a separate assessment. It is very difficult. Every time you tinker with the descriptors, somebody has to go away and change the IT, and see if it throws out of balance some other descriptor. I don't necessarily want that to be the major part of the process. I want the major part of the process to be the decision-makers trained up to be capable of looking at the individual in the round, of which a computer-driven assessment is just part.

Q238 Kate Green: And is there any need at any time for a second expert medical opinion as part of that looking at it in the round?

Professor Harrington: I don't think there is. My fear about that is second opinions are very often different, and that is what happens when you get two experts looking at the same person. I am not saying a second opinion should not be used, I think this is something that, given the expertise that Atos Healthcare ought to be able to bring to this, and the expertise the trained up decision-makers bring to it, and the information they collect from the claimant's practitioner, we ought to be capable of coming to a pretty reasonable decision on.

Q239 Glenda Jackson: Following on from that, is it not the case actually that the major, major change that we are seeing has to do with people who for considerable periods of time have been on Incapacity Benefit. And in a sense they have learned to be ill, or rather learned, because they have been ignored, that they are not fit for work. And surely one of the major changes that should be possible to invest into the whole system, as it exists at the moment, is precisely what you said earlier, that with the WCA you have failed if you pass the test. This is linked with what the Government has assiduously been running with, that everybody who is a benefit claimant is in fact workshy. So there needs to be, does there not, within the whole panoply of how people are being defined as far as their fitness for work is concerned, a major, major change in the approach to their people? Because the amount of evidence that we have received, where people say as far as the test is concerned it is a completely confrontational situation where they believe they are deemed to be in the wrong, and the job of the assessor is to prove that they are in the wrong. If the vast majority of people who are going to go through this process do not have what one could define as a disability or an illness other than the fact that they have been left to do absolutely nothing for a long time, that surely would be a major, major way of avoiding appeals, if the approach to that was on an issue other than just assessing whether they are fit and well in health terms, but whether they are fit and capable for work.

Professor Harrington: Absolutely, and I think one of the things that the Department was trying to do was to make sure that the way in which they approach these people who have been cast aside for a decade or more is in some ways much more sensitive than you might do for somebody who is coming forward for the first time with their first illness who has run out of statutory pay and needs some form of benefit.

Q240 Glenda Jackson: Well, if they are it is a well kept secret as far as the individuals are concerned.

Professor Harrington: I can only say that I hope that is changing. It is possible that in a number of places the recommendations from Year One, which are supposed to make it less mechanistic and more empathetic, have not trickled down to every Jobcentre Plus in the country. I went to Plymouth recently—it was the first place I went to—just to see how that compared with Aberdeen. You would expect Aberdeen to be on top of it because they have gone through the process, and know that well. In Plymouth they have not had all the training. They know that the decision-makers are going to be empowered. Some of them are up for doing it now, and the attitude of the people that run the centre was, "We want to give people more autonomy about how they handle people; we want to decide how many phone calls an individual needs and at what point they need it." I was very impressed with that because they are not in the front line of having the new recommendations rolled out on them, and yet they have got the basic message

Glenda Jackson: They've got the message.

Q241 Chair: You mentioned new claimants and people who have just run out of their statutory sick pay. Are you doing any work to chart what happens to the people who go through the WCA, who end up in the WRAG group, but when they go for their first interview with their personal advisor, they are still ill. They are not terminally ill, so they are not in the Support Group, but they may have cancer or they may be at the early stages of MS, but not severe enough to be in the Support Group. So they might be able to do some work in the future, but they are too ill at the moment so they are told to come back in three months' time. And then they come back in three months' time and they are still ill, or in the case of one of my constituents they have not even got a diagnosis at that stage but they are clearly ill, and they go away and they come back. And before you know it they have actually had their year on the contributory ESA and their money has stopped and they haven't actually got near the Work Programme or near any help in getting into work. They have quite rightly been declared fit for work some time in the future, and they are quite rightly in the WRAG group. Are you doing any work around that group, because I suspect that might be quite a sizeable group.

Professor Harrington: That's a very good point. No, I have not, but I will do that.

Q242 Chair: Because they are going to end up on some strange treadmill. The other thing that is a corollary of that is when do they have to go through the WCA again, because one of the complaints is that

18 May 2011 Professor Malcolm Harrington

they have just gone through the WCA, they have just got their appeal, and two months later they get an invite to go through the whole process again?

Professor Harrington: The Citizens Advice Bureau's interim report to me about the real world test, and I know they said it in the evidence to you, are also concerned about people's five-year prognosis about whether they are likely to get back to work again, and I think that is another thing we need to look at. The problem with that is you end up by starting talking with diagnostic labels again rather than with functionality, and the Department has tried to get away from diagnostic labels, because you know as well as I do that some people can have quite serious problems and still be perfectly capable of working and others with the same condition cannot, or their condition deteriorates at a faster rate than other people. Multiple sclerosis is a good example of that. So if you are not going to go with diagnostic labels, how do you assess the severity of people's problems and the likelihood of that becoming more severe with time, in which case you probably would not bother to push them too hard to try to get them back into work because you know they are going to deteriorate.

Q243 Chair: The assumption often is that people will get better, not the fact that people are going to get worse. Final question is on employers' attitudes, because that is also very important. Is that within your remit?

Professor Harrington: Yes, it is. One of the members of my scrutiny group is a CBI Appointee, Neil Lennox, who is Health & Safety Chief for Sainsbury's. And in the course of going through the first year I have kept asking Neil at what point we needed to talk to the employers about this. And he says it is more important in the second year when there have been discussions about the descriptors and the real world test. And I am going to go to a seminar with the CBI in September to talk through some of this. At the moment he feels the issues I have been raising are not directly related to employers, and you could argue my remit does not extend to the business of how we are going to find jobs for these people. But I am going to bring them into this, and they want to be part of the process this year.

Chair: Okay, thank you very much. That was really interesting, and thank you for waiting, and thank you for our going on a bit, but I think it was well worth it.

Wednesday 8 June 2011

Members present:

Dame Anne Begg (Chair)

Harriett Baldwin
Andrew Bingham
Karen Bradley
Kate Green
Mr Oliver Heald

Glenda Jackson
Brandon Lewis
Stephen Lloyd
Teresa Pearce

Examination of Witnesses

Witnesses: **Rt Hon Chris Grayling MP**, Minister for Employment, **Karen Foulds**, IB/IS to ESA Migration Project Manager, Jobcentre Plus, **Dr Bill Gunnyeon**, Director for Health, Work and Wellbeing, Chief Medical Adviser and Chief Scientist, Department for Work and Pensions, gave evidence.

Q244 Chair: We have discovered, Minister, that the acoustics in this room are not terribly great.

Chris Grayling: I will try to speak up.

Chair: Hopefully everybody will speak up. Welcome this morning. Thank you very much for appearing before us.

Chris Grayling: You are welcome.

Q245 Chair: You have probably appeared before us as a Committee more than the Secretary of State has; I am not sure whether that reflects the heavy workload that you have, or the interests of the Committee. You do not need to introduce yourself, as we know who you are, but could you introduce your colleagues for the record?

Chris Grayling: I will indeed. I have Dr Bill Gunnyeon, who is our Chief Medical Adviser to the Department, who has overall responsibility for the Work Capability Assessment Policy, and on my left is Karen Foulds, who is overseeing the migration from within Jobcentre Plus—the organisation on the ground of the Jobcentre Plus interaction with claimants and the management of the process.

Q246 Chair: All three of you are very welcome. We have visited Burnley, and yesterday morning we visited an Atos Assessment Centre, so we have had some practical insight into the process, and, needless to say, as an Aberdeen MP I have been well briefed by colleagues in Aberdeen who are involved in this. Our first set of questions is about your policy and the objectives.

Q247 Stephen Lloyd: Good morning, Minister. Thank you for coming this morning. Before we get into the details of the assessment process itself, we would like to hear from you what the Government's objectives are for the Incapacity Benefit (IB) reassessment?

Chris Grayling: The rationale for this goes back three years, when we were shaping the Green Paper on Welfare Reform in opposition, and were looking at the ideas that have turned into the Work Programme and a number of other changes that have materialised under the last Government and this Government. The one huge gap seemed to me to be the fact that at that point we had in excess of 2.5 million people on Incapacity Benefit—it has come down a bit since

then—that were just being left there. There was no real process of challenge to say, “Is there something better you can do with your life if we provide you with the right help and support to get back into work?” They were being left on the margins, which seemed to me to be completely wrong.

Most sensible assessments suggested that there were a significant number who had the potential to return to work, but maybe not doing the same thing they were doing before; you might have somebody who had been a manual worker who had got an orthopaedic problem who was not able to return to manual work, but that did not mean there was not something else they could do. We recommended in that Green Paper, and the then Secretary of State, James Purnell, picked it up rapidly afterwards, the concept of reassessing all of those people, except for those who are going to be reaching state retirement age in the very near term.

The aim is not savings measure—it is not a financially based exercise, although clearly if we succeed it will save money—but is about identifying the people who have the potential to return to work, and helping them to do so. Interlocking with that is the launch of the Work Programme to provide specialist back-to-work help for those people. It does seem to me to be completely wrong that we should be in a position where we have this big block of people who we are effectively abandoning, and not trying to find something better to do with their lives.

Glenda Jackson: Good morning, Minister, and thank you for coming. If that is indeed the Government's aim, which is entirely laudable, and which everyone here would support, why has the Government sold this programme, or attempted to sell this programme, as being attacking the workshy? They have not only said it up front; it has also been the subterranean message that the majority of people who are on this benefit could easily work but simply do not want to. This has had a very serious impact on people who—and this is anecdotal—

Chair: That was actually Stephen's question.

Q248 Stephen Lloyd: That is exactly what I was coming to—thank you very much for that, colleague—because I do want to drill down to that, but I want to get to it with a series of steps, because, as you know, Minister, I have been incredibly supportive of what the Government is trying to do. It

8 June 2011 Rt Hon Chris Grayling MP, Karen Foulds and Dr Bill Gunnyeon

is something I am very passionate about, but on the issue around language I have real concerns, but I want to get there step by step. Are you satisfied that the Government's objectives in relation to the assessment for ESA¹ are being communicated clearly and that claimants understand them?

Chris Grayling: I think it has got a lot better than it was. Being absolutely frank—and we will go on to talk about the Harrington process and the changes that have been made in the previous few months—I do not believe that the system that was inherited, the original system that was set up for new claimants for ESA around three years ago, was up to the job. It was very clear to me last summer on becoming a Minister, when I saw some of the early feedback, that there was something amiss, and that is what led to the Harrington Process. I hope and believe that we have significantly improved the communication around that.

Most directly and most importantly, as we will discuss during the morning, in the direct communication to individuals whose turn comes up to go through this process, the contacts are much more personal, and the level of detailed explanation is much greater than it was. At the start of April, when we began the national rollout, we distributed articles and letters to as many papers around the country as we possibly could with the very clear message: this is not about forcing people who cannot work into work. If you are not able to work, you have nothing to fear from this, and, in fact, if you end up in the Support Group, you get more money than you do now. It is absolutely clear: we have done everything we can. It is almost impossible to stop the rumour mill, but we will do, and are doing, everything we can to dampen that rumour mill down.

Q249 Stephen Lloyd: Thank you for that. Let me read you a couple of things. "The WCA is based on the principle that a health condition or disability should not automatically be regarded as a barrier to work." I am sure you recognise this. "There is a large body of evidence which shows that work is good for physical and mental wellbeing, and can be beneficial for individuals with health conditions and disabilities." I know you believe that, and I know you know I believe that, practically, and people around the table do. Let me read you a couple of things that we have had from two professors. One of them is a professor at Atos, Professor O'Donnell, who says that, "One thing that would make a difference would be if we could find a way of explaining to people that failure to be awarded ESA is not the same as being classed as a malingerer, someone who does not have a disability, or someone who is not ill. I think we need to get that across very clearly." Clearly we are going in the same direction of travel as what you have been saying.

I would like to read you something that Professor Gregg said: he highlighted the importance of creating a culture of trust around the assessment process, exactly what you said. Professor Gregg: "A lot of the messages that are coming out—and I think the Government is guilty of this—are creating a culture where the disabled community feels the primary

function is about driving them off the benefits onto lower value, less supported-type benefits, and is destroying the potential to create a trust environment. I am deeply concerned that the work related activity programme, which is for those who need significant help, requires positive engagement from individuals." I support totally the direction of travel of Professor Harrington, and I applaud the Government for taking on board a lot of his recommendations—I really do. However, the Government has singularly failed with the tabloids, with the media, and with the messages getting out: completely failed.

Chris, I feel so supportive of this programme, you cannot believe it, but I think you have failed. I think there have been examples of the Government Ministers still using inappropriate language. I certainly do not see any vision at all of the Ministers and the Government going out selling this for what it is, which is a once-in-three-lifetimes enormously positive opportunity to transform the lives of many disabled people. I think it has been shocking.

Chris Grayling: Okay.

Q250 Stephen Lloyd: What I would be really interested to hear from you as the Minister, with all the good things that you and the Department are doing, is how you can turn this around. I understand there are some irrational fears out there, but how can you as a Government Minister give a commitment that you are going to draw a line in the sand and start selling this programme for what it is, which is a hugely positive once-in-a-multi-generation opportunity to transform people's lives, with the media, starting now?

Chris Grayling: Okay. Let me take both of those points together, and let me push back to a degree on that. First, I challenge anybody on the Committee to find any quote from me or any quote from the Secretary of State that uses the kind of language that Ms Jackson referred to. I have gone out of my way in the last few months to set these reforms and the challenge of getting people back into work in the context of the specialist support we are going to be providing through the Work Programme. I have not used the language of scroungers and, indeed, I have been criticised by the tabloid press for not using the language of scroungers. Let us be clear about that. I cannot guarantee to control every newspaper outlet or every parliamentarian, but I can give a clear statement: we, as Ministers in the DWP, go out of our way to set what we are doing in the context of helping people and delivering specialist support to get back into the workplace, and we do not use some of the language that has been used in some quarters.

I would also dispute the fact that we have not sought to try to sell the kind of message you are asking for. If I look back to what we did at the start of the launch in April, we produced an article that I wrote for local newspapers, which set out what we were trying to do and the purpose of it; the fact that it was designed to identify those with the potential to work, not to force those who could not work into the workplace; that there were no financial targets attached to it; that there was specialist support available through the Work Programme for those who could return to work; and

¹ Employment and Support Allowance

8 June 2011 Rt Hon Chris Grayling MP, Karen Foulds and Dr Bill Gunnyeon

that there was actually extra money available for those who ended up in the Support Group.

That article was placed in a very substantial number of newspapers around the country: the cuttings file was about that thick. We reinforced that with a letter with the same message that went to each local paper. I did a web chat with one of the mental health charities for their members to question. I have convened meetings with the voluntary sector groups involved in this field. We have had discussions at local level between Jobcentre Plus teams and the representative groups. I have prepared presentation packs for colleagues, some of whom are in this room, to enable them to have discussions with local representative groups for those most affected by the changes about what we are trying to do and why. I have done briefings for parliamentary researchers to enable them to deal with casework, enquiries and concerns. I asked if I could go and speak to the CAB²'s conference in February to set out what was happening, so they could communicate to people they were dealing with; unfortunately they were not willing to allow me to do that.

That is just a snapshot of what I have done. There has been a very determined effort. I make no bones about it; there are moments in which one would love to control the editorial tone of the newspapers, and there are strong feelings about this issue out there. In my view, on the record, we are clearly dealing with some people who are claiming Incapacity Benefit who are perfectly fit for work. The majority of those who could return to work are people who are a long way away from the workplace, who have become detached from the world of work through that length of time on benefits, who probably no longer have the self-confidence to get back into the workplace, and who often think they do not have the ability to work. I have talked to some of them myself who do not think of themselves as being able to work, where somebody else has no doubt that they could.

The challenge for us, through the reassessment process, and then through the Work Programme, is to re-energise those people and focus them on the things they can do. I do not profess that this process will always be perfect, but we have done everything we can to get things back on to the straight and narrow and deliver a package that is thoughtful, considerate and sensible. There is also a duty on the part of the representative groups, who are, on occasions, apt to voice strong opinions themselves, which can exacerbate the very real concerns that are out there, and there are real concerns. We are not going to remove those concerns; we are putting people through a process that is quite difficult for them, potentially quite life-changing for them, and some of them will find it very difficult. I think they will look back in a few years' time and say, "That was the best thing that ever happened to me," but it probably will not feel like that at the time. But I passionately believe it is the right thing to do.

Q251 Stephen Lloyd: Good. One more question, Chair, and then I will pass over. I am reassured by a lot of what you say, and I believe you, because I have

watched your direction of travel over the last eight to nine months on this whole process. What I would add is, we still have not broken the fixed way of looking with the tabloids, middle market media, and the media generally. I would like you and your team, the Secretary of State to the Department—the DWP, to keep that focus absolutely remorselessly for the next few years. You have not turned the tide yet; there is still all this nonsense out there, there is a lot of fear, there are still people on IB that you and I know should work, and their lives would be transformed if they were supported back into work. To change that narrative, what I would urge is make it one of your three priorities in the Department—constant: again, and again, and again. Eventually we might begin to get the message out to the media, and they might begin to sell it the way it is. Until that is done, we are still fighting against the tide.

Chris Grayling: One of the things I am very much hoping is, as we go through this year and we start to see people move into work, there will be more role models that we can use to communicate this message. Therefore it starts to be a story about what we are achieving rather than the theoretical direction of travel. I very much want to use role models. We have people that have in the past moved off ESA into work; we have a few from the trial areas who look like they have got into jobs. As we start to build up a portfolio of people who have got into work and are saying, "This is much better," we will have some positive stories to tell. I hope that will come up.

You made reference to Professor Gregg. I want the Committee to be aware that when Professor Gregg first made criticisms of the process and the system, shortly after we were elected last summer, the Department tried to contact Professor Gregg. I left a message on his mobile phone saying, "Please phone me: here is my mobile phone." As of yet we have had no response whatsoever from him—a total lack of willingness to engage and come back. He admitted in a radio interview when challenged about this that he had not come back to us. I want the Committee to be aware that I was, have been, and am still very happy to brief Professor Gregg, but, as far as I am concerned, he does not have current information about what we are doing, despite being offered the opportunity to be briefed on what we are doing.

Chair: I am sure he will have heard you this morning.

Q252 Oliver Heald: The charities and representative groups have argued for years that people with disabilities could work: hundreds of thousands of people are missing this life-enhancing opportunity. Now that you are finding out what people's capabilities are, offering them help to work, these charities seem to have turned their backs on the whole project, and seem to be complaining about every aspect of it. Do you feel you are getting adequate support from these groups given their long-term aims and ambitions?

Chris Grayling: They are in a slightly difficult position. We have, generally speaking, a good and constructive relationship with these groups. They have been involved at all stages of the development of the Work Capability Assessment, the development by the

² Citizen's Advice Bureau

8 June 2011 Rt Hon Chris Grayling MP, Karen Foulds and Dr Bill Gunnyeon

previous Government of the Internal Review, the Harrington process, and are continuing to be engaged in the Harrington process. Paul Farmer, the Chief Executive of Mind, became one of the Harrington Review Group at my specific request, because I wanted to see somebody with real mental health expertise in that environment. At the same time, I recognise there is a lot of uncertainty out there, a lot of concern out there, and to some extent they have to voice that.

Q253 Oliver Heald: But isn't he a signatory this week to a letter in the national press that is highly critical of the whole process, and makes no reference to Harrington, his role in the Review, at all?

Chris Grayling: There are sometimes a few frustrations, I would say. Perhaps Bill Gunnyeon could talk a little bit about how they were involved in the shaping of the Work Capability Assessment in the first place?

Chair: We will be coming to that later; we have a lot of questions on that. At the moment we are looking at the perceptions of the press.

Q254 Glenda Jackson: I want to take you back, Minister, to your assertion, which I entirely accept, that “workshy” or “scrounger” are not words that have been used either by you or other Ministers. It has undoubtedly been the case, since the whole introduction of the change to welfare and to benefits, that the Government's line has been that the comparison is between those people who are hardworking families and those who are claiming benefit. I cannot remember the precise percentage of the statistics, but for example when the first report came out of the pilots of the schemes that were running in Aberdeen and Burnley, the whole thrust of what the Government was putting out was that the majority of people in those schemes were fit and capable for work. When I remember the enormous lobby that there was here in the House of Commons only a few weeks ago of people with disabilities—The Hardest Hit, I think it was called—your message is clearly not getting through to them, that this is actually supportive of what everyone in this room supports: of assisting people back into work. They regard it as some kind of punitive action on the part of your Government. Who puts out these stories? Do you have a press office that is linked in to the philosophical arguments that you are putting forward, or does somebody just hand out the figures? None of us in this room are prepared to accept that the stories Government puts out are not stories that Government wants to put out?

Chris Grayling: First, we have some requirements to put out statistics. The periodic publication of the ESA new claim figures are a statutory requirement that has run through both Governments, so there are some figures that we have to publish come what may. If you look across the last few months at the press releases we have put out, the news stories we have pushed, they have had one single consistent narrative, which is that there are people there with the potential to get back into work, and through the Work Programme

there will be specialist help for them to do so. That is a message I stand by four square.

We have delivered on that: we are doing the official launch for the Work Programme on Friday. There will be support for many hundreds of thousands of people; there will be premium prices for job outcomes for people coming from ESA, being mandated into the Work Group. There should be better support than we have had before. One of the ironies is that on the list of subcontractors for the Work Programme are some of the very same groups that Mr Heald was talking about. He is absolutely right: there is an interesting challenge there in terms of the relationships that we have. I personally believe there is a real expertise to capture, and I am delighted that some of those organisations are going to be working on the Work Programme.

The message that we are putting out is absolutely consistent: that there are a large number of people on benefits who have been there for an extremely long period of time that have been effectively abandoned on the fringes of society. We want to help those that can potentially get back into the workplace and do something more with their lives to do so. We are carrying out the assessments so that we can identify those people who can return to work, and the Work Programme will deliver specialist support to them to help them get back into the workplace. That is the sole and single message we have put out as a Department over the last few months on this subject.

Q255 Chair: Do you not accept that some of the responsibility on your Department is to make sure that the press releases that go out do contextualise the statistics? As Glenda referred to, after the initial statistics came out of the trial in Aberdeen and Burnley, your own press release said the trial found 70% of people could work. It was that that allowed, not just the tabloid press, but *The Telegraph* and others, to be censured by the Press Complaints Commission³, because of the misleading nature of the statistics. It was the phrase in your own press release that allowed the tabloids to say, “All these people could be working, therefore they must be workshy,” without the subtleties that 30% that did not qualify for ESA were going on to JSA⁴ but would still need extra help to get into work, and the other 40% might be fit for work sometime in the future if they got better. The subtleties were not reflected in your own press release. Your press release was quite short.

Chris Grayling: I will have to check back on the original wording, but, as far as I am concerned, we have always presented the distinction between the fit for work and the Work-Related Activity Group (WRAG). The Work Related Activity Group is made up of people who have the potential to return to work. It may be that they cannot return to all roles, as I have said, and every one of those people will have access to the Work Programme, and some of them will be mandated to the Work Programme. I share the goal of all of the voluntary sector groups that I have ever

³ The newspapers were required by the PCC to correct the record, rather than being censured

⁴ Jobseeker's Allowance

8 June 2011 Rt Hon Chris Grayling MP, Karen Foulds and Dr Bill Gunnyeon

spoken to of helping as many of those people into the workplace as possible. I sat with a group last week who all wanted to work.

Q256 Chair: There is no disputing that we want people to work—that is not the issue. It is about the language that is being used, or the way that those who could work sometime in the future have now been stigmatised as being able to work now and just trying to avoid work. It is the language around all that. Does your press office in the Department, when they see something that is clearly wrong—and a lot of the coverage around the trial statistic was clearly wrong—get in touch with those media outlets and point that out?

Chris Grayling: I have had personal discussions with a number of media outlets about the need to be careful about how the issue is presented. I will carry on doing so, because it is very important that we get the balance right. I do not control the editorial approach of the tabloids, and sometimes stories run in ways that completely bemuse me and are certainly beyond any expectations. We have had a couple of times when stories that were of not particularly great news significance in our eyes actually soared to the top of the news agenda in some of the newspapers. I cannot control the editorial approach of the tabloids, but I have had a number of conversations with people in the media about the need for care in this area. Indeed, if you look back to a number of the papers in November, I was accused of watering down our approach on welfare reform, because I made the point that it is important not to judge people as scroungers but as people who were a long way away from the workplace and face big challenges.

Q257 Chair: People who have gone through the new WCA, have found themselves on JSA, and despite the help they get still cannot get a job. Can they expect headlines in the tabloid saying, “Look, they are continuing to be workshy even when they have been moved off Incapacity Benefit”?

Chris Grayling: No. First of all, if you look at the people who have been through the pilots, in Burnley a number of them are working with Vedas. In Aberdeen a number of them are working with people in the voluntary sector to find jobs, and some have. What I will be championing in the future is those who have succeeded in getting jobs. There are the people who are long-term unemployed who are trying to get a job and have not succeeded, and I see our job as to help them.

Chair: Can we move on to questions around the contract with Atos?

Q258 Kate Green: We are going to ask some questions later about the actual content of the service that Atos provides, but first of all I would like to ask some questions about the contract. There has been a lot of interest in the contract, and people have asked questions and not been able to get information, sometimes perhaps for commercial reasons. I hope you can be quite open with us today. The first question is straightforward: the Department told us last September that the contract with Atos had been

extended to 2017 in order to allow for the ESA migration. Atos told us in oral evidence last month that it has been extended only to 2015, so we would like to understand which is correct.

Chris Grayling: It is 2015. I do not know where the 2017 has come from. It is definitely 2015. I took the decision to extend it, because, first of all, I think it would be good for the marketplace in this area if there were more than one supplier in it, but it seemed to be a bad idea to try to change the supplier in the middle of the migration process. Having inherited a contract for this work with Atos it seemed wrong and impractical to try to make a change in 2012, which is when we would have been doing so otherwise.

Q259 Kate Green: You will re-open a tendering process before 2015?

Chris Grayling: Yes.

Q260 Kate Green: We have been told that the contract extension is subject to Atos delivering substantial savings against the current cost of £100 million a year. We are interested to know how the requirement to achieve those savings will work in the context of the national rollout, which will require them to assess and accelerate a number of claimants—up to 1.5 million—by 2014?

Chris Grayling: I will ask Bill to talk about the detail, but I will give you the overall context. Atos were one of the suppliers who went through the renegotiation process with us and the Cabinet Office. After we took office, the Cabinet Office summoned in all of the Government’s major contractors and effectively beat them down on price. I was one of the Ministers involved in some of those negotiations, and the starter for 10 was: you are getting a lot of business from Government, we expect you to cut your prices accordingly—reduce your margins, reduce your day rates and so forth. That is one part of the savings that have been built into the work with Atos for the next few years. Bill can talk about other elements of that.

Dr Gunnyeon: It is reasonable to expect any organisation to look at how it can do things more efficiently, and certainly Atos have been doing that. There has also been a move to look at how we can use different healthcare professionals, and that is in keeping with what is happening across healthcare generally: for example, the use of more nurses to undertake assessments after appropriate training. That happens in different aspects of the NHS, where there is more responsibility being devolved to other healthcare professionals who have the right skills to do things, and that has an impact on costs as well. A number of things were part of that process.

Q261 Kate Green: But we are in a position where you have beaten them down on price, they have an increasing caseload—up to 11,000 assessments a week—and we understand that the payments are based on the number of assessments that they undertake—that is what Atos told us in the oral evidence session we had with them last month. With that payment structure, and with pressure on Atos to do things within a smaller overall financial envelope, how does

8 June 2011 Rt Hon Chris Grayling MP, Karen Foulds and Dr Bill Gunnyeon

the payment system guarantee quality and effectiveness in the assessment process?

Dr Gunnyeon: It is important that the payment is based on a report that is acceptable to the decision maker, and the decision maker, if the report is not acceptable, will send it back. The reworking that needs to be done by Atos has to be undertaken at Atos's cost. If anything, in fact, there is a strong incentive for Atos to try to focus on producing reports of the right quality first time, and that is the quality process that is in place anyway: to try to achieve that. Obviously it is not in their interests to have lots of cases referred back.

Karen Foulds: It is not all additional work, because they would have been doing the Personal Capability Assessments, but instead of that they are doing the Work Capability Assessments. The 1.5 million people that are going through the reassessment process are not all new customers to Atos; they would have seen them, but they were doing a different thing with them. There is an increase, but it is not an increase of 1.5 million.

Q262 Kate Green: I am interested in what you say, Dr Gunnyeon, that the reports need to be acceptable to the decision maker: what does that mean? Yesterday we saw, in a mock Atos assessment, that the interview was carried out with the aid of the online information sheet, and I am not quite clear what coming off that sheet would or would not be acceptable to a decision maker?

Dr Gunnyeon: Obviously the decision maker needs to be able to have a report that shows why the recommendation of the healthcare professional is as it is. They have to be reassured that the points that have been allocated look right on the basis of the information that the claimant has provided and the assessment report itself. Clearly if the decision maker cannot see why the recommendation is as it is, for example, if it looks as though points should have been scored on some descriptors where they have not, then that would not be acceptable, and the decision maker would send that back. It is about getting clarity of the reason for reaching the conclusion the healthcare professional has reached.

Since Professor Harrington's report, at the end of each report we now have a very clear paragraph, which the healthcare professional is required to complete, justifying the conclusion they have reached. That is very much in keeping with what would happen in any other report by a healthcare professional, but that will be much more helpful to the decision maker as well. Hopefully that will ensure that the healthcare professional confirms they have reached a robust decision, which will also help quality.

Q263 Kate Green: Are you able to tell us what proportion of Atos reports have been sent back by decision makers?

Dr Gunnyeon: I do not know if I have the number, but I can find that out for the Committee. Each healthcare professional is subject to audit once they have completed their training until they have reached an acceptable standard, and they are then subject to random audit, so that we are continuing to check the

quality. Those reports are graded either A, B, or C, and C are of an unacceptable standard. The proportion of Cs is very small, and remedial action is taken. The challenge is to try to have as many at grade-A standard as possible and to continue to look at that, and there are certain standards set.

Atos audit their auditing process, and we in the Department also do that periodically. In each of the regions, we audit their auditing process to look at how quality standards are being maintained. Everything is designed to continue to drive up quality, and where problems are identified with individual healthcare practitioners there is a very clear programme of remedial action and ongoing closer auditing until either things have improved or that healthcare practitioner's approval to undertake work is revoked. Those approvals are done by me on behalf of the Secretary of State.

Q264 Kate Green: We still have a very high level of successful appeals. That might be a problem at the Atos stage of the process, or at the decision-making stage of the process, or both. We are going to ask some questions about appeals later, but one of the concerns we have had expressed to us is that, while the average time for an assessment to take place is 45 minutes, many claimants have told us that they were only in a face-to-face interview with the Atos assessor for 20 minutes. Yesterday we were given to understand that the 45 minutes was the total process of the Atos healthcare professional working on the individual case, not the total face-to-face time. That seems to have led quite a number of claimants to feel that they are being rushed through. Are you concerned about that? Do you feel that the payment system might incentivise Atos to process as many cases as quickly as possible?

Dr Gunnyeon: We have identified some of the challenges: people sometimes have a misunderstanding of what they are going to go through. They expect that, if it is referred to as a medical examination, they are going to have some very detailed medical examination the way they might if they were going to see a specialist. That is not the case, and people's expectations of how long something might take differ. It depends on the complexity of the case. If somebody has a simple physical problem, for example, it may be very easy to assess very quickly, and it does not take terribly long. If somebody has a complex problem, a number of problems, or a complex mental health problem, it will take much longer. In the range of time that assessments take, the upper end is 200 minutes, which is quite a long time.

Although some cases are done in less time than the average, many cases take a lot longer, and the time is based not just on the contact with the individual but the healthcare practitioner's time reflecting upon that and completing the report. They have not necessarily concluded everything by the time the individual leaves the consulting room. They then reflect upon the evidence they have gathered and reach their conclusion, which can sometimes be quite difficult. They may need to consult colleagues, because, as you would do in any other healthcare setting, if you have

8 June 2011 Rt Hon Chris Grayling MP, Karen Foulds and Dr Bill Gunnyeon

a difficult case you will often discuss it with another colleague first.

Q265 Chair: That sounds counter-intuitive, because surely the more complex cases should be the easier ones in a Work Capability Assessment. Someone coming in that is a quadriplegic will have complex medical needs, but it is pretty clear they are in the Support Group—

Chris Grayling: That is probably the easy case. It is the ones that are more complex in terms of judging where they fall.

Dr Gunnyeon: The more complex a problem, the longer it takes to gather the evidence. Remember that we are looking at this being a robust process. We are also looking at being able to identify when it is reasonable to expect somebody to have improved to the point where consideration of being fit for work again may be a possibility, so that we can identify when it is reasonable to see an individual again. It is important that we look at things, because the next time somebody is reviewed we want to be able to consider whether they have improved, and what the likely pattern is beyond that. If you have not collected the information and considered the case carefully, you will not be able to do that.

Q266 Stephen Lloyd: To an extent this is about psychology. Whatever we are saying, it is a perfectly rational position for these individuals to feel that “I am going through a test to find out whether I keep the money”. It is a bit like when we go for a job interview: if I am in and out of a job interview in 10 minutes flat, I know I have not got the job. I do understand rationally where you are coming from, and we saw it yesterday—a very experienced assessor can take 25 minutes and do a very thorough job, and that gives him and her slack to do 50 minutes for a more complicated one. But the issue you are dealing with here is psychology: “Crumbs. I was in and out of there in 20 minutes and they have taken my money away.” Do you understand the counter-intuitiveness of that?

Dr Gunnyeon: That is why a lot of work has gone into preparing claimants in advance for what they should expect. I visited Aberdeen and looked at some of the assessments, and I know that the healthcare professional doing the assessments felt that those coming through having been prepared for reassessment had a much better understanding of why they were there, and what to expect, and I think that is helpful. If it is very clear to a healthcare professional early on that it is someone whose problems are such that they are quite clearly in the Support Group, then they will quickly bring things to a conclusion. Although we do a paper review of cases to try to identify people who should be in the Support Group early on, with the best will in the world with some people the evidence will not have been there, but it will be clear at the start of the assessment that they should be in the Support Group, and that there is no point in continuing.

Chris Grayling: One point that I would like to make to the Committee is I would ask you, in the context of preparing your report, to bear in mind that there is almost nobody that has been through the Work

Capability Assessment as a result of following the lessons learnt from the two pilots, and also from the Harrington Review. We are talking about a very small number of people who will not, at this stage, know the full results of their assessments. Almost nobody has experienced the system that we have put in place over the past few months, and we have learnt lessons from the trials in Burnley and Aberdeen, which have been put into place. We have learnt lessons and put in changes as a result of the Harrington Review. Any experience that you are hearing from individuals or recounted from pressure groups, unless they are from people in Burnley and Aberdeen going through the trials, will by definition have come from the previous system as new claimants for ESA—a system that I fully accept was flawed and that we sought to improve.

Q267 Glenda Jackson: That leads me on to my question for you, Minister: apart from being the cheapest bid, why did you give the contract to Atos? On a constituency case basis their past working has hardly been glorious. Dr Gunnyeon, I would like to know what constitutes a grade-A Atos worker? What is the desired outcome for Government as far as the assessment process is concerned?

Chris Grayling: That is a lot of questions—

Q268 Glenda Jackson: Let me finish—what is the desired outcome? Is it to save money? Is it genuinely to assist people into work? If we accept that, that is okay, but I cannot find the linkages between the Government’s desired aim, if that is what it is, and what Atos is doing, because that does not seem to be their desired aim.

Chris Grayling: Let us be clear: Atos were contracted by the previous Labour Government. They were not contracted by the current Government; they were contracted by the previous Labour Government. I took the decision last summer that it was impractical to re-contract this contract, and to continue the IB reassessment process. Therefore it is better to improve the system, to improve any issues there might be with Atos, or with the rest of the process, rather than try to re-contract it, because otherwise we would have had to go back to square one. Let us be clear that it was not the current Government that contracted Atos: my view is that it is better to improve what they do.

The goal of the reassessment is absolutely clear: it is to find the right number of people who fit in each category, and then to provide specialist support to those who have the potential to return to work to do so. There is no financial target. Occasionally people in the media put in a goal of a £1 billion saving: that is not the case. There is no financial target. The number of people we end up with in the three groups will be the number of people we end up with. There is no target for Atos. There is no target for decision makers. I want to get this as right as we possibly can. It is not in our interests as the administration, it is not in the interest of individuals, to find people in the wrong place. It is in everyone’s interests to try to get them in the right place, because for those who have the potential to return to work, if we can help them to

8 June 2011 Rt Hon Chris Grayling MP, Karen Foulds and Dr Bill Gunnyeon

do so, there is a win-win for everyone, and in that way you do save money.

Q269 Harriett Baldwin: Further to my colleague's questions, one of the first decisions you took was to set up the Harrington Review, which has been so widely welcomed, and the impact is just beginning to be felt. You also decided, and we have looked at this separately, to set up the Work Programme contracts, where you had a very specific system in different regions of at least two contractors in every area. I wondered whether you also thought, in making that decision about sticking with Atos, it would be appropriate at that point to perhaps bring in a second provider to do some of the incremental work to create a little bit more of the competitive tension that I know you wanted to see on the Work Programme?

Chris Grayling: I did give that some thought, and there were organisations that were interested in doing so. The problem you have is, if in the middle of the migration process you effectively retender what you are doing, which you would be—currently the contract that Atos has is to carry out all of the assessments for the DWP—it would unduly disrupt the migration process, and would leave people for longer before we had the opportunity to help them through the Work Programme. That is why we did not, but there is another important point to make in relation to Atos: Atos get a lot of grief. They are very much in the firing line in the eyes of a lot of the claimants, because they are the ones seen to be carrying out the assessments. Like every big organisation, they have not got everything right, and they probably will not get everything right. We have put a lot of effort into working with them to ensure that they improve and have got the right quality of people. I think they would acknowledge that the quality of the professionals working on this, the level of training and so forth, has steadily improved as time has gone by.

It is also important to remember that, as a result of the Harrington Review, we have downgraded the role of the Atos-carried-out Work Capability Assessment in this process. What Professor Harrington said was, effectively, decision makers in Jobcentre Plus were rubber-stamping the assessment, because they felt it had been carried out by a medical professional, and that was it, so they had to take that as gospel. We have clearly said to our decision makers: "That is not right." They have all been retrained, and I will ask Karen to say a bit about that. They have been told very clearly that they should use the assessment as an important part of their decision-making, but not the only part, and that they should also be looking at input from the evidence from a hospital consultant, for example, or a mental health specialist. Karen, do you want to say more about the decision maker's role?

Karen Foulds: Thank you. The role of the decision makers has changed quite significantly, because, as the Minister said, previously it had been very much following a set process.

Chair: Can I stop you there? I know we have questions on the decision maker's role.

Q270 Harriett Baldwin: I have one supplementary on that. Minister, do you think, in retrospect, that the previous Government made a mistake in deciding to award the contract to Atos as the sole provider?

Chris Grayling: That is a difficult one. Would I have appointed two organisations at the start? Probably, yes, but I did not think it was possible to change horses mid-race effectively.

Q271 Karen Bradley: If I could take you back, Minister, to the comments about how we will not have seen anybody who has gone through the revised process following the lessons learnt from the trials and the Harrington Review. You may not be able to answer this question, but is the mock-up that we saw yesterday of a Work Capability Assessment likely to be the new style?

Chris Grayling: Yes. Yes it is.

Q272 Karen Bradley: There was a big poster in the assessment room—I do not have the exact wording—talking about the process. It was a big picture map, but it talked about "ESA entitlement test". That immediately sets alarm bells ringing that people are going to come into this room and think, "This is about my level of money, not my ability to work."

Dr Gunnyeon: I am surprised: I cannot answer that, because I was not there. Apart from anything else, one of my key concerns is try to move away from talking about this as a test anyway, because a test implies something that somebody has to pass or to fail, and it has been a problem all the way through. One of the challenges of changing perceptions is getting people to see this as an assessment: it is an assessment that is designed to try to identify where somebody sits on this continuum, from being in work and fit for work to being a long way from work because of a health condition. Whether they are close to being fit for work, whether they are actually fit for work in spite of a health condition, and whether they are a long way away, and how long it might take them to move back towards that, and therefore it is about that assessment process.

As you highlighted at the start, it is important to remember that, of those who are in work, about 25% of people in work suffer from a long-term health condition. Of working age people as a whole with a long-term health condition, about 60% are in work. One of the challenges we have with perceptions is that people think that, if they are considered fit for work, that means the assessment has concluded there is nothing wrong with them: that is a problem. I cannot answer your question on that, but I will find out. Certainly, if there is something that says "test", that will be addressed immediately because that is exactly what we are trying not to present.

Q273 Karen Bradley: I cannot remember the exact words, but it was very clear that it said "ESA", and that immediately said you are looking at the benefit rather than the ability to work and what work you are fit to do, or how far you are from the workplace.

Chris Grayling: If we may, we will go and remove said poster from the wall, take a look at it, and write to the Committee.

8 June 2011 Rt Hon Chris Grayling MP, Karen Foulds and Dr Bill Gunnyeon

Q274 Chair: It was also the screensaver.

Chris Grayling: We will take a look at those and write to you.

Q275 Kate Green: On the contract, and the issue that Harriett Baldwin was raising about the single supplier and your answer to me earlier about the period of the contract being until 2015, as I understand it, the agreement with Atos covers not just the Work Capability Assessment for ESA but a range of tests for different benefits, including Disability Living Allowance, which will disappear before 2015.

Chris Grayling: No. That is not right. This contract is purely for the Work Capability Assessment⁵. I believe Atos have a limited role in helping share their experience of the WCA with the project team working on DLA, but no contracts have been placed. The final test for DLA has not been designed—I have used the word test—the final assessment for DLA—

Dr Gunnyeon: I will remind you of that later, Minister.

Chris Grayling:—has not been designed, so we are not at that stage now.

Q276 Kate Green: That would be a separate contract letting process?

Chris Grayling: Yes.

Q277 Kate Green: And will be open to competitive bidding whereby you might introduce a second supplier into the DWP assessments?

Chris Grayling: Absolutely it will. Yes.

Dr Gunnyeon: Very specifically the extension to 2015 excluded DLA from 2013. It was very specific and it will be subject to a separate process.

Q278 Chair: A letter that we received from the Secretary of State on 28 September 2010, which was the letter that said the contract was to go to 2017, says, “The scope of the Medical Service Agreement is to provide medical advice to the DWP, Her Majesty’s Revenue and Customs, Service Personnel and Veterans Agency and Tribunals Service, to support decisions in relation to a number of benefits and pensions. These include, but are not limited to: Incapacity Benefits, Employment and Support Allowance, Industrial Injuries Disablement Benefits, Disability Living Allowance, Attendance Allowance, Statutory Sick Pay, Child Trust Fund etc”⁶ This would suggest that there is one contract with Government that Atos has that includes all of this. That is not what you are saying.

Dr Gunnyeon: No it does not. Most DLA assessments are self-assessments by individuals, but when they need it, it is Atos which does it at the moment, but that will not continue beyond 2013.

Q279 Chair: The assessment centre we were in yesterday did DLA assessments.

Dr Gunnyeon: Indeed. What the Minister was showing was the difference between the extension to 2015, which is for the assessments except for DLA, because DLA will only continue until 2013 when obviously the new Personal Independence Payment assessment will come in.

Q280 Chair: That contract comes to an end at that stage?

Dr Gunnyeon: It will be tendered before then.

Q281 Glenda Jackson: I did not get a reply from Dr Gunnyeon on what constitutes a grade A report?

Dr Gunnyeon: Yes. If you think about what I said about the assessment, what we are trying to do in the assessment is to, as accurately as possible, identify those individuals who in spite of an ongoing health condition, for whom it would be reasonable for them to work because other people with similar conditions, in similar situations, do, against those who, at this moment in time, it is not reasonable to work. What we are trying to do in assessing the quality of the report is to determine whether the evidence is there that supports the conclusion that the healthcare professional has reached in terms of the descriptors they have used, and the points that have been allocated. Do the descriptors that they have used fit with the evidence that they have gathered and the conclusions they have reached? Unless we manage that, we run the risk of not correctly identifying those who are on the borderline in the difficult cases—who potentially are fit to work, but equally might just not quite be. Those where it is clear it is much easier, so it is about trying to ensure that we have a report that shows clearly the conclusion that has been reached, that demonstrates that all the evidence has been gathered, and that that evidence supports the allocation of descriptors, and the points arising from those descriptors.

Q282 Glenda Jackson: Who screens that report?

Dr Gunnyeon: Those are audited by experienced healthcare professionals in Atos. You saw the sort of standard of healthcare professionals that Atos has yesterday. It is their most senior, most experienced healthcare professionals who do the audit and review cases. Clearly the decision maker also has a role in this. They get a report in to them, and the decision makers handle a lot of reports. They become very experienced at identifying what reports are good, what looks right, and where they can see that the descriptors have been appropriately allocated based on the evidence. They are also identifying those and sending them back for reworking if it is not right.

Q283 Oliver Heald: Professor Gregg, who you have already mentioned, told us that he thought you should have delayed the trials in Aberdeen and Burnley until you were able to run the whole of the new system, so all the Harrington changes, which you have now implemented, plus the Internal Review changes. That would have given you a good opportunity to see how the whole package worked.

Chris Grayling: There are a number of people who have suggested we should have delayed, and there are

⁵ *Note by witness;* ATOS do undertake a range of assessments for different benefits. The contract extension however, excluded DLA.

⁶ This letter is published with the oral evidence the Committee took from the Secretary of State on 15 September 2010 and is available on the Committee’s website

8 June 2011 Rt Hon Chris Grayling MP, Karen Foulds and Dr Bill Gunnyeon

those who still argue today that we should delay for further changes. I personally take the view that doing this is the right thing to do, and doing it in as timely a way as we possibly can is the right thing to do, because every month, every quarter, every six months and every year that we delay is another period where we leave a large number of people with the potential to get back into work on the sidelines. As the economy recovers, as we hope it will over the next few years, and we hope we see the increase in employment that the OBR⁷ is currently forecasting, it would be a tragedy if we do not have a system in place that is working to prepare those people with the potential to return to work to take advantage of those vacancies as and when they arise. Otherwise we will see what has happened over the past decade: new vacancies have gone to migrant workers from overseas.

My view has been we need to get on with this as quickly as possible. We have learnt lessons from both Burnley and Aberdeen; we have learnt lessons from the Harrington Review. The two have fed off each other. Professor Harrington has spent a lot of time with the teams in Burnley and Aberdeen sharing experiences, and his work, as he went through, helped influence what they did. The work being done in Jobcentre Plus helped influence his recommendations, because some of the ideas he put forward came from professionals within Jobcentre Plus. I made sure before we progressed the national migration that Professor Harrington said, "It is fine to go ahead: it is fit for purpose." I am very sure that we have done the right thing. I have said I am not pretending that the system is perfect—I am not certain it will ever be perfect, because some of this is subjective—but this will be a continuous process of improvement.

I am open to all further suggestions as to how we improve what we do, but the key question for me is, do we go ahead or don't we? I predicate it on Professor Harrington saying either this is fit for purpose or it is not. What he came back to me and effectively said was, "You can drive this car. It may need some more fine-tuning in the future, but it is fine to drive right now." If he turned up and said, "Do not drive it; it will blow up after 10 yards," I would have not gone ahead with the national migration, but that is not what he said to us.

Q284 Oliver Heald: What Harrington has proposed is quite resource and staff intensive in the sense that it requires a lot of extra communication with the people who are to be assessed. Is that something that you are able to afford in your budget, and how does it fit in with the cuts you are having to make, as all public services are, in staffing? Is this something that is sustainable? How is it being paid for? What is the situation now?

Chris Grayling: Let me get Karen to start off in answering that in terms of the impact on the organisation, and then I will talk a bit about the budget.

Karen Foulds: In Jobcentre Plus, what we have learnt from the trial—because as the Minister said, the trial has been invaluable to us—in relation to Harrington

specifically is it is in all our interests to get the decision right for the customer from the earliest possible opportunity. Particularly, one of the things that we are trying to achieve through the customer journey for IB reassessment and through Harrington is to gather all the medical evidence as early as possible in the journey. One of the things that makes this cost-effective and makes it affordable is that, if we get that evidence earlier, then we make the right decision earlier, and that is obviously better for the customer and more cost-effective for us as an organisation. So although we are putting extra steps into the journey, and when we come to that I can talk more about how we have done that within the IB reassessment, they will pay for themselves, because we are actually offering a more efficient and streamlined and better customer-focused service from the outset, particularly around further medical evidence at an earlier stage.

Q285 Oliver Heald: And you have not had to change the plans in terms of how many staff are in the offices?

Karen Foulds: No. We had a certain amount of staffing available to us to reassess Incapacity Benefit, because that is obviously a big, single, one-off exercise over three years. So, we had staffing allocated for that, which I can give you the details of, but for the changes that Harrington is wanting to make to the ESA journey, we are just at the very start of that and we are just starting to test some of that as part of a controlled national rollout. We have not had to adjust our staffing in our offices for that, no.

Chris Grayling: It is worth adding, Mr Heald, if I may: I have been very clear in budget terms that this is something we have to do, but Professor Harrington in his report said specifically he believed in the end this would save money rather than cost money because of the impact it would have on the workings of the organisation and the effectiveness of the system.

Q286 Oliver Heald: Now, one of the things that has been heavily criticised is the Internal Review and Professor Harrington did say to us that he would have preferred the implementation of that to have been delayed until his process was complete. What would you say about that?

Chris Grayling: Let's be clear first of all and say why we went ahead with the Internal Review, and I thought quite long and hard about this. The Internal Review was carried out by the previous Government. Can I just ask Bill Gunnyeon to give you a quick snapshot of how the Internal Review was carried out so that the Committee has the context and then I will explain why I introduced it?

Dr Gunnyeon: When we developed the Work Capability Assessment it was very much transforming the previous Personal Capability Assessment. When we developed the Work Capability Assessment, we tried as hard as we could to ensure that the assessment was going to be robust and accurate, but we recognised that we would not get everything right at the start and we committed to a process of change anyway. We wanted to, fairly quickly after the introduction of the assessment, look at it, review it, to see whether particularly there were some anomalies.

⁷ Office for Budget Responsibility

8 June 2011 Rt Hon Chris Grayling MP, Karen Foulds and Dr Bill Gunnyeon

There was always a risk—things that we had not managed to pick up when we were doing the testing of the assessment, and we knew that we had not focused on adaptation as well. So, we started the process about six to nine months after the introduction of ESA, and we brought together a group of technical experts, some of whom are the same as those who have been involved in developing the WCA and some were new, and representatives from specialist disability groups.

Now, we learnt something from the way we did the initial assessment development; when we did that we had two separate groups. We had a technical expert group and we had a consultative group, which was the specialist disability group representatives, and they worked separately. We did bring them together, but they worked separately. We felt when we did the Internal Review that it would be much more sensible to have a single group that included the technical experts and representatives from specialist disability groups, and that is, in fact, what we did. That process, therefore, reviewed the descriptors; it reviewed evidence from cases that had been received and, in fact, when we did the modelling, eventually, on the new descriptors, we ran that against about 50,000 cases that by that stage had been through the WCA. So that process was done.

At the end of that there were still some issues that specialist disability groups identified because there was the initial report produced by the group. I then chaired two sessions with representatives of the specialist disability groups to look at particular concerns and, as a result of that, we made some further and, indeed, not insignificant amendments to the proposals from the Internal Review, and, in fact, so it was clear what had been done, that formed an addendum to the report, but all the recommendations in that addendum were included in the legislative changes to the WCA, which have led to the amended WCA, which is the one that is now being used.

Chris Grayling: Now, that is what I inherited on coming into office, and basically it did three things that I felt were justifiable and important. The first is it dealt with some specialist individual anomalies, which I felt needed to be dealt with. So, for example, in the case of people going through chemotherapy, you could be found fit for work between courses of chemotherapy, and I had a friend who was going through chemotherapy and thought, “This is mad.” We should have people who are in between courses of chemotherapy in the Support Group. The review does that and therefore we should make that change. It also made changes, for example, where somebody is in residential rehab; they are counted as being in the work related activity group, and that again seemed logical to me.

This had been the subject of debate, but the second thing it did was to make a comparison of the new descriptors against the 50,000 previous cases, which demonstrated that the new descriptors placed more people with mental health problems in the Support Group than had previously been the case, left about the same number of people in the Work-Related Activity Group, and therefore had fewer people with mental health problems found fit for work. Now, given

the fact that mental health in this is one of my big concerns, that seemed to be a sensible and desirable outcome, and again, something I wanted to support.

The third was the issue of adaptation and, again, I think that this is something that I believe is right as well—to factor in the degree to which somebody has adapted to their condition. We are in the situation where, in extremis, a Paralympic athlete with a university degree has no obligation to look for a job. Now that does not seem sensible to me. Equally, somebody who is blind or partially sighted who has been in work for 20 years who is made redundant would not theoretically have the obligation to look for a job. It seemed to me to be sensible to have an adaptation element within the process. So, all of those seemed sensible to me. Professor Harrington did not, in his report, say, “I do not think you should go ahead with this,” so therefore it made sense. Particularly on the mental health issue, I personally want to see people with mental health problems in the right place, but I do not want people with mental health issues who should be in the Support Group pushed into the WRAG. I would rather err on the other side of things. So, I formed the judgment it was best to implement that Internal Review because of those reasons.

Q287 Chair: Can I just clarify something you just said, because you said that, as a result of the Internal Review, fewer people would end up on JSA, but your own memorandum to us in paragraph 60 says: “By accounting for adaptation, the number of new claimants being found fit for work is also expected to increase by around 5%.”

Chris Grayling: That is the adaptation issue; that is not people with mental health problems.

Q288 Chair: You said about the Paralympic athlete with a university degree, but you do not ask about people’s educational qualifications when you are going through the WCA.

Chris Grayling: I am simply illustrating the point that I think there are some people—

Q289 Chair: But how can you make that assessment if you do not ask the questions?

Chris Grayling: Well, the whole philosophy of the approach that we are seeking to take with the Work Capability Assessment and the reassessment process is not to put any group entirely in one box. The fact that you might be blind or partially sighted or the fact that you might be in a wheelchair should not predetermine whether you are in one group or another.

Q290 Chair: But the questions that would allow you to make that differentiation are not asked. That is one of the major complaints. The things that will allow someone with a very severe disability to work are actually not the physical things, nor, indeed covered by the WCA questions at all.

Chris Grayling: I am using those two examples illustratively, but the WCA line of questioning is designed, as I am sure you saw when you sat through the assessment yesterday, to establish the nature of someone’s circumstance—what they can do and what they cannot do—very often by asking them questions

8 June 2011 Rt Hon Chris Grayling MP, Karen Foulds and Dr Bill Gunnyeon

about the way they live their lives: about things that they can do, things that they cannot do. If you are looking at somebody who is blind or partially sighted, then I would expect one of the lines of questioning from the assessor to be to probe how that person does or does not manage to perform routine duties. Are they able to perform particular tasks? It is designed to establish what their capabilities are, and I think the adaptation issue is very important. I do not think it is right to assume that by default because you have a particular disability you are automatically and in all circumstances unable to work. The circumstances for somebody who has been blind or partially sighted for all of their life who has previously worked are very different for somebody who has just been through a health trauma and lost their sight.

Q291 Glenda Jackson: With respect, Minister, earlier, at the end of your entirely understandable and acceptable definition of what the Government wishes to achieve in getting people back to work, your culminating sentence was—and I am paraphrasing slightly—to assist them into jobs that at the moment are taken by migrant workers. You put all those people into that box, and as far as, certainly, the people out there are concerned, migrant workers do things like picking strawberries, digging for potatoes; it is temporary and they tend to be students. So, on two counts there, it seems to me, you do have a mindset here and despite everything that we have heard earlier, you are being extremely casual about your use of language.

Chris Grayling: I am afraid I think that is not correct.

Glenda Jackson: Well, there you go.

Chris Grayling: I think if you look at the jobs being performed in our society by migrant workers you will find an enormous range of tasks by people from countries around the world. As I say, I think one of the things we should be ashamed of if we look back over the past 15 years is that probably between 3 and 4 million new jobs were created in that period of time and yet through that period we consistently had almost 5 million people on out-of-work benefits, and in those years we did nothing as a nation to try to help those people with the potential to get into work to escape from that environment and get back into the workplace.

Q292 Chair: That is not strictly true. There was the Flexible New Deal; there was New Deal for Disabled People, there was Pathways to Work, which your Government has now cancelled, so I think that is a bit disingenuous, Minister, to say that nothing was done, when a great deal has been done through the various New Deals over the years. You may not agree with whether they were effective or not, but there was a huge attempt.

Chris Grayling: I think I would argue in the case of what is technically and crudely called the Incapacity Benefit stock, who are by far the biggest block and were by far the biggest block of the people on benefits during those years, actually nothing was done to help them—virtually nothing.

Q293 Chair: A large number of them went through Personal Capability Assessment (PCA), carried out by Atos. It is wrong—and it has been repeated again this morning—to say that when someone got their Incapacity Benefit they were not called back for reassessment. Particularly those with mental health problems very often had yearly reassessments, and they were classed as the stock because over the years they had been out of work for some time. So, I think, again, there is a bit of rewriting of history going on here this morning, otherwise the Personal Capability Assessments would not have existed or Atos would not have got the contract. One of the reasons why Atos is going to be able to deal with the increase of the WCAs is because they were already doing PCAs.

Chris Grayling: I think we could have a debate about political history. I would look back to the work done by James Purnell as Secretary of State in the wake of the publication of our Green Paper three years ago, which was the moment at which it first started to feel as if the previous Government recognised there was a problem that they had to do more about. But we could debate that one a long time. I think that virtually nothing was done over that period of time to try to deal with that problem of 2.6 million people, as it was then, on Incapacity Benefit, and it was a crying shame. Had more been done earlier, had this process happened properly 10 years ago, we would now see far more of those people in work, because we would have gone through the process that we are going through now at a time when there was a much more buoyant labour market. I am absolutely determined that, as we go through the next four years, and if the OBR is right and we see almost 1 million net new jobs created in this country over the next four years, I want some of the people who are currently sitting on Incapacity Benefit at home to have the opportunity with the specialist help from the Work Programme to get into those jobs.

Q294 Chair: But the lesson from the last Government was that is incredibly difficult; you can redefine people but actually getting them a job, even with a great deal of help, can still face insuperable barriers.

Chris Grayling: That is precisely why we have set a much higher tariff in the Work Programme: to get people into work who are facing bigger challenges in their lives.

Chair: Obviously, only time will tell.

Q295 Oliver Heald: I have two questions left and will put them together so we can move on. The descriptors are likely to change again, aren't they, as a result of the second Harrington Review? As you change descriptors over time, are you going to be assessing how that works and what the effect of it is, and how are you going to do it?

Chris Grayling: The answer to that is yes. My expectation is we will go through, in looking at descriptor changes as rapidly as possible, a similar exercise to what we did before. Do you want to just explain that again, Bill?

Dr Gunnyeon: Yes, I think one of the challenges, of course, is that the amended WCA was only introduced

8 June 2011 Rt Hon Chris Grayling MP, Karen Foulds and Dr Bill Gunnyeon

at the end of March this year, so we still have not got any data on how the new descriptors are performing, which is one of the challenges, because one of the significant areas of change in descriptors was around the mental health descriptors to try to simplify the descriptors, improve the language, make it easier and provide more flexibility for the way they were applied. We are obviously not going to know yet just quite how that is working. But, as you know, Professor Harrington, in his year two programme of work, asked three of the mental health charities to look at how to refine those descriptors to further improve things. That was recently delivered to the Department, and we are just looking at the moment at how easy it will be to implement because I think the charities have gone, perhaps, a little bit further than expected and taken a slightly different approach to the assessments, so it is going to take us a little bit of time to work out just how we can actually assess the potential impact.

The challenge, of course, is that we have not been given any robust evidence so far that the previous set of mental health descriptors was not working, other than in the assessment that we, ourselves, had done with the technical working group, which included specialist disability group representatives. We have not got any evidence that what is being proposed is necessarily going to be any better, so we need to be very careful. What we clearly do not want to do is to do something that has the opposite effect of what we intend, which is obviously to improve the accuracy and the fairness of the assessment for people with mental health conditions.

Chris Grayling: One point, Dame Anne, very quickly: I am very clear that there needs to be a process for continuous improvement, and I am very clear that we are and will remain open to changes that improve the robustness of this process. I do not think we will ever get a system that is 100% perfect, but we will work as hard as we can towards that and we will continue to do so.

Q296 Andrew Bingham: Professor Paul Gregg again, although from what you said I am not sure how much store we should place into some of his comments, refers to this profound disconnect between what people expect from the assessment and what they get when they get there. Is there a better way we can make them more prepared or aware of what they are walking into when they walk into an assessment? I have a big bugbear that people see being found fit for work as failing, which to me is a pass, if you want to condense it into that.

Chris Grayling: I completely agree and I am going to ask Karen to talk through how we have changed the human side of the process. I think this is one of the big flaws of what we inherited. I have had some of the standard letters passed back through my office so we can get them rewritten, and my correspondence team member has rewritten some of the original letters so they come across as being human. They were previously your kind of classic computer generated: "Dear Claimant, following your assessment..." But one of the key recommendations of Professor Harrington's review was to humanise the process, and we have worked extremely hard to do that. I ask

Karen to now talk you through how things are done differently.

Karen Foulds: Thank you. Yes, we have made massive effort with this change to really address and focus on customer need. That starts right at the beginning of the customer journey, where we have learnt from ESA, as the Minister says, and we have put quite a few additional steps in, particularly a telephone call to the customer that has no other purpose other than to help the customer and to orientate the customer. We do not collect any information; we do not press any buttons. It is purely about talking to the customer to do exactly as you have asked, which is to explain what the process is about and how they need to engage with us.

Q297 Chair: Can I just stop you there. This is all really good stuff, but we have already heard it from when we went to Burnley. We have also got it in a lot of our documentation, and in fact interestingly enough in your own review of the actual administrative processes, which is what this trial was, there is not a lot of criticism about that. That was actually quite well handled. I think Andrew can concentrate on the questions about the customer experience of the things that are going wrong, not the things that are necessarily going right—

Karen Foulds: Okay. Yes.

Chair:—rather than this detailed step-by-step account, because we do not have time. We have only got a half hour left and we have got lots and lots of questions.

Q298 Andrew Bingham: We have been told by claimants that some of the Atos centres are not appropriately located or appropriately accessible. Has that come back to you? Have you discussed this with Atos?

Chris Grayling: In the past few months, I have had two meetings with the Chief Executive of Atos, in which a clear message has been handed across and changes have happened and indeed are happening as a result. I was pretty surprised to discover the issue existed in the first place. Bill can explain to you the exact detail of what they have now done.

Dr Gunnyeon: Obviously, part of the issue is access for people with disabilities and obviously a lot of buildings that are used are difficult. The requirement would obviously be to have wheelchair access, for example, and other suitable access. If there are buildings where that is not possible, Atos are making arrangements for the assessment to be carried out in other locations, or indeed, in an individual's home. In fact, they are trying to ensure that there is always ground-floor access in those buildings, which goes beyond, really, what they need. So long as there is lift access and there are arrangements for emergency egress in the event of a fire, it would be okay to have somebody on the first floor. They are actually going further; they want to try to ensure that they can always offer ground-floor access that will meet the requirements of anyone with a disability, and they are moving rapidly towards that.

Chris Grayling: I was amazed that this was not part of the original process three years ago.

8 June 2011 Rt Hon Chris Grayling MP, Karen Foulds and Dr Bill Gunnyeon

Q299 Andrew Bingham: Did I hear you right then when you said that they would do them in people's homes?

Dr Gunnyeon: If it is not possible to—

Q300 Andrew Bingham: In extreme circumstances. **Dr Gunnyeon:** In some circumstances assessments are done at home for other reasons anyway, because individuals perhaps are not able to travel, but if it was not possible to find a suitable alternative location that is going to be suitable for the customer, either because of geographical issues or whatever, then they would consider a home-based assessment. They will also provide transport if it means someone travelling further than the normally expected distance.

Q301 Andrew Bingham: I was almost speechless when Atos told me that 30% of claimants do not turn up for their assessments. Now, I know Atos do not follow up non-attendance, but I know that Jobcentre Plus do. Is information collated on the people who do not turn up to see if it is a particular group or a particular demographic that does not turn up, because I think that is a huge difficulty for them?

Karen Foulds: I think that is a really important point, because that is the national figures for Atos for ESA, but for the IB reassessment trial, which is following a new process and, as you said, you have details of that, the fail-to-attend rate is only 9%⁸.

Q302 Andrew Bingham: Is it? Oh, right.

Karen Foulds: And that is, in our view, a direct result of this additional engagement with customers from the beginning of the process so that they understand what is happening to them, what we are going to do for them and with them. So that is not an issue in IB reassessment.

Q303 Stephen Lloyd: That is going to cost a lot more money, so are the Department committed to rolling that more detailed and comprehensive process out across the whole piece?

Karen Foulds: Yes. We have got about 1,150 staff that are working particularly on IB reassessment, but, as I answered in the previous question, as far as ESA is concerned, it is actually more cost-effective, because if those 30% do not turn up, as the questioner has just said, we then have to get in touch with them again, find out why they have not and send them another letter—all those sorts of processes. If only 9% are not turning up, that in itself is much more cost-effective and that will be part of, we hope, the impact on ESA. But at the moment that figure is purely about IB reassessment; I should just stress that.

Q304 Andrew Bingham: Are Atos going to review their policy of overbooking—I think they booked around 120%—to allow for that 30%?

Karen Foulds: Yes.

Q305 Andrew Bingham: I presume that they are now going to review that as well.

Karen Foulds: Their policy of overbooking is based on 30%.

Andrew Bingham: Right.

Karen Foulds: They are now reviewing that, but remembering again, as the Minister said earlier, the number of customers who have actually gone through the IB reassessment process is still very small in comparison to those that are going through ESA, and we have not seen that impact yet on the whole of ESA. But they will be reviewing their policy on that basis.

Andrew Bingham: I only wondered if they review it accordingly. That is fine.

Q306 Glenda Jackson: On this issue you mentioned of “failed to attend”, this was something that Atos raised with us. Is there any push on your part for Atos to change that, because the implication of “failed to attend” is that it is the responsibility of the claimant, whereas we have had evidence where the inability to attend had absolutely nothing to do with the unwillingness of the claimant. There were things outside their control quite often but it is still put down as failure and that can carry sanctions, can't it?

Karen Foulds: Yes. The term “failed to attend” is a term that we use widely within Jobcentre Plus for people not attending interviews, and I take the point that you are making. The sanctions would only apply if we had considered good cause and we considered there was no good cause for the person not attending. But, for example, if we know that somebody's got a mental health condition, then we would take that into account with good cause. We would do safeguarding visits to people's homes if they had not responded to either our telephone call, our letter, and had not attended the appointment. We put safeguards in place to ensure that, where there is a good reason why the person has not attended, or, in fact, they have not been able to engage with the process at all because they have not perhaps understood what is happening to them, we would put those measures in place.

Q307 Glenda Jackson: We had evidence of people who had been deemed to fail to attend when actually they had been part of that 120% of over-bookings and the time simply ran out before the Atos individual could interview them.

Karen Foulds: We are aware of that and that categorically should not happen. Any cases where that has happened, we need to know about.

Chris Grayling: I would just emphasise on that latter point: that is utterly unacceptable. I do not believe it has happened in very many cases. I am not saying it has never happened. If there was evidence of it happening in significant volumes we would have to clearly go for process changes, but in every big organisation things sometimes go wrong. It is not supposed to be the case and we would not tolerate it being the case.

Chair: Yes. Certainly, I have a constituent in exactly that position.

Q308 Brandon Lewis: I just want to disassociate myself with comments that Ms Jackson made earlier and agree with the comments you made about migrant workers. Representing Great Yarmouth, obviously I

⁸ Note by witness: 9% is the failure to attend rate experience during the trials

8 June 2011 Rt Hon Chris Grayling MP, Karen Foulds and Dr Bill Gunnyeon

cover a huge number of people from whole different backgrounds doing this whole different range of work, and I fully support the comments you made earlier; I just wanted to put that on the record. What I want to ask is about the appeal rates. I think, to an extent, you might have already answered this when you explained earlier that a lot of the data we have is on the old system rather than the new system. Is the aim of the changes that have been made, that are coming into place with the trials, and, indeed, the new system you have put in place, to see that the level of appeals falls, basically? Because I can understand a lot of people will appeal if they get a decision that they are not happy with, but there has been about a 40% on average success rate for those appeals. Is the aim that the new system will see that come down?

Chris Grayling: We have two aims in this. The first is to reduce the number of people who feel the need to go for appeal. That is going to be a big challenge and I will explain why. The reason we are putting extra emphasis on reconsideration within Jobcentre Plus is I want people to bring forward new evidence, if they have it, before it ever goes to the Tribunal Service. One of the things Professor Harrington found was that evidence was emerging at the tribunal that Jobcentre Plus had never seen. So one of the things we are seeking to do after the decision is taken, if somebody comes back and says, "I am not happy," is to say to them at that point very clearly, "You can give us further evidence to take into account."

I want to be absolutely clear about this: it is likely that an awful lot of people will appeal. They have a statutory right to appeal. They are being found fit for work and many will be reluctant to take that step. They are moving on to JSA in many cases and many will be reluctant to take that step as well. I do not think it is going to be possible to reduce the number of appeals that are actually lodged. What I want to do is to reduce the number of appeals that are successful, and that could be done by making sure we take much better decisions right the way through the process.

Q309 Brandon Lewis: Yes, I agree with that. I can see that being the perfect end. As to the comment you made about new evidence, a couple of witnesses have made a comment about the proposal in the Welfare Reform Bill to enable the Secretary of State to acquire consideration of revision before appeal. Is that partly linked to this issue around new evidence?

Chris Grayling: We need to really try to make sure we get it right within Jobcentre Plus before things ever go to the Tribunal Service, and what we wanted to do is to create a kind of sequential process rather than a parallel process and really make sure we get the decisions right within Jobcentre Plus where we can. So, that amendment is designed to try to achieve that.

Q310 Brandon Lewis: There have been some comments from some of the people looking to appeal about the length of time an appeal can take, and then after the appeal how quickly they can then be reassessed sometimes. Is there an aim that, with potentially there being fewer successful appeals, that time would be reduced or are there other things coming into place that might be able to reduce the

length of the appeal process and also to give support to people who are going through that process?

Chris Grayling: Yes, there is and there has been a big backlog for some very considerable time in the appeals service. They are now beginning to make headway on that. For the last three or four months there has been a reduction in that backlog and they are gearing up capacity wise quite substantially, so effectively the Tribunal Service will have doubled its capacity between 2009 and 2012 in part to deal with the extra people who are being assessed as a result of the migration. We are in close contact with the Ministry of Justice; we are trying to identify sensible and smart ways to improve the process. But, of course, if we can get the quality of decision making up to the really best possible level in Jobcentre Plus then I hope that the reputation that goes round will be that they are being treated fairly and so, in the end, we will start to see fewer people appeal. But in the short term, as I say, I think an awful lot will do.

Q311 Chair: While the percentage appealing may drop, the numbers will go up simply because the number coming through the system—

Chris Grayling: That is right and that is why the Tribunal Service is doubling its capacity.

Q312 Chair: Have you managed to quantify that, because doubling may not be enough. At the moment, in some areas it is gridlock. It can be taking up to nine or 10 months to get an appeal.

Chris Grayling: It has been very long, and in the last four months or so we have seen the backlog beginning to come down for the first time in recent times. At the same time the Tribunal Service is ramping up capacity as rapidly as it sensibly can. We will keep working with them to make sure that we head off and address the problem, but it is certainly a challenge; I make no bones about the fact it is a challenge.

Q313 Andrew Bingham: I just want to pick up a point that Professor Harrington confirmed and I believe was true: when it goes to appeal, no representations are made to the tribunal by the Jobcentre Plus who made the original decision. It seems that the appeal is a bit one-sided when it gets there. Is that something that we want to look at, given the level of appeals that are upheld?

Chris Grayling: Yes, definitely. In recent times we have had staff there. Karen, do you want to say a bit about that?

Karen Foulds: Yes. The appeals that are going through from the trial we are having presenting officers, as we call them, there to see what impact that has, and that is part of all of the work that we are doing with decision makers to enable decision makers to use the increased discretion that was mentioned earlier. We are putting a quality assurance framework in; we have introduced three new training packages for decision makers; we have monthly telekits with all the decision makers nationally—the Minister is actually dialling into the next one—all around trying to support our decision makers, who then also become the presenting officers, obviously, as they are part of the same team, in being able to implement the findings

8 June 2011 Rt Hon Chris Grayling MP, Karen Foulds and Dr Bill Gunnyeon

of Harrington and support the customer service through this journey.

Andrew Bingham: Thank you.

Dr Gunnyeon: One of Professor Harrington's recommendations as well around the personalised summary, which we referred to earlier, is also an attempt to make sure that, when the decision is fed back to the claimant, they have a much better understanding of why they have been unsuccessful. Often people have appealed in the past because they did not really understand why they had not been successful. If we can start by helping people to understand better the reason for the decision, that may help some people accept that that is a reasonable decision. There are a number of things that are all designed to try to help this process.

Q314 Glenda Jackson: You said it was unsuccessful. I thought the whole thrust was that, post the process, it was successful if you had to move on to—

Chris Grayling: I do not think we will see it that way.

Q315 Glenda Jackson: This comes from your guy in the Department.

Dr Gunnyeon: Sorry. I apologise if the language I used was slightly inconsistent.

Q316 Glenda Jackson: We have been talking about language used from the beginning.

Dr Gunnyeon: I think I have just demonstrated exactly why it is so difficult. I apologise, Chair, but the message I was trying to communicate was that somebody's understanding of the reason why the decision has been made may help them feel that they do not need to appeal. There is a risk that people appeal simply because they do not understand. That is one of the things we are trying to move away from.

Q317 Teresa Pearce: This is probably a question for Karen. We have heard a lot today about the improvements to Atos and the process and all the lessons that have been learnt. My concern is that Jobcentre Plus staff, who are used to dealing with people who are seeking work and on JSA, are now dealing in numbers with people who are on IB who are going to be coming through this process. What sort of budget have you had for development and training of the staff to deal with that much more nuanced, soft-skill-needing—

Karen Foulds: We have put 16,700 advisers through training and awareness for the Incapacity Benefit reassessment. Our advisers have dealt with these customers more than most people realise, because customers through Pathways to Work and other things have been coming into Jobcentres for some time. But we have given them all cultural training and also enhanced training around dealing with people with mental health issues, etc. We are also bringing in at the same time, as part of the pre-Work Programme Jobcentre Plus offer, a named adviser for customers when they walk in. So if they are found fit for work and claim Jobseeker's Allowance, or, indeed, if they are in the Work-Related Activity Group for ESA, when they attend the Jobcentre for the first time they will be given a named adviser who will work with

them and support them until they are moved to the Work Programme. That is quite a big change that we introduced in April, and the reason for that is for that adviser to use their discretion in terms of the time that they spend with that customer and offer as tailored a service as possible to support that customer taking work-related activity or some active steps to get closer to work, or, indeed, if they are on Jobseeker's Allowance, helping them actually apply for jobs.

We have examples already from the trial where we have somebody in Aberdeen who was profoundly deaf who has already established a relationship with her personal adviser; they found some provision locally that is going to help that person with confidence to get closer to the labour market. They are on ESA so they are not required to find a job, but to actually help them get more confidence, and their adviser is staying in touch with them whilst they work with the provider. I think that the experience of our advisers and the training and support we have given them really is there to make sure that they can deal effectively with this customer group.

Q318 Karen Bradley: Continuing with the decision-making process and going back to what we started earlier—and I am conscious of time—perhaps if you could quickly explain to the Committee what changes you have made to the decision-making process. Are you planning to use the information to measure the impact of these changes on the levels of customer satisfaction and number of appeals?

Karen Foulds: Yes. I will just try to keep to some quick points then. The first thing that we learnt from the trial is around our decision call to the customer. That is the biggest change really for decision makers. Previously, decision makers have had a set of case papers; they have looked at them and they have made a decision, quite often, and normally, following the advice of Atos. As the Minister has already said, this is all about the decision makers using their judgement with the Atos information along with other things. The key part of the customer journey that is different, as you will be aware from your visits, is what we call Touchpoint 13, which is our contact with the customer.

One of the key lessons we learnt from the trial—and this is around customer satisfaction, because it came from the independent research—was that customers found that single call too difficult to deal with; they were getting news that perhaps they did not want to hear or were not expecting, and having to make some decisions about what to do next in one conversation. We have split that into two, so that now we will call a claimant, explain at that point in our understanding we think we may well disallow them; ask if they have anything that they want to discuss with us, additional evidence; and then give them the opportunity for us to call them back in about three days, where they can either have a representative with them or source some advice, or indeed gone and got some additional information themselves. So that is based entirely on customer feedback that that was not working in the way in which we had intended it.

We obviously have not, as previously said, seen the impact of that yet, because we have only had a very

8 June 2011 Rt Hon Chris Grayling MP, Karen Foulds and Dr Bill Gunnyeon

small trickle of people through the national reassessment that will have experienced that new approach, but in terms of the decision makers themselves we are encouraging them to use their judgement. One of the other things that we are learning now is that we need to just make sure that we have the guidance right and the steer for them about what information they can take into account, what carries more weight and how they effectively use that discretion. Primarily it is about trying to get all the evidence, so that, as the Minister said, we do not go to an appeal and find new evidence being presented at that time.

Q319 Karen Bradley: How long is it between the assessment and the decision being communicated to the claimant?

Karen Foulds: It is actually only about 10 days or so, because the report is done the next day by Atos—that comes straight through to us, and we get in contact with the customer pretty quickly after that. Then we will give them a call back in three days or so if that is what they want. In response to some previous questions, because we have helped orientate the customer throughout, they do know what to expect and they know the importance of engaging with us and what we are doing to support them, and that, again, from the trial research, came across strongly—that customers welcomed that journey and understood what was happening to them.

I think the final point I would make on that is just for the national reassessment our assumptions were that we might have at this point anything up to about 40,000 people contacting our Contact Centres with concerns and questions: “What is happening to me?” That has only been 10,000, so it has been significantly less than we thought based on the information that we are giving to customers.

Q320 Chair: Are you going to pay your decision makers a lot more money, because they, at present, earn less than 20 grand a year; the doctor, I suspect, probably earns more than 60 grand a year, and yet they have the final say and they are being asked to use their judgment, perhaps even more so than the medical assessor in the first place. Do we need the medical assessors? Why don't we just leave it all to the decision makers?

Karen Foulds: The decision makers are graded at the same grade as our personal advisers and they also, obviously, have a very important role to play. What we are doing, as I have said, is increasing the support for them, particularly from their managers. I have worked in Jobcentre Plus all my life and worked with decision makers, and I know that at times they have just been left to get on with it. Now, with the line managers, they have got a Quality Assurance Framework, they are quality assessing what they are doing, and offering the support through learning and development and coaching.

Q321 Chair: And that is why they should be paid more money, surely? I think that is a question for the Minister about valuing your staff? Is that not the important thing? I think most of the Committee agrees

that it is right that the decision maker has that final say, and Professor Harrington's recommendation was absolutely right, but it does beg the question: why do we need these expensive people and a computer programme to do a lot of the earlier stuff?

Chris Grayling: I think I would answer that by saying you need both. Obviously I do not know the detail of the circumstance of the assessment process you were shown, but very early on I sat through a genuine assessment. I will not discuss it in great detail, but the nature of the questioning in that discussion was designed to tease out—although it was clearly trying to answer the questions in the assessment process—much more about how that person lived their life and on the basis of that form judgments about what they could or could not do. I think that is still a very important part of the evidence for consideration, but what I also want to see is a situation where, if there was a letter from a hospital consultant saying, “This person has bipolar disorder; you may see them on a good day but please bear in mind that they have some very bad days,” that is something the decision maker takes into account as well.

Dr Gunnyeon: And the decision maker also has the opportunity to go back and have further discussions with the healthcare professional, and, indeed, to get medical advice as well in trying to weigh up the different bits of evidence they have.

Q322 Chair: That process and discussion is obviously very important. The original assessment of the numbers who would end up in each group, the Support Group and the Work-Related Activity Group, are quite different for the migration group as opposed to the new claimants. But even once migration is done you are still going to have the new claimants, so obviously those groups are important. In both cases those figures were way out from the original estimates that the Government had about the proportion that would end up in the JSA, WRAG or Support Group.

Chris Grayling: One of the things I made clear in my comments at the time was that some of those decisions would be overturned on appeal or in reconsideration, and so therefore the overall number will come down. The truth is that now that we have been through the full Harrington process, now that we have implemented the changes that arose as a result of the two pilots, we genuinely do not know. Now the national migration is starting. It is going to be a few months before we get a genuine picture, and what has been clear from both the pilots and all the work done so far is that there is a significant number of people who will be found fit for work, who can get support through the Work Programme and who I hope we can get into employment. There is also a significant number of people who will go into the Work-Related Activity Group who we can offer support to and guidance, both through Jobcentre Plus and through the Work Programme. So, where we end up in terms of the final numbers will really only become apparent in a few months' time.

Q323 Chair: Will you be tracking people, particularly the migration group, who have been found fully fit for work and put on JSA, and revisit them six

8 June 2011 Rt Hon Chris Grayling MP, Karen Foulds and Dr Bill Gunnyeon

months down the line to find out if that assessment was correct, because the suspicion is that the reason they were on IB in the first place was they fell out of work. They had been in work; they fell out of work because they had a health issue, and perhaps even being on JSA and not getting work will exacerbate that health issue and they really should be back either in the WRAG or by this time in the Support Group. Will you be doing that kind of intensive tracking?

Chris Grayling: We will do a lot of tracking, and we will have to as a result of the monitoring of the Work Programme anyway, because those people would be referred to the Work Programme and the JSA group who came from Incapacity Benefit are a discrete group within the Work Programme and so therefore we will certainly monitor very carefully what happens to them. We will understand if there are differences in the work placement rates between that group and others, how great those differences are and then we will carry out detailed research on a number of the groups post the WCA. For example, we are going to be looking at what happens to those people who disappear off benefits altogether after the WCA. There are certainly some; that is the case with new claims as well. I do want to understand and make sure we do not have people who are genuinely falling through gaps in the system as a result of what is happening to them.

Q324 Chair: 36% of new claimants do not complete their claim, and at the moment you do not know what has happened to those people?

Chris Grayling: No, well a number of those are people who have a short-term condition; they are people who sign on to ESA for a couple of months because they have been seriously ill and have reached the end of their sick leave at work, and then will go back into the workplace. You are absolutely right; this is a concern for us and it is something that we are researching and will be researching.

Q325 Chair: In the IB migration group, it is interesting, again, from the report that was done for you on that, the late and non-compliant customers proved not to be the workshy or the people who had been swinging the lead but actually proved to be the most vulnerable—

Chris Grayling: Absolutely.

Q326 Chair: —who had got the letter in and the phone calls and everything, and had panicked and not been able to fill the form in, and actually there was good reason; it was not a wilfulness that they had not appeared at their assessment. There was good reason.

Chris Grayling: Yes.

Dr Gunnyeon: There was actually a survey done by the Department over the period July to September of last year, which looked at those who had made ESA claims—this is obviously the new ESA claims, not the reassessment—during the period of April to June 2009 and looked at what happened to the closed claims. Of that, 24% went back to their own jobs—they obviously were making a claim but still had a job—and another 23% got a job or were self-employed. So we have some idea.

Q327 Chair: Is there maybe something in the system that, once they have had their six months of SSP⁹, there was nowhere else for them to go but to make a claim for ESA when they really were never going to qualify for the ESA for one reason or another? All the other support that they had had come to an end.

Karen Foulds: There is going to be a report published in July on the reasons why people ended a claim for ESA, so that might give us some of that information.

Chris Grayling: Yes. We do need to be careful about this. We are not about creating a situation where people just drop out of the system and disappear into obscure poverty. There has been plenty of talk about the reforms in the United States, for example, leading to people disappearing out of the system altogether. Now the system they have there of welfare support is very different to the one we have here, but we are absolutely not interested in creating a situation where people just vanish from the system and end up with no money and in extreme poverty.

Karen Foulds: We are going to great lengths to ensure that people do not, as the Minister said, slip through the gaps, and that goes from the sort of safeguarding visits that I mentioned earlier, phone calls, the extra steps in the customer journey, which I will not repeat, all the way to the IT system. We have had a big investment in an IT system and a management information system, which means that, for the whole of the life of the three-year reassessment process, we can track all 1.5 million customers and what stage they are at. We will be able to see very quickly down to quite small local levels if there are gaps or if there are groups that seem not to be progressing to the next stage. So, we are very aware, because our aim is to get all 1.5 million customers through this journey as effectively and in as customer-focused a way as we possibly can. We have gone to great lengths to try to secure that.

Q328 Kate Green: I just wanted to ask a little more about the outcomes and the different categories people arrived in, and this relates to the period before the migration, so I am talking about the new ESA assessments. It was noted by some of the organisations we have been dealing with that the figures tended to be very consistent month on month. The same proportion were ending up in the WRAG or in the Support Group or whatever, and that was in the context where it appeared at the time, at least in some parts of Jobcentre Plus, that there seemed to be some sense of targets being set for the number of people that might be refused benefits.

Chris Grayling: No, that has never been the case in relation to this.

Q329 Kate Green: I am talking about the way people have perceived what might be the cause of that. I hear exactly what you are saying.

Chris Grayling: Let me be absolutely clear. As I sit here today, I am not aware, and I am sure that neither Karen nor Bill are, of any attempt anywhere in Jobcentre Plus to impose any targets around the categorisation of this, and I would not tolerate it for a second if I discovered that was the case.

⁹ Statutory Sick Pay

8 June 2011 Rt Hon Chris Grayling MP, Karen Foulds and Dr Bill Gunnyeon

Q330 Kate Green: Can I ask two questions about that? The first is: are there any benchmarks, levels of expectation that you have, albeit that there are not targets for the proportion that will end up in each group?

Karen Foulds: The only benchmark we have is a benchmark for the number of decisions that we would expect decision makers to be able to deal with. So we have planning assumptions but not any of the outcomes from them.

Q331 Kate Green: And that is very specifically in relation to the decisions to award or not to award ESA?

Karen Foulds: Yes, it is just the number of cases. The number of cases that an individual decision maker would look at, but there is nothing below that in terms of what the outcome of any of those decisions would be.

Q332 Kate Green: Do you have any comment on why the figures have been so consistent month on month? Is that something that you would have expected?

Chris Grayling: Now that the system has bedded in, what you see is a fairly consistent pattern of new claims. You have a fairly consistent pattern of people who are claiming short term, and it is something we do not yet understand enough about, and I have certainly seen examples in looking over the shoulders of advisers where I think there is more work to be done on those first 13 weeks, but we have 36% who never make it to the 13-week assessment. We have then another 39%-odd consistently who are actually found fit for work, and then the remainder divides between the Work-Related Activity Group and the Support Group. Of course, a proportion of the fit for work numbers go to appeal. In reality it is 39% of about 36%, which is 6% extras; you end up with about 35%, not 39%, who end up being fit for work. I think it is just that the system has bedded down and that is a fairly consistent pattern. Once we get to later in the year we will have some genuinely robust numbers to publish around the national migration, and I suspect we will see a fairly consistent pattern all the way through the migration.

Q333 Chair: You said it was not your aim to take people off a benefit and for people to lose money, but there is one group of people who will lose money, and my constituents will be at the forefront of it—they will be the first to lose money—and that is the group that are in the WRAG group who qualify for contributory ESA, who will lose that ESA after a year and, because of household income, will not qualify for any other benefits, and therefore, as individuals, they will lose that benefit. Why have you decided to penalise that group in particular?

Chris Grayling: I think basically it is applying to ESA the same principles that apply to JSA in terms of the contributory element. Through the benefits system, we provide, and indeed Governments of both persuasions for a very long time have provided, a basic level of financial support for those who have no other financial means. But there has always been in regard to JSA,

for those that contribute, a limit to the amount that is paid. We pay something back in recognition of the fact you have yourself paid in, but we only allow you to draw for a period of time. With ESA, regardless of your means, you can draw benefits indefinitely and regardless of your household income, and amongst the tough decisions we have had to take to deal with the deficit challenge that we face, one of them has been to say, “We actually need to apply the same principle to ESA as we do to JSA.”

Now, it is not related to health conditions; there has been a lot of talk about recuperation periods and so forth. It is not a decision about how long or how short a period of time we expect somebody to need to make a recovery before they can return to the workplace; it is a simple, pragmatic decision that says these are benefits that are being paid to people who have other household financial means, either income or capital. In straitened times financially we cannot afford to pay that on an unlimited, unconditional and ongoing basis, and so therefore we have placed a time limit, which is higher than the time limit for JSA because we recognise that people need a bit more time to sort their affairs out if they have a health problem, but it is one of the budgetary decisions we have had to take to deal with the deficit.

Q334 Chair: But you have pointed out in what you have just said there that they are not the same. Someone who goes onto JSA will be looking for work from day one and will be able to take up that work from day one. The person who goes onto contributory ESA may still be very ill. They still may be signed off their work. They may actually be signed off their work for the whole of the year that they get the contributory ESA. They have worked all of their life; they have paid their National Insurance contributions; they thought that the welfare state would be there to give them that insurance that, should they fall out of work because of ill health, they will continue to get an income in their own right, and you are saying, “Well, you can only get that income for a year.” Surely the social contract that people sign up to when they pay their National Insurance contributions has been broken as a result?

Chris Grayling: Well, it is applying the same principles as we do to JSA, and we have had to, and will have to, take a number of difficult financial decisions across the piece because of the scale of the public finances crisis that we inherited last year. I am sure that there are many decisions that we will have to take as a Government that we would rather not have to do, but when you get left a major problem on that scale, you do have to do difficult things.

Q335 Chair: Have you done any analysis of the potential social consequences of this decision, where perhaps a working partner, because they perhaps earn around £20,000 a year and therefore the household would not qualify for income-related JSA, takes a decision to give up their work, which is what the Government wants them to do, in order to be the full-time carer of the person because that is the only way that the income of the household actually can be protected and they would be no worse off by that time,

8 June 2011 Rt Hon Chris Grayling MP, Karen Foulds and Dr Bill Gunnyeon

perhaps, with the carer getting Carer's Allowance and be able to earn the £100 a week that they could with Carer's Allowance. Have you done any research into what might happen just because of human behaviour, because the loss of that particular piece of income, that £85 a week out of that household income, might be quite devastating?

Chris Grayling: Well, we have done detailed analysis of what we think the consequences might be for this particular group. We expect around 30% of them to move straight to income-based ESA because of their financial circumstances. We expect around another 30% to receive some element of income-based ESA, and we expect another 40% not to require ESA at all. So we have done some analysis of this group and the financial impact on them, but, as I say, it is a decision that probably would not have been top of our agenda if we had come into government in different circumstances, but across the portfolio of what Government does we have had to take tough decisions financially because of the scale of the deficit.

Q336 Chair: But there is also an unfairness, as I say, with my constituents. Because they went through the trial, they will have their contributory ESA taken away from them quicker than elsewhere in the country because of the nature of the rollout. Is the fact that you are bringing it in so quickly fair? Would it not be better to roll out everything and then perhaps bring this in? I do not agree with you bringing it in in the first place, but if you are saying that it is financially unaffordable, then surely it would have been fairer to make sure that everybody was onto the ESA before you start withdrawing the benefit from a particular group.

Chris Grayling: In the case of your constituents, of course, the numbers who went through the assessment in Aberdeen were only a proportion of the claimants in the city and, indeed, in the area. But, as I say, we have had to take some difficult decisions to tackle the financial crisis, and the impact of that will be felt across society. We are making changes to child benefit, for example, that will, I am sure, be unpopular when they are implemented.

Q337 Chair: But the people going through the migration process today will be the first to lose it in a year's time because the clock is already ticking for them, and that is surely unfair when there is another 2 million or so still to go through it, and they at least get their money for slightly longer. Is there not a bit of unfairness in that?

Chris Grayling: In an ideal world it would not take us three years to do the migration, but the practicality is that it does because it is huge logistical task. It is a shame that it was not done years ago.

Q338 Chair: Obviously, that is an area where we will differ, but it does seem incredibly unfair and a lot of people feel very let down. They thought they had done what the Government asked of them. They had worked all their life; they had paid their National Insurance, and it was an insurance for ill health. Their family income is taking a double hit. It will have come down because that earner is no longer earning because

they are now on ESA, and in a year's time they get another £85 taken out of what was already at least half, if not more, of the household income. Do you have a sense of or think that perhaps that is being very harsh?

Chris Grayling: I understand the point you are making, but we live in challenging times financially.

Q339 Chair: Can I explore the employment support for the ESA claimants, because obviously that is now coming in. This is our last set of questions, honest. What support will there be to find work for those who have come through the WCA process and have been found fully fit for work and are on JSA, because ultimately the real test of this, as was earlier suggested, is whether these people will get into work. So, what support is there going to be into work? I think that might help to allay some of the fears that are out there that Stephen Lloyd was talking about, the references to "the workshy". The reason people are frightened is that they do not believe that the other side of the equation, the support, the help and, indeed, the jobs, is going to be there. So that is really important.

Chris Grayling: The way it is going to work is that, if somebody is found fit for work and transferred onto JSA, they will spend three months receiving the standard form of support through Jobcentre Plus, but they will then, after three months, get early entry into the Work Programme. We decided not to refer them to the Work Programme on day one, because I think it is only right and fair that we allow everyone in the Jobcentre Plus world, all of the claimants who pass through the doors, to have a period of independent job search, with some guidance from Jobcentre Plus and, obviously, the support that Jobcentre Plus offers, and we are looking at ways of strengthening the capabilities, for example, by close partnerships with the careers service. For those first three months, we felt it was right and proper that they should have a window of independent job search.

They will then have early access to the Work Programme after three months and that will offer them the kind of personalised and tailored support that we talked about when we discussed the Work Programme previously, and I very much hope, of course, that they will also command a higher tariff than the conventional Jobseeker's Allowance claimant, which again provides an incentive to providers to provide extra support to them in getting them into the workplace. Then it will be a matter of the providers and the provider network doing their stuff and helping them get into work.

One of the points I was making to Glenda Jackson, which I have sought to make all the way through this, is the narrative about the migration: every time I talk about it, I always talk about it in the context of the specialist support that is then going to be available to get people back into work. You cannot have one without the other. I am absolutely with you; it would not be right to reassess people and then say, "Right; you are on your own." It is all about making sure that there is proper specialist support available to help them into work, and we felt that the three-month early entry point was the right point to do it.

8 June 2011 Rt Hon Chris Grayling MP, Karen Foulds and Dr Bill Gunnyeon

Q340 Chair: But in the discussion we had with Dr Gunnyeon earlier, the WCA does not ask the questions about real life chances of that individual getting a job. It does not take into account labour market conditions in the area, educational ability or ability to retrain or any of that. Now, we have been told that it takes the contractors' personal advisers about 15 minutes to decide if somebody is work ready or not. They are obviously using different criteria and a different assessment from the WCA. Is there any way that the WCA can start to take into account that kind of real life experience to make a more sensitive judgment as to just how work ready someone is? So it is not just a, "Yes, that person can work," but also there is a second part to their assessment, which is, "Yes, they can work, but they will need this particular type of help and it is probably in these areas that they are going to be able to work." Now, I understand that Professor Harrington is suggesting that that should be part and parcel of the process of the assessment as well.

Chris Grayling: The one thing I am absolutely unreservedly and implacably opposed to in all of this is a real world test. Either somebody is fit for work or they are not, and what I am not prepared to do is to countenance a situation where we are saying: "You are fit for work, but you should not be on JSA because there is high unemployment in your area." I think that does a huge disservice to those people—some of whom have health problems—who are on JSA. I think what is important, and what the Work Programme is there to provide and what the higher tariff for this group is designed to help support, is that where people are moving off IB, we recognise the fact they have bigger challenges and therefore there is extra work for the providers to do with them, and that is why, as I say, the outcome price for the JSA ex-IB group is 50% higher, and why for those who are mandated from ESA onto the Work Programme, the tariff is almost £14,000 to get them into work. That is really important. But what I do not think we could possibly countenance is the situation where we are saying, "Because of circumstances in the labour market in your area, we will treat you differently." I think that would be a huge mistake.

Q341 Chair: Right. I take that from the labour market respect, but what about the educational opportunities and the type of jobs that exist anywhere in the labour market, not just in the locality? Someone who is illiterate is not going to get a desk job, for instance.

Karen Foulds: In those three months before they go to the Work Programme, when they first come to the Jobcentre they have a 45 minute diagnostic interview with a personal adviser, so it is not 15 minutes; it is 45 minutes with a personal adviser. That person's job is to work with that claimant to look at their educational qualifications, their previous work experience, life experiences, etc, to come up with a jobseeker's agreement that gives that person the best possible opportunity of finding work. Now, obviously, as the Minister said, in three months they would go to the Work Programme and we would expect that quite a lot of this claimant group, because they are coming

from Incapacity Benefit, probably will still be with us after three months and go to the Work Programme, but it is not that those three months is wasted. If, for example, somebody needs some help with literacy, that would be one of the things that the personal adviser—the named one that they would have for that three months—would work with them on.

Chris Grayling: There is provision to pay for training courses and all people on JSA have access to short-term training courses, so we could refer that person to an IT course to fill an IT gap, literacy or numeracy—there are mechanisms there to help them move ahead fairly rapidly.

Q342 Kate Green: I just wondered, in view of your very, very definite position on a real life test, why Professor Harrington is being allowed to continue to investigate it and work with a number of external groups to look at ways in which it could be designed. Is that not rather a cynical situation that we find ourselves in?

Chris Grayling: Professor Harrington is independent and is entitled—and, indeed, should be entitled—to make any recommendation to us that he believes is appropriate. But sitting in front of the Committee asking my view on this, clearly it depends on the nature of his recommendation, but I would not countenance a situation where we said to somebody who was on JSA long term, "You are subject to conditionality and £67 a week," but somebody who had come off IB and was found fit for work we would not move into the same position, even though their circumstances might be very similar, simply because the world is quite challenging and we have built a real world test into the Work Capability Assessment. That seems to me to be likely to build a huge injustice into the system. The labour market is a challenge for us in some parts of the country, which is why we have measures like the Regional Growth Fund in place to try to stimulate private-sector growth in those areas. It is right and proper we do that, but what you cannot do is say to somebody, "Actually the labour market is a bit tough in your area, therefore we will not expect you to look for work." That would be a huge mistake.

Dr Gunnyeon: I think there is also quite a lot of confusion around the issue of a real world test, and I think one view is, as the Minister has outlined. There is another aspect—I think it is probably more in Professor Harrington's mind, although it may not be in some other groups' minds—which is, is the assessment correctly assessing whether people really are fit for work or not? I think that issue—whether the way we do the assessment properly reflects capability for work—is slightly different from the other aspect, which I think is what many people mean by real world test. But I think Professor Harrington has a much wider view, and I think one of the areas that he is certainly interested in looking at is whether we can find ways of ensuring that what we are doing in the assessment is really properly determining people's suitability for work. Then, of course, there is the separate issue of how you identify what support people might need.

Kate Green: Are you committed to that particular definition of a set of proposals around a real life test?

8 June 2011 Rt Hon Chris Grayling MP, Karen Foulds and Dr Bill Gunnyeon

Chris Grayling: Let's be clear: I have said to Professor Harrington we will do everything we can to improve the process. It is just that that red line for me is we cannot create a point of discrimination to say that, because you are fit for work but you are on IB, somehow you should be treated differently to somebody who is fit for work but never was on IB.

Q343 Oliver Heald: It is often said, "Well it is not fair to do this, to have this test, because there are no jobs." Now, what would your take be on that? In all parts of the country there are people moving into work every month. Now, obviously it is much more difficult in some areas than in others. Would you want to comment at all on that general proposition, which one hears quite often?

Chris Grayling: Well, I think it is important to remember that 90% of people move off JSA within the first year, and I remember—I have not actually checked the figures for the last two or three years—in 1993, which was the deepest year of the last recession, which had a higher level of unemployment than we have seen in the recession we have just finished, around 700,000 people who had been out of work for more than three months moved into work. So there is a constant flow of people into and out of work. There are job vacancies in every single part of the country. There are more in some than in others. There are some where the labour market is quite challenging, but there are still vacancies.

My particular view is that we should not allow people who have been out of work for a longer period of time to end up stranded. We have seen statistics emerge over the last couple of weeks suggesting that the problem of long-term unemployment is getting worse, and I see the role of the Work Programme particularly as being to tackle that problem. I apply that not simply to those on JSA long term but the people we are talking about today. I want some of that flow, which is happening all the time, from benefits into work to be the 10% of long-term JSA claimants and those who are long-term IB but could get back to work. So I think it is really important that we do not write off any individual or any area and say it is just not worth bothering about. Every single individual is worth an effort; every single area is worth having some belief in and it is really important that we do not take a step back and say, "That is all a bit too difficult."

Karen Foulds: In Jobcentre Plus alone we take 10,000 vacancies a day. That is just Jobcentre Plus—there are other recruitment methods. So there is quite a dynamic labour market, even in the current position.

Q344 Oliver Heald: That is what I was going to ask you.

Karen Foulds: Oh, sorry.

Q345 Chair: I represent a constituency where there is still a dynamic labour market, but disabled people still do not get jobs. Now, that is not because they do not try but because there is the other side of the equation. All of our questions this morning have been on the claimant's side, but would you accept, Minister, that actually there is a problem from the employers' side? The employers are reluctant to employ people

with disabilities. They are most certainly very reluctant to employ people with mental health problems or a history of mental health conditions, to the extent that people lie on their application forms. First of all, do you accept that that is a problem and therefore they are always going to be disadvantaged in the labour market because of that prejudice and that discrimination? If you do accept it, what is the Government going to do, because that needs to be tackled and it is very important that it is tackled.

Chris Grayling: I think it is particularly about breaking down barriers. On the day I came up at the start of the trial process in Aberdeen, you and I met a young man with learning difficulties who was in his first job and getting lots of praise from his employer. I think there you have an employer that now has a much clearer understanding of the issues and challenges somebody in that position faces and the difference they can make to that organisation nonetheless, and so that employer will be much more willing to do the same in the future. I think it is about getting more and more employers to take that first step, to understand that somebody with a disability can make a really positive difference to their organisation, and then the door will be open to more. I would describe the Work Programme as a sort of giant employment dating service of matching individuals to employers, fitting individuals to jobs that work and fit. One of the reasons that we are paying providers more to help people from ESA who are mandated onto the Work Programme into work is that it will take that extra investment of breaking down barriers: persuading employers to give someone a work placement; of helping them get to know how to deal with the issues and challenges; but also helping them to understand the difference those people can make. I think it is a really important part of what they do, and it is why the differential pricing in the Work Programme is so important.

Q346 Chair: Has Jobcentre Plus got the power to take action against an employer they suspect is turning people away that have been sent through Jobcentre Plus because they have a disability or a mental health history?

Karen Foulds: If we suspected that an employer was actually breaking the law and breaking the Equality Act, then yes, we would take steps in terms of our servicing of that employer, in terms of taking their vacancies. We would also provide advice to the individual if they wanted to take it forward themselves.

Q347 Chair: How many cases have you taken?

Karen Foulds: I do not know. We could find out. I do not know.

Q348 Chair: Because it is very difficult in the circumstances—

Karen Foulds: It is very difficult and I think it is more—and I have worked in Jobcentres for many years—a conversation with a senior person and the employer to say, "This cannot happen; we are not dealing with your vacancies anymore unless you get your act together," rather than taking legal action. But

8 June 2011 Rt Hon Chris Grayling MP, Karen Foulds and Dr Bill Gunnyeon

certainly we would not knowingly take any vacancies and advertise them through Jobcentre Plus if we had evidence that that was happening.

Q349 Chair: Maybe we do need to take to take legal action to encourage *les autres*, as they say. Can I say thanks? It has been a long morning, but thanks very

much for coming along and thanks very much for your time.

Chris Grayling: You are welcome.

Chair: This is the last evidence session so we will be writing a report based on the evidence we have taken so far.

Chris Grayling: Okay. Thanks very much. Thank you.

Written evidence

Written evidence submitted by the Department for Work and Pensions

SUMMARY

1. Starting in October 2010 and ending in spring 2014, customers who receive Incapacity Benefit, Severe Disablement Allowance and Income Support paid on the grounds of illness or disability will be assessed to see if they qualify for Employment and Support Allowance (ESA).

2. Approximately 1.5 million people will be reassessed. Reassessment commenced in October 2010 with a trial in the Aberdeen and Burnley areas. At the end of February, the Department began a limited introductory phase reassessing 1,000 cases a week. Full national reassessment began in April 2010. Jobcentre Plus has redeployed around 1,200 extra staff to handle the reassessment of these cases. Around 16,700 personal advisers will also be trained to deal with reassessment customers.

3. The Government will ensure that the transition runs smoothly for all customers. For those who transfer to ESA the Department will ensure that benefit payments are not disrupted. No one moving from their existing benefits to ESA will see a reduction in the level of their benefit entitlement at the point of change.

4. Other important changes are being introduced alongside the reassessment exercise that will ensure the necessary support is available to incapacity benefits customers both during and after the reassessment process: delivery of changes from Professor Harrington's independent review of the WCA and the introduction of the new Work Programme arrangements are being dovetailed with reassessment, to optimise the experience for customers, the quality of decision making and therefore delivery of the overall policy objectives.

INTRODUCTION

Background to the reassessment

5. The Department introduced ESA for new customers with a health condition or disability from 27 October 2008.

6. "The Coalition: our programme for government" published on 20 May 2010 committed to reassessing people on Incapacity Benefits for potential entitlement to ESA between 2010 and 2014. Further detail was provided in Written Ministerial Statements on 29 June 2010 and 25 January 2011. A summary of key facts about the reassessment is included at Annex A.

7. The Employment and Support Allowance (Transitional Provisions, Housing Benefit and Council Tax Benefit) (Existing Awards) (No.2) Regulations 2010 (SI 2010/1907), were laid before Parliament on 29 March 2010. They came into force on 1 October 2010 and provide the legal basis for reassessment.

The case for change

8. There are over 2.5 million people on Incapacity Benefits¹ and Employment and Support Allowance. This is some 7% of the working age population at a cost to the taxpayer of around £13 billion a year. The Government recognises that many of these people, with the right support, could and indeed do want to work, but the current system does not give them that opportunity.

9. For someone on Incapacity Benefits it may have been some considerable time since they last spoke to anyone at the Department about their condition or their work options. People have been left on their own with no support or sense of when and how they might get back to work. The Government believes this is not right and that radical reform is needed.

10. The Government will bring people into the Work Programme which will offer targeted, personalised help for those who need it most, when they need it. Supporting families back to work is the only way to break the cycle of inter-generational poverty.

Implementing the change

11. Approximately 1.5 million people will be reassessed by April 2014. This represents a significant challenge for Jobcentre Plus and its partners. Around 1,200 Jobcentre Plus staff have been redeployed to handle the reassessment. Atos Healthcare, the Department's medical services contractor, is recruiting over 100 additional Healthcare Professionals to support reassessment.

12. The Government recognises that the timescale for delivery of this change is challenging, but it is important that customers are provided with employment support as quickly as possible.

13. To support staff in delivering this change the Department has produced extensive guidance. A comprehensive programme of learning has also been developed. Overall, the following approximate numbers of staff will be trained:

¹ "incapacity benefits" is a collective term for Incapacity Benefit (IB), Severe Disablement Allowance (SDA) and Income Support (IS) paid on the grounds of illness or disability.

- 900 staff engaged in processing activities in Benefit Processing Centres;
- 260 staff engaged in telephony activities in contact centres; and
- 16,700 staff in Jobcentres—including advisers involved in back to work activities.

14. The implementation of reassessment is being carefully managed. Rigorous project disciplines, including comprehensive and integrated planning and the management of risk have been adopted. External assurance has been applied throughout the lifetime of the project, including two independent Gateway reviews by the Office of Government Commerce.

Continuous improvement and evaluating the change

15. The reassessment has been informed by learning from the current ESA experience, best practice within the Department and research with customers.

16. Before reassessment commenced the Department commissioned insight research, including a survey of 2,000 current Incapacity Benefits customers. This research examined customers' attitudes towards work, their levels of skills and their preferred methods of communication. The results were used to inform customer communication strategies and Jobcentre Plus staff training.

17. The Department also trialled the reassessment process. This began in October 2010 and involved 1,700 customers in the Jobcentre Plus-led Pathways Districts supported by Burnley and Aberdeen Benefit Centres. 850 customers were selected from each Benefit Centre. The trial was designed to provide early indicators about customer and staff reactions to the reassessment process, evaluate whether the communications were effective and to provide recommendations on how the process could be improved.

THE CUSTOMER JOURNEY

Designing the customer journey

18. The reassessment process, or “customer journey”, was designed based on learning from the implementation of Employment and Support Allowance. Feedback from ESA revealed that some customers found it difficult to understand the end-to-end claim process because they were unsure of where they were in the journey and what to expect next.

19. In response Jobcentre Plus have added additional points of contact with the customer. Specifically a telephone call is made to the customer after they have been notified that they are having their benefit reassessed and an additional call is made to discuss the decision about their benefit entitlement. Simplifying the journey for customers in this way allows Jobcentre Plus to:

- identify any additional needs a customer may have, such as the need for an interpreter or other reasonable adjustments;
- provide further information to the customer at each step;
- provide the customer with more opportunities to ask questions;
- explain what will happen next so that the customer knows exactly where they are in the journey; and
- improve the decision making process by providing an opportunity for customers, who may be disallowed, to provide additional evidence in support of their claim.

20. Reassessment also builds in many of the recommendations of the recent review of the Work Capability Assessment (WCA) undertaken by Professor Malcolm Harrington,² including additional telephone contact with customers, and giving customers a chance to discuss the decision in their claim with a decision maker.

The reassessment customer journey

21. A diagram of the customer journey is included at Annex B.

22. Customers are first informed that their benefit is being reassessed when Jobcentre Plus sends them a written notification. Within two weeks of sending this notification, Jobcentre Plus telephones the customer. The member of staff will check that the customer has received the letter, that they understand the action they need to take, and find out if they need any extra help.

The medical questionnaire and WCA

23. Customers will then be sent a limited capability for work questionnaire (ESA50) by Atos Healthcare to complete and return. The customer is asked to provide as much detail as possible on this form about their medical condition and how it affects them. In order to improve this part of the process, the Department has amended the ESA50 to encourage customers to send any relevant, additional, medical evidence when they return the form.

² <http://www.dwp.gov.uk/policy/welfare-reform/employment-and-support/wca-independent-review/>

24. Upon receipt of the ESA50 at Atos, a Healthcare Professional will review the questionnaire and any other medical evidence supplied to decide if the customer needs to attend a face-to-face assessment. If necessary, the Healthcare Professional can request further medical evidence from a customer's GP or other professionals.

25. If Atos are able to conclude that a customer satisfies the conditions for the Support Group or Work Related Activity Group (WRAG) on the basis of paper evidence, for example if the customer is terminally ill or is very seriously disabled, they can return the case to Jobcentre Plus with a recommendation without inviting the customer to a face-to-face assessment.

26. If a customer is asked to attend a face-to-face WCA, Atos Healthcare will telephone them to arrange an appointment. A Healthcare Professional, employed by Atos, will produce an independent medical assessment based on how the customer's condition affects them. The assessment is a functional assessment which focuses not on diagnosing an individual's condition but on the effects the condition has on that individual. This report is sent to Jobcentre Plus.

27. Using the information from the questionnaire, the face-to-face assessment and any other evidence provided, a Jobcentre Plus decision maker will decide if the person's existing award qualifies for conversion to ESA and, if so, whether they qualify for the Support Group or the WRAG.

If a customer qualifies for ESA

28. If a customer's qualifies for ESA, Jobcentre Plus will telephone them to inform them of the decision, whether they are in the Support Group or WRAG, and what they need to do next, before putting the customer's benefit into payment. They will be sent a letter to confirm the decision.

29. Customers placed in the WRAG will be told during this call that they will be invited to a work-focused interview at a Jobcentre. At this interview they will be able to discuss any support they will need to return to work.

If a customer does not qualify for ESA

30. If, on reviewing the evidence, the Jobcentre Plus decision maker believes the customer is likely to be disallowed, they will telephone the customer and explain why they believe the customer may not be entitled to ESA and the evidence they have used to reach this conclusion.

31. If the customer queries the decision and has additional evidence which may alter the decision, this call provides an opportunity for the customer to bring further evidence forward. They will then be given 14 days to send in this evidence before a final decision is made.

32. If the decision maker decides the award does not qualify for conversion to ESA they will then discuss with the customer their benefit options. If a disallowed customer wishes to claim Jobseeker's Allowance (JSA), they will be transferred straight to someone who will take their claim details. This will help to ensure that customers who claim another benefit do not have a break in their payments.

33. Following a disallowance, benefit will not stop immediately. The date a customer's payment stops will be at least two weeks after the decision has made. This will provide time for a new benefit claim to be processed and put into payment.

34. Disallowed customers will be sent a letter to confirm the decision.

If a customer thinks the decision is wrong

35. When telephoning or writing about a decision, Jobcentre Plus will also advise people what to do if they think the decision is wrong. If a customer decides to appeal against a decision their case will be automatically reconsidered, before the case is sent to Her Majesty's Court and Tribunals Service.³ A decision maker will call the customer to see if they have any additional information to inform this reconsideration.

Support for vulnerable customers

36. Customers with health conditions that may affect their ability to comply will not be disadvantaged. If someone who is known to have a mental health condition or a learning disability fails to return the ESA50 or attend a face-to-face WCA their case will not be closed immediately. The Department will make every effort to gather the information necessary to process it, including undertaking safeguarding visits to the customer's home if necessary.

37. During the initial telephone call to the customer, Jobcentre Plus will ask if the customer has any additional needs and will endeavour to meet any reasonable adjustment request.

38. Not receiving the telephone calls from Jobcentre Plus does not stop the journey moving forwards. Where a customer is unable to use the telephone they can request contact is delivered face-to-face. Customers can also contact Jobcentre Plus via a textphone/textbox and the Royal National Institute for the Deaf (RNID)

³ Her Majesty's Courts and Tribunals Service was created on 1 April 2011. It brings together Her Majesty's Courts Service and the Tribunals Service into one integrated agency providing support for the administration of justice in courts and tribunals.

typetalk service. Large print forms are available for people with visual impairments. Jobcentre Plus also supports customers' right to be accompanied by a representative.

COMMUNICATIONS WITH CUSTOMERS

39. The primary channels of communication with customers are the telephone calls and written notifications delivered by Jobcentre Plus and Atos Healthcare. Comprehensive information has also been made available for customers on the DirectGov website.

Involvement and best practice

40. Reassessment notifications and forms were developed with involvement from the Social Security Advisory Committee, Customer Representative Groups and the Department's psychologists. For example, at the request of Citizen's Advice, the initial notification and disallowance notifications highlight to customers that they can seek additional support from welfare rights organisations.

41. Jobcentre Plus has worked with the Department's Transforming Letters Project, in conjunction with Reading University, to ensure that the letters are in plain English.

42. Members of the Jobcentre Plus Customer Representative Group Forum were given the opportunity to comment on the customer information published on the Government's DirectGov website. As part of focus groups in the Aberdeen and Burnley trial areas, customer representative groups were also asked to evaluate this content.

Results and learning from the reassessment trial

43. The trial demonstrated that the customer journey and customer communications are working well. The customer journey has been shown to be viable, with staff and customers reacting positively to the additional customer interventions. There was little adverse customer reaction and low levels of active non-compliance. Enquiries by telephone and in person have been much lower than expected, suggesting that the communications provided to customers have effectively provided for their needs.

44. Management information gathered during the trial suggests that the additional customer contact has improved compliance with the reassessment process. 13% of customers contacted the Department after receiving their initial notification to correct their contact details. 68% of initial outbound phone calls were successful. Finally, only 14% of customers failed to return their ESA50 medical questionnaire and 9% failed to attend their WCA. This compares favourably with the experience of new claims to ESA.

Improvements from the trial

45. The trial evaluation identified some specific recommendations to improve the customer journey and communications, which are being implemented. These improvements include:

- The language used when customers are informed they have been placed in the WRAG has been clarified as some customers were unsure about what was expected of them.
- Decision makers have been given the flexibility to arrange a break of up to 72 hours in the outbound call to disallowed customers, if necessary. This was introduced because the research showed that customers were sometimes unable to engage with this phone call because they needed time to take in the fact they were being disallowed ESA.
- Atos Healthcare is addressing feedback by some customers that the face-to-face WCA felt impersonal through its soft skills training which is already taking account of feedback from the customer satisfaction survey, analysis of complaints trends and the Harrington review.

Further testing and assurance

46. Staff guidance, learning and development and supporting IT have been evaluated through model office testing, which replicated the conditions in a real, live office environment. Jobcentre Plus operational staff have also been involved throughout the development and testing of supporting IT and business processes. This has taken many forms, including the embedding of operational staff within the project development teams to add technical expertise and assurance at source. These arrangements have identified improvements and confirmed that all products are fit for purpose for national reassessment.

Communications with external stakeholders

47. As well as communicating directly with customers the Department also recognised that customers currently in receipt of Incapacity Benefits may be vulnerable, may not have had contact with the Department for a considerable period of time and may look to third sector organisations for support. A comprehensive communications strategy for external stakeholders was therefore developed. This involved:

- meetings with representatives of national external stakeholders in July 2010 and again in March 2011, alongside regular updates to stakeholders at the quarterly Jobcentre Plus Customer Representative Group Forum;
- local liaison between Jobcentre Plus District External Relations teams and third sector organisations. As part of this activity External Relations Teams were asked to liaise with Primary Care Trusts, local authorities and relevant disability charities; and
- a series of communications products for external stakeholders, developed with input from key stakeholder groups, hosted on the Department's Adviser website.⁴

WORK CAPABILITY ASSESSMENT

Background

48. The Work Capability Assessment (WCA) was introduced in October 2008 to assess entitlement to Employment and Support Allowance.

49. The WCA is based on the principle that a health condition or disability should not automatically be regarded as a barrier to work, that there is a large body of evidence which shows that work is good for physical and mental well-being and can be beneficial for individuals with health conditions and disabilities, and that being out of work can contribute to poorer health and other negative outcomes.

50. The WCA is an independent functional assessment which focuses on the overall effects of a condition or impairment on the individual. This is different from assessments by GPs or other Healthcare Professionals where the emphasis is on specific diagnosis and condition management, and the Healthcare Professional takes an advocate role for their patient. Thus as an independent assessment the WCA can help better determine an individual's readiness for work. Other supporting evidence is considered alongside the WCA, where appropriate, to get the fullest picture.

51. To determine how an individual is affected by their condition or impairment, the WCA looks at a range of different activities related to physical, mental, cognitive and intellectual functions. It also assesses certain additional criteria that do not directly measure function (such as terminal illness) to determine capability for work.

52. The WCA also takes account of conditions that fluctuate. If a customer is unable to complete an activity repeatedly, reliably and safely, then they are considered unable to complete it at all.

Development of the WCA

53. The WCA was developed by technical experts and medical specialists, in consultation with specialist disability groups. It sought to take account of the demands of the modern workplace, developments in medicine and our understanding of disability.

54. The Welfare Reform Act 2007 legislated for the introduction of the WCA. Chapter 5, Part I, sections 8 and 9 outline the structure of the assessment, establishing that individuals will be assessed for benefit entitlement on the basis of their Limited Capability for Work (LCW), and for membership of the Support Group on the basis of Limited Capability for Work Related Activity (LCWRA).

55. Enshrined in this legislation was the need to monitor and update the assessment in the light of new experience. A number of reviews have examined the WCA and made recommendations for improvements, which are now being implemented.

The Department-led review of the WCA

56. In March 2010 the Department published an internal review of the WCA. This was undertaken with significant input from technical experts and specialist disability groups. It focused on the technical descriptors and made recommendations for improvements. These changes came into force through regulations on 28 March 2011.

57. Recognising ongoing concerns of specialist disability groups, further detailed work was undertaken. The outcome of this was published as an addendum to the report. These changes are fully reflected in the final legislation.

58. The changes ensure the assessment makes greater provision for individuals awaiting or in between courses of chemotherapy, individuals receiving residential treatment for drug or alcohol misuse and those with severe mental health conditions or communication difficulties. They also ensure the assessment takes greater account of how an individual has adapted to their condition.

59. The Department modelled the impact of these changes using data from almost 60,000 assessments. From this analysis the number of new claimants put in the Support Group, specifically those who are awaiting or between courses of chemotherapy, and some whose limited capability relates to certain mental function and communication difficulties, is expected to increase.

⁴ <http://www.dwp.gov.uk/adviser/updates/ib-reassessing-claims>

60. By accounting for adaptation, the number of new claimants being found fit for work is also expected to increase by around 5%. This will affect individuals who are well-adapted to their condition and will benefit from the support available on Jobseeker's Allowance. For individuals with mental health and cognitive conditions a slight increase in the number in the Support Group and broadly no change to the numbers in the Work Related Activity Group are expected.

The Harrington Review

61. In November 2010, Professor Malcolm Harrington published his Independent Review of the Work Capability Assessment, the first of five annual Independent Reviews. The review examined the end-to-end process for the assessment, including the Atos assessment, the decision making process and the appeals process. It found the WCA is the right assessment but it is not working as well as it should. As a result he made a series of practical recommendations for improving the WCA, which the Government has committed to implementing as quickly as possible.

62. As a result, the Department is:

- empowering Jobcentre Plus decision makers to make the right decision. They are being given clear responsibility for the decisions they make and the support they need to ensure those decisions are independent and considered;
- ensuring individuals are treated with compassion by clearly explaining everything to them, helping them fully understand the process they will go through, and ensuring they know they can provide additional evidence for consideration at any time;
- improving the transparency of the face-to-face assessment by running a pilot to look at audio recording assessments; and
- accounting for the particular difficulties in assessing mental health conditions by supporting Atos to create and use mental health champions.

63. Many of the recommendations are already in place and the remainder of those that the Department is responsible for will be in place by this summer. A high level timeline for the remainder includes the following milestones:

- a review of the ESA customer journey, to include additional interventions supporting customers throughout their benefit journey. This will be tested from June 2011, prior to national rollout from October 2011; and
- the introduction of a plain English Personalised Summary Statement of a customer's medical assessment from June 2011, copied to disallowed customers from the end of September 2011.

64. Professor Harrington has been reappointed to take forward the second annual review of the WCA, continuing the process of improvement. As part of this, he will look in more detail at the assessment of mental health and other fluctuating conditions and provide any recommendations as appropriate.

The role of Atos Healthcare

65. Atos Healthcare provides independent medical assessments on behalf of the Department for Work and Pensions. The Departmental decision maker makes a decision on benefits entitlement using this advice as well as other equally important sources of information. The result of the assessment has no bearing on Atos Healthcare targets or remuneration.

66. Atos Healthcare is responsible for:

- recruitment and training of Healthcare Professionals—doctors, nurses and physiotherapists;
- managing the assessment centres;
- scheduling appointments via its contact centre;
- conducting medical assessments developed by the Department that are designed to see what people can do; they are not the same as an examination carried out by a doctor or consultant which is designed to diagnose a medical condition; and
- providing an independent medical report to decision makers in the Department.

67. An overview of the Atos Healthcare process for ESA is included at Annex C.

68. Each assessment looks at how the customer's health condition affects their ability to do everyday tasks, so is not the same for everyone. The average time taken for an assessment is around forty five minutes, calculated from over five hundred thousand assessments completed each year.

69. The assessment is largely "non touch". The physical aspects of the assessment are different from that used for diagnostic/treatment purposes and rely largely on "active movements" (that is, movements carried out under the direction of, but without the physical intervention of, the assessing healthcare professional. This is as opposed to the "passive movement" examination often carried out in the diagnostic setting (where the examiner will move the joints without the customer having to do anything). The level of the physical assessment

is determined by the claimed medical conditions i.e. asthma (a peak flow would be taken), hypertension (blood pressure would be taken).

70. During the assessment, the healthcare professional refers to a computer programme to complete the assessment and captures information given by the customer in real time. The programme, called LiMA (Logic-integrated Medical Assessment), was developed to improve and ensure consistency and quality of the reports. It is an evidence-based computer programme that includes medical protocols and incorporates the latest clinical research on mental health, musculo-skeletal and cardio-respiratory conditions. It serves as a guide only and the Healthcare Professionals are required to use their own clinical judgement to justify the medical opinion contained on the medical report.

71. Atos Healthcare professionals are expected to be mindful of the fact that many illnesses produce symptoms that vary in intensity over time and are instructed not to base their opinion solely on the situation as observed at the medical assessment. Part of the training for healthcare professionals involves the effects of variable conditions on daily life. The aim is to make sure that the assessing healthcare professional provides sufficient information on the pattern of variability for the decision maker.

Training for Atos Healthcare staff

72. All doctors working for Atos Healthcare must be registered with the General Medical Council, all nurses with the Nursing and Midwifery Council and all physiotherapists with the Health Professions Council. There are about 1,400 doctors, nurses and physiotherapists working to deliver the contract.

73. All Healthcare Professionals must have three years broad-based clinical post-registration experience and achieve approval (post training) from the Department for Work and Pensions Chief Medical Adviser in the appropriate benefit. All doctors, nurses and physiotherapists are provided with comprehensive training in disability analysis. For the WCA this includes an eight day course for all doctors and a seventeen day course for nurses and physiotherapists, which is accredited by the University of Derby.

74. To provide consistent, high quality, independent medical assessments to the Department, Atos Healthcare has put in place:

- a rigorous selection process to recruit the best medical and non-medical staff—less than 15% of applicants who apply are successful;
- comprehensive training in disability assessment on joining for all doctors, nurses and physiotherapists plus on-going training to ensure skills and knowledge are up to date;
- a continual programme of internal and external audits to ensure high standards in medical assessments and reports are maintained; and
- strong performance management governance to enable high performance of all staff and to support their career development.

75. Training of Healthcare Professionals consists of three distinct areas:

- generic training—includes principles of disability analysis, professional standards (including manner and behaviour) and multi-cultural awareness;
- training to undertake benefit-specific assessments—includes learning path approach for ESA and other benefits, assessments, modular training with competency testing at each stage and approval process; and
- scrutiny/file work training—includes provision of advice to the decision maker when appropriate on the basis of available documentation within a customer's file, theory and casework exercises followed by supported individual casework.

76. Following the WCA training course, Healthcare Professionals will complete assessments under the supervision of an experienced trainer. Only when they are deemed to have achieved competency will they progress to unsupervised assessments. Every assessment is audited until they produce four consecutive A grade reports. Once this has happened they will be referred to the Chief Medical Adviser for approval on behalf of the Secretary of State.

77. Atos Healthcare has a strong Continuing Medical Education programme. Healthcare Professionals receive training in response to changes in legislation, changes resulting from decisions made by the Upper Tribunal, and alterations in procedure. Atos Healthcare regularly updates Healthcare Professionals on current best practice, often in response to issues that have been identified as causing difficulty to the decision maker or customer. The data derived from Atos Healthcare's auditing processes is used extensively as a source of information to assist it to determine the content and priorities for the Continuing Medical Education programme.

78. Training in medical topics is based on up to date, critically evaluated published research and, wherever possible, is evidence-based. Different training media are employed according to circumstances. These range from formal trainer-led sessions to the issue of bulletins and guidance notes or the use of video. The trainer-led sessions are designed to promote participation by trainees by including inter-active elements and case examples. In 2010 a National Training Event was held for all employed Healthcare Professionals in preparation

for reassessment. Expert independent speakers presented on a range of topics such as Cognitive Impairment, Chronic Pain, Fatigue and Post Traumatic Stress Disorder. All training that takes place is recorded in the individual Healthcare Professional's record.

Quality monitoring

79. Quality monitoring is carried out by both Atos Healthcare and the Department. This includes regular audit of reports by accredited auditors and the monitoring of complaints. Atos Healthcare aims to audit every Healthcare Professional every six months.

80. Management information is provided to the Department on a regular basis. If the Department has any concerns in relation to an individual healthcare professional, Atos will investigate further and subsequent action will be taken in consultation with the Department.

81. Doctors working for the Department and experienced auditors from within Atos Healthcare carry out a regular programme of joint audit in order to ensure the quality of audit at individual units is maintained.

82. If any individual Healthcare Professional's work is found to be deficient, he or she is contacted by a mentor. The mentor will arrange for retraining if necessary, or feedback face-to-face, by letter or telephone call depending upon the issue raised.

83. Targeted audit is used when a problem has been identified with a particular healthcare professional, as a result of random audit, a complaint, rework, or as a chance finding. It involves consideration of a number of reports by the Healthcare Professional to gauge the overall standard of their work. Persistent failure, despite remedial action by Atos Healthcare, to meet a satisfactory standard may result in revocation of approval to carry out medical assessments by the Department's Chief Medical Adviser.

84. Medical reports that are audited are rated with an A, B or C grade to enable appropriate feedback, mentoring and retraining as necessary. Up to 20,000 national audits were randomly undertaken in the last 12 month period. Atos Healthcare has a target to achieve 95% reports rated A or B. In the past 12 months its achievement has been consistently above 95%. Medical and Clinical Directors participate in the Atos Healthcare Clinical Governance Forum where all aspects of their clinical practice and standards are reviewed regularly.

85. The Department's Commercial Management Team undertakes continuous monitoring of Atos Healthcare's performance. Information is gathered from various sources including customer surveys, mystery shopping activity, and information from complaints. Other sources of information include reports which Atos Healthcare is mandated to supply to the Commercial Management Team, and various checks are undertaken to ensure that the reports are accurate. The Team also has access to staff working at the Department for Work and Pensions local offices who report issues when they arise.

Contract and buildings

86. The services are delivered from 123 permanent assessment locations and 25 casual hire sites. Of the permanent sites, 20 are directly leased by Atos Healthcare to deliver the contract and 103 are located within government buildings. The majority of these are Jobcentre Plus offices.

87. The majority of assessment centres are located on the ground floor. There are 31 locations that are not located on the ground floor. For these locations, prior to a customer being called to an assessment, efforts are made to identify customers who may have problems in evacuating via the stairs during an emergency. These customers are either offered an assessment at the nearest ground floor centre or a home visit. Inevitably however, some customers in this category are not identified and still attend the centre.

88. In four of the sites, that difficulty has been overcome by acquiring the use of a ground floor room in the building that can be used on an ad hoc basis for customers who arrive at the locations and who would not be able to safely exit the building in the event of an emergency evacuation.

89. Atos Healthcare is exploring a range of measures to improve service to these customers including:

- improving communications when scheduling of the appointment over the telephone;
- improving appointment documentation; and
- the use of Personal Emergency Evacuation Plans with increased on site support with a "buddy system".

Customer satisfaction

90. Atos Healthcare uses an independent market research company to survey over 31,000 customers each year. Customers are selected at random and include those who failed to attend an assessment. Customers are informed their replies are anonymous and their identity will not be shared with Atos Healthcare. Questions asked of the customer focus on six key areas:

- scheduling of the appointment over the telephone;
- appointment letter information;

- queries made by the customer;
- how polite, helpful and knowledgeable the receptionist at the assessment centre is;
- the facilities in the assessment centre; and
- how courteous, professional, gentle and unhurried the healthcare professional is.

91. For 2010, Atos Healthcare's overall satisfaction rating was 88.6%. The professionalism and approach of Atos' Healthcare Professionals is often in excess of 90%.

92. Atos Healthcare analyses the results and comments on the surveys at an individual Assessment Centre level. It ensures that appropriate action is taken to rectify problems with accommodation, administration or staff.

93. Nationally, Atos Healthcare has instigated a number of activities to ensure levels of customer satisfaction are improved. These include additional enhanced customer service training for staff at the Virtual Contact Centre, for assessment centre receptionists and Healthcare Professionals.

94. As part of the implementation of the recommendations of the Harrington review, Atos Healthcare has recently launched a Customer Charter which explains to customers what to expect during an assessment and what their responsibilities are.

Atos Healthcare complaints

95. Atos Healthcare has a three-tier complaints process agreed with the Department. All customers are informed about how to make a complaint. All issues of dissatisfaction are investigated and following the investigation, the appropriate remedial action is always taken.

96. Complaints about the manner or approach of Healthcare Professionals are very low at approximately 0.14% of all assessments.

DECISION MAKING

97. The decision-making process starts when the decision maker in Jobcentre Plus considers information from the ESA50 questionnaire, the WCA and any other relevant evidence provided. Where there is a discrepancy in the medical evidence, the decision maker can seek advice from Atos Healthcare, our medical services provider, or ask the customer for clarification.

98. The decision maker assesses this information and, following any discussion with the customer, decides whether or not the customer is entitled to ESA. The decision maker issues a decision notice informing the customer of the outcome and whether or not they are entitled to ESA. If benefit is awarded, the notice specifies the amount of benefit and the date from which it is paid, and informs customers whether they will be placed in the Work Related Activity Group or the Support Group.

99. The decision notice advises the customer on what they can do if they are not satisfied with the decision, and informs them of their right to appeal to an independent tribunal. The decision notice informs customers that they can ask for leaflet GL24, If you think our decision is wrong, which provides a detailed explanation of the decision-making and appeals process.

100. The decision notice invites customers to get in touch with Jobcentre Plus by telephone or in writing, within one month of the date of the letter. The customer can do any or all of the following:

- ask for an explanation;
- ask for a written statement of the reasons for the decision;
- ask for the decision to be looked at again to see if it can be changed, pointing out that there may be some facts they think have been overlooked, or that they may have more information which affects the decision; and
- appeal against the decision.

Improvements to decision making

101. Jobcentre Plus has recently made improvements to the decision making process. Since 13 December 2010 arrangements have been made for Atos Healthcare practitioner advice to be provided to ESA decision makers. 33 Benefit Centres now benefit from a weekly on site visit by a healthcare practitioner. This enables decision makers to discuss complex cases and to raise questions relating to the WCA report before deciding a case, or if an appeal has been received, to seek advice on the issues raised by the customer as part of their appeal. The healthcare practitioners can provide advice to decision makers at other Benefit Centres that do not have someone from Atos on site.

102. Since September 2010 the Jobcentre Plus Director of Benefit Centres has regularly hosted a conference telephone call with decision makers to share information and views on issues relating to decision making and appeals. The call allows decision makers to hear directly about initiatives to improve quality and effectiveness. It also provides an opportunity for decision makers to ask questions and offer their thoughts and comments on decision making and appeals related topics. A recording is made available after the call to ensure all decision

makers have had the opportunity to hear it. All questions and answers are published internally for future reference, to extend knowledge and spread best practice.

103. Jobcentre Plus has developed a new learning and development package for all decision makers. The learning focuses on equipping decision makers with the skills and knowledge required to make good quality decisions on a consistent basis.

104. The training emphasises the role of the decision maker in the process and, in so doing, implements one of the key findings from Professor Harrington's review of the WCA. It builds on the lessons learnt from the Aberdeen and Burnley trials. The content centres on: understanding the Limited Capability for Work Assessment, raising awareness of the WCA descriptors, facilitated by Atos Healthcare practitioners, and gathering and using evidence effectively. It also equips decision makers with the skills for communicating their decisions by phone with customers.

The reconsideration process

105. If a customer is not satisfied with a decision, they can ask for an explanation and for the decision to be reconsidered. If a customer appeals this will also trigger the reconsideration process, as the Department aims to put decisions right at the earliest opportunity. A decision maker will telephone the customer to see if there is any additional evidence the customer wishes to be taken into account, re-examine the original decision in the light of the customer's representations or additional evidence, and decide if the decision should be changed; legally this is known as a revision. If the decision is changed, the customer has the right of appeal against the new decision. If an appealed decision is revised in favour of the customer, the appeal will lapse and action is discontinued.

Improvements to the reconsideration process for ESA

106. Her Majesty's Courts and Tribunals Service is an executive agency of the Ministry of Justice and its responsibilities include administration of the First-tier Tribunal. The Department and the Ministry of Justice have been working together to improve the appeals handling process, including the reconsideration stage. During 2009–10 there were three joint Lean⁵ exercises to review the end-to-end appeals process, including one between Jobcentre Plus and the former Tribunals Service that focussed on ESA appeals.

107. Jobcentre Plus conducted a pilot at Wrexham following the joint Lean exercises with the Tribunals Service on the appeals process for ESA and Income Support. Following this, Jobcentre Plus implemented a new approach to have one person conducting both the reconsideration and preparation of the appeal response on an individual case, which has reduced the need for two people to look at a case in detail. This was fully rolled out nationally for all benefits by 1 November 2010.⁶ The new approach also involves direct telephone contact with ESA customers, to explain how the decision has been arrived at and to identify any other information that may be relevant to the decision. This telephone contact has been built into the incapacity benefits reassessment process.

108. An exercise was also carried out to apply this more robust reconsideration process to over 55,000 appeals that had already been sent to the Tribunals Service, but not yet heard. This took the form of seven teams of decision makers deployed on Tribunals Service premises carrying out a systematic review of live appeals and revising decisions if appropriate. Ultimately the objective of the exercise was to prevent appellants needlessly attending tribunal hearings. The work was completed at the end of March 2011 and saw approximately 7,000 decisions revised, removing the associated appeals from the Tribunals Service workload.

APPEALS

109. Customers are informed of their appeal rights by the decision notice, which explains what needs to be done and within what time. However, the Department encourages customers to seek explanations for decisions before appealing. Where a customer feels that the decision is wrong, the Department will look at it again, so that any favourable change can be made as soon as possible. Where the Department does not change the decision, the customer has the right of appeal.

110. The Department produces an appeal response that gives a full explanation of how the decision was reached, including copies of all the evidence used to reach the decision. The response sets out the relevant law, case law, evidence and argument in support of the decision under appeal and stands alone as the Department's case. The appeal response is copied to the customer at the same time as the case is referred to the Her Majesty's Courts and Tribunals Service, well in advance of the hearing.

111. The First-tier Tribunals are administered by the Ministry of Justice's Her Majesty's Courts and Tribunals Service, and are independent of the Department. An appeal can be decided at an oral hearing or the customer can ask the tribunal to make a decision on the papers only.

⁵ Lean is the application of a set of behaviours and techniques to improve the Department's benefit administration. By using Lean ways of working and a set of techniques to make the most of staff knowledge and experience, Lean reduces waste, engages staff and improves efficiency.

⁶ For reassessment, the reassessment site will do the reconsideration, whilst the appeals work will be prepared in the benefit centre that will maintain the case after it has been reassessed.

112. The tribunal will consider the appeal and the evidence submitted by the customer and the Secretary of State, as well as taking oral evidence at a hearing. The tribunal will then consider the evidence and issue its decision. Both the customer and the Secretary of State have the right of appeal, with permission, on a point of law only, to the Upper Tribunal. Further rights of appeal lie with the higher appellate courts.

Support for customers during the appeal process

113. The Department publishes leaflet GL24 If you think our decision is wrong which contains the form that can be used to make an appeal. The leaflet explains how the appeals process works and provides advice on the type of organisations who may provide free assistance in preparing for a tribunal hearing. This information is also available on the Directgov website, together with links to the website for Her Majesty's Courts and Tribunals Service.

114. On receipt of the appeal response, Her Majesty's Courts and Tribunals Service assumes responsibility for handling the appeal and providing support for the appellant. They will contact the appellant and provide further information about the hearing.

115. The Department sends a Presenting Officer to a hearing if the appeal is complex or where directed to attend by the tribunal. If the Presenting Officer attends, he or she will make points in favour of the customer where appropriate, as part of their role.

Time taken for the appeal process

116. There is currently no single system that records the average length of time taken for appeals to be processed from initial lodgement at the Department until receipt at Her Majesty's Courts and Tribunals Service and final clearance of the appeal. Information is only held on those cases which proceed to the tribunal. Therefore, customers who abandon their appeal, fail to provide evidence or withdraw their original appeal, are not recorded. Her Majesty's Courts and Tribunals Service data indicates that for ESA, on average, it takes 9.2 weeks between an appeal being notified to the Department and submission of papers to the tribunal.

117. Her Majesty's Courts and Tribunals Service records all appeals received within the Social Security and Child Support (SSCS) jurisdiction of the First-tier Tribunal and has a published performance indicator which measures the percentage of appeals where the final outcome is promulgated within 16 weeks of receipt at SSCS.⁷ In the period between April 2010 and the end of February 2011 the SSCS performance stood at 47%, against a target of 75%. SSCS also records the average time taken to clear or dispose of a case and as at February 2011, this average stood at 21.8 weeks.

118. In the financial year to February 2011 the combined total of Employment Support Allowance and Incapacity Benefit (ESA/IB) cases accounted for 55% of the SSCS intake of appeals. Sizeable monthly increases have been evident since June 2009 when the monthly intake stood at 10,200 appeals. Since that time the number of appeals has generally continued to increase until August 2010, reaching a peak of 23,600 appeals for that month. Since then receipts have gone down each month until December 2010. There was a slight increase in the following two months and in February there were 18,500 ESA/IB appeals received.

119. Both the Department and the Ministry of Justice recognise the importance of reducing the time taken to process appeals which has been mainly caused by the introduction of ESA which resulted in a large number of appeals being received above original forecasts. As a result, tribunals capacity was not then in place. In 2009–10 receipts exceeded the original autumn 2008 forecast by 82,000. For the period 1 April 2010 to 28 February 2011 receipts exceeded the original 2008 forecast by 107,000.

120. The Ministry of Justice and the Department are working together to manage the increase as part of a Task Force with Her Majesty's Courts and Tribunals Service, Jobcentre Plus and the Pensions, Disability and Carers Service. The Task Force is working on two broad fronts. The first is to reduce the high level of appeals arising from initial decision making. The second is to increase capacity within Her Majesty's Courts and Tribunals Service.

121. As discussed above, Jobcentre Plus is focussing its efforts on improving the quality of decision making and the reconsideration process so that cases do not unnecessarily proceed to a hearing. Her Majesty's Courts and Tribunals Service has been concentrating on increasing its capacity through the recruitment of additional staff, judiciary and medical Tribunal Members, as well as a range of judicial and business process improvements. As a consequence Her Majesty's Courts and Tribunals Service will, by the end of the 2010–11 business year, have cleared a third more social security cases than in 2009–10, and 50% more than it did in 2008–09. It is also significant that ESA/IB disposals have generally increased month on month since June 2009, reaching the highest level of 20,100 appeals in the month of February 2011 and at three times in the last four months: November 2010, January 2011 and February 2011, the number of disposals has outstripped receipts. In December 2010 receipts outstripped disposals by eight appeals.

⁷ The latest statistical information on SSCS appeals can be found at:
 SSCS Statistical notice for April 2010 to February 2011—
<http://www.justice.gov.uk/publications/statistics-and-data/tribunals/sscs-stats.htm>
 Quarterly Tribunals Statistics (latest quarter is for October to December of 2010)—
<http://www.justice.gov.uk/publications/statistics-and-data/tribunals/quarterly.htm>

THE OUTCOME OF THE REASSESSMENT PROCESS

122. The Department published interim results from the reassessment trial on 1 April 2011. These show that, as of the 22 March, 1,626 decisions on whether a customer's claim qualifies for conversion to Employment and Support Allowance had been made. Of these:

- 526 individuals (32%) were not entitled to Employment and Support Allowance;
- 484 individuals (30%) were placed in the Support Group; and
- 616 individuals (38%) were placed in the Work Related Activity Group.

123. Further results from the trial are being received and the Department will update the findings in due course. The Department commissioned the independent research company, IFF Research Ltd, to carry out research into the trial reassessment and the results from this research will be published in mid-May. This should provide insights into the impact of the process and the final decision on claimants.

124. The trial has run from October 2010 and the results are still coming through. Information on claimants destinations is particularly thin because it is presently too early in the process. For ESA claims the Department does not get reliable information about destinations until a few months after the decision.

The impact of the decision to time limit contribution based ESA

125. On 20 October, the Chancellor set out the intention to introduce a time limit of one year for those claiming contributory ESA who are placed in the WRAG. This proposal will not apply to people in the Support Group and income-related ESA will continue to be available for the poorest. The change requires primary legislation and is included in the Welfare Reform Bill which is currently being considered in Parliament.

126. As with other contributory ESA claims, those people who have undergone the reassessment process will be affected by the time limiting proposals if they have been allocated to the WRAG. Subject to Parliamentary approval, the proposals are:

- customers in receipt of Incapacity Benefits who are reassessed and qualify for contributory ESA before April 2012 will have their benefit time limited, with the 12 months period running from the point of conversion. As with existing claims, the period of time already spent on contributory ESA before April 2012 will be taken into account in calculating the one year period; and
- those who are in receipt of incapacity benefits and are reassessed and qualify for contributory ESA after April 2012 will also receive 12 months benefit from the point of conversion.

127. No one will receive less than 12 months contributory ESA, and those who were reassessed early in the process will receive more than a years benefit entitlement by the time the change comes into effect. Introducing a time limit of a year from the individual date of conversion will ensure that reassessment cases are treated in the same way as new ESA claims.

Back to work Support for customers moving onto ESA

128. The vast majority of ESA customers who want the more intensive support offered by the Work Programme will be able to access it as soon as they are placed in the WRAG or Support Group. Additionally, where a Healthcare Professional assesses that a return to work in six months or less is likely, the customer will be required to access the Work Programme if they receive income-related ESA. This will place these customers in the best possible position to return to work once they are well enough to do so.

129. Contributory ESA customers will be able to volunteer for the Work Programme, and if they wish, remain on the Programme after their benefit has come to an end.

130. Most ESA customers in the WRAG who do not access the Work Programme will be expected to prepare for a return to work with support from Jobcentre Plus. Those with greater disability related barriers to work may be referred to Work Choice, if mainstream support is not appropriate for them. Work Choice helps people with more severe disabilities or complex needs to prepare for work and to undertake supported employment, with the aim of progressing into unsupported employment where possible.

131. Disabled people will also have access to Residential Training College provision, which can provide intensive support and training, in particular for people with sensory impairments or very complex barriers to work. Where a disabled person moves into work, Access to Work can provide funds for support over and above that which an employer could reasonably be expected to provide.

132. Subject to the passage of secondary legislation, from June 2011 advisers will be able to require customers in the ESA WRAG, with some exceptions, to undertake work related activity to prepare for a return to work.

Back to work support for customers claiming JSA

133. Most people who make a claim for Jobseeker's Allowance are able to move off benefit relatively quickly. This reflects in part that the labour market is dynamic, with thousands of new job opportunities coming

up every day, so that people who are actively looking for a job have a good chance of finding one. However, the Department recognises that former Incapacity Benefits claimants who choose to claim JSA may need extra support to find work compared to a typical claimant, particularly at a time when unemployment remains high following the recession.

134. Therefore, customers who move from Incapacity Benefits on to JSA will be able to access the Work Programme from three months into their claim, recognising the additional challenges that may be faced by jobseekers that have been away from the labour market for a long time. They will receive personalised support from Jobcentre Plus before their Work Programme referral.

135. Customers on JSA must actively seek work and be available for work. However, the requirement may be tailored to individual circumstances. For example, an adviser may agree with a customer that he or she can limit his or her availability for work to a certain number of hours, in light of a health condition or caring responsibilities.

The Work Programme offer

136. For customers entering the Work Programme, the Government is clear that providers are best placed to know what works for customers and as such the Government will not specify what providers should deliver. This means that the exact nature of the support provided will vary from provider to provider, and from customer to customer.

137. However, all bidders for Work Programme contracts have been asked to provide a summary in their tender of the minimum service they will offer to all customer groups. These promised service levels will be made public so that customers and their representatives will be able to judge whether providers are delivering what they have promised.

138. All customers will be attached to the Work Programme for two years, or until the provider has received all the sustainment payments that they are able to, as a result of the customer spending a sustained period in work. During this period the customer will remain attached to the programme whether they are in work or not, incentivising providers to help customers stay in, as well as find, work.

The Jobcentre Plus offer

139. Jobcentre Plus managers and advisers will have more flexibility to judge which interventions will help individual customers. Advisers will be able to refer customers to a flexible menu of activities for additional support, to complement one-to-one support from an adviser. The specific options will depend on local circumstances but are likely to include services such as job brokering, Next Steps skills training, Work Clubs, support for those seeking to move into self employment, and Service Academies. They will also be able to refer customers to external services such as those provided by the voluntary sector or health service, supported by resources from a Flexible Fund where appropriate.

TIMETABLE AND SEQUENCING OF NATIONAL REASSESSMENT

140. The reassessment exercise is scheduled to be completed by April 2014. Customers receiving Incapacity Benefit and Income Support paid on the grounds of illness or disability, previously attended Personal Capability Assessments (PCA) to determine and review their entitlement for benefit. The order in which customers will be selected for reassessment will be based upon the date on which they would otherwise have been called for their next PCA. Customers currently claiming Severe Disablement Allowance will be reassessed at the end of the reassessment process.

141. The national rollout of reassessment is being undertaken in three stages:

- On 28 February 2011, a limited introductory phase was implemented. This involved the extension of the controlled trial conditions nationwide, with around 1,000 customers commencing their reassessment journeys every week, for five weeks.
- On 4 April 2011 national reassessment was implemented. From this date around 7,000 customers a week are being reassessed.
- On 9 May 2011 this number will be increased to around 11,000 cases per week.

142. This steady increase in activity has been designed to ensure that Jobcentre Plus and its partners are ready for and could deal with customers effectively as the volumes built. The approach also meant that the lessons learned from the trial in Aberdeen and Burnley could be shared across all centres and progress carefully monitored. Importantly, the timetable also enabled many of the findings in the recent Professor Harrington review of the Work Capability Assessment to be put into practice.

143. The Department is committed to continually monitoring and reviewing the reassessment process. Management information is reviewed at a senior level, supported by regular and close liaison between the project and operational working teams. Plans are currently on track. Further improvements will be incorporated

into the reassessment process going forward as they are identified. The Department is confident that it has the capacity to deliver the reassessment exercise to the agreed timetable.

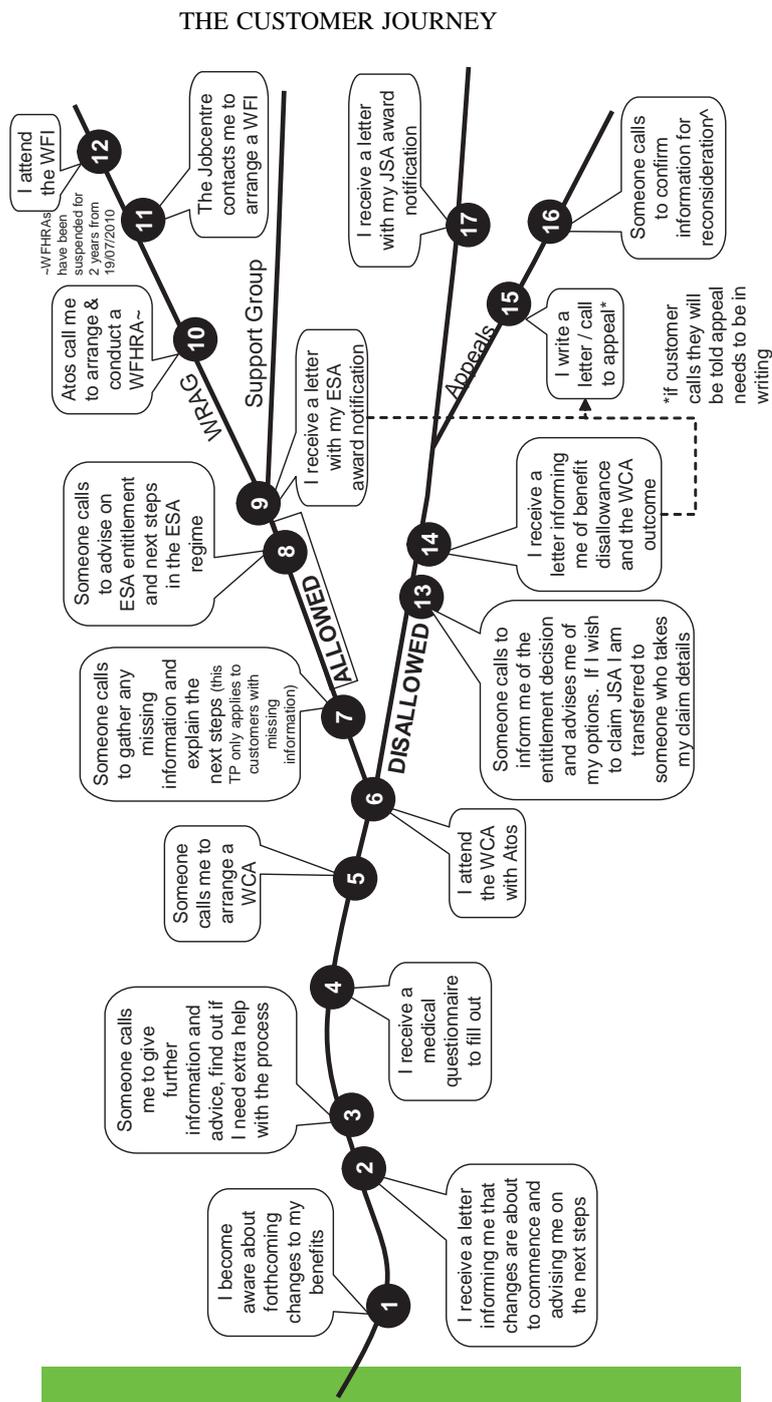
April 2011

Annex A

SUMMARY OF KEY FACTS

- No new claim will be required for reassessment of Incapacity Benefits, the process will be triggered by a notice to the customer.
- The date of a customer's reassessment will be based on the review date of their Personal Capability Assessment. Customers exempt from undertaking a Personal Capability Assessment will have a review date set.
- People already over State Pension age or who reach State Pension age before April 2014 will not be reassessed.
- Where possible, the Department will use existing data held for Incapacity Benefits claims to determine entitlement to Employment and Support Allowance.
- The Department will help customers adapt to their new circumstances and ensure continuity of payment is maintained.
- Existing awards of incapacity benefits will continue to be paid to the day before the conversion decision takes effect, whether or not those awards qualify for conversion to Employment and Support Allowance.
- Where people who are eligible for Employment and Support Allowance receive more on existing Incapacity Benefits than the appropriate Employment and Support Allowance rate, their existing rate of benefit will be protected at the point of conversion.
- Where people who are eligible for Employment and Support Allowance receive less on Incapacity Benefits than the appropriate Employment and Support Allowance rate, their benefit will immediately be increased to the Employment and Support Allowance rate on conversion.
- On conversion to contribution-based Employment and Support Allowance, all customers are liable to income tax on the rates payable, regardless of whether their previous benefit was exempt from tax.
- Contribution-based Employment and Support Allowance is a taxable income for Tax Credits purposes, so the rate of Tax Credits may be affected if the customer previously received Severe Disablement Allowance or non-taxable Incapacity Benefit.
- All claims to Incapacity Benefits on or after 31 January 2011 will be treated as new Employment and Support Allowance claims—there will be no link to earlier claims for Incapacity Benefits.
- Where a person is appealing against a decision that their award does not qualify for conversion to Employment and Support Allowance, and this decision was made on the basis that the person failed to meet the Work Capability Assessment threshold, Employment and Support Allowance will be paid, pending the outcome of the appeal, at a rate equivalent to the rate that new Employment and Support Allowance customers receive in the 13 week assessment phase at the beginning of their claim.
- The Housing Benefit/Council Tax Benefit Regulations have been amended to ensure that the majority of customers moving onto Employment and Support Allowance will see no reduction in their overall benefits income solely because of this change (however, some Child Dependency Allowance customers may be affected by the change).

Reassessment of Incapacity Benefits Customer journey



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OVERVIEW OF THE ATOS HEALTHCARE PROCESS

- Customer referrals for ESA are either electronically registered by Jobcentre Plus staff and sent to Atos Healthcare or sent via an electronic interface (IB Reassessment customers only). A central print facility then sends a medical questionnaire to the customer along with an information leaflet.
- When Atos Healthcare receives the questionnaire, a Healthcare Professional will assess whether the customer is to be called for assessment or qualifies for the Support Group or WRAG based on the paper evidence alone.
- Details of customers who are to be assessed are then entered onto the workflow system, MSRS (Medical Services Referrals System). Separately dedicated Resource Management Teams will manage Healthcare Professional capacity to meet the volumes of customers requiring assessments.

- The customer is then contacted by staff operating out of two dedicated “Virtual” Contact Centres, situated in Cardiff and Newcastle, to agree an appointment date. A letter is sent to confirm the appointment along with an information leaflet confirming the date, providing directions to the assessment centre and additional information about the assessment.
- If the Contact Centre agent is not able to contact the customer by telephone, an appointment letter is issued to them by post.
- The requirement laid down by the Department is that under normal circumstances, customers are not asked to travel more than ninety minutes by public transport.
- A customer can request a home visit. They may need to provide medical evidence from their GP to confirm they are not able to travel to an assessment centre.
- When the customer arrives at the assessment centre, the receptionist takes their details and the healthcare professional carries out the assessment.
- The report which is produced following the assessment advises the DWP decision maker if the customer has Limited Capability for Work or Limited Capability for Work Related Activity. The decision maker uses the report to help them make the decision on benefit.

Supplementary written evidence submitted by DWP

CLARIFICATION TO SELECT COMMITTEE—ORAL EVIDENCE SESSION 8 JUNE 2011

During the Committee's evidence session, I promised to write to clarify three points

Firstly I will clarify the length of contract extension awarded to Atos Healthcare. The letter of 28 September from the Secretary of State to you as the Chair of the Committee explained that while officials had negotiated an extension to 2017 there would be no decision on whether to grant the extension until the autumn. I can confirm that an extension to 31 August 2015 was subsequently awarded to Atos Healthcare on 1 November 2010.

The Committee also asked for the number of Atos Healthcare reports, arising from the Work Capability Assessment, sent back by DWP decision-makers because they were not of an acceptable quality. I can confirm that for the period 1 March 2011 to 31 May 2011 the total number of Work Capability Assessments returned to Atos Healthcare by my Department's decision makers because they were not acceptable is 306 of 138,573, ie 0.22%.

I also promised to write to clarify a point raised by Karen Bradley MP (question 272) regarding the wording of a poster that she viewed during the visit to the Marylebone MEC. In particular, Karen was concerned about the use of the following phrase: “ESA entitlement test” within the poster. I can confirm that the poster is one that is not displayed in public areas of examination centres. Instead it is an educational tool used to explain both to staff and visitors the Atos Healthcare contribution to the Employment and Support Allowance (ESA) regime and how that fits into the overall process. The poster was displayed in the assessment room in Marylebone MEC on 7 June purely for the information of Committee members and it was removed before the afternoon sessions commenced.

Additionally, having now had the opportunity to view and further consider the poster's content, I can confirm that there is no reference to an “entitlement test” contained within it.

Rt Hon Chris Grayling MP
Minister for Employment

15 June 2011

Written evidence submitted by the Careers Development Group

EXECUTIVE SUMMARY

1. Welfare to work charity Careers Development Group (CDG) supports the overarching principles of the Work Capability Assessment (WCA). It welcomes the coalition Government's commitment to reassess the capability of Incapacity Benefit (IB) claimants to participate in work-related activity leading to employment.

2. CDG also welcomes the recommendations to improve the WCA made by the Independent Review of the WCA by Professor Malcolm Harrington¹ and welcomes the Government's commitment to implementing its recommendations in full. In particular, we support the coalition Government's commitment to refine the WCA's mental, cognitive and intellectual descriptors. In CDG's experience it has been those customers with primary or secondary health conditions who have fallen under this category who have occasionally felt that the WCA has not effectively and accurately assessed their capability to work.

3. This is of particular importance to the Work Programme, as former IB claimants will be a key customer group for CDG to work with throughout contract delivery. Currently, 46%ⁱⁱ of IB claimants in London claim IB due to mental health conditions. CDG therefore welcomes continued improvement of the WCA to ensure migrating IB customers receive effective back to work support through the Work Programme.

4. CDG is pleased the coalition Government recognises the more complex employability support needs of former IB customers through the Work Programme. This enables providers to more effectively meet these needs by encouraging the use of a flexible and personalised “black box delivery methodology”. The more intensive and bespoke service required by former IB customers during the Work Programme has also been reflected in the payment and performance targets for this customer group.

5. However, CDG is raising the importance of ensuring there is a high level of accuracy on every individual’s WCA. This will mitigate any adverse impact on customers’ wellbeing through the ongoing WCAs that occur throughout the duration of the Work Programme for former IB claimants and Employment Support Allowance (ESA) claimants.

6. The importance of accurate and consistent results from an individual’s WCA throughout their time on the Work Programme is vital, due to the potential impact on prime providers if individuals move between Work Programme customer groups as a result of ongoing WCAs. This also applies to the proposed changes claimant conditionality for the ESA Work Related Activity Group outlined in the Welfare Reform Bill.

7. CDG welcomes the opportunity to submit evidence to the Work and Pensions Committee in relation to the migration process and the different paths taken by the various customers.

OVERVIEW OF CAREERS DEVELOPMENT GROUP

8. CDG is a welfare to work charity with nearly 30 years’ experience in helping those who are unemployed find and sustain employment. Many of the people CDG supports have multiple barriers to employment including a lack of recent work experience and disabilities. CDG’s customers include those claiming IB, ESA, JSA (Jobseekers’ allowance) and individuals with health conditions. The charity provides its customers with training, work experience and the support necessary to move into and sustain employment and to achieve a better quality of life.

9. With over 350 employees, CDG currently operates from 27 centres across London, the South East and the East Midlands. In 2009–10, CDG supported 33,000 people on their journey back into work.

10. The charity provides employment programmes as both a prime contractor and subcontractor including New Deal, Flexible New Deal, Pathways to Work, Work Choice and European Social Fund contracts.

11. In April 2011, CDG received preferred bidder status as a prime contractor for the Work Programme in London East, and as part of an alliance with MAXIMUS this status was received in London West and the Berkshire, Buckinghamshire, Oxfordshire, Hampshire and the Isle of Wight contract package area. Throughout the life of these Work Programme contracts it is estimated that CDG will support approximately 100,000 customers.

INTRODUCTION

12. CDG is delighted to respond to this inquiry and CDG has provided evidence based on its knowledge of the Work Capability Assessment through its introduction in 2008 which has impacted on the delivery and its customers’ experience of the Pathways to Work subcontract.

13. Pathways to Work is a national programme to support individuals with mild to moderate health problems claiming IB and ESA back into sustained employment. Jobcentre Plus provides the programme in 40% of the country with the private and voluntary sector providing the programme in 60% of the country. CDG delivers Pathways to Work as a subcontractor in Sussex, and has worked with over 400 customers on the provision since delivery commenced in 2008. The contract is due to end on 27 April 2011.

14. CDG is also responding to the inquiry in its capacity as a charity and a future provider of the Work Programme.

15. Based on its experience CDG believes that it is most appropriate to respond to the following issue in this inquiry:

16. *“The outcome of the migration process and the different paths taken by the various client groups: those moved to Jobseeker’s Allowance, including the support provided to find work and the impact of the labour market on employment prospects; those found fit for work who may be entitled to no further benefits; those placed in the Work Related Activity Group of the ESA, including the likely impact of the Department’s decision to time-limit contribution-based ESA to a year; and those placed in the Support Group.”*

17. As a charity that seeks to help those who are unemployed to find and sustain employment, many of whom suffer from health related barriers to working, CDG believes that a refined Work Capability Assessment will ensure that it is better able to provide relevant support to progress our customers into sustainable work.

18. CDG's experience on Pathways to Work demonstrates a number of challenges related to ongoing WCAs at regular intervals in a customer's ESA claim, which has impacted both on our customers' ability to secure suitable work and on our ability to provide the most appropriate support level to customers. An improved assessment will lead to customers being allocated to the most appropriate customer group on the Work Programme, consequently improving customers well being and their ability to find and sustain work.

Impact on customers' well being of ongoing WCAs

19. The experiences of the charity's Pathways to Work customers have been overall positive, with regard to the WCA. However, there are a small number of issues that could be refined, particularly regarding customers with cognitive and mental health problems.

20. Currently, customers access Pathways to Work provision if they have been allocated to the ESA Work Related Activity Group (WRAG) after their first WCA has been completed. Customers in the ESA Support Group and IB customers can volunteer to access Pathways to Work at any time.

21. Once allocated to the ESA WRAG group customers will be expected to participate in additional limited capability to work assessments—the medical evaluation part of the WCA. This includes customers participating in back to work provision such as Pathways to Work.

22. On CDG's Pathways to Work provision, customers have sometimes experienced a lack of consistent decision making within the WCA process. ESA WRAG customers undertaking subsequent WCAs, particularly those with mental health related problems, have been deemed fit for work as a result of the follow up WCAs, despite a lack of perceived change in their health condition. In addition, some customers who have been moved into the ESA WRAG group as a result of a successful appeal have also experienced being deemed fit for work in a follow up WCA shortly after the appeal's outcome. It is therefore imperative that the WCA process is consistent and accurate for future customers.

23. Where customers believe they have been assigned the wrong benefit this can particularly lead to significant distress and anxiety and in some circumstances can accentuate existing mental health conditions.

24. Some customers who believe an inappropriate decision has been made following WCA have decided to make an appeal. Of the charity's Pathways to Work customers expressing concern with the outcome of their WCA, CDG has offered support to prepare for and navigate the appeals process. This has been on the basis of facilitating the achievement of an accurate and decisive outcome.

25. The appeals process places a lot of emotional strain on customers and they can spend a significant amount of time contesting the decision. The uncertainty and time consuming nature of the appeals process can be counter-productive if it reduces the amount of time and effort they spend on preparing for and looking for employment.

26. This occasional lack of consistency with the WCA combined with the stress and anxiety of undertaking an appeal can create an additional barrier to work for some of the most vulnerable customers with health problems. The implementation of the recommendations of the Harrington report will in the long-term lead to the refinement of the WCA. This in turn will lead to a more accurate assessment of an individual's capability to work, fewer appeals and an increased capability for customers to find and enter work.

Impact on Work Programme prime providers of ongoing WCAs

27. The Work Programme enables providers to deliver a personalised journey for each customer dependent on individual needs and CDG wholeheartedly supports this approach. Alongside employability training and back to work support, providers are able to work in partnership with a range of specialist organisations to tackle customer's barriers to work. This can include through condition management programmes, drug and alcohol support and rehabilitation, specialist support for people with learning disabilities and mental health issues.

28. Work Programme customers will be divided into eight different customer groups dependent on benefit claimed and the level of support they require to help them return to work. There are two customer groups specifically for former IB claimants: ESA ex-IB and JSA (Jobseekers Allowance) ex-IB.

29. The payment structure for the Work Programme is dependent on the type of benefit that customers are claiming and their previous benefit status. It allows more money to be paid for customers with a greater level of need. For example, providers will be paid more to support former IB customers claiming JSA into work than JSA customers aged 18–24 due to the more complex, often health related, support needs former IB customers experience on their journey into work. The level of need is defined by their current and previous benefit type. Therefore it is of paramount importance that the WCA leads to the customer being transferred to the correct benefit at the earliest opportunity. A full overview of the levels of payment for each Work Programme customer group can be found on page 10 of the Work Programme specification document.ⁱⁱⁱ

30. If WCA does not lead to the correct decision being made regarding a customer's readiness for employment, prime providers may not be in the best position to provide the required level of support because of financial restrictions in the Work Programme payment structure. Customers could potentially be initially

allocated to the JSA ex-IB Work Programme customer group and could then be moved into the ESA ex-IB customer group after an appeal or subsequent WCA. This could lead to providers receiving initially a lower amount of funding to support more disadvantaged customers thereby limiting the amount of support they are able to buy in from specialist support agencies across their partnership network. This could have an effect on each customer's ability to move towards and enter employment. This is why it is vital that WCAs are accurate and consistent throughout delivery, to ensure that customers can fully receive the right level of individualised support to enable them to move into work.

31. On CDG's Pathways to Work contract, where customers believe they have not been allocated to the correct benefit, the charity has been required to provide considerable additional support to overcome the resultant emotional issues encountered by our customers. This is particularly the case for those with cognitive and mental health problems. This is in addition to delivering the employability and motivational support required by the Pathways to Work contract.

32. The charity envisages that a similar level of support would need to be provided in such circumstances in the Work Programme contract. In London, 46% of IB claimants receive this benefit due to mental health problems. Refinement of the WCA will lead to a more effective assessment of a IB customers' long term work capability, however, this may not happen until Professor Harrington's working group reports back on how to further improve the WCA for customers with mental, intellectual and cognitive problems.

33. The importance of consistency and accuracy can also be seen in the implications of the proposed changes to the claim period for contributions-based ESA customers allocated to the ESA WRAG group. Under the Government's welfare reform proposals, these customers would lose eligibility to claim the benefit after one year of unemployment. As per the previous example, this could lead to customers moving from the ESA Flow Work Programme customer group and into one of the JSA customer groups. This changes the payment received by the provider for the customer, which could potentially affect the level of support providers could offer the customer. In addition, many of the Pathways to Work customers the charity works with who have more complex health needs, for example those with Multiple Sclerosis, potentially need longer than one year to move into employment.

34. Ongoing WCAs and changes to the ESA claim period could mean that a customer's status changes a number of times during their engagement on the Work Programme. This could cause confusion amongst providers around the payment structure and the level of support they are thus able to provide to customers. It is therefore vital that WCAs are accurate and consistent to support both providers and more importantly, customers.

35. Where customers decide to appeal a decision, previous experience through CDG's Pathways to Work contract demonstrates further support is required to help customers manage the appeals process. In some instances, support from CDG's team of advisors has been very extensive and has included help to complete the appeal form, continual emotional support and advice throughout the process, ongoing liaison with Atos Healthcare, liaison with GPs and contacting tribunal telephone lines on behalf of customers. This is to facilitate the achievement of an accurate and decisive outcome. Based on our previous experience CDG envisages that a similar level of support will need to be provided to customers throughout the appeals process whilst on the Work Programme. The consistency and accuracy of WCAs are imperative to the success of the Work Programme.

CONCLUSION

36. CDG welcomes the Government's improvements to the Work Capability Assessment as recommended in the Harrington report. The charity anticipates that the impact of these changes, particularly for customers with mental health problems, will be positive and that the changes will go some way to address the issues faced previously by our customers particularly those who have appealed a WCA decision.

37. In addition, CDG has raised the importance of clarity regarding how the movements between Work Programme customer groups as a result of WCA decisions will impact on our customers' abilities to find work and on the payments to prime providers. The charity is confident the coalition Government will address this.

REFERENCES

ⁱ Harrington, M (2010), An Independent Review of the Work Capability Assessment.

ⁱⁱ Office of National Statistics, IB/SDA statistics for small areas, November 2010.

ⁱⁱⁱ Department of Work and Pensions, (2010) Work Programme Invitation to Tender, Specification and Supporting Information.

Written evidence submitted by Citizens Advice

INTRODUCTION

The Citizens Advice service consists of the national charity, Citizens Advice, and a network of local bureaux—all of which are independent charities. Together we help people resolve their money, benefits, employment and other problems. We provide free, impartial and confidential advice, and we use our evidence to influence policy makers, to improve the lives of our clients.

In 2009—10, Citizens Advice Bureaux in England and Wales advised 2.1 million clients on 7.1 million problems—an 18% increase from the previous year. We advised on 209,641 enquiries about Incapacity Benefits, including 147,286 on ESA. Bureaux in Burnley have monitored enquiries from clients being reassessed on the pilot process, and we have designed an “ESA diary” for clients to describe their experiences. We are therefore well-placed to comment on the subject of this inquiry.

THE DEPARTMENT’S COMMUNICATIONS TO CUSTOMERS

DWP consulted stakeholders at each stage of the process, and the resulting customer journey shows evidence of this. Citizens Advice Bureaux in the trial area handled relatively few enquiries from anxious clients, suggesting that the telephoning of claimants at key stages in the journey was helpful and reassuring.

We do have concerns, however, about claimants who don’t have telephones. Vulnerable people, such as those with mental health problems or learning difficulties, are disproportionately unlikely to have telephones.

We understand from one claimant who doesn’t have a telephone that the letter from DWP gives an 0845 number for customers without a telephone. When the claimant rang it, the person who answered knew nothing about the arrangements of the trial, and offered no further help.

It is important that procedures are put in place to ensure that people who are hard to reach do not miss out on help and support that they are likely to need with the assessment process.

We also have concerns about the communication of the decision, and information on appeals, which we develop below.

THE WORK CAPABILITY ASSESSMENT

The process

A full assessment is made up of several stages:

- Collection of evidence from the claimant about how their condition/disability affects their ability to function. Face to face assessments by HCPs are an inefficient and expensive way to do this.
- Verification of the claimant’s condition/impairment and its level of severity. We believe that there should be greater reference to the client’s medical records, especially when there have been investigations by a consultant.
- A decision as to whether what the claimant says about their level of functioning fits with what is known about that condition/impairment. The DWP Disability and Carers Service has built up a detailed database which describes the likely effects on functioning of a given level of condition/impairment.

The assessment and its descriptors

We consider that any assessment tool based purely on a functional assessment cannot fairly assess whether someone should be awarded sickness benefit. With a functional assessment, wherever the threshold is set, there will be people who meet the criteria for benefit but who could work—such as Professor Stephen Hawkins. Conversely, there will be people who don’t meet the functional criteria, but who cannot work.

A man in his late fifties who has done manual work all his life, has a physiological age of 80 years, struggles to walk more than 60 metres because of heart problems and emphysema, and is unlikely to live to draw a state pension, will be found fit for work.

A CAB in the South East saw a client who had to stop work as a cleaner because of severe breathlessness caused by emphysema. After his statutory sick pay ran out, he applied for ESA but was found fit for work. The bureau helped him to appeal this decision, and noted that the worry of appealing was exacerbating his breathlessness. Five months later—while the appeal was still pending—his son rang to tell the bureau that his father had died: the cause of death was a heart attack and emphysema.

The new regulations which came into force in April will restrict still further the number of descriptors under which people in this situation can qualify. They are likely to score points only under the walking descriptor, whereas at present they would probably score points under the walking, standing and bending descriptors.

A client of a Yorkshire bureau had cancer. He had had his oesophagus and part of his stomach removed, and was initially placed in the Support Group under the special rules.

After six months, he was sent for an assessment and placed in the Work Related Activity Group. He was awarded nine points because he was unable to walk more than 100 metres and six points for not being able to stand for more than 30 minutes without needing to sit down. The bureau helped him to appeal, as his doctors still considered him terminally ill, but the decision maker refused to change the decision. The client died shortly afterwards, leaving his family feeling very angry that he was put through this stress in the last few weeks of his life.

Under the new regulations this man would have been found fit for work, as he would have scored no points for his limited ability to stand, and so would not have attained the necessary 15 points to be allocated to the Support Group.

As a result of the first year review, led by Professor Harrington, work has started on refining the mental, intellectual and cognitive descriptors for the WCA. The Professor has also asked Citizens Advice to report on whether the assessment could and should incorporate more “real world” elements, following our arguments for a “real world” test (see our report *Not Working*⁸). Citizens Advice believes that the new regulations should be suspended until Professor Harrington reports back at the end of the second review year, and DWP have acted on his findings.

Customers’ experiences of the process

CAB clients report varied experiences of the manner and politeness of Healthcare Professionals (HCPs), but we consistently hear descriptions of the poor delivery of the assessment, including concentration on the computer rather than eye contact with the claimant; closed questions; lack of time given to answer fully; and repetition of “just answer yes or no.” In these conditions, it is impossible to take an accurate history that reflects variability, or general pain.

A CAB in the South West saw a client who was a barrister, but was unable to practise because of cancer and lymphoma. She described the assessment as like an “interrogation” led by a computer, held in a bleak assessment centre, by unprofessional HCPs. The HCP moved the client’s legs which caused her great pain, even though she had forewarned the assessor that this would happen. The client said she was shocked by the way claimants were treated and sent a complaint to Atos.

This does not encourage clients to talk about sensitive topics:

One bureau described a client with learning difficulties who went for an assessment. He was awarded some points for physical limitations, but none for his learning difficulties and was found fit for work. One of the key reasons given was that he had found his way to the assessment centre on his own. When the CAB adviser asked him about this, he explained that he had got up very early, taken the bus to the town centre and then kept asking passers-by. He couldn’t follow instructions, so he would show the letter, walk in the direction they pointed, then ask again until he arrived at his destination. This man was very sensitive about his learning difficulties and had developed strategies for hiding them. The closed question “Did you come on your own?” clearly failed to elucidate this information. (CAB evidence enabled the decision to be overturned).

The accuracy of medical reports

Citizens Advice has had long-standing concerns about the lack of accuracy in Atos reports. We have several years of evidence, including some extraordinarily inaccurate assessments. It is alleged that our evidence is selective and not representative, but CAB welfare rights workers consider this is a systemic problem.

To assess the extent to which these problems are systemic, Citizens Advice is surveying clients identified in advance of their assessments. Before the assessment, they agree to ask for their report afterwards. Once they have received their report, they check the accuracy of the record and the basis on which they were, or were not, found fit for work. Initial results confirm that there are significant mistakes in a majority of the reports, and serious errors in some.

Recommendation: We would like to see the reliability of the WCA tests independently measured, using the standard measures of the accuracy of any diagnostic or classificatory test (its false positives and false negatives), and research into the most accurate methods of assessment.

The role of UNUM

We are concerned about the apparent conflict of interest between UNUM’s role in the internal review governing entitlement to ESA, and their commercial interests as a leading provider of health insurance. There is clear potential for a financial motivation in undermining the benefit payable by the state, when someone is too ill to work.

THE DECISION-MAKING PROCESS

In our report *Not working*, one of our key recommendations was the need for a thorough consideration—and re-consideration—by the DWP decision maker (DM), not simply a rubber stamping of the Atos

⁸ http://www.citizensadvice.org.uk/not_working

recommendation. We are very pleased that this concern was taken seriously by both Jobcentre Plus and Professor Harrington, and there is now some movement on the issue. We hear from welfare rights workers that when strong evidence is presented, decisions are sometimes—though far from always—reconsidered in the client’s favour, without going to a tribunal.

In the recent trial of the process for the reassessment of Incapacity Benefit (IB) claimants, claimants were encouraged to send medical evidence with their ESA50 forms. DMs were also encouraged to take account of other evidence than that provided by Atos. We welcome these steps, which we see as significant improvements. Ideally, we would like to see medical evidence—or evidence from other relevant professionals—sought in all cases.

We are concerned, however, that it is the claimant’s responsibility to produce such evidence. Some clients are unable to get such evidence because GPs frequently charge for the information. Someone receiving £65 per week for all their living expenses will not be able to pay £30 for a letter. A two tier system will emerge if those who can afford to pay for medical evidence are more likely to be found eligible for ESA.

THE APPEALS PROCESS

In the recent trial, before the DM made the formal decision to find someone fit for work, they rang the claimant to discuss the assessment, to ask if the claimant disagreed with the conclusions about their level of functioning, and if so, whether they were likely to provide further supporting evidence. This call—named “touchpoint 13”—has the potential to be very positive, and to save claimants the stress of an appeal and tribunal hearing. However, we believe that safeguards are necessary to ensure that these calls do not become a mechanism to persuade someone that it isn’t worth appealing when they have a strong case.

If someone does have a good case for appeal, they stand a much better chance if they are represented. A client, or even a health professional, can often find it difficult to know what will be relevant:

An adviser from a CAB in Yorkshire saw a client who came to the bureau, astounded after losing her appeal at tribunal. She was too ill to attend the hearing, but had sent very strong letters from her GP, her consultant and her physiotherapist, all of whom had said very clearly that in their opinion, she could not work. The reason she had lost was that neither she nor the health professionals had realised that the tribunal did not need their opinion on whether she could work. The legal issue was whether she had been awarded the right number of points on the various descriptors, which the letters did not address.

The DWP has had to provide additional funding to the Tribunals Service to manage extra demand since the introduction of ESA in 2008, and the number of appeals is likely to increase again in the next few years because of:

- the IB reassessment process;
- the time limit of one year for ESA(CB) for those in the WRAG;
- the introduction of a large financial difference between the Support Group and WRAG, when the Welfare Reform Bill is enacted; and
- the introduction of face to face assessments for PIP.

We are very concerned that support through legal aid will no longer be available, so there will be a huge cutback in welfare rights workers. We believe that many more people will face the wrong decision, as a result of these cuts. There is likely to be more strain on the appeals service, and judges and doctors will be asked to spend more time helping unadvised and unrepresented clients.

EVIDENCE OF DIFFERENT OUTCOMES FOR VARIOUS CLIENT GROUPS

Research shows that claimants who move off benefits and re-enter work generally experience improvements in income, health and well being. However, it is vital that someone is not forced into taking a job that makes their condition worse.

A client had his ESA stopped after being assessed and found fit for work. He had a congenital hip problem but had worked all his life as a plasterer. After a serious fall, he was in a great deal of pain and could not do his old job. His wife worked, but they struggled to manage financially since he had stopped work, and they couldn’t manage with the loss of his ESA as well. He felt he had no option but to take a job working in a supermarket, despite this work causing him severe pain and a resulting change in personality that nearly broke his marriage of over 30 years. He won his tribunal, but was very angry that the benefits system failed to support him when he most needed it, after having paid contributions all his life.

Others who have their benefits stopped may be faced with having no job at all. Research not only demonstrates the benefits of good work, it also demonstrates that:

“those who move off benefits but do not enter work are more likely to report a deterioration in health and well being”⁹

⁹ Waddell and Burton (2006) *Is work good for your health and wellbeing?*

Limiting of ESA(CB) for those in the WRAG to one year

A number of people will not be eligible for income-based ESA after one year on contribution-based ESA, either because of savings, or because of other income in the household. This could typically be a drop in household income from, say, £500 per week when the main earner was in work, to £150 per week if a partner is in low-paid or part-time work. We are concerned that many more people will find themselves in the position of choosing between a totally unsuitable job which aggravates their condition, or having no income of their own and struggling financially. Many of these will be people who have worked and paid contributions all their working lives, but whose life expectancy means that they will not live long enough to draw a retirement pension.

We are currently conducting a survey on our website, of people who are claiming ESA(CB), are placed in the WRAG group, and have a partner who works, or have savings over £16,000. One very clear message already coming through, is that people feel betrayed because, after working for many years and paying their contributions, the system will not help them when they need it. Some respondents with mental health problems express their feelings of hopelessness if their benefit stops, and some say that they will end their lives. Most respondents are very worried about how they will cope:

One woman dictated her response to her daughter to send in: she and her husband both worked until she lost her sight. She is now unable to cope with all the everyday tasks unaided, and she is unable to leave the house safely on her own. Since she had to give up her job, they have struggled to manage financially, as her husband's wages pay the mortgage and all the household bills, while her ESA pays for their family's food and other expenses. Since she heard that her ESA is likely to be stopped, she says she has not stopped crying, as she thinks there is no way they can manage financially and they will lose their home.

Many of those found fit for work will not be able to look for work

We are also concerned for those who are found fit for work. The new descriptors for the WCA have been brought in with reference to a modern office environment, but with no reference to how someone could actually look for work. A person who can walk only 50 to 100 meters, has difficulty standing for long, and receives just £65 per week to live on, will have considerable difficulty getting to the jobcentre to sign on, getting to the library to do a job search, and getting to interviews—especially as they are likely to be reliant on public transport. While, in principle, reasonable adjustments have to be made, we fear that, in practice, many such claimants will find themselves sanctioned.

We think it is vital, as Professor Harrington has recommended, that research is rapidly undertaken to find out what happens to people who are found fit for work, or have their benefit stopped at the end of a year in the WRAG. We also think this research should examine whether people actually move further away from support and help—especially those who are not entitled to JSA—and are therefore less likely to move into work.

IMPLICATIONS FOR THE NATIONAL ROLL-OUT OF THE REASSESSMENT

We strongly recommend that the new WCA descriptors are not applied, at least until Professor Harrington has reported back at the end of his second year review.

We are already seeing some signs that shortcuts will be taken with the process, as the system struggles to manage the high volume of reassessments: the telephone call to new ESA claimants who are going to be found fit for work, is *not* being made by a decision maker. This means that the caller therefore simply explains the decision, without offering an informed discussion about whether the client may have other evidence. As outlined above, this is much more likely to result in pressure to drop an appeal and claim JSA, even if the client has a good case to take to appeal.

April 2011

Written evidence submitted by Professor Paul Gregg

In 2008 the previous Labour government introduced a new benefit for the sick and disabled called the Employment Support Allowance (ESA). The new benefit replaced two existing benefits for new claims on its introduction but at its heart were two major differences. First, was a new test called the Work Capability Assessment (WCA), to determine eligibility for the benefit and for the majority of claimants, called the Work Related Activity Group (WRAG) there was to be a new regime of personalised support and engagement to help people back to work (which I designed). The new regime initially applied only to new claimants but this week existing claimants are starting to be re-tested under the new WCA test and may potentially be reclassified as Fit for Work.

There are two major reasons why getting this transition process right is critical. First, this is a large and vulnerable group and thus the introduction of the new benefit eligibility test has the potential to cause huge anxiety and distress to people. Many, especially those with mental health problems, may well fall into the sizable crack between ESA and JSA (unemployment benefit) and end up destitute, homeless or worse. Second, those denied access to the benefit are likely to end up on unemployment benefits which are not designed to

help sick people back to work. Under the new Work Programme providers are paid to get claimants into sustained work are divided into three groups, the first are mainly adult unemployed who receive help after 12 months claiming benefits. Here the payment to a provider for getting them into work for a year will be of the order of £3,500. Those “being found fit for work” and hence signing on as unemployed rather than disabled will normally be allocated to this group, although if they were previously claiming Incapacity Benefit they will get the help after three months. For those on ESA the package of support starts immediately and providers will be paid about £14,000 if they get someone into work for two years. Getting the sick and disabled in the right category thus matters greatly in terms of the chances of helping them into work. Those on unemployment benefits with significant barriers to work may well be ignored by providers as offering little hope of a pay off given the high investment needed to get them back to work.

Given the imperative of getting people into the right category, common sense would suggest the Government should move slowly and check at each stage that any changes were working. So starting with new claimants makes sense and a five year review process was specified in the original legislation I believe. Yet the developments so far have been deeply flawed. Concerns with the WCA test emerged in late 2009–early 2010 with strong reports of major problems, especially around individuals with cancer, mental health problems and variable conditions. It also emerged that a huge number of cases were going to appeal, jamming the system, and often being overturned. The Government responded with changes to address these issues, but there were no subsequent checks that the problems had been dealt with. In fact, the cries of anguish continued unabated. In the summer of 2010, Prof. Malcolm Harrington was commissioned to undertake the first major review and it was quickly apparent that he saw the need for extensive changes to the process of the decision making after the test was undertaken. Furthermore, the DWP was also internally reviewing the medical test. Yet the first trial of the WCA test on existing disability claimants went ahead in Burnley and Aberdeen on the old test and the old decision process. So now as the medical test goes national the new regime outlined by Harrington and the DWP internal review is being implemented with no prior testing. The Government claims these changes have fixed the earlier problem and undoubtedly the Harrington Review will have made a difference, but surely it should be tested and checked before being applied nationally. It is baffling why the trials in Burnley and Aberdeen were not delayed just four months to test run the new regime. Likewise it is clearly essential to track the progress of those denied access to the new benefit, especially among those previously claiming Incapacity Benefits, to study what is happening to them. Are they moving to JSA, getting jobs or suffering acute deprivation without any financial support? By tracking people according to what conditions they are presenting with, we can assess which conditions are not being picked up well, if groups fail to move into work. But again no such research or tracking is apparently being undertaken.

The process seems to have been characterised by undue haste, a lack of testing and immediate assessment. It may be that this derives from a view that those denied benefit will be healthy and undeserving of support, rather than emphasising the risk of vulnerable people being treated inappropriately. This has become an interactive process of changes being followed by a chorus of complaints, revision, a wait to see if complaints diminish, and further revision when they don't. The current national roll out will not be the end regime but just the latest iteration in my view. This is no way to introduce such a fundamental reform affecting so many vulnerable people.

March 2011

Written evidence submitted jointly by Centre for Mental Health, Hafal, Mind, Rethink, the Royal College of Psychiatrists and SAMH (the Scottish Association for Mental Health)

ABOUT US

Centre for Mental Health

Centre for Mental Health is an independent, national charity that aims to help to create a society in which people with mental health problems enjoy equal chances in life to those without. We aim to find practical and effective ways of overcoming barriers to a fulfilling life so that people with mental health problems can make their own lives better with good quality support from the services they need to achieve their aspirations. Through focused research, development and analysis, we identify the barriers to equality for people with mental health problems, we explore ways to overcome those and we advocate for change across the UK.

Hafal

Hafal is run by its 1,000 members—people with a serious mental illness and their families and carers. Every day our 160 staff and 150 volunteers provide help to over 1,000 people affected by serious mental illness across all the 22 counties of Wales. The charity is founded on the belief that people who have direct experience of mental illness know best how services can be delivered. In practice this means that at every project our clients meet to make decisions about how the service will move forward and the charity itself is led by a board of elected Trustees, most of whom either have serious mental illness themselves or are carers of a person with a mental illness. “Hafal” means equal. Our mission is to empower people with serious mental illness and their families to enjoy equal access to health and social care, housing, income, education, and employment, and to achieve a better quality of life, fulfil their ambitions for recovery, and fight discrimination.

Mind

Mind is the leading mental health charity in England and Wales. We work to create a better life for everyone with experience of mental distress by:

- Campaigning for people’s rights.
- Challenging poor practice in mental health.
- Informing and supporting thousands of people on a daily basis.

A fundamental part of Mind’s work is provided through our network of over 180 local Mind associations who last year worked with over 220,000 people running around 1,600 services locally. Services on offer include supported housing, crisis help lines, drop-in centres, counselling, befriending, advocacy, and employment and training schemes. Over 30,000 people are supported by our national telephone help lines. Welfare reform is a key issue for many of the people Mind has contact with. We also work extensively with the Disability Benefits Consortium (DBC) on issues of welfare and benefits.

Rethink

Rethink Mental Illness, the leading national mental health membership charity, works to help everyone affected by severe mental illness recover a better quality of life. We help over 52,000 people each year through our services and support groups and by providing information on mental health problems. Our website receives over 600,000 visitors every year. Rethink’s Advice and Information Service helps almost 8,000 people each year and advises people daily with benefit claims.

Royal College of Psychiatrists

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

SAMH (Scottish Association for Mental Health)

SAMH is the biggest mental health charity in Scotland, providing an independent voice on all matters of relevance to people with mental health and related problems and delivering direct support to around 3,000 people through over 80 services across Scotland. SAMH provides direct line-management to *respectme* (Scotland’s anti-bullying service) and “see me” (Scotland’s anti-stigma campaign).

1. Summary

1.1 Our organisations understand the motivation for moving claimants off existing Incapacity Benefits (IB), which is seen as a “passive” benefit, onto Employment and Support Allowance (ESA), which is seen as more “active benefit”. Around 43% of those people due to be migrated are claiming primarily due to a mental health problem,¹⁰ and many more will have experienced mental distress. We welcome efforts to help people with mental health problems back to work, where appropriate and if done in a supportive and understanding manner. However, we are concerned that the process will not be fair; will cause substantial distress; and will lead to many people receiving inadequate support and being subject to inappropriate and potentially harmful requirements.

1.2 All of our organisations have received substantial feedback, from people with mental health problems who have experienced the WCA and from professionals who work with them, that the assessment is unsuitable for gauging the impact of mental health problems on an individual’s ability to work. Some of our organisations have also been involved in various stages of creating and reviewing the assessment, but have often felt that our perspectives and objections have been largely disregarded. We do not believe the assessment is working fairly and effectively and we do not think migration should go ahead until these issues are resolved.

1.3 We are also concerned about the way in which the process will be communicated to IB claimants; the timescale of the migration; and the outcome of the process for those claimants reassessed.

2. The Department’s communications to customers going through the assessment and whether the information, guidance and advice provided by the Department and Jobcentre Plus is effective in supporting customers through the process

2.1 It is clear that, in response to Professor Harrington’s Independent Review, the Department and Jobcentre Plus in particular is paying considerable attention to how the process of migration is communicated. We welcome recent innovations in the customer journey, such as additional phone calls during the process to ensure that the customer is kept informed and up-to-date.

¹⁰ *DWP Incapacity Benefits Migration: Customer Segmentation Programme Summary of Key Findings and Final Customer Segments*, April 2010, Government and Public Sector Consulting.

2.2 However, we are keen that, throughout the process, customers are regularly reminded of their rights at each stage of the process around submitting additional evidence; being accompanied during the assessment; accessing their report from the assessment questioning the Decision Makers verdict; and appealing the final decision. We would be very concerned if any of the additional contact established with the customer resulted in a sense that it wasn't worth questioning or appealing a decision that they were not happy with.

2.3 We are not confident that people feel well informed about the process of migration and we are concerned that uncertainty and anxiety about the process is having a detrimental effect on people's health. In a recent survey on the Mind website of over 300 current IB claimants:

- 78% did not feel well informed about the process.
- Only 20% had received their information from the Department (62% had picked up their information from the media).
- 75% said concern about the WCA had made their mental health worse and 51% reported it had made them have suicidal thoughts.
- 95% do not think that they will be believed at their assessment and 89% believe that they will be forced back to work before they are ready or able.

2.4 Although we understand that a huge number of people are due to be reassessed over a significant period of time, we do feel that it would be helpful if the Department could indicate to people when they are likely to be reassessed. The knowledge that you are due to go through a process that could have a profound impact on your life, along with the uncertainty of when this will occur in the next three years, is an unpleasant combination for those concerned. The ongoing anxiety this situation is causing may well worsen people's mental health and could place them even further from the job market.

“I was due to be re-assessed for IB last September, nothing has happened yet except for a daily dread of brown envelopes.”

“I dread the post coming each morning just in case there is a brown envelope with DWP printed on it and can no longer listen to news reports on the radio about anything to do with benefit changes.”¹¹

2.5 Informing people would not need to involve sending letters out to all those due to be reassessed, or even identifying specific dates. It could simply consist of a webpage where people can check the month or quarter when they are likely to be called in for reassessment. This webpage could be promoted to third sector organisations who could assist those without direct access to the internet. We feel that this would prove beneficial to a huge number of people.

3. The Work Capability Assessment including: the assessment criteria; the service provided by Atos staff; the suitability of assessment centres; and customers' overall experience of the process

3.1 Our organisations have, between us, worked extensively on the WCA: from involvement in the meetings that led to the creation of the assessment and two reviews of its functioning, to listening to the concerns of people with mental health problems going through the process and feeding these concerns back to government. However, we do not feel that the DWP or successive governments have been particularly responsive. We believe that the assessment is not fit for the purpose of gauging the impact of mental health problems on an individual's ability to work.

3.2 Professor Harrington's Independent Review in 2010 vindicated the vast majority of the criticisms of the WCA that we had been expressing. We do not go into detail here about all of these criticisms, as the majority are well known. However, we have summarised our concerns below and have also enclosed our joint submission to the Harrington review, which explains these concerns in more detail:

- Many people with mental health problems that pose a serious barrier to them finding employment are being found “fit for work” and that many of these people are scoring zero points.
- A huge number “fit for work” verdicts are being successfully overturned at appeal, suggesting that these cases are not initially being assessed fairly or effectively.
- The process is impersonal and mechanistic and does not allow the applicant to express the extent of their impairments and the details of their circumstances.
- Applicants often feel that they have been treated unfairly and that this can cause distress that can both worsen their mental health and put them further away from the job market
- The assessment does not take sufficient account of fluctuations in conditions, which is vital to understanding the impact of mental health conditions.
- The assessors do not have adequate expertise or training to understand mental health problems and the impact they have on an individual's ability to work.
- Too much weight is given to the verdict of the assessment and not enough to the perspective of clinicians who have a more complex and nuanced understanding of the applicant's condition.

¹¹ Quotes taken from claimants who have contacted our organisations.

3.3 We are pleased that the Department has now taken some of these criticisms on board and is looking to implement Professor Harrington's recommendations. We support these recommendations and believe that they should help to significantly improve the WCA for people with mental health problems. We are also pleased that Professor Harrington has been kept on to perform a subsequent review which will include monitoring the implementation and effectiveness of his initial recommendations.

3.4 However, we do have some remaining concerns about the assessment that were not fully addressed by Professor Harrington's review:

3.4.1 We do not feel that there has ever been a rigorous evaluation of whether the WCA is both valid (ie it correctly measures what it is intended to measure) and reliable (ie it provides consistent and reproducible results). The high rate of successful appeals suggests that there is poor reliability and validity. We recommend that a thorough and scientifically rigorous evaluation of the WCA is undertaken, with a view to a more scientific approach to redesign if necessary.

3.4.2 We are concerned that the format and content of the current descriptors drives the behaviour of assessors in terms of only requiring them to seek a minimal amount of information from an applicant before assigning them to a particular category. The descriptors tend to try and measure complex impairments with multiple dimensions on a linear scale and we believe this fundamentally undermines their capacity to assess mental health problems. An example of this would be the descriptor on "coping with social situations" which primarily measures the frequency of this impairment but doesn't treat severity or duration as a variable. Professor Harrington has asked Mind to make proposals on improving the descriptors along with Mencap and the National Autistic Society. These proposals have been submitted to Professor Harrington and should go before Ministers around June 2011. We believe that these proposals would help to alleviate the limitations of the current descriptors but nonetheless call for fundamental review of assessment format.

3.4.3 The Government recently began implementing the recommendations of a previous, internal review of the WCA. Our organisations have significant concerns about both the process of this review and the outcomes. We are particularly concerned about the reduction in descriptors around mental, intellectual and cognitive function from 10 to seven and we believe that this will render the assessment even less fair and effective for gauging the impact of mental health on an individual's ability to work.

3.4.4 We believe that the guidance given to assessors compounds the problems with the descriptors by suggesting that they should look for sufficient cause to *disqualify* the applicant rather than rigorously assessing for reasons to qualify them. For example, there are a number of descriptors where simply turning up alone for the assessment is seen as cause for scoring zero points for the area impairment. This is particularly problematic for mental health where the impairments may not be obvious from appearance or even behaviour and where people's condition as presented on the day of assessment may not be representative of their usual or worst states of fluctuation. The guidance often cites the most extreme example of impairment, rather than providing suggestions around more borderline cases which may allow assessors to make more balanced decisions. For example, descriptor 15 (execution of tasks) has the following guidance:

"The pattern of typical day activity should really reflect a person who should struggle to get through the basics of a day due to their mental disablement as a result of tasks taking so long to complete that they would be unable to cope with work due to the length of time required for basic tasks. For example those who have severe and continuous disabling anxiety where they struggle to even get out of their bedroom may come into this category".

By citing such an extreme case, it can overshadow less extreme, but still serious, cases and may lead to people being "under-assessed".

4. The decision-making process and how it could be improved to ensure that customers are confident that the outcome of their assessment is a fair and transparent reflection of their capacity for work

4.1 As stated in our joint submission to Professor Harrington (see attached) we believe more weighting should be given to the professional opinion of those clinicians in contact with the individual making the claim. This would help not only to reduce the number of people erroneously judged to be "fit for work" but would assist in dealing with some of the problems of fluctuating conditions and symptoms and of combined mental and physical disorders. These clinicians would also have a greater understanding of how the condition affects the individual and how it might impact on their ability to work. The process would be more transparent if DWP Decision Makers were obliged to explain to the applicant why they had contradicted the opinion of the clinician, where relevant.

4.2 We are pleased that Professor Harrington recognised the problems in this area and we hope that his recommendations on this issue are fully implemented. Since this will involve retraining Decision Makers and a culture-shift in their approach to balancing different sources of information it is likely to be a lengthy process.

4.3 We would also like to see applicants regularly reminded during the process that they can submit additional evidence; that they can request a copy of their report from the WCA to check for accuracy; and that they can ask for reconsideration of their decision or go to appeal.

4.4 To support this it would be helpful to have a named person from the DWP system to be responsible for each claimant's benefits claim who could be contacted by the claimant or clinicians when queries are required and who can assist in guiding the claimant through the benefits system.

5. The appeals process, including the time taken for the appeals process to be completed; and whether customers who decide to appeal the outcome of their assessment have all the necessary guidance, information and advice to support them through the process

5.1 A number of Community Mental Health Teams (CMHTs) have reported that many of their service users have been winning their appeals. Under the old Incapacity Benefit system, the fact that they were using a CMHT would be an indicator of a severe mental health condition and so the benefit would be awarded. The fact that the WCA no longer has this feature increases the likelihood of people being assessed and placed in the wrong groups as well as the cost/trauma of subsequent successful appeals.

5.2 We are also concerned that clients who have won their appeals are being reassessed through the WCA within a very short time frame. We have been in touch with a claimant who was initially declared "fit for work", but overturned this verdict at appeal. He was sent an ESA50 form within months of the appeal being settled, and has now been called for a further medical assessment. This is causing him great distress and could potentially impact on his health, causing unnecessary expense for the NHS; particularly as he was assured it would be at least a year before he is reassessed.

5.3 Success rates for appeals are much higher when appellants are accompanied by an advocate or companion, suggesting that people appealing alone may not be able to adequately represent their case. People need to be encouraged to bring support to appeals.

5.4 We would like to see evidence from appeals being fed into the WCA system to ensure that those whom a tribunal has found to be eligible for ESA do not have to suffer the distress of presenting the same information to a different part of the system shortly afterwards, and that the DWP learns from these cases for future reference. This would also allow Decision Makers to understand why their decision was overturned, which should lead in time to a reduction in the need for appeals. At present, there is no systematic method for Decision Makers to learn from the decisions of Appeals Tribunals.

6. The outcome of the migration process and the different paths taken by the various client groups

6.1 1.6 million IB claimants will be migrated onto ESA by March 2014. We are concerned that many of these people may drop out of the benefits system due to the stress of the process or because they are not eligible for other benefits. Even if people are found to be legitimately "fit for work", they will have been on benefits for many years, often without the right support to find paid work, and thus will take time to adjust to the demands being made of them and will in the interim face distress and hardship. As the current system of assessment is presently not sufficiently efficient they will be doubly disadvantaged. Policy will need adjusting to allow the long-term IB claimants who are found to be "fit for work" to have a period of time on ESA before being moved to JSA.

7. The time-scale for the national roll-out for the migration process, including the Department's capacity to introduce changes identified as necessary in the Aberdeen and Burnley trials

7.1 We have been aware for several years that the WCA is a flawed process and often denies people with mental health problems the benefits and support that they are entitled to. The Harrington review has highlighted many of the problems in the process of assessment that contribute to this. The number and extent of the recommendations from this review demonstrate that the assessment is not functioning fairly and effectively. These recommendations need to be implemented in full, and their impact assessed to ensure they have had the desired effect, before the migration of existing IB claimants goes ahead.

7.2 We understand that it would be extremely complicated to halt new assessments of ESA applicants while reforming the assessment. However, there is no such imperative to begin migration at this precise moment. The average duration of claim for those due to be reassessed is nine years. We agree that it is hugely regrettable that so many people have been left for so long without active support, but it is absurd to claim that starting migration now should take priority over ensuring that the assessment process is fair and effective. A delay of a few months to ensure that the recommendations are implemented and have taken effect is clearly preferable to a more immediate migration with a flawed assessment.

Annex

THE WORK CAPABILITY ASSESSMENT—A CALL FOR EVIDENCE. DEPARTMENT FOR WORK AND PENSIONS, JULY 2010

Joint response from Centre for Mental Health, Mind, Rethink and the Royal College of Psychiatrists

INTRODUCTION

We welcome the opportunity to respond to this consultation.

As leading organisations in the mental health field we know that the great majority of people who experience mental ill health, even those with serious conditions, see some paid employment as a contribution to and a marker of their recovery.

We also know that there is good evidence that given the right conditions and the right support, for most people work is a realistic ambition. In our response we will focus on the ways in which the WCA as it is presently constituted and delivered creates the wrong conditions for people with mental health conditions to (re)launch themselves into the world of work by creating uncertainty, anxiety and unfairness. This is a matter of great concern to us and the people we represent because it not only impacts on quality of life and hope for a better future, but can also lead to worsening mental health for which mental health services will have to pick up the tab.

“We know that people with mental health conditions can and do pursue successful careers. We know that the majority would dearly love to be gainfully employed—in fact, people with a mental health problem have the highest ‘want to work’ rate of all disabled groups. We know that appropriate employment improves mental health and can protect against relapse. There is a wealth of research evidence showing how we can help many people with a mental health condition to realise their ambitions, yet, in most areas, we have failed to provide this support. And the number of people with a mental health condition who are workless continues to rise”. (Perkins *et al*, 2009)

RECOMMENDATIONS

In our evidence we are aware that in many ways the problems that existed for the PCA are still being replicated in the WCA process, particularly the problems with the Atos clinicians and the accuracy of the WCA medical assessment.

Centre for Mental Health, Mind, Rethink, and The Royal College of Psychiatrists recommend the following:

- Greater use of treating clinician’s opinions should be made throughout the WCA process.
- A claimant’s exemption should be based on the recommendation of the medical professionals who work with them that the assessment process would cause harm to health, rather than being prescribed for any particular health conditions.
- The overall assessment of claimants requires a more realistic approach to functionality, reflecting more accurately how a disability affects someone’s entire life, rather than identifying which tasks they can perform in isolation.
- Policy will need adjusting to allow the long-term IB claimants who are found to be fit for work to have a period of time on ESA before being moved to JSA.
- We recommend that regular thorough and scientifically rigorous evaluations of the WCA medical assessment are undertaken to ensure that it reflects new health conditions and evidence.
- The current WCA interview and associated assessments should be reconsidered and the views of clinical, service user and third sector experts used to reconsider the current interview process, the descriptors and additional ratings.
- The current descriptors should be supplemented by an additional rating that assesses the overall impact on functionality caused by claimants’ conditions. These subjective aspects of distress could be used to determine an overall score of the claimant’s current functioning in addition to the current descriptors. We recommend that serious consideration is given to this proposal.
- The assessment should take account of how the illness or impairment affects an individual’s chances of finding work in the context of the workplace environment. We recommend that the WCA takes them into account for those people who may have reasonable functioning and may not automatically qualify for benefit, but have reduced chances of being able to work. This includes issues such as employer stigma.
- We recommend that improvements are made to the clarity of the WCA medical assessment. The WCA interview could be made into a semi-structured interview which would aid the systematic collection of data and may also help improve the interaction of the assessing doctor and claimant.
- We recommend that a thorough evaluation of the ability of the medical assessors is undertaken.

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- The guidance given to WCA assessors should be improved, giving more and less extreme examples.
 - For fluctuating conditions we recommend that the assessment differentiates between variable conditions and variable symptoms. Assessors should be asked to evaluate the variability in several ways and use these methods to develop a judgement as to the combined effects of these fluctuations.
 - The contribution of multiple conditions may be managed by improving the assessment by the Atos clinicians, making it more reliable and valid. The process should assume at least an additive model such that the scores on the individual mental and physical descriptors are summated to provide the final score.
 - Evidence from the appeal should be fed into the WCA systems to ensure that those whom a tribunal has found should be on ESA do not have to present the same information to a different part of the system shortly afterwards. This would save time and reduce stress for claimants, which can cause relapse.

RESPONSE TO QUESTIONS

In our response, we will concentrate on the effects of the Work Capability Assessment (WCA) on people with mental health problems. We are aware that this group of people form a significant proportion of those on welfare benefits. We believe that the process that assesses the eligibility of people for welfare benefits should be fair, accurate and just. It should not discriminate against any particular group and the benefits should offer protection to people when vulnerable and should offer a means of support to improve their opportunities when they are able to do so.

1(a) How effectively does the WCA correctly identify those claimants whose condition is such that they are unable to undertake any form of work related activity (the Support Group)

Current DWP figures for ESA claims to November 2009 show that 6.8% of those with mental health problems assessed through the WCA were placed in the Support Group and 24% in the Work-Related Activity Group, whilst 69.2% were found to be “fit for work”.¹² The equivalent figures for those with physical problems are 11.6%, 23.7% and 64.7% (Department for Work and Pensions, 2010a). It is not known how appropriate this figure is as we know of no evaluations that assess the accuracy for the assessments of people entering the Support group, but the figure for those being found “fit for work” is much higher than that of 49% originally estimated by the DWP (Citizens Advice Bureau, 2010).

However Mind, Rethink and The Royal College of Psychiatrists are aware through their support work that many with mental health conditions who should be placed in the Support Group are inaccurately placed in other groups. Due to limitations of the current WCA, it is likely in our experience that people who are too disabled by their condition to work, and should be in the Support Group, are assessed as ready to engage with work-related activity.

The assessment for ESA does include “special circumstances” in which claimants can automatically be considered as having limited capability, and therefore eligible for the benefit. However, these “special circumstances” cover far fewer situations than for the Personal Capability Assessment (PCA), which was used to determine eligibility for Incapacity Benefit (IB). One exemption from the PCA that is not now included in the “special circumstances” for ESA is medical evidence to show: “A severe mental illness which severely and adversely affects mood or behaviour and which severely restricts social functioning or awareness of the immediate environment”. We will return to this point in our response to question two.

It is now very common to employ Benefits Advisors in Community Mental Health Teams to advise and assist service users in making claims. These advisors, along with clinicians working in these teams, report an increase in problems with those people with severe mental illness who should be placed in the Support Group being called for assessment and being refused ESA (Citizens Advice Bureau, 2010). They also report that it is less common now for clinicians to be sent the form ESA 113 than it was to be sent IB50 forms under the previous system. These errors are damaging to the patients’ mental health and costly in terms of money and resources. This means that the system ignores the expertise of mental health practitioners to accurately assess the capabilities and any support needs of their patients. The CAB report also finds that seriously sick and disabled people are being found ineligible for ESA. It is generally recognised that people who move off benefits but do not enter work show deterioration in their health (Waddell and Burton, 2006). One example from the CAB illustrates this:

An adviser from a community mental health team reported that almost all their new clients applying for ESA are being refused benefit. In the last few months, she has helped 10 clients appeal ESA decisions: three have been resolved, and the other seven are all waiting to go to tribunal. None of these clients would be getting the very significant resources of the community mental health team if they were not seriously mentally ill. Under the IB rules, this would be used as an indicator that there was a severe mental health problem and the benefit would be awarded. The stress and worry of the

¹² Table 5, page 12, Department for Work and Pensions, 2010a.

ESA process is damaging the clients' mental health and delaying recovery and the possibility of an eventual return to work.

1(b) *How effectively does the WCA correctly identify those claimants whose condition is such that they are currently unable to work due to illness or disability (the limited capability for work group)?*

Without further evaluation of the accuracy of the WCA to place people in the correct eligibility groups it is not possible to give a firm answer to this. However, from the official statistics we are aware that of the overall appeals against the decision of fitness to work, 40% of the decisions are overturned.¹³ Up until November 2009, 66% of those assessed were found to be "fit for work"¹⁴ so if the 40% error rate were applied across all those people then a further 131,400 would be found to be eligible giving a total rate of eligibility of 60%, and would account for some of the overall rates of eligibility being 20% less than the government originally expected (Citizens Advice Bureau, 2010).

A potential error rate of up to 40% in the WCA process implies some serious inaccuracies in the assessment system. If there was a more accurate assessment of people's eligibility for benefit, this would result in a reduction in the number of appeals to the decision, and ultimate cost savings to the DWP, and a reduction in distress for those making the appeal (Department for Work and Pensions, 2008). Where decisions are not appealed, inaccurate assessment has a detrimental effect on the wellbeing of the person with mental illness, as they are put through a programme which is not suited to their needs or denied support tailored to their situation, further damaging their confidence and ability to work.

"I have had to appeal a decision for my benefits that said, after a medical assessment, that I did not qualify due to the points system on certain issues they use. I did win my appeal though went through a lot of stress which was hard to deal with, particularly with a mental health condition. Now, only months after winning the appeal, I have been called to another medical assessment"—Rethink Supporter with severe mental illness

This not only results in worsened health but also denies appropriately tailored support to those who most need it. Within a competitive job market and where employers still hold stigmatising attitudes towards those with mental illnesses, this can increase rather than reduce an individual's distance from the job market.

Our responses to questions 1a and 1b indicate that there is overall evidence that the WCA is not sufficiently accurate in identifying people with ill-health who are eligible for ESA. This suggests that the WCA process is not efficient in providing a structure in which information is processed and it is likely that the medical assessment is not being carried out adequately and is not able to identify people who are unable to work due to ill health or disability. However we know of no published data that allows us to examine differences in outcome (correct identification of eligibility for ESA) between people who have mental health problems and those with physical impairments or disabilities. Such data would be essential to examine any bias or inaccuracy in the WCA process.

1(c) *What are the main characteristics that should identify claimants for each group, where these may differ from the current assessment?*

Identification of all claimants needs a more realistic and evidence-based approach to functionality. The test needs to more accurately reflect how a disability affects someone's entire life, rather than identifying which tasks they can perform in isolation. This should take into account how their quality of life, and health would be impacted, both in the short and long term, by any work that they are performing. Clinical practitioners who know an individual well, such as their GP or psychiatrist, could play a vital role in providing this contextual information and in reducing the risk of inaccurate assessments and subsequent appeals or loss of income.

The assessment also needs to take into account the quality of the support that will be available to individuals in the different groups and the external barriers they may face in finding work. Particularly for existing IB claimants, many of whom will not have worked for a long time, a "fit for work" decision based on a purely functional assessment does not address the fact that they will inevitably face difficulties in actually returning to the workplace after such a long time away from it. These claimants in reality may not be able to access the support that would be necessary to overcome these realities—it is unfair for the system to work as though this support is available when in many localities it is not and claimants should not be penalised for this lack of provision.

2. *What evidence is there to suggest that any issues with the operation of the WCA are as a result of the policy design and what evidence is there to suggest that they are a result of delivery?*

Policy design

Current policy affects the operation of the WCA in several ways:

1. *Migration from Incapacity Benefit*

Policy suggests that 1.6 million IB claimants will be migrated onto ESA by March 2014. None of this

¹³ Table 1, page 7, Department for Work and Pensions, 2010b.

¹⁴ Tables 3 and 4, pages 9, 10, Department for Work and Pensions, 2010b.

group are likely to be eligible for contribution-based JSA if they are found fit for work and the majority who are not eligible for a top-up on their current sickness benefit are not likely to qualify for income-related JSA. Thus, many of those migrating who are then found ineligible for ESA will have no benefit to replace the income they have lost as a result of their illness or disability. Many of these people, even if they are found to be legitimately fit for work, will have been on benefits for many years, often without the right support to find paid work, and thus will take time to adjust to the demands being made of them and will in the interim face distress and hardship. As the current system of assessment is presently not sufficiently efficient they will be doubly disadvantaged. Policy will need adjusting to allow the long-term IB claimants who are found to be fit for work to have a period of time on ESA before being moved to JSA.

In addition there are concerns that there may not be the capacity to process the migration from IB to ESA. The House of Lords Merits of Statutory Instruments Committee (2010) notes that the DWP has revised its estimates of those likely to be found to be fit for work during phase two from 15% to 23% but they comment that there is no indication of how robust is this assumption. They also have concerns about the lack of evidence to support the methods of migration:

“... the Committee’s view that, from the limited evidence we have seen, a major project with a potential impact on the lives of some of the most vulnerable in the community is being conducted in a rather ad hoc fashion. The second phase is being rolled out before the first has been evaluated and although better information will be sought on the outcomes, the Department’s intended course of action, and evidence to support it, all seem rather vague.” House of Lords Merits of Statutory Instruments Committee (2010).

The Social Security Advisory Committee report (2010) echoes this concern:

“It is of particular concern to the Committee that the Department is moving ahead with the migration of existing claimants of incapacity benefits without a solid evidence base for either the decision to migrate or the proposed migration arrangements. The Committee notes that the evaluation of ESA for new claimant is not planned to be complete until 2011 by which time the proposed migration arrangements will have commenced.”

2. *Greater areas for exemption*

Some people with mental health conditions, particularly those being seen by Community Mental Health teams may be too unwell to work. In addition, participating in the process of the WCA itself is further detrimental to their mental health. Under the previous IB system those with severe mental illnesses were exempt from having to undertake the PCA (see: our response to Q1(a)). There are also specific problems for the group of people with mental health conditions who have limited awareness into the nature of their illness and who may complete the self-assessment ESA50 form on the basis of this and thus not be found eligible for ESA despite being unable to work.

Rethink have collected many examples of cases of people attending Community Mental Health Teams (CMHTs) for whom the WCA process does not work well. These have been highlighted in the CAB *Not Working* report (Citizens Advice Bureau, 2010), for example:

“A client with a diagnosis of schizophrenia who lacked insight into his mental health and was non-compliant with treatment. He had paranoid thoughts, had hallucinations and heard voices, and had suicidal thoughts, having previously attempted suicide. He claimed DLA and was awarded higher rate care and lower rate mobility. He was detained under Section 3 of the Mental Health Act 1983 (MHA83). Regulations state that a claimant should be treated as having limited capability for work on any day that they are receiving hospital treatment—thus he should have been automatically placed in the Support Group. He received the ESA50 in hospital and returned it while he will still detained. The ESA50 was not completed accurately as he was acutely unwell, but he attended a WCA a few months later and was found fit for work.”

“An adviser with a Community Mental Health Team recorded grave concerns about a client diagnosed with bipolar disorder but who had no insight into his condition. He had a WCA and was found fit for work. The client signed on and was delighted because he believed that it showed he was right all along and was not ill. The psychiatrist wanted this decision to be challenged but it was not possible because the client did not want to appeal.”

Considerable amounts of money and resources are invested in treating and supporting the patients of CMHTs, who are mainly diagnosed as being seriously ill. CMHTs have expert and often long-term knowledge of the people they see and it is this expertise and knowledge that should be sought, rather than decisions made on the basis of an assessment by a generalist health care professional. Greater weight should be given to supplementary evidence provided by the claimants’ own physicians and carers. Incorrect decisions are damaging the work done by the CMHTs, thus costing further resources to the public purse.

We believe that this aspect of current regulations should be changed to protect those using secondary mental health services from being subject to unnecessarily entering the WCA process and being allowed to enter the Support Group at an early stage. We suggest that this group are exempt from the process as they were for the PCA under the IB system. We recommend that their exemption should

be based on the recommendation of the medical professionals who work with them, rather than being prescribed to any particular conditions.

3. *The WCA process re-starts too soon after settlement of an appeal*

We are also concerned that clients who have won their appeals are being reassessed through the WCA within a very short time frame. Rethink has been in touch with a supporter who was initially put onto JSA, but who appealed and had won his appeal. He was sent an ESA50 form within months of the appeal being settled, and has now been called for a further medical assessment. This is causing him great distress and could potentially impact on his health, causing unnecessary expense for the NHS; particularly as he was assured it would be at least a year before he is reassessed.

We would like to see evidence from appeals being fed into the WCA system to ensure that those whom a tribunal has found to be eligible for ESA do not have to suffer the distress of presenting the same information to a different part of the system shortly afterwards.

Delivery

There are several problems with the current delivery of the WCA process:

1. *The medical assessment interview of the WCA has never been subjected to scientific scrutiny*

For any test to be able to correctly identify individuals as experiencing any problem (in this case having reduced functioning that impairs their ability to work) it must be both valid (correctly measuring what it is intended to measure) and reliable (provides consistent and reproducible results). It should also be comprehensive and easy to administer. The WCA was a revision of the PCA and claimed to be a more robust, accurate and fair assessment than its predecessor (Department for Work and Pensions, 2006). The WCA has been re-assessed (Department for Work and Pensions, 2009; 2010c) but it has never been exposed to any rigorous evaluation and its validity and reliability is not known (Verbeek and van Dijk, 2008).

The evidence given above (Questions 1(a) and 1(b)) shows that the current WCA is subject to a high rate of errors suggesting poor reliability and validity. There is much at stake for the WCA. Not only does it dominate the provision of sickness benefits, it also determines the financial survival of many people with incapacities owing to illness. As it stands, the WCA does not yet pass the test of a fair and just process. We recommend that a thorough and scientifically rigorous evaluation of the WCA is undertaken, with a view to a more scientific approach to redesign if necessary.

2. *Current content of the medical assessment*

The medical assessment interview component of the WCA currently contains 10 descriptors relating to mental health but the DWP's internal review proposes to reduce the descriptors to seven (Department for Work and Pensions, 2010c). These represent a much revised version of the original WCA (Department for Work and Pensions, 2006) and have not yet been evaluated.

In addition to the lack of evaluation, these specific descriptors are limited as they do not assess the overall impact of performing the tasks mentioned in the descriptors. This could be addressed by the overall assessment process by paying greater attention to the "subjective" experience of the claimant, which the current score of ability to perform tasks or present well does not capture. These subjective experiences potentially include: overall distress experienced; chaotic thinking, difficulty organizing self or routine; feeling overwhelmed; tolerance for frustration; self confidence; fear of others' expectations; debilitating side effects of medication; and difficulty coping with stress. We need assurance that these things are considered when assessing people's ability against the descriptors. We are told by our beneficiaries that these aspects of their condition are not taken into account. Data on these issues is currently being collated through a major survey being conducted by Rethink on behalf of the Disability Benefits Consortium and we will be able to report results in October this year. We recommend that serious consideration is given to this proposal.

In addition, the WCA has further problems that need to be addressed:

(a) *Evaluation of variability*

The WCA is not sufficiently robust to deal with either the variation of the conditions, or the variability of symptoms. For example, a person with a mental health problem may find that 30% of the time their mood is low and at other times they cannot concentrate or at other times they are irritable or have to withdraw to deal with their auditory hallucinations. Perhaps none of these factors, on their own, may affect the items on the WCA sufficiently to achieve the desired points, but together they are sufficient to affect their overall functioning. The same may apply to the variation of these individual symptoms.

The present guidance states that "For conditions which vary from day to day a reasonable approach would be to choose the functional descriptors which apply for the majority of the days." However, for those with variable conditions this is not sufficient or reasonable as they may be fit for work on their better days, but on their bad days they may not be able to work. Symptoms may be so severe on the minority of days that they need to be given greater weighting.

(b) Combining physical and mental descriptors

For people with more than one condition, the evidence suggests that the combined effect may be more than the sum of the two conditions (Scott *et al*, 2009). Many people with mental health problems also have physical problems and their combination is not taken into account in the WCA. These combined problems often make adaptation to work difficult.

This is a particular concern for those with mental health conditions where some elements of the condition can impact on others. For example, if a person is unable to cope well with change and is also unable to deal well with other people, they are likely to become worse at dealing with other people in times of change. This will then compound the anxiety about the change and create a problem which is greater than the WCA would reflect.

Citizens Advice (2010) found that when there are physical problems as well as mental health problems, the mental health problem is more likely to be ignored in the WCA. They cite this example in their report:

“A Midlands bureau saw a client with a long history of depression, as well as many other problems including back problems and diabetes, and who was also having investigations for possible epilepsy following a series of blackouts. The assessment only seemed to have considered the physical problems and the client was awarded no points. Yet at that point, the client’s mental health was causing more concern than the serious physical problems. The client had made three suicide attempts that year, still had suicidal thoughts and was unable to go out the house on their own. The bureau noted that the client had a social worker who confirmed all the details.”

This point will be returned to in our response to question four.

(c) Relating the assessment to the “real world”

The current assessment takes no account of how the illness or impairment affects an individual’s chances of finding work in the context of the workplace environment, such as the impact of long-term unemployment, adapting to the workplace and the barriers to getting into work. People with mental health problems face particular prejudice and discrimination from employers. The WCA does not take these factors into account. We recommend that the WCA is expanded to take these factors into account for those people who may have reasonable functioning and may not automatically qualify for benefit.

3. *The competence of the WCA medical assessors to undertake effective assessments for people with mental health problems*

One possible reason for a lack of reliability in the WCA system may be the ability of the medical assessors to accurately assess the level of functioning in this group of people.

There is no published data on the quality of the assessments carried out by the WCA medical assessors, but the reports of people who have been assessed suggest that this is poor. In 2006, Citizens Advice questioned the quality of the medical assessments for the PCA, reporting that these did not give sufficient consideration to mental health problems, were often hurried, that many clients reported encountering rude or insensitive examining doctors, and that reports were inaccurate and took answers out of context. (Citizens Advice, 2006). In their latest report Citizens Advice paint a similar picture for people with mental health problems (Citizens Advice, 2010). They found repeated evidence of people with severe mental health problems being found fit for work, that the impact of mental health problems was being underestimated in the presence of co-existing physical problems, and that people’s mental health difficulties were downplayed.

There seems little doubt that the medical assessors still have a poor awareness of mental health problems. People attending consultation events facilitated by Mind and Rethink, during the development of the original WCA in 2007, highlighted that assessors tend to make judgements on a person’s capability based on their appearance or ability to articulate their problems rather than on their capability to work as measured by the WCA.

There are reports of claimants who are assessed being frequently confused about the purpose of the medical assessment and not understanding why the doctors performing the assessment reach a different conclusion to their own doctor. Communication about the assessment needs to be more accessible and provide a clear explanation of the purpose of the assessment should be provided.

Further to this, the ability of the medical assessors to carry out high-quality assessment for all claimants has been questioned by the findings of the CAB report (Citizens Advice, 2010). The report highlights several important factors including: the accuracy of the medical history in the clinician’s report; distortions of what they were told in the interview; poor questioning by the clinician; inadequate recording of claimants’ responses; a failure to observe accurately; a lack of understanding of the criteria; poor recording of variable conditions; the downplaying of the severity of conditions; and overuse of referral for repeated medicals.

The evidence gathered by Citizens Advice and others over the years points to the need to evaluate formally the ability of the medical assessors to accurately assess the functioning of the claimants. It also suggests that there may be systematic problems in relation to those with mental health problems. At present the process run by Atos is opaque and has not been subject to external scrutiny. Some of

this may be improved by improvements in the clarity of the WCA medical assessment. The WCA interview could be made into a semi-structured interview which would aid the systematic collection of data (as with many research interviews) and may also help improve the interaction of the assessing doctor and claimant. Such an interview design would also allow for improved training of the assessors and a ready means of evaluating the quality of their interviews and rating. We recommend that a thorough evaluation of the competence of the medical assessors is undertaken.

4. *Problems with the guidance*

There are some areas where the guidance to the assessing clinicians may contribute to underestimating the degree of incapacity. The guidance often cites the most extreme example of impairment, rather than providing suggestions around more borderline cases which may allow assessors to make more balanced decisions. For example, descriptor 15 (execution of tasks) has the following guidance:

“The pattern of typical day activity should really reflect a person who should struggle to get through the basics of a day due to their mental disablement as a result of tasks taking so long to complete that they would be unable to cope with work due to the length of time required for basic tasks. For example those who have severe and continuous disabling anxiety where they struggle to even get out of their bedroom may come into this category”.

By citing such an extreme case, it can overshadow less extreme, but still serious, cases and may lead to them being under assessed.

3. *What is the best way to ensure that the effect of fluctuating conditions is reflected in the recommendation of the WCA?*

We have covered the problems with fluctuating conditions and symptoms above.

While there seems no single reliable way of assessing this, we recommend that the assessment distinguishes more clearly between variable conditions and variable symptoms.

Assessors should be asked to evaluate variability in several ways and use these methods to develop a judgement as to the combined effects of these fluctuations. These multiple ways could include not only the assessment of a “typical day”, but also a “typical week”. A judgement should also be made of the claimant’s functioning at its worst. Each of the functional descriptors rated could be assessed as to how often they apply, and the worst case scenario could be used to provide a reliable rating. The subjective components that we outlined above could be assessed in a similar way. The use of a semi-structured format to the interview as outlined above would also facilitate this process.

We would like to see the WCA reflect the nature and severity of variations in mental health conditions. At the very least, we would like individuals to be provided with a greater explanation of how the effect of fluctuating conditions is assessed in the WCA. This would allow individuals to be clear in explaining how their condition does vary.

4. *What is the best way to ensure that the effect of multiple conditions is reflected in the recommendation of the WCA? Are there specific conditions that should be regarded as contributing to or adding additional weight to others, where both are present?*

We know from past research that mental health problems are at least as disabling as common physical conditions (Moussavi et al, 2007) and that mental and physical disorders are known to co-occur at greater than chance levels (Scott et al, 2009; Buist-Bouwman et al, 2005). There are two main ways of considering the effects of co-existing mental and physical disorders: first that their effects are *additive* ie that the individual components of these co-existing disorders have independent effects on functioning and thus the total effects are equivalent to the sum of the parts. The second view is that this co-existence is interactive and is associated with significantly greater levels of dysfunction than predicted by a simple sum of the main disorders ie the total dysfunction is greater than the sum of the parts. By contrast there is no evidence that mental health and physical health problems add up to less than the sum of their parts, yet in the operation of the WCA this is often how they are interpreted.

There is evidence for both additive and interactive effects when mental and physical disorders co-exist. A recent large international survey (Scott et al, 2009) found that people with depression and anxiety are more likely to be severely disabled than those with physical disorders and that those with combined physical and mental disorders are more likely to be severely disabled than those with one condition alone. Those with combined disorders also had higher levels of disability than predicted by the sum of the disability attributable to the individual disorders.

The evidence suggests there may be an alternative method of managing the contribution of multiple conditions. We recommend making the assessment more reliable and valid by the means suggested above and by ensuring that equal weight is given to the assessment of mental and physical conditions.

5. *What is the best way to give adequate weighting to additional (or initial) evidence outside of that through the WCA? How can any changes be achieved without placing a burden on GPs and health care professionals, and without compromising their relationships with their patients?*

We believe more weighting should be given to the professional opinion of those clinicians in contact with the individual making the claim. This would help not only to reduce the number of people erroneously judged to be fit for work but would assist in dealing with some of the problems of fluctuating conditions and symptoms and of combined mental and physical disorders. These clinicians would also have a greater understanding of how the condition affects the individual and how it might impact on their ability to work.

We would suggest that clinicians are routinely sent ESA 113 forms at the early stages of the process and that these should be sent to CMHT clinicians if appropriate. The clinicians who carry out the WCA assessments should also have sight of these medical assessments when they see the claimants and should be obliged to fully account for a decision which contradicts the advice of the relevant clinicians in terms of the claimant's ability to work.

While it could be argued that this may place an additional burden on clinicians, we believe that supporting service users in their employment aspirations should be a core function of NHS workers. Many clinical teams already offer benefits advice and where a service user is subject to an inaccurate WCA, this can increase the burden on clinical teams. Therefore, involving professionals up-front in getting the assessment right would be a more cost-effective option than leaving them to pick up the pieces of a poorly administered WCA.

To support this it would be helpful to have a named person from the DWP system to be responsible for each claimant's benefits claim who could be contacted by the claimant or clinicians when queries are required and who can assist in guiding the claimant through the benefits system.

6. *Is there any evidence to show that there has been particular problems with the WCA for any specific groups? These groups may include, but are not limited to, men and women, people from black and minority ethnic backgrounds, or people from differing age groups*

The information outlined above provides evidence for the specific problems with the WCA faced by those with mental health conditions.

7. *Do you have any suggestions for how the WCA process could be improved to better assign people with health conditions to the most appropriate part of the benefits system?*

In our evidence we are aware that in many ways the problems that existed for the PCA are still being replicated in the WCA process, particularly the problems with the Atos clinicians and the accuracy of the WCA medical assessment.

Our recommendations are outlined at the beginning of this document.

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