Right first time?

An indicative study of the accuracy of ESA work capability assessment reports

January 2012

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Summary

In order to claim benefits, most people who are too ill or disabled to work need to undergo a medical assessment. The report of the assessment is passed to a decision maker, who decides whether, and at what level, people will qualify for benefit.

Employment and support allowance (ESA) was introduced in October 2008, as a replacement for incapacity benefits and a new medical assessment, the work capability assessment (WCA), was introduced alongside it.

There are 6.9 million disabled people of working age in the UK.[1] In the year to the end of May 2011, 662,000 people were in receipt of ESA, 1.8 million received incapacity benefits and 3.2 million people disability living allowance (DLA).

Citizens Advice has long had concerns about the nature of medical assessments for incapacity and disability benefits, and the quality of decisions based upon them. We have been monitoring the introduction of the WCA and the whole process for claiming ESA. By May 2011, Citizens Advice Bureaux in England and Wales had given advice on almost 350,000 enquiries about the new benefit, from making an initial claim for benefit to help with appealing decisions. The large number of enquiries reflects the level of anxiety that ESA is causing clients.

CAB advisers tell us that inaccurate medical assessment reports are creating huge difficulties for their clients as well as potentially undermining the Government's welfare reform programme. People with serious illnesses and disabilities, who could not reasonably be expected to seek work, are found 'fit for work'. Others, who, with considerable support, could undertake some work, are denied benefit and, with it, the support it offers to prepare for returning to work. Many of these people are too ill to sign on for jobseekers' allowance (JSA) – they are left with no money to live on and are unable to seek work.

It is not just CAB evidence that indicates that there are problems with the accuracy of the assessments. In a system that was working well, we might expect appeals to concern marginal cases where points awarded were not quite sufficient to meet the criteria. However, of the appeals heard by February 2011, 39 per cent were overturned in favour of the claimant. Of these, 60 per cent had originally been awarded no points at all.[2]

It is crucial that WCA reports provide an accurate account of the medical assessment. Not only does the report impact directly on awards for ESA, it is also increasingly used to determine entitlement to DLA, a non-means tested benefit that helps disabled people meet the additional costs of their disability. In the future, the content of the assessment report, and the awarding of ESA, will become ever more significant. It is proposed that the award of ESA will become the main route to disability-related support within universal credit, and the report itself will play a greater role in deciding entitlement to the personal independent payment.

With this in mind, we have undertaken a detailed analysis of the accuracy of WCA reports. We examined, in-depth, reports collected from clients applying for ESA across the country, identified before they attended their initial WCAs. We asked each participant to request a copy of their WCA report from the Department for Work and Pensions (DWP), following their medical assessment. A total of 80 reports were provided by clients – this report describes analysis of 37 of these reports, all of which came from clients verified as having agreed to take part before they had had their assessment.[3]

Our analysis indicates that the level of accuracy in reports is worryingly low. This is true even where ESA has been awarded. Sixteen of the 37 in-depth reports reveal a serious level of inaccuracy, 10 a medium level of inaccuracy – enough to have a detrimental effect on an award of DLA, and 11 had a low (or no) level of inaccuracy.

This report calls on the DWP to undertake, with some urgency, regular, independent monitoring of

1. http://www.dlf.org.uk/content/key-facts
2. HC Deb, 28 June 2011, c662W
3. Ony 37 were analysed as we were confident that they were recruited before they had their WCA

the accuracy of WCA reports, to ensure that people who are too ill or disabled to work, either in the short- or long-term, are properly supported by the benefit system.

Part one — background

Introduction

In 2010/11, Citizens Advice Bureaux in England and Wales saw 2.1 million clients and helped them to resolve 7.1 million problems. Benefits and tax credits, and debt, are the two biggest areas of advice, and account for almost two thirds of issues advised on. Bureaux handled over two million benefits and tax credit issues. From its introduction in October 2008 to May 2011, Citizens Advice Bureaux in England and Wales have given advice on almost 350,000 enquiries about ESA. In 2010/11, bureaux gave advice on 202,449 problems on ESA, a 37 per cent increase on the previous year, and an indication of the increasing concern that the benefit is causing to bureaux clients. Between April and September 2011, more than 19 per cent of ESA enquiries to bureaux were about appeals.

ESA was introduced in October 2008 to replace the existing incapacity benefit (IB) for new claimants. It aims to provide increased help – through work-related activity – to ill or disabled people who may, with support, be able to move off benefit and into work. It also provides a slightly higher level of financial support to people assessed as being too ill or disabled for it to be reasonable for them to seek work. The 'work related activity' component is paid at £94.35 per week and the 'support' component at £99.85. At the end of May 2011, 662,000 people were receiving ESA.[4]

Citizens Advice has been monitoring the impact of the new benefit. *Limited capability*, our report published in November 2009, covered the administration of the benefit, and *Not working*, published in March 2010, looked at the assessment process – the WCA. This, our third report on ESA, looks specifically at the accuracy of WCA reports.

We, and other organisations, have been concerned for many years about the quality and accuracy of medical assessments for disability benefits. We receive numerous client reports of rushed assessments, assumptions being made without exploration, inaccurate recording and poor recognition of mental health problems. The descriptors on which the assessment is made have become much tougher, meaning that people have to be considerably 'more disabled' to qualify for ESA than they would have had to be to receive incapacity benefit. As a result, the accuracy of WCA reports has been brought into sharper focus.

To be found not capable of work (either initially or at appeal), a claimant must score a total of 15 points at a medical assessment conducted as part of the claims process for ESA. It would be expected that, where an assessment process was working properly, appeals would largely concern marginal cases – those that had been awarded just less than the required 15 points.

Yet, data for appeals heard up to February 2011, found that 60 per cent of decisions overturned at appeal involved cases in which claimants were initially awarded no points at all in their WCA.[5]

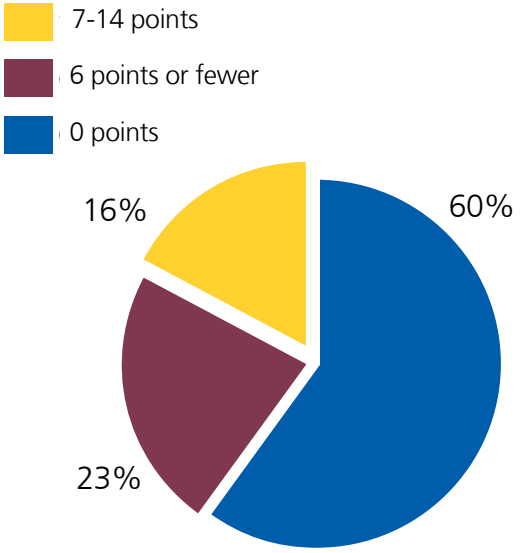
Of the claims made between October 2008 and February 2010, 335,900 were found fit for work at their initial assessment. 122,500 (36 per cent) appealed and had them heard by February 2011. In 48,000 (39 per cent) of these appeals, the original decision was overturned in favour of the claimant.[6]

Of these 48,000 successful appeals, 40,100 (83 per cent) were by people awarded six points or fewer at their initial WCA. Twenty nine thousand (60 per cent) had originally been awarded no points.[7] The following chart shows the percentage of cases overturned at tribunal, divided according to the number of points awarded at initial assessment:

4. http://statistics.dwp.gov.uk/asd/asd1/stats_summary/stats_summary_nov11.pdf
5. HC Deb 28 June 2011, c662w
6. http://statistics.dwp.gov.uk/asd/workingage/esa_wca/index.php?page=esa_wca_arc (April 2011)
7. HC Deb, 28 June 2011, c662W

Points awarded at initial assessment of those who subsequently won at tribunal

(Of claims received between October 2008 and February 2010)



* 1% unkown
Source: HC Deb, 28 June 2011, c662W

That 83 per cent of claimants, who were successful at appeal, were re-assessed from an initial assessment of six points or fewer to a score of 15 indicates that these are not a few borderline cases where initial assessments need modest adjustments by a few points. **These are cases where something was seriously wrong with the assessment.**

The need for an evaluation of the accuracy of WCA reports is continually reinforced in evidence from Citizens Advice Bureaux:

> A client of a bureau in the North East won her appeal tribunal after a very short hearing. The judge of the tribunal produced – without request – a statement of reasons for his decision, which included the following comment: "The report is misleading, superficial and shallow. It is not fit for purpose. …It is inexcusable that the Secretary of State should seek to justify this report as a basis for making a decision. Sadly there are too many reports of this standard."

Some changes have been made to the assessment process during the course of this study, following the report of the first year of the Harrington Review[8], and bureaux do report improvements in the reconsideration process by the DWP. Indeed, several of the cases in our study were reconsidered and the decisions changed. Some changes are currently being trialled, which may improve the accuracy of reports; their success will depend on how they are implemented.

We discuss these changes later in the report, together with recommendations from year two of the Harrington Review, published in November 2011.[9] However, we remain concerned about the limited nature of the recommendations, and the slow pace of implementing change.

Importance of accurate reports

It is crucial that WCA reports provide an accurate account of the assessment. The content of the report, and the awarding of ESA, will become ever more significant as it will be the main route to disability-related support within universal credit. The report itself will play a greater role in defining eligibility for the Personal Independence Payment (PIP - the replacement for DLA in the Welfare Reform Bill). The DWP is also considering the potential use of the report by Work Programme providers.

Increased impact of inaccurate reports

Bureaux advisers have, for many years, reported the problems caused by inaccurate medical assessments for disability benefits. In the past, however, people with serious health conditions were exempted from the face-to-face assessment, so they were not at risk of being found fit for work from a poorly conducted assessment. Decisions were based on written applications and evidence.

The level of impairment required to be found eligible for sickness and incapacity benefits has steadily increased, so there is now much less room for error in the assessment.

8. Harrington Prof M (2010) *Independent Review of the Work Capability Assessment – year one*
9. Harrington Prof M (2011) *An Independent Review of the Work Capability Assessment – year two*

Personal Capability Assessment (incapacity benefits)	Pre-April 2011 WCA	New regulations (post-April 2011)
Someone with emphysema and heart disease may well have been exempt from the PCA. Certainly would have qualified for IB if they had difficulty walking more than **200 metres**, standing for longer than 20 minutes and, sometimes, bending.	Under the pre-April 2011 WCA, they would have qualified if they could not walk more than **100 metres**, stand for no longer than 30 minutes or if they could not bend.	The bending descriptor has been removed and the standing and sitting descriptor now applies only to people who can neither sit nor stand. Such a client would only qualify if they could walk no more than **50 metres**.

For a client to be awarded ESA, the assessment process (the WCA) requires a higher level of impairment than the former personal capability assessment (PCA) – the process for assessing entitlement to incapacity benefit. New regulations for the WCA introduced in April 2011 have made the qualifying level of sickness or disability even higher – as the table above illustrates in relation to a person with emphysema and heart disease.

A decision by a health care professional between whether someone can walk 100 metres or no more than 50 metres is a fine judgement to make, and a small error is more likely to lead to an incorrect decision.

Impact on decisions about disability living allowance and personal independence payments

WCA reports are increasingly being used to decide whether someone is entitled to DLA. This benefit is intended to recognise the additional costs of disability, rather than compensating for an income lost through not being in work. It is paid at several different levels depending on need, the care component ranges from £19.55 to £73.60 per week and the mobility component from £19.55 to £51.40.

The walking descriptor is particularly important, as the claimant's capacity to walk may have no effect on their ESA award (as they may meet the criteria on other grounds) but frequently leads to refusal of the higher rate of the mobility component of DLA. Face-to-face assessments and medical reports, similar to the WCA, are planned for the personal independence payment. Evidence such as the following is common in bureaux:

A client had a life threatening condition (anorexia nervosa), and had recently been in hospital for six months. He had been sectioned under the Mental Health Act. He was attending the hospital weekly for therapy, monitoring and supervision. He also suffered with obsessive-compulsive disorder, linked to the anorexia, and had a body mass index of 14, which is in the severe range for anorexia nervosa. He was turned down for ESA scoring nil points and put in an appeal. The adviser at the bureau remarked that the report was "poor and unfactual" and his claim for DLA was also turned down on the basis of the report. He has won his ESA appeal and is awaiting the outcome of his DLA appeal.

Another client was awarded ESA after an assessment. He had a number of conditions including prostate cancer, renal failure, type two diabetes and a large umbilical hernia. He needed a lot of help with care needs and had difficulty moving around, even indoors. He applied for DLA but was refused. When he appealed, he discovered that the reason he was refused was the report from his WCA.

He had qualified for ESA on the basis of descriptors other than walking, but the report had concluded, to his surprise, that he had been assessed as being able to walk more than 200 metres. This was not an accurate assessment of his mobility and if he had been able to walk 200 metres, he would not qualify for the mobility component of DLA.

Possible use of the assessment by Work Programme providers

The DWP is currently considering whether some of the information from the WCA report could be shared with Work Programme providers, to assist them in assessing individuals' barriers to work. This will only be valuable if the information is accurate. If, for example, a claimant has both a mental health condition and a physical impairment, but the health care professional only awards points for the physical impairment, the Work Programme provider is then unlikely to assess the client's barriers to work correctly.

The ESA claim process

When someone applies for ESA, they send a 'fit note' to the DWP from their GP stating the reasons why they are unable to work. Over the subsequent 13 weeks, the person is assessed by the DWP to decide whether they are entitled to ESA and which group they should be in. There are three potential outcomes from the assessment. They can be:

- allocated to the ESA support group
- allocated to the ESA work related activity group (WRAG)
- found fit for work and not entitled to ESA.

The assessment is carried out by a health care professional (usually a doctor or nurse) employed by Atos Healthcare, and the decision to award ESA – and at what level – is made by a DWP decision maker.

The work capability assessment

The WCA is the functional assessment used in most cases to decide whether someone is entitled to receive ESA and at what level. There are a few exceptional circumstances in which someone can be placed in the support group without the need for a WCA (such as if someone has less than six months to live, or if it would be dangerous to their health to be found fit for work-related activity).

In the WCA scheme, there are 17 descriptors each relating to a different type of functioning. Each descriptor scores different points, depending on the level of an individual's impairment. In order to be placed in the WRAG, a person needs to score at least 15 points. For example, the first descriptor looks at how far someone can mobilise (walk, move on crutches or self-propel a wheelchair): if the person can't mobilise more than 50 metres, they would score 15 points and so be placed in the WRAG on the basis of that descriptor alone. If they can't mobilise more than 100 metres, they would score nine points, so would need points from another descriptor to be awarded ESA.

For allocation to the support group, there is a separate set of descriptors denoting a more severe level of impairment, but with no gradation of levels. To be allocated to the support group, a person has to qualify for at least one of these descriptors. For example, if someone can't mobilise more than 30 metres, they would be placed in the support group. People are not, however, allocated to the support group if they have a number of different impairments below the prescribed level for the support group, even though the combined effect may have a greater impact on their life than a single impairment at the severe level.

The role of Atos Healthcare

The ESA WCAs are conducted by health care professionals employed by Atos Healthcare, a private company contracted to carry out the assessments on behalf of the DWP.[10] Atos is also involved in the assessment process for other DWP sickness and disability benefits, incapacity benefit (IB), disability living allowance (DLA) and industrial injuries disablement benefit (IIDB).[11]

10. Atos Healthcare is a business division of Atos
11. HC Deb, 21 Jun 2011, c187w

The current Medical Services agreement between Atos and the DWP started in September 2005 and was extended at the end of 2010 to run until August 2015.[12] The amount that the DWP pays to Atos to carry out contracted services is driven by the volume of assessments, and the total cost to the Department for all benefit streams covered under the contract amounts to approximately £100 million per annum.[13] The DWP estimates that over the lifetime of the contract, Atos will have been paid about £1 billion.[14] Details of how much Atos is paid for each medical assessment is "commercially sensitive" and therefore not publicly available.[15] However, it would appear to be in taxpayers' interest if unnecessary face-to-face assessments were avoided and if the number of appeals against inaccurate WCA reports were reduced.

Atos employees must be registered as health care professionals with the General Medical Council (GMC) or the Nursing and Midwifery Council, and must comply with the respective body's codes of conduct and confidentiality. To carry out an assessment on behalf of the DWP, the health care professional must be approved by the Secretary of State, which involves initial and ongoing training and ensuring that they meet the required standards.[16]

The contract includes quality indicators, which are used to measure the performance of health care professionals. These include management information, customer satisfaction surveys and complaint feedback. Healthcare professionals are subject to quality audits, conducted by Atos medical auditors, which are in turn monitored by doctors working for the chief medical adviser to the DWP.[17] It is not known if Atos' remuneration is affected if it appears that a report that they produced is inaccurate, for example following an appeal. It is not therefore clear if there are any financial incentives for quality and accuracy.

The Independent Case Examiner investigates complaints about Atos relating to administrative issues, such as a breach of confidentiality. The GMC would, ultimately, handle serious complaints about the conduct of individual Atos health care professionals, when the complaint is about a doctor.[18] Where the complaint is about a nurse, the Nursing and Midwifery Council would ultimately handle the complaint. We understand that a number of individual complaints, about doctors employed as health care professionals by Atos, have been made to the GMC which are being investigated. In response to a letter to the *British Medical Journal*, the GMC has made clear that "The first duty of all doctors is 'to make the care of your patient your first concern'" and that includes "doctors when they are assessing benefits claimants on behalf of Atos".[19]

In view of the many concerns that have been raised over the years, about the quality of the assessments and the detrimental effects to claimants' health and well-being if they are wrongly assessed, we believe that there should be independent quality assurance of contractors carrying out assessments on behalf of the DWP.

We also recommend that the DWP considers, if they do not already do so, imposing financial penalties on Atos for every inaccurate report they produce.

The claims process

Most claimants will be sent a form, the ESA50, which asks for details of how their condition or impairment affects their functioning.

Further medical evidence may be sought at any time from any claimant's own doctor (using the form ESA113), but we understand that it is most commonly collected only in cases where an Atos doctor decides that the claimant could potentially be placed in the support group without a face-to-face assessment. Only about eight per cent of ESA claims involved the use of an ESA113 form, from October 2008 until January 2010 (the latest figures available).[20] In these cases, once the evidence is received, the Atos health care

12. HC Deb, 2 Dec 2010, c955w
13. HC Deb, 21 Jun 2011, C186w, This includes medical assessment, medical advice, IT support infrastructure and maintenance of facilities
14. HC Deb, 17 Jun 2011, c1027w
15. HC Deb, 18 Oct 2010, c461w
16. http://www.dwp.gov.uk/healthcare-professional/guidance/atos-healthcare/
17. HC Deb, 2 Nov, 2010, c784w
18. HC Deb, 8 Nov 2010, c178w
19. http://www.bmj.com/content/342/bmj.d1155.full/reply#bmj_el_251102

professional decides whether to recommend to the DWP decision maker that the person is placed in the support group (or occasionally the WRAG) without the need for a face-to-face assessment.

The large majority of new claimants, however, are asked to attend a face-to-face assessment. Claimants can send medical evidence with their ESA50 but it is not automatically collected by the DWP. In many cases, NHS doctors will charge an average of £30 (we have evidence of consultants charging £200 an hour) for medical evidence and few people on low incomes can afford to pay this much out of an income of £67.50 ESA (assessment phase rate) per week.

Almost 1.8 million existing IB claimants are being reassessed and migrated over to ESA. It is likely that a greater proportion of these people will be placed in the support group, without the need for a face-to-face assessment, than 'new' ESA claimants, but the majority will still have to attend an assessment.

Clients are sent a letter with appointment details and the telephone number of a helpline to ring if they are unable to attend on the date given. At the face-to-face assessment, the health care professional will take an account of the client's typical day and a short history of their medical condition, which will be entered into the computer as the claimant talks. The health care professional may also conduct a short medical examination. On the basis of his/her observations and the information the claimant has given, the health care professional will then decide on the claimant's level of functioning for each of the descriptors. This information will be entered into the computer after the claimant has left the room.

The assessment report (ESA85)

The first page of the report gives details of who carried out the assessment, where and how long it took. The health care professional records the duration of the assessment by pressing a computer button to indicate when the claimant enters the room, and pressing a further button when the claimant leaves the room. The time when the health care professional sends the report to the decision maker is also recorded electronically.

The next section is an account of the interview with the claimant, and should record what the claimant tells the health care professional about the history of their condition or impairment, and how it affects their day-to-day life, including variations. This part is completed by the health care professional on the computer as s/he asks the questions, and should not include any judgement by the health care professional on the accuracy of the claimant's account, as there is an opportunity for comment later.

The next part of the report (completed immediately after the claimant has left the room) requires the health care professional to make a judgement based on what the claimant has said, their own observations and any other evidence they may have, as to the level of functionality for each of the 17 descriptors. The computer automatically recalls relevant information from the claimant from the previous section. The health care professional can select from this information and can also add any observations s/he has made to justify the level of functionality chosen. If the health care professional disagrees with a level of functionality indicated by the claimant's information, this is the opportunity to give reasons for disagreeing, for example by stating that the history given by the claimant is not consistent with the condition or with the health care professional's own observations.

The ESA85 is then sent electronically to the DWP decision maker.

Part two – the study

Aim of the study

CAB advisers frequently report a very significant level of inaccuracy in many of the Atos medical reports they see in ESA appeal papers. We have repeatedly raised this with the DWP and with Atos. The response from both has been that there are

20. HC Deb, 30 Mar 2010, c966w

bound to be a "few mistakes" in as large an organisation as Atos, but that it is a very tiny proportion of the total number of reports prepared.

This is not consistent with the experience of welfare rights advisers who have worked with many thousands of clients, who say that a significant proportion of their clients have received an incorrect decision based on an inaccurate report and need to appeal. It is also inconsistent with the DWP's own statistics which show that 60 per cent of decisions over turned at appeal were initially awarded no points at all. This suggests that there were fundamental problems with the reports' accounts of the claimants condition in these cases.[21]

In February 2006 Citizens Advice published *What the doctor ordered? – CAB evidence on medical assessments for incapacity and disability benefits.*[22] In March 2010 we published *Not working – CAB evidence on the ESA work capability assessment.*[23] Both reports reflected the views of advisers – that there is a systemic problem with the accuracy of the face-to-face assessment reports.

The accuracy of recording is becoming increasingly important, as set out above. It is crucial, therefore to establish an estimate of the scale of the problem. To achieve this, we undertook an indicative study. CAB advisers across England and Wales were asked to identify clients before they had attended a WCA, and ask them to take part in the study. We could not know how well they would be treated, or what the outcome of the assessment would be. The study ran from summer 2010 to June 2011.

Methodology

Investigation

The two main parts of the ESA85 are the account the claimant gives of his or her daily life, and the judgement of the health care professional as to the effect of the impairment or condition on the claimant's level of functioning. This study focused on the accuracy of the history taken by the health care professional at the interview with the client, and how this evidence was used in the assessment process. Our advisers are not medical practitioners, so we cannot comment on the health care professional's medical competencies.

CAB advisers across England and Wales were asked to:

- identify clients who were on basic ESA but had not yet attended their WCA
- ask consenting clients to sign a letter requesting the medical report be sent to them after the assessment
- arrange an appointment with the client to discuss the report, specifically the account they gave about their medical history and their daily life
- make a note of:
  - any factual errors
  - anything the client said that had been left out
  - any subjects which would have been relevant, but where the client felt they weren't given enough time to discuss or expand further
  - any untrue conclusions drawn later in the report because assumptions had been made.
- anonymise the report and send it to Citizens Advice with the above list of errors or omissions.

Study participants

People often visit a CAB because something has gone wrong, because they have had a bad experience of an assessment or want to challenge the outcome. To ensure an unbiased sample of CAB clients for this study, participants were recruited before they attended their WCA, and so they could not know how the assessment would go, or what the outcome would be. Those claimants who seek help from bureaux are likely to have had help from an adviser in completing their ESA50, and so more detailed information than might otherwise be the case is likely to have been available to the health care professional, potentially resulting in a more accurate report.

21. HC Deb, 28 June 2011, c662W
22. http://www.citizensadvice.org.uk/index/policy/policy_publications/what_the_doctor_ordered.htm
23. http://www.citizensadvice.org.uk/index/policy/policy_publications/not_working.htm

The proportion of claimants in the study who were eventually awarded ESA (19 out of 37: 51 per cent) is considerably higher than the proportion of ESA recipients overall (24 per cent), according to DWP figures.[24] CAB advisers are aware of the criteria for entitlement and so would advise anyone who does not fulfil the criteria that they are likely to be found fit for work and would discuss other options with them.

While the survey relied on what the claimant reported that they told the health care professional, there is no reason for them to be any less truthful than in any other customer service survey, and the information was often verifiable from other sources, such as medical records, or what clients had said about their daily life in their ESA50.

The sample size is necessarily fairly small, as the survey method demanded a considerable time and resource commitment from advisers, including volunteer advisers. We are very grateful to those bureaux who undertook this work, and we are satisfied that the survey has succeeded in identifying significant concerns about the accuracy of WCA reports which should be further investigated by the DWP.

Analysis

This report draws on evidence from 37 of the 80 claimants identified in this way, from 20 bureaux across England and Wales. Almost 80 cases were received in total, but many had to be discounted simply because we could not be absolutely sure that the clients were recruited before they attended their initial WCA.

The WCA reports were divided into three main groups according to the overall level of reported inaccuracy – serious, medium and low (or no). To illustrate the difference between these types, Appendix 1 provides a summary of two of the cases in the 'serious level of inaccuracy' group, and a very short overview of each of the rest of the 37 cases in the study.

Each report was analysed by i) type of reported inaccuracy, ii) degree of reported inaccuracy, and iii) the extent to which these inaccuracies could have affected the eventual points score made by the DWP decision maker.

Reports were classified as having a *serious level of inaccuracy* if:

- the errors in the report were very substantial **and**
- were likely to have a very significant impact on either the ESA award or a DLA award.

Reports were classified as having a *medium level of inaccuracy* if:

- there were some significant errors/omissions **and**
- these could affect the points score and potentially whether the person should have been awarded ESA, or if a claim for DLA would be affected.

Reports were classified as having a *low (or no) level of inaccuracy* if:

- there were only a few or no reported errors or omissions **and**
- the errors or omissions would probably not be a deciding factor in the award of either ESA or DLA.

Findings: type and degree of reported inaccuracy

- Thirty seven reports were from claimants who had agreed to take part in the study before attending their WCA.
- Sixteen of the 37 cases indicated a serious level of reported inaccuracy.
- Ten of the cases indicated a medium level of reported inaccuracy.
- Eleven of the cases indicated a low (or no) level of inaccuracy.

Cases were analysed by type of reported inaccuracy and degree of reported inaccuracy, based on the stages in the assessment – i.e. collecting the evidence from listening to, observing and examining the claimant; summarising the evidence; and recommending the level of points for each descriptor.

24. http://statistics.dwp.gov.uk/asd/workingage/index.php?page=esa_wca

It was also noted whether the recommendations made by the health care professional were consistent with the material in the report.

Type of reported inaccuracy

Five main types of reported error or omission were recorded, which appeared to have a significant impact on the accuracy of the report and the level of points awarded. An example of each main type is given below.

1. Omissions or incorrect observations recorded

A pronounced and clearly observable impairment was simply not recorded in several cases. In others, the health care professional recorded that the client could perform an action they denied being able to perform, or that they performed it unaided, when they had actually needed help. For example:

> A client had curvature of the spine. The bureau adviser who interviewed this client was a retired health care professional herself and reported that the curvature was very pronounced – the claimant obviously had a lot of pain when sitting and could only sit in a sideways position. For the sitting descriptor, the Atos health care professional observed that "[the client] had no problem sitting" and therefore recommended no points for this descriptor. She made no mention of the curvature of the spine or the obvious pain it caused while the claimant was sitting.

2. Incorrect factual recording of the history given by the claimant

Within this category we considered any facts given by the claimant that were recorded incorrectly in the report, or any significant omissions where important information was given by the claimant, but not recorded. For example:

> A client with a serious and painful shoulder injury said that he told the health care professional he couldn't get dressed, shower, put on socks, tie shoe laces etc without help from his wife, as it was too painful to use his left arm at all. However the description of a typical day stated, "has a problem with dexterity, holding items, reaching, bending and pain, but manages to dress and undress without help or aids" and "has a problem with gripping… but manages to shower". The difference between being able to use or not use the arm would make the difference between being awarded ESA or not. Indeed this client was refused ESA on the basis of the report but won his appeal based on the evidence of his inability to use his left arm, which he believes he gave to the health care professional and the assessment, in theory, had adequate opportunity to explore.

3. Medical evidence inappropriately determined

In a number of instances, the health care professional reported information about the client's medical condition, which they were not actually in a position to decide, or made unjustified assumptions about the claimant's condition. For example:

> An Atos health care professional gave a claimant, who was registered blind and was under a consultant ophthalmologist, a sight test. The claimant was astonished when the health care professional held a card with letters on it at a seemingly random distance away from her and asked her to read them. She has regular tests from her ophthalmologist and was perplexed as to why a test was necessary at the WCA. She was horrified to find that the health care professional had actually come up with a measurement from that test which was substantially different from that of her consultant. While the level of sight loss was still sufficient to qualify for the benefit, this information could lead to problems claiming DLA, for example, where – if it went unchallenged – that degree of sight loss might be seen to be inconsistent with the care needs described.

4. Closed questions, lack of empathy to encourage the person to talk and incorrect assumptions made when the information was not gathered

We have welcomed proposals in Professor

Harrington's first independent review to improve the manner and style of WCAs[25], but evidence from this study indicates that there are still problems with the manner of some health care professionals.

A number of respondents reported having been interviewed by an abrupt health care professional, and two people felt that the health care professional had been rude. Those who reported abruptness said the health care professionals had used closed questions demanding yes/no answers, and they had experienced an atmosphere in which they did not feel able to talk about difficult or embarrassing topics and were not given opportunities to qualify their answers. Even when clients did not report that the health care professional was abrupt, it was common for clients to report difficulty in being allowed to expand on the variability of their conditions. Some health care professionals then appear to have made incorrect assumptions, reflected in their report. Although these reports may represent a factual recording of what was said, they cannot be considered complete if the full information was not gathered accurately.

A client reported that the health care professional was abrupt and didn't listen to any qualifying remarks. She also reported that the questions were very closed so it was very difficult to explain her problems. She claimed that the health care professional refused to look at the latest medical evidence which the client had brought with her from her consultant, which stated that problems were long-term and more likely to deteriorate than improve.

5. Inconsistency within the report

There were cases where the history taken from the claimant and the observations made by the health care professional were consistent, and should have led to a specific level of descriptor, yet a different level of descriptor was then recorded. This led to the wrong number of points being recommended by the health care professional and subsequently awarded by the decision maker.

The health care professional recorded: "due to poorly controlled diabetes he gets hypo attacks on a weekly basis" but in the descriptor he chose "at least once a month, has involuntary episode of lost or altered consciousness". This level of descriptor carries nine points, whereas experiencing weekly attacks carries 15 points.

There were a number of instances where a history was taken, which indicated a certain level of descriptor, and yet the health care professional stated that there was no evidence of any problem with this descriptor, when the evidence from the claimant clearly indicates a very significant problem.

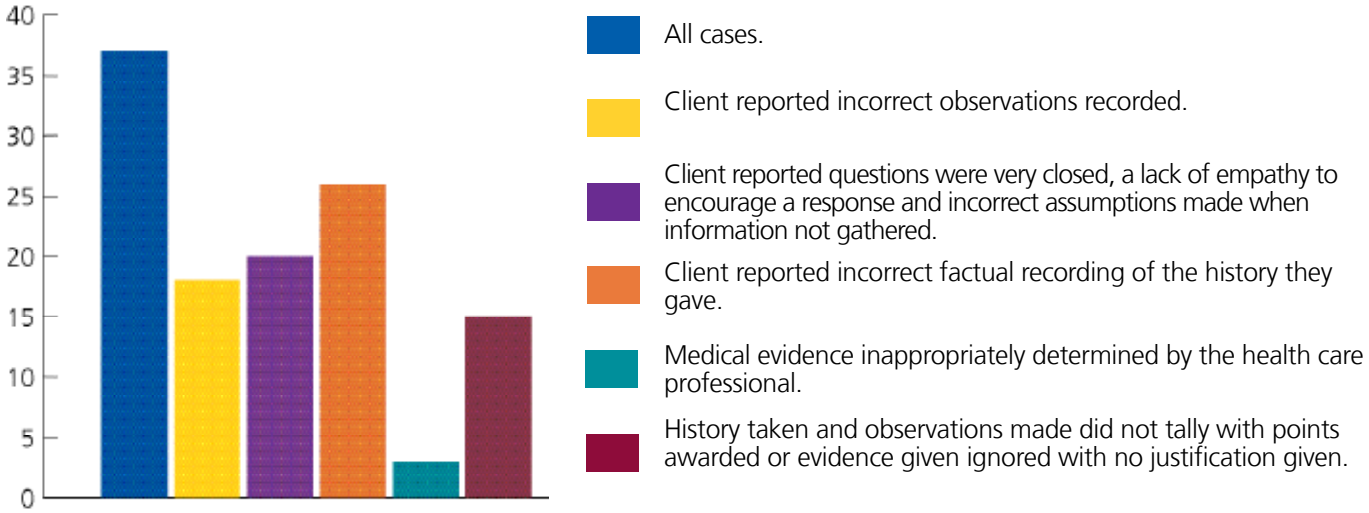
In one case, under the walking descriptor, the health care professional chose to not recommend any points for this descriptor and gave as his reasons – "there is no evidence to support problems walking". Yet in the claimant history, he recorded "always unable to go to the supermarket, alone or with someone else because of pain, fatigue, hypo attacks; usually uses crutches to get around" and in his observations: "used two crutches to walk 10 metres to the examination room". He also recorded that his examination of the claimant's lower limbs "is consistent with typical day and observations".

If the claimant was unable to walk round a supermarket and this was consistent with the examination, it is hard to understand why the health care professional recorded no problems with walking. This client qualified for ESA under a different descriptor so it might seem unimportant, but it could seriously affect a claim for the mobility component of DLA.

The most common reported problem overall was general inaccuracy in the recording of what the client had said. The next most common problem – reported by just over half the participants – was lack of exploration of the effect, or variability, of the condition. Problems with inconsistency within the reports are particularly worrying, because decision makers did not pick up these inconsistencies until pointed out by welfare rights workers when the appeals were submitted. We are also concerned about these types of inaccuracies, as they have significant implications for DLA awards.

25. Harrington Prof M (2010) *Independent Review of the Work Capability Assessment – year one*

The frequency of different types of reported inaccuracy

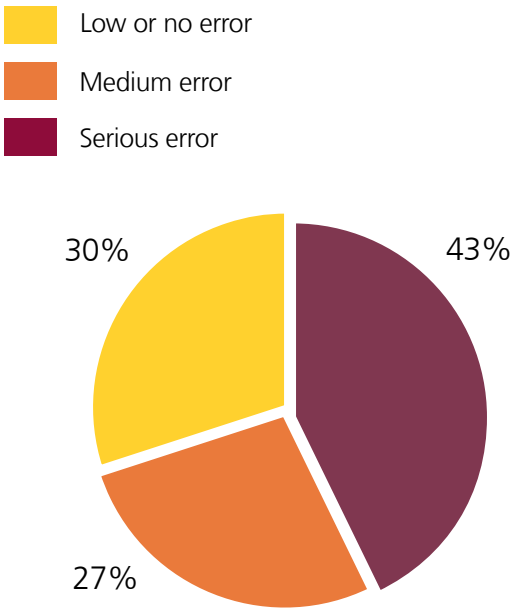


Degree of reported inaccuracy

In this section we show how we have assessed the degree of reported inaccuracy, classified as serious, medium and low. In the Appendix, we describe in detail two cases and provide a short summary of every other case, with the main reason for our categorisation. This provides more detail of the criteria we have used to determine our analysis.

Sixteen of the cases we analysed (43 per cent) were judged as having a serious level of reported inaccuracy, 10 (27 per cent) a medium level of reported inaccuracy and 11 (30 per cent) no or a low level of reported inaccuracy.

The percentage of WCA reports in each category of inaccuracy



Base: 37 reports

No or low level of reported inaccuracy

These WCA reports, 30 per cent of our sample of 37 cases, had either no, or only a few, reported inaccuracies and the inaccuracies would be unlikely to affect the points scored or any award of benefit.

There were cases in this group where the client felt the assessment had been carried out well and gave a true picture of the impact of their impairment or condition on their life.

Other clients felt that, while there were no major inaccuracies in the account of their situation, the impact of their impairment or condition on their life was not as complete as it might have been, and rather underestimated the impact of their condition.

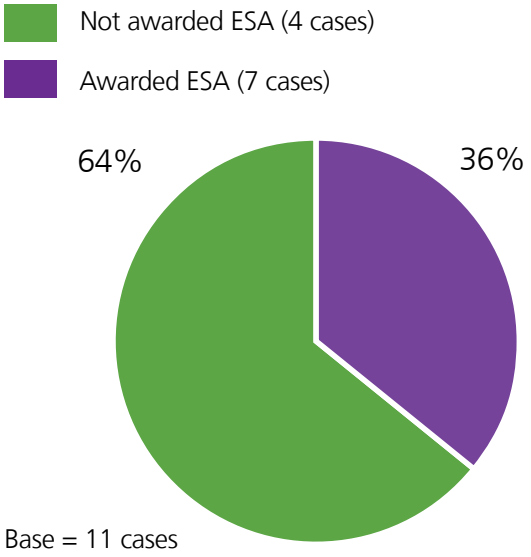
Of the 11 cases in this group, seven were awarded ESA. Of the remaining four cases, not all clients agreed with the result, but they nevertheless felt that there were no serious errors in the report.

It is notable that a CAB adviser accompanied two of the seven clients who were awarded ESA, to the assessment. In both cases, the assessment was reported as being considerably longer than any of the other assessments and was very thorough. One of these two clients had scored no points in a previous assessment when he had been found fit for work and had had to claim JSA. In this case, he believed that his health condition was largely the same as before, but he scored 33 points. This could point to the very natural tendency of health care professionals – like most people – to perform more thoroughly

when observed, and indicates that any checks on quality could be more effective if some form of mystery shopping is used.

The same client pointed out that as a result of the first decision, and having to cope with the increased conditionality of JSA, his health had been badly affected and his suicidal thoughts had increased. It had taken the rest of the year for his health to recover to a level equivalent to the time of the first assessment. He felt that *"a year of my life was lost – a year which, if I had been properly supported, I could have spent finding my way back to work"*.

Outcomes where a low level of error was reported



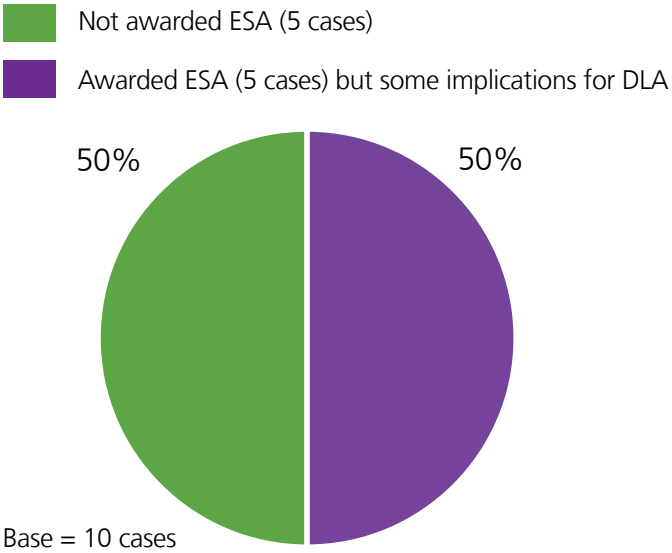
Base = 11 cases

Medium level of reported inaccuracy

These cases had a lower reported level of inaccuracy than those considered serious, but there were still some significant errors and omissions which could affect the points score – and potentially, therefore, whether the person should have been awarded the benefit.

Of the 10 clients in this group, five were awarded ESA but the reported errors in the assessment record would be likely to have a detrimental effect on an application for DLA. There were several cases where important areas such as variability of condition was not explored, and where reported physical problems were ignored with no justification given. There were also two cases where the client felt it was difficult to talk because of the health care professional's manner. As mentioned above, while the account was therefore largely correct, the assessment was likely to be incomplete, because the client's problems were not fully explored.

Outcomes where a medium level of error was reported



Base = 10 cases

Serious level of reported inaccuracy

Each of the 16 clients in this group reported a level of errors and omissions in the report that effectively built a false picture of how the client felt they had described their daily life.

Seven clients in this group were refused ESA, and DWP decision makers overturned three of these decisions, once an appeal had been submitted. One was actually put in the support group. This indicates a strong level of medical evidence supporting the claimants' view of their reports. Another was overturned on appeal; a further one on a paper hearing; one is waiting for their appeal to be heard; the final client in this group did not return to the bureau so it is very likely that he decided not to appeal.

Decision makers do now seem to be looking more carefully at all the evidence when claimants appeal. We are concerned, however, that in none

of these cases did the decision maker overturn the recommendation of the report until an appeal was made, even where the health care professional had recommended the wrong level for the descriptor according to his own evidence. We continue to press for the right decisions to be made in the first place, and we re-iterate our concern that an inaccurate report could have significant implications for a DLA application. This is particularly the case where a claimant is awarded ESA and does not ask to see their report, so remaining unaware of the problem.

Nine clients were awarded ESA, despite their view that the report was very inaccurate. This is because the level of impairment they reported describing was considerably more severe than the level required to be awarded ESA, so the inaccurate recording did not materially affect the outcome. As the benefit was awarded, however, they would have been unlikely to ask to see their reports if they had not been taking part in this study – but an inaccurate report could have a serious impact on a claim for DLA.

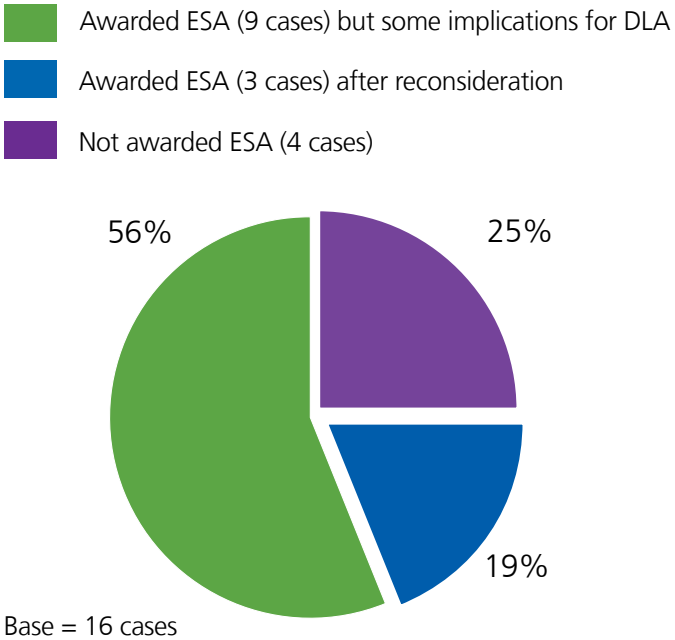
There were a number of cases where the health care professional recommended awarding ESA on mental health grounds, and no points were awarded for the physical descriptors, even when they had obvious physical disabilities. There was no justification given for awarding no points against these descriptors. Conversely, there were also two cases where, despite the client having a diagnosed mental health condition, no points were recommended for these descriptors and no justification given, after a sufficient level of functional physical impairment had been assessed.

As the use of evidence from these assessments gradually extends, we believe it is vital that all descriptors are addressed, and a full and accurate picture of the client's condition and circumstances is recorded. More than half of clients in this group had been awarded ESA so would be totally unaware of the wrong information which could be used to decide an application for DLA.

There were two cases where the wrong level of functional impairment seems to have been chosen by the health care professional – i.e. the health care professional quoted evidence and his own observations, which equated to one level of impairment, but then chose a different level. It is worrying that the decision maker picked up neither of these mistakes when making the original decision. Clients do not routinely see their reports, so could not pick up such mistakes themselves.

The majority of claimants in this group who hadn't been awarded ESA had their decision overturned at the reconsideration stage when a bureau helped them appeal. This is a sign of progress: at the time of our report *Not working* in March 2010, advisers reported that the reconsideration process appeared to be just a 'rubber stamping' of the original decision. Two of the three remaining clients won at appeal and in the final case it is unknown whether they decided to appeal. We believe it is preferable, however, to ensure that more correct decisions are made initially, to save resources for all concerned.

Outcomes where serious level of error was reported



Base = 16 cases

Findings: use of medical evidence

In previous evidence on ESA, we have offered a number of recommendations, which we believe would improve the assessment process. Evidence from this survey supports two of these recommendations in particular:

- DWP should be responsible for collecting evidence from the claimant's own doctor.
- Decision makers should be given the power to delay the assessment in certain circumstances.

The use of medical evidence from the claimant's own doctor before the WCA

We welcome the fact that clients are now encouraged to send in medical evidence with the ESA50. As explained above, however, we believe that DWP should take responsibility for collecting the evidence and we are disappointed that the Harrington Review year two report did not recommend this.[26] In at least four of the 37 cases in this study, Atos or DWP could have gathered all the necessary evidence from the clients' own doctors to award the benefit, without the need for a face-to-face assessment.

- Two cases relied on how frequently the clients experienced episodes of loss of consciousness. In both cases the clients' consultants could have reliably supplied this evidence.
- Another case hinged on the client's level of visual impairment, which had been expertly determined by a consultant ophthalmologist, and did not need, therefore, to be assessed by Atos.
- The fourth case was that of a client who had had spinal surgery two weeks earlier. The health care professional was shocked that the client had been asked to attend, and curtailed the assessment, placing the claimant in the support group.

It is highly likely that many more of the assessments – such as those which were overturned on reconsideration – would also have benefitted from medical information being available to the health care professional. Using existing medical evidence should reduce costs, speed up decision making and reduce inaccuracy.

Power for the decision maker to delay assessments on the basis of medical evidence

There were a number of cases where medical evidence would have indicated that it would be sensible to delay the assessment. The current system relies on the Atos helpline agents – who are not medically trained – to make this decision. For example:

> The client who had just had spinal surgery phoned the helpline and explained her position, but she was, however, told she had to attend as arranged, or her benefit might be at risk.

There were a number of other cases where it appears that a delay in the assessment and placing someone temporarily in the WRAG would have been helpful. For example:

> A client who had just been diagnosed with bone cancer was having ongoing tests. Within a month or so of her face-to-face assessment, she had received a diagnosis of terminal illness and was therefore placed in the support group. It would have been sensible to delay the assessment until the investigations were completed.

> A client was suffering breathlessness and chest pains. Despite an absence of diagnosis, and the fact that investigations were ongoing, the health care professional assumed the client had asthma. In the report, many of the things the client had said about his typical day were downplayed in the way they were recorded, and the client was awarded no points. The client was subsequently diagnosed with emphysema and is having further "cardio investigations".

We recommend that medical evidence should be requested in all cases from the professional nominated by the claimant as knowing them best.

26. www.dwp.gov.uk/wca-review

We welcome the fact that the value of medical evidence is now recognised but it should not be the responsibility of the claimant to provide that evidence. This will lead to a two-tier system whereby the poorest and most vulnerable claimants, who cannot afford to pay for the evidence, could receive a less reliable decision.

This medical evidence should also state if there are serious investigations underway, or if the claimant is likely to have a serious operation in the near future. In cases where there is likely to be fuller information available shortly, the assessment should be delayed for a short time until the investigations are complete.

We believe that both of these recommendations would be cost effective in terms of producing more accurate outcomes and fewer appeals.

Changes to the assessment process in the last year

Our survey was carried out between summer 2010 and June 2011, during which time there were some changes made to the assessment process. A specific survey was carried out by Mind for the Disability Benefits Consortium (DBC) in August 2011 to evaluate the impact of these changes.[27] Three hundred welfare benefits advisers (including CAB advisers) responded.

Changes in the descriptors were introduced in April 2011, which make it more difficult for clients to qualify for ESA. In the DBC survey, only just over two per cent of respondents agreed that the new descriptors have led to a more fair and accurate reflection of applicant's impairments in the assessment outcome, whereas 92 per cent disagreed. In several of the cases in our survey, clients who were awarded ESA despite a poor report would not have been awarded the benefit should they have been assessed under the new, tighter descriptors, thus reinforcing again the importance of accurate reporting.

The first annual independent review led by Professor Harrington recommended that decision makers be given more power to consider all the evidence. In the last year, advisers have told us that they have noticed an improvement in the reconsideration process but much less improvement in the original decision-making. In the DBC survey, 32 per cent of advisers thought that changes in the way decision makers used the reconsideration process had had a positive impact on outcomes, and only slightly more (36 per cent) thought it hadn't; but only 11 per cent thought that a decision maker was more likely now to overrule the Atos recommendation in the original decision.

The evidence from our study reflects this. The reports that we identified as having the highest level of reported inaccuracy had a high rate of decisions being reconsidered and overturned. Three of the seven cases in the group with a serious level of reported inaccuracy, where clients were found fit for work, were overturned on reconsideration; a further one was overturned at a paper hearing and another at an oral appeal (one of the others is waiting for their appeal to be heard, the other client did not come back to the bureau so it is likely they have decided not to go ahead with an appeal). However in none of the cases did the decision maker use their power to override the recommendation of the report in making the original decision, even when the health care professional had clearly made a recommendation that was inconsistent with information in the report. This raises serious concerns about those who were, and were not, awarded ESA, and the implications for their DLA award, and also about those who did not appeal. All of the clients in the survey who were refused benefit were in touch with a CAB adviser who could help them with the appeal process, but many other claimants are not similarly advised or represented.

In the DBC survey, fewer than two per cent of welfare benefits advisers agreed that the accuracy of Atos reports has improved, while more than 87 per cent disagreed. Two changes proposed in the independent review are currently being trialled, which may have some effect on this:

27. http://www.disabilityalliance.org/dbcharrington2.pdf

i. Audio recording of the assessments: If rolled out nationally, this should be helpful, and may help change behaviour. It will nevertheless be important that there is a regular process of checking the accuracy of all reports.

ii. Summary of the report prepared by the health care professional: A trial is being conducted in which a summary of the health care professional's report is sent to claimants. This could also be very helpful, but its value will depend on whether there is sufficient information given in the summary for the claimant to check the accuracy of the account, *and* whether such summaries are sent to all claimants. The detail of what the claimant says such as how often they visit the supermarket or exactly what help they require to get dressed is often used as evidence in the report of what they can do.

It is important that clear systems are in place for claimants to respond when they believe a report is inaccurate. We are concerned that there are some indications that the summary will only go to those who are judged not entitled to ESA – this gives no opportunity for those claiming DLA to challenge the report.

Consistency of Atos Healthcare professional performance

Professor Harrington published the second annual report of his independent review of the WCA in November 2011. A key recommendation from year one was that, in year two, the Review should explore the use of other health care professionals in the Atos assessments and check the consistency of assessments by different professions. Based on the audit data provided by Atos, and his own analysis, Professor Harrington has recommended that:

- Given the importance of the quality of assessments (especially with incapacity benefit reassessment fully underway), DWP should consider tightening the target for C-grade reports (this currently stands at five per cent. Elsewhere in his report, Harrington notes that B-grade reports are contractually fit for purpose, so it can be assumed that C-grade reports are inaccurate).
- To improve the transparency of the face-to-face assessment, data on Atos performance and quality should be regularly published.

We look forward to contributing to the third year of Professor Harrington's independent review.

Part three – conclusions and recommendations

This study confirms existing concerns about the accuracy of ESA WCAs. While the clients accepted a number of the reports as giving an accurate picture of the impact of their condition or impairment on their life, this was not the case for the majority. Of particular concern is the level of error in cases where ESA is awarded but the report is subsequently used to decide entitlement to DLA. A claimant in this situation would have no reason to request a copy of their WCA report from DWP and would be unaware of the potential impact on a claim for DLA.

These findings clearly support a recommendation that the DWP should introduce a routine method of monitoring for accuracy, before increasing the use of this type of assessment.

In his *Independent Review of the Work Capability Assessment – year two*, Professor Harrington expresses concern about continued negative experiences of the face-to-face assessment and the WCA process as a whole, including inaccurate WCA reports. Citizens Advice submitted an early version of the findings of this study to his call for evidence and the report recognises the value of our indicative study in highlighting concerns about the accuracy of reports. Indeed, Harrington suggests that the study be repeated, in 2012, "so that trends in accuracy of reports can be monitored and further recommendations, if appropriate, can be made".[28]

The Government, in its response to the Work and Pensions Select Committee report on the reassessment of incapacity benefit claimants, recognises that "there is more to be done to learn lessons from the management of this [the

28. www.dwp.gov.uk/wca-review p64

Atos] contract and improve quality monitoring of future contacts. There must be robust indicators and levers to monitor performance and quality and prompt action should be taken where either fall below acceptable standards".[29]

Citizens Advice believes that independent monitoring of the accuracy of WCA reports would be a very good place to start.

Quality assurance

- Citizens Advice recommends that the DWP conducts regular, independent, assessments of the accuracy of the reports prepared by health care professionals employed by contractors on behalf of the DWP, which make recommendations to decision makers about entitlement to ESA.

Improving accuracy

- Health care professionals conducting WCAs must be reminded that, even if someone would score enough points to receive ESA on the basis of one or a few descriptors, all of the descriptors must be fully considered in order to give a full assessment of the client's situation.
- DWP decision makers must be trained to examine the internal consistency of WCA reports from Atos, and more readily reject reports that do not justify the recommendations made.
- As part of Atos' customer service surveys, we recommend that they regularly send a copy of the WCA report to claimants and ask them to verify the accuracy of the record of what they said and did during the assessment.
- The Atos personalised summary – or the report itself – must be sent to all claimants, not just those found fit for work. It must also be made clear to claimants that whether or not they receive ESA, it is important that they challenge any inaccuracies, and why.
- The DWP should consider imposing financial penalties on Atos for every inaccurate report that they produce.

Collecting other evidence

- Medical evidence must be requested in all cases from the professional nominated by the claimant as knowing them best. We welcome the fact that the value of medical evidence is now recognised. However, it should not be the responsibility of the claimant to provide the medical evidence as this will lead to a two-tier system whereby the poorest and most vulnerable claimants, who cannot afford to pay for the evidence, could receive a less reliable decision.
- This medical evidence must also state if there are serious investigations underway, or if the claimant is likely to have a serious operation in the near future. In cases where there is likely to be fuller information available shortly, the assessment should be delayed for a short time until the investigations are complete. Power should be given to the decision maker to assign the client temporarily to an appropriate group.
- Medical tests – such as a vision test – must not be carried out at assessments if a more accurate record is available from the claimant's medical records.

Use of face-to-face assessments for other purposes

- WCAs must not be used for other purposes – such as deciding a DLA award – until the accuracy of the reports has been independently verified, or – at the very least – the claimant has had an opportunity to correct errors.
- Face-to-face assessments must not be used as the primary method of assessment for the personal independence payment (PIP) without further research into the accuracy of this method of assessment.
- Research must also be commissioned into the most effective method of assessment, by comparing, testing and piloting different methods.

29. http:www.publications.parliament.uk/pa/cm201012/cmselect/cmworpen/1641/164103.htm

Appendix – an overview of all case studies

Each of the WCA reports in the study was classified in one of three ways - as having a low level of inaccuracy (or none), a medium level or a serious level of inaccuracy. This appendix contains a very short overview of each of the cases, and the outcome of each claim for ESA, and a more detailed summary of two of the reports classified as having a 'serious level of inaccuracy'.

Many clients were awarded ESA, but on the basis of an incomplete or inaccurate report. The accuracy of WCA reports will, as discussed in the main body of our report, take on even greater significance with the introduction of universal credit, and with the increasing use of WCA reports as evidence for claims for DLA. Clients who are awarded ESA would have no reason to request a copy of the report from DWP and so would not know that inaccuracies contained within it could have an impact on their claim for DLA.

No or low level of reported inaccuracy

In these cases, the report was considered broadly accurate, and ESA was awarded. There were some concerns about low level inaccuracies that could impact on a claim for DLA, and about the way in which the assessment was conducted:

The client reported that the report was an accurate account of what had happened. There were just a couple of observations which the health care professional recorded with which she disagreed – for example, it was noted that the client had some difficulty rising but did not need physical assistance from another person. The client claims she was helped to stand by her husband. However the client did add that she felt "The interview was conducted in a courteous and professional manner".

The client had just had spinal surgery and was in a great deal of pain. The report is very short and factually correct. The assessment was curtailed as it was clear to the health care professional that client should be in the support group. The health care professional also remarks in the report that the client should not have been required to attend. The client had tried to postpone the assessment but the decision was made by the adviser on the Atos helpline (who is not medically trained) and delivered the standard answer to enquiries – "if you don't attend your benefit may stop".

The client had learning difficulties and found social contact very difficult. The client clearly found this interview very difficult and his mother who was present answered most of the questions. However, although the assessment was clearly very stressful for the client, his mother felt it gave an accurate picture of his situation and the barriers he faced.

The client reported that the report was factually accurate apart from a couple of observations with which she disagreed. For example, it records that she was not trembling or sweating – she states she was trembling throughout and had to wipe her face because of the sweating caused by the stress, and that her clothes were damp after the assessment.

The client thought the report was detailed and on the whole accurate. He had attended the assessment with an adviser because his experience of a previous assessment had been so poor. At the previous assessment, his mental health condition had been about the same, but he had scored no points. The latest assessment was much more thorough, took an hour and he was awarded 33 points. He felt there were some small distortions and omissions but overall it gave an accurate account. He did however add that he felt angry this hadn't happened the previous year. As a result of the previous assessment finding him fit for work, (despite his health being the same as at this assessment) and subsequently

finding it very difficult to cope with JSA, his mental health had got worse. It had taken the year to get back to where he was before – he felt that it was a year which had been wasted when he could have been getting the support to get back to work more quickly.

The client was awarded ESA but felt that there were a few errors and omissions in the report. For example the report states that the claimant "didn't use chair arms to get up from sitting". This is true but the report doesn't note that he used the table. The client also felt that when he tried to explain how he managed his condition the health care professional had not been interested in building up a full picture.

The client had been asked to attend a medical at an assessment centre, but when she got there she was turned away because she couldn't use stairs and wasn't allowed to use the lift for health and safety reasons. She was very upset that she had not been notified in advance, especially when the person who told her she would have to go away gave the reason for not phoning her in advance as being there would have been " too many to phone around". Her assessment was therefore conducted at a later date in her own home. An adviser from the bureau was present and identified himself as such. It may be a coincidence but this assessment took the longest of all the assessments in this survey (1 hour 20 minutes) and was described as being very thorough.

In the following cases, minor errors and omissions were noted, and ESA was not awarded:

The client does not agree with the result of the assessment and is appealing. She nevertheless thought that the report accurately summarises what she said at the medical apart from one factual error where it reports that she said she "carries all the shopping". The client says she can't carry the shopping. Apart from this error – which is important because entitlement to ESA will depend on the upper limb descriptors – this case is a genuine dispute over medical evidence, which the tribunal will decide.

The adviser records that the client believes that most of the report accurately records what he said, but when some activities were recorded the health care professional did not probe to find out how regularly he could do them or how he carried them out. There is also an inconsistency in the evidence of the sitting descriptor: the health care professional records that the client sat for 25 minutes as evidence that he had no problem sitting, but he also records that he rose from sitting three times yet only twice would be necessary during the interview unless he had to rise as a result of severe discomfort. The descriptor is not about how long someone can sit in total – it is about how whether someone can sit for more than 30 minutes without having to get up because of severe discomfort.

The client gets severe headaches that leave her unable to function at all on that day. The report did not accurately report either the frequency or how this condition affected her. The points score is probably right (even though because of the frequency and unpredictability she would be unlikely to find anyone to employ her) but it does not give an accurate picture of the extent of her problems. The client has decided not to appeal.

The client felt most of the report was accurate. There was one inaccuracy – the report recorded that he had no side effects from medication – the client didn't think he had been asked this and if he had been asked he would have explained the side effects that he does experience. He also felt that the assessment did not really give him the opportunity to explain in the necessary detail how his condition affects his everyday life.

Medium degree of reported inaccuracy

In these cases, clients were awarded ESA but reported errors and omissions that could have a detrimental effect on a claim for DLA:

The client has epilepsy and, at present, her seizures are very frequent and unpredictable. She attended the assessment with her mother, as she is unable to go out alone at all. They report that the "typical day" section of the report has a number omissions of what she said, which together mean that the report significantly underplays what she said was the effect of her condition on her life. For example, the report states her "tonic-clonic seizures last about three minutes" but doesn't mention the long recovery time or the full effects of the seizures. This could have a significant impact on a DLA award.

The client was awarded ESA for physical problems, but the report glosses over his mental health condition. The client believes that his ongoing mental health condition is the main reason why he can't return to work at the moment but reported that the health care professional did not want to know about the impact this has on his life. The report does not recommend that points be awarded for any of the mental health descriptors. After his previous assessment a tribunal awarded him 24 points for mental health descriptors – his condition had not changed since that decision.

The client had had an aggressive form of breast cancer – the adviser who interviewed this client was a retired health professional – she was concerned to see incorrect medical terminology used in several different places throughout the report. She felt this lack of knowledge about the condition would have an impact on the health care professional's understanding of the impact of the treatment this client had been through. This might explain why the effect of fatigue was ignored and the variability of condition not explored.

No account is taken of the effects of fatigue and no attempt made to justify the ignoring of all the physical descriptors apart from those caused to upper limbs by lymphedema. Again this could have an impact on an application for DLA.

This client had chronic fatigue syndrome, anxiety and depression and post-traumatic stress disorder. The client was awarded ESA on mental health grounds. The client reported a number of factual errors and omissions in this report. In particular her condition is very variable and the report does not reflect sufficiently the variability in what she is able to do. The observations on her physical condition were all about that day and did not take into account that she had had to cancel two previous appointments because she had been too ill to attend. However the history that was taken still demonstrated a significant level of physical difficulty. Despite this every one of the physical descriptors was ignored with no justification given as to why the history was being ignored. This could have a significant impact on an award of DLA.

The client reported significant factual inaccuracies and omissions in the report which taken together meant that the record of what he said significantly underplays what he said was the effect of his condition on his life. There were a number of careless factual inaccuracies in recording the history. At one point the report records is "unable to do chess" (should say chores – chess was not discussed) further down it says "has no problem doing routine chores". The client reported that on a scale of one to five (one being poor, five being good) this report would score a two.

The client reported significant factual inaccuracies in the report but unusually these factual inaccuracies in what she had said were to exaggerate rather than to diminish her eligibility on mental health grounds. The client reported that part way through the

interview the health care professional seemed to decide that she should be awarded the benefit on mental health grounds and any comment about a natural lowness having just received a diagnosis of bone cancer was exaggerated to fit the mental health descriptors.

In this case, the client reported errors and omissions, and was awarded ESA at appeal:

The client reported a number of errors in what she had been recorded as having said and done. For example the health care professional recorded she had no difficulty removing her coat – she was not wearing a coat that day. There were also inconsistencies in the level of one of the descriptors chosen compared to the evidence quoted. She was awarded six points, but won on appeal.

These clients were not awarded ESA and are either awaiting the outcome of their appeal or have decided not to appeal. In each case, significant errors and omissions were reported:

The client reported significant factual inaccuracies and omissions in the report of what she said. For example, the report noted that there were no side effects of the medication. The client states she was not asked that question and that she does sometimes have side effects from insulin when she doesn't get the dosage right. More importantly, she felt that the health care professional was very abrupt, didn't allow her to make qualifying remarks, wasn't really listening and asked very closed questions, so she found it very difficult to explain her problems. The health care professional also refused look at the latest medical evidence that she had brought with her from her consultant. No points were awarded and the client is appealing.

The client has mental health problems. He attended the examination centre with his mother. His mother remarked that the health care professional asked closed questions and didn't explain the questions, and when she intervened to explain to her son the health care professional was rude to her. The client reports that he found it very difficult to talk after the exchange. The health care professional also reportedly made very little eye contact with them, which further affected any possible rapport. They also report a few factual errors in the report but the main issue is that the client found it difficult to explain his problems.

The client started to make an appeal, but the Community Psychiatric Nurse who was supporting him informed us that he had decided to withdraw from the process. Many clients find the thought of a tribunal very daunting. It is very worrying that young people such as this might end up having to be supported by their parents, entirely outside of the system of support back into work, if they are unable to claim ESA and are too ill to cope with JSA conditionality.

The client reported some significant errors and omissions in what was said and observed. For example, the health care professional reports that the "right hip bends fully; able to fully straighten right knee". The client strongly disputes this, he says that he was not able to bend his right hip fully; he was not able to straighten his right knee. In justifying that our client can rise from seating unaided the health care professional says client rose twice without help. The client doesn't dispute this but says that it does not record that he rose without being asked to move because his hip was so painful he needed to get up. This was not noted and not recorded as a problem with sitting.

Serious degree of reported inaccuracy

In these cases, ESA was awarded, but a significant and serious degree of inaccuracy and omission was reported:

The client reported a very significant level of error in what he was recorded as having said and done. For example, the client is described as having no difficulty getting to the local

shops. He claims to have explained that he finds it very difficult and has to stop three or four times but knows that it is important that he tries to go out.

The client maintains that the report contains a considerable number of inaccuracies in the record of what happened at the medical and in what she was able to do. For example, the report states that she remained seated for 25 minutes – she said she had to get up after ten minutes because she was in so much discomfort. The client described the report as "inaccurate, vague and misleading".

The client has a serious condition that causes her a great deal of pain – she says that "the pain varies from moderate to severe" and when the pain is severe she is unable to do anything. She has needed to be an inpatient in hospital 25 times in the last two to three years as a result of this condition. The report took no account of the variability of her condition only considering what she could do when at her best.

The client is registered as blind and regularly sees a consultant ophthalmologist. She reported a number of errors in the report. However the main issue is an incorrect recording of her visual impairment. In the assessment she was surprised when the health care professional held a card with letters on it at a seemingly random distance away from her and asked her to read them. She has regular tests from her ophthalmologist and was perplexed as to why a test was necessary, especially in such a manner. If the client had not been participating in the survey, it is unlikely that she would have been aware of the contents of the report, but when she went through it with the adviser to do this survey, she was horrified to find that the health care professional had actually come up with a measurement from that test, which was also a substantially different measurement from that of her consultant. Whilst the level of sight loss was still sufficient to qualify for ESA it could lead to problems claiming DLA if it went unchallenged.

The client reported a number of inaccuracies in the report such as not recording all the medication that he takes. He felt that he was not given enough time to explain how his mental health condition affected his everyday life. He said that the health care professional often moved on to the next question before he had finished speaking. He was awarded points for physical problems, however he regards his mental health condition as the reason he is unable to work – no points were awarded for mental health descriptors.

The client was awarded points on the mental health descriptors but the report ignored her very obvious physical problems. The client has kyphosis (curvature of the spine), a mental health condition and cardiovascular problems. The adviser who went through the report with the client is a retired health professional. The adviser observed that the client's curvature is very pronounced, she obviously has a lot of pain when sitting and can only sit in a sideways position. The health care professional observed the client had no problem sitting in her justification for choosing "none of the above apply" for the sitting descriptor. She made no mention of the curvature of the spine or the obvious pain it caused whilst the claimant was sitting.

The history taken describes how this client experiences considerable difficulties because of arthritis in her hands, wrists and shoulder, which was in fact the reason why she had to stop work. However, the report does not contain any justification as to why no points were advised for these descriptors, and it also seems inconsistent in the level of functionality recommended for walking compared to the evidence quoted. This could have implications for a DLA award. The client also reported some inaccuracies in the record of what happened at the assessment.

The client reports significant factual inaccuracies and omissions and a lack of consideration of variability. For example, the report records that the client shops weekly, whereas the client reports that the weekly shopping is done online and delivered. A year ago she was awarded 15 points for the walking descriptor – not able to walk more than 50 metres. Her condition has deteriorated since then but health care professional chose the descriptor - not able to walk more than 200 metres, despite his history demonstrating otherwise. The health care professional stated in the report that "client does not walk anywhere and too tired to do it and pain". This is inconsistent with the level of descriptor chosen but no reason is given – this could have serious repercussions for an award of DLA mobility.

In these cases, ESA was awarded at reconsideration and appeal, following significant serious errors and omissions in the report:

The client, who has a serious and painful shoulder injury, reports that he told the health care professional he couldn't get dressed, shower, put on socks, shoe laces etc without help from his wife as it is too painful to use his left arm at all. However, the description of a typical day states, "has a problem with dexterity, holding items, reaching, bending and pain, but manages to dress and undress without help or aids" and "has a problem with gripping… but manages to shower". The health care professional justifies his judgement to say he doesn't have "significant disability of manual dexterity and picking up and moving objects" by quoting that the claimant manages to shower, dress etc without help. Someone who is unable to use one of his arms in the way that the claimant describes would score 15 points and be awarded ESA. Clearly the health care professional has the right to decide that the claimant would be able to use his left arm, but in this case he justifies his grounds by reportedly misquoting the client. The bureau said that there was very strong evidence supporting what he has said. The client won his appeal having been awarded fifteen points.

The client has a long-standing degenerative spine condition. The client reported some important inconsistencies and omissions between what he said and what the health care professional records. For example, the history taken records the client as saying he "prepares evening meal" – the client says he explained that he only is able to do it on some days and even then he said he took two to three hours longer than normal because he takes it in stages because of the pain. The client also reported that the questions were very closed and that the health care professional did not explore the variability of his condition, even though he tried to explain this. Again the medical evidence clearly supports the client's version as the decision was overturned.

The client has serious mental health problems as result of a series of traumatic circumstances. The client felt that the health care professional was not interested in listening to what he had to say and was not concentrating on what he said. The client reports a number of factual errors, for example the report states that the "results of an MRI scan and ECG were normal" – ECG should have been EEG and the client had actually explained that he hadn't yet had the results. There were also significant omissions and distortions in what the client is recorded as having said and false assumptions made as a result. For example, the client says he told the health care professional that he couldn't concentrate on television but that he had it on all the time "because it was better than silence" – this was recorded in the report as "the client likes to watch television". The medical evidence clearly backed the client's view of the assessment as the decision was changed without the need to go to a tribunal.

An adviser attended the assessment with the client. The adviser stated that his notes of what happened and what was said at the assessment did not tally with the report. The

adviser said that the health care professional was not interested in any further medical evidence that the client offered and that he would not consider his visual impairment because the client had not mentioned this on the ESA50. This client also reported some important omissions and inconsistencies. She reported the questions were asked "very quickly" and variability was not sufficiently explored. There is a record of the number of good and bad days but no record of how they differ from each other. She also reported inconsistency between what the health care professional observed and what his consultant has stated. For example, her spinal surgeon remarked that her walking is lopsided whereas the health care professional in the report says that her "gait is normal".

In this case, the client reported serious omissions in the report and no points were awarded. The client has not returned to the bureaux and so it is assumed that they have decided not to appeal:

The client had been suffering from severe shortness of breath and chest pains. The health care professional has made an assumption in the report that client's breathlessness is caused by asthma. This appears to have coloured how seriously the health care professional takes what the claimant says about his functional ability. He has since been diagnosed with emphysema and is having investigations for possible heart disease. The client reported some important inconsistencies and omissions between what he said and what the health care professional records. For example, he states that he told the assessor that he does not shop himself but goes to have tea while his wife shops. The medical report records that he goes shopping with his wife and adds that his wife does the shopping. However in the evidence for the walking descriptor, the health care professional repeats that the client goes shopping with his wife but fails to mention that it is his wife that does the shopping while he sits in the cafe. This is a serious omission as the guidance for health care professionals gives ability to walk round supermarket as an indicator of how far someone can walk. The client did not return to the bureau so it is very likely that he decided not to appeal the decision.

Detailed analysis of two cases with serious levels of inaccuracy

1. In this case, the client was awarded ESA , but the points scored significantly under-estimated the level of impairment:

The client had been a manual worker. Eighteen months before the WCA he had been retired on medical grounds. The client had a shoulder problem, generalised osteoarthritis, hypertension, diabetes, sleep apnoea, a hernia and anxiety and depression.

He was awarded ESA as he got 18 points in the WCA – nine points for bending/ kneeling and nine points for loss of consciousness. However, this report is of concern for a number of reasons:

- Under the new descriptors, brought in from April 2011, this man would have been found fit for work.
- There is considerable evidence of very significant difficulty walking but the health care professional has recorded that none of the levels of difficulty apply – this could have a very significant effect on a DLA application.
- Under the descriptor covering consciousness, the health care professional seems to have made a straightforward mistake in that the level of descriptor chosen is different from what he quotes as evidence. The decision maker did not pick up this mistake.

Walking: The client believes he has very significant problems walking. The client was correctly quoted in the *description of typical day section of the interview* that he "usually needs to use a walking aid to move indoors on one level due to lower limb problem" was

"always unable to go to the supermarket, alone or with someone because of pain, fatigue and hypo attacks" and "he usually uses crutches to get around for balance support and reassurance." These were repeated in the *supporting medical evidence – lower limb* section. The health care professional observed the client's difficulties with walking in behaviour observed during assessment - he notes "used crutches to stand for three minutes"; "used two crutches to walk 10 metres to the examination room". The health care professional noted in *relevant features of clinical examination* the client had problems with breathlessness and also noted in the *summary of functional ability* that his examination is consistent with the typical day and observations, yet he chose the descriptor which states none of the levels of difficulty apply. This implies that the client can walk at least 400 metres without stopping to rest – this does not seem consistent with the evidence.

Consciousness: *Activity Outcome: remaining conscious during waking moments* [Activity 11] descriptor states that "at least once a month, has an involuntary episode of lost or altered consciousness, resulting in a significantly disrupted awareness or concentration". However, under *relevant features of clinical examination*, the health care professional notes that, "due to poorly controlled diabetes he gets hypoglycaemic attacks on a weekly basis".

2. In this case, the client was awarded no points initially. The decision was reconsidered and the client placed in support group:

The client has a heart condition, arthritis and sciatica. The client was awarded no points. The following is a detailed analysis of the section of the report, which is meant to record what the claimant says – the client reports multiple errors. The record of what the client said he could do was then used to justify a low level of impairment. Whilst we cannot confirm the detail of what the client said, the evidence to back his account of his level of impairment (and therefore by implication his account of what was said and done) was clearly extremely strong as the decision maker reconsidered the decision and he was placed in the support group – the group for those with the most serious level of impairment or condition.

In the *Medical conditions* section, the report did not record that the client had spondylosis in his neck and sciatica in the legs, or that the client was recovering from a heart attack.

In the *Description of a typical day*, the client reported the following differences between what he said and what was recorded. Omissions of qualifying statements included:

- The report states that the client had a bath every day – it does not mention that the client had said that he needed help getting in and out of the bath.
- The report states that the client "manages to dress himself every day", – it does not mention that he is unable to fasten buttons.
- The report states that the client can use stairs. It did not include that the client says that he has "grave difficulty" getting up and down stairs, has to take them one step at a time because of leg pain and sciatica.

Inaccurate records:

- The health care professional records that client "goes to local shops most days" and "usually goes shopping alone". The client doesn't go most days and when he does go he does not go alone.
- The report states that the client can make meals for himself and "has no problems maintaining safety in the kitchen". However, the client says that he told the health care professional that he could only prepare tea and toast and that he cannot make meals for himself as he can't lift pans full of water and vegetables, and he has problems holding cutlery and cups because of arthritic pain.

- The health care professional states that the client is usually able to do housework, when the client said that he helped with housework on some days.

The client also reported that the health care professional made several errors in his observations:

- The health care professional observed that, "the client was able to sit on a chair with a back for 35 minutes". This observation did not include that the client had to stand up several times during this period to relieve leg pains. The descriptor covering sitting awards a level of points depending on how long someone can remain sitting before needing to get up because of the pain.
- The health care professional stated that the client was not under the care of a hospital specialist for arthritis – he has been referred to a musculoskeletal centre and has had steroid injections.

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