Evaluation of the Capability Report: Identifying the work-related capabilities of incapacity benefits claimants

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The study was carried out by a research team from the National Centre for Social Research (formerly SCPR) on behalf of the Department of Social Security (DSS), the bulk of which during the course of the study became part of the Department for Work and Pensions (DWP).

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At the National Centre for Social Research, we would like to thank Kit Ward for her invaluable contribution to the fieldwork and Tim Knight and Nicola Hosfield for their role in the analysis of the data.
The authors all work in the Qualitative Research Unit (QRU) of the National Centre for Social Research, the UK's largest independent institute specialising in social policy research. Jane Lewis is the Director of the Unit; Robin Legard and Julia Hiscock are both senior researchers; James Scott is a research assistant. The QRU conducts a wide range of qualitative studies in the social policy field both jointly with, and independently of, the survey division of the institute. It also runs courses in qualitative research methods both in-house and for external bodies.
Approved doctor: Specially trained doctor who is approved by the Secretary of State for Work and Pensions to provide advice and undertake examinations of Incapacity Benefit claimants.

Capability Report: Report designed to provide information on the work-related capabilities of incapacity benefits claimants, which is completed by an approved doctor at the same time as the Incapacity Report and provided for Personal Advisers in the ONE and NDDP Personal Adviser Service pilots.

Disability Employment Advisers (DEAs): Specialist advisers, mainly based in the Employment Service, who deliver employment support and advice to sick and disabled people and employers.

Incapacity benefits: The range of different benefits, including Incapacity Benefit and Income Support, awarded on the basis of sickness or disability.

Incapacity Report: Report compiled by an approved doctor to inform the benefit entitlement decision maker, who is applying the Personal Capability Assessment.

Jobseeker's Allowance: The benefit paid to people who are unemployed and seeking work.

Medical Services doctors: Approved doctors contracted to Schlumberger SEMA Medical Services, which provides an advice and examination service for the Department for Work and Pensions.

New Deal for Disabled People (NDDP) Personal Adviser Service: A pilot service that aimed to assist people of working age, in receipt of incapacity benefits, who want to work, to do so. In addition, people at risk of losing their jobs because of ill-health could use the pilot service, which was available in 12 areas in Great Britain between September 1998 and June 2001.

ONE: A new service for delivering benefits to people of working age which brings together the Employment Service, Benefits Agency, and Local Authorities to provide prospective claimants with a single point of entry to the benefit system. ONE is currently operating in 12 pilot areas in Great Britain.

Personal Adviser: Staff within the NDDP Personal Adviser Service and ONE pilots who work with clients on an individual basis, in a case management model.

Personal Capability Assessment (PCA): The PCA was previously known as the All Work Test. It is the functionally based assessment used to determine if a person is considered as meeting the threshold of incapacity for state benefit purposes. The PCA decision is informed by medical advice from an approved doctor who may conduct a medical examination of the claimant.
The National Centre for Social Research was commissioned by the Department for Work and Pensions to carry out an evaluation of the Capability Report. The Capability Report was introduced to assist Personal Advisers within ONE and New Deal for Disabled People Personal Adviser Service (NDDP) pilot areas in encouraging clients on incapacity benefits to consider the option of returning to some form of employment. Personal Advisers in the NDDP pilots worked with people receiving benefits on grounds of incapacity; in ONE they work with clients receiving a range benefits, including incapacity benefits. In both services, they provided advice and encouragement, help with job search and applying for jobs, and assistance with accessing training and placements. The Capability Report is intended to provide work-focused information about clients’ conditions or impairments and is completed by Medical Services doctors while they are examining clients as part of the Personal Capability Assessment (PCA).

In ONE pilot areas, a Capability Report is automatically completed for all Incapacity Benefit claimants who are called for a medical examination. In the NDDP pilot areas involved in the study, two approaches were tested. Under the first approach, clients were told about NDDP when they attended for the medical examination. If the client agreed to volunteer for NDDP, a Capability Report was produced. Under the second, clients were invited to volunteer for NDDP, in writing, when they were sent the IB50 questionnaire as part of their application for Incapacity Benefit. If they were subsequently called for a medical examination, the Capability Report was completed.

The objectives of this study were to explore the process of completion of Capability Reports, the various processes by which clients were told about it and invited to participate in NDDP, Personal Advisers’ use of Capability Reports, their views about its content, and whether and how the report assisted their work with clients. The study was conducted in three ONE pilot areas and three NDDP pilot areas, selected to reflect different models of delivery as well as different labour markets. It involved in-depth interviews with 13 Medical Services doctors, 29 Personal Advisers or other members of the Personal Adviser Service staff, and 25 clients. The samples were purposively selected to be as diverse as possible. Fieldwork was conducted between January and April 2001 and the data

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1 The NDDP Personal Adviser Service pilots came to an end in June 2001, to be replaced by a national extension of NDDP drawing on experience with the pilots and the NDDP Innovative Schemes, but rolling neither model out as such. The ONE pilots continue to operate.
were analysed using Framework, a thematic content analysis method for analysing qualitative research. (Sections 1.3 and 1.4)

The fieldwork was carried out at a stage where Personal Advisers and clients had, for the most part, only limited understanding of the intended role and purpose of the Capability Report, for reasons which are clearly documented in the report. It is, therefore, important to bear in mind that findings about the effectiveness and usefulness of the Capability Report may not always be based on a full appreciation of its role and purpose. (Section 1.3.3)

Different Medical Services doctors adopted different approaches to the way in which they integrated the Incapacity Report and the Capability Report within the PCA medical examination. Some sought to ‘weave’ the two reports together in one process, whereas others first completed the Incapacity Report and then asked the additional questions that were required for the Capability Report. On the whole, few problems were experienced with combining mindsets of ‘incapacity’ and ‘capacity’, or with the requirement for consistency between the two reports. The Medical Services doctors drew on multiple sources of evidence in completing the Capability Report. There were those doctors who endeavoured to stick rigidly to the requirement to complete the Capability Report based on medical evidence only. However, there were also doctors who, despite awareness of this requirement, said they took into consideration broader factors such as claimant’s age, caring responsibilities or perception of ‘employability’, in completion of the Capability Report. (Sections 2.2.1 and 2.2.3)

Medical Services doctors felt that their work would benefit from a greater understanding of the ONE and NDDP systems generally, of the role and work of the Personal Advisers, and of the ways in which the Personal Advisers used the Capability Report. Contact with, and feedback from, the Personal Advisers was currently minimal, but was seen by the doctors to have potential to enhance the quality of the completion of the Capability Report. The doctors also felt that a degree of occupational health expertise was necessary in order to fill in parts of the form satisfactorily. A number believed they lacked the necessary expertise and experienced some difficulty filling in certain parts of the form. Some of the Medical Services doctors questioned whether they were the most suitable group of professionals to be providing all of the information required for the Capability Report. (Section 2.2.4 and 2.3.1)

Training for Medical Services doctors emphasises the need for a positive approach when completing the Capability Report. This was welcomed by the Medical Services doctors as both satisfying and constructive. However, they sometimes experienced a conflict between being positive and being what they perceived as ‘realistic’. They felt it was inappropriate to be asked to provide a Capability Report for certain types of claimants...
who, they felt, would not work again because of their medical condition, personal motivation or attitude to work, or because of labour market factors. Although the Medical Services doctors are required to provide their medical opinion only, some doctors were keen to express their own views about the reality of the prospect of work for specific clients and to provide on the form an alternative viewpoint from that expressed by the claimants. However, they were unsure of whether this was formally encouraged. As a result, different practices emerged, with some doctors putting their own views in the report and others not. (Sections 2.2.5, 2.3.2 and 2.3.3)

Personal Advisers from both the ONE and NDDP pilot services had dealt with very few cases involving a Capability Report. This was influenced by three principal factors: low levels of understanding amongst Personal Advisers about the rationale for the Capability Report; specific issues relating to the operating context of ONE and NDDP; and the value Personal Advisers attached to the Capability Report. (Section 3.1)

Advisers were often not clear why the Capability Report had been introduced and how they should use the information it contained. There was also a lack of knowledge about the process whereby the Capability Report was produced. Factors contributing to low levels of awareness and understanding were the amount, format and timing of training and guidance given specifically for the Capability Report and little liaison between Medical Services doctors producing the report and the Personal Advisers using it. The uncertainty and confusion created by low levels of awareness and understanding affected the willingness and ability of individual Personal Advisers to use the Capability Report. (Section 3.2)

Operational issues also affected levels of use, although these differed between the two services. In ONE, the emphasis on placement targets and processing new claims left Personal Advisers little time for work with existing clients on Incapacity Benefit. There was also a widespread view amongst staff that the Capability Report was intended primarily for clients who moved to Jobseeker’s Allowance, rather than those who remained on Incapacity Benefit. This view was reinforced by the conviction that clients who had been awarded Incapacity Benefit had been classified unfit for work. In addition, the administrative systems in local offices often did not provide Personal Advisers with sufficient ease of access to the Capability Report. (Section 3.3.1)

In the NDDP pilots, the initiative to link recruitment to the service with completion of a Capability Report at the PCA had led to fewer referrals than expected. This was felt to be largely due to the incompatibility of a mandatory medical examination as a forum for marketing a voluntary service. The preferred working methods of Personal Advisers, and their access to other sources of information, also influenced low usage of Capability Reports in NDDP areas. (Section 3.3.2)
Personal Advisers required three types of information for effective work with clients: general information about clients; medical information about the nature of the condition and about its implications for the client’s ability to work; and specific employment-related information for facilitating the client’s move into work. There were diverging views about the extent to which clients could supply all the information required. Some Personal Advisers preferred to be ‘client-led’ whilst others preferred a ‘multi-source’ approach. Personal Advisers in ONE were likely to refer any disabled client to a Disability Employment Adviser (DEA). In the NDDP pilots, Personal Advisers were also able to seek further information from the client’s GP, or other people with a close knowledge of the client’s condition, in appropriate cases. (Section 4.1)

Views about the value of the Capability Report were mixed. Some Personal Advisers felt that it added little to the information that could be obtained from the client. Others felt that it provided a useful medical perspective on the client’s condition and its implications for work, and that it helped in discussions with clients to have the view of an independent third party. However, doubts were expressed about the value of the information, particularly since it was gathered in a one-off examination of the client. If there were gaps in Personal Advisers’ access to information, some felt that they were better filled by other sources, such as occupational health specialists. (Section 4.1)

Some individual Personal Advisers were making fairly extensive use of Capability Reports in their work with clients. These tended to be people with some experience of disability who also had a preference for using information from a range of different sources in their work with clients. The report was being used to inform the Personal Adviser about the client’s condition in advance of their first meeting. However, its use during interviews was restricted, partly because Personal Advisers were unclear about whether or not to show the report to clients. Where it was being used in interviews, the Capability Report was used in a number of different ways: as confirmation or otherwise of the evidence supplied by the client; for raising issues and countering unrealistic expectations; and for use as a shared starting point for discussions of work options. (Section 4.2)

Views about the future role of the Capability Report were very varied among Personal Advisers in both pilots. Some, especially those who took a ‘client-led’ approach to their work, felt that it should be discontinued. Others felt it was useful and should be retained, and Personal Adviser managers in particular felt that it should be retained as its potential had not yet been realised. However, there was broad consensus amongst those in favour of retaining the Capability Report that changes needed to be made to support its use, particularly to the form itself, to training and liaison, to the service ONE provides to Incapacity Benefit clients, and to its use as a method of recruitment to NDDP. (Section 4.3)
There were mixed views about the format of the form. Some Medical Services doctors and Personal Advisers would have welcomed a shorter form, and one structured more around tick boxes, but others found the descriptive boxes gave the most useful information. Legibility was sometimes an issue and Personal Advisers generally would prefer the document to be typed and provided electronically, although this would be problematic for some Medical Services doctors. The language used in the formulation of questions and in Medical Services doctors’ answers was sometimes seen by Personal Advisers as being excessively technical. Medical Services doctors felt some parts of the form could be completed by someone else – a Personal Adviser, an occupational health nurse or the client themselves. Personal Advisers sometimes questioned whether the doctors had enough occupational health expertise and detailed knowledge of the client and felt some sections at least would usefully be completed by clients’ GPs or by an occupational health specialist. (Sections 5.1.1 and 5.1.3)

There was considerable divergence between Personal Advisers and Medical Services doctors in their comments on specific questions, some of which was based on their different understanding about the nature of the PCA medical assessment and the role of the Medical Services doctor. Broadly, however, among Personal Advisers there were calls for more clarity about the Medical Services doctor’s perception of the client’s job-readiness; more direction about whether they could work and whether full or part time; more explicit information about the implications for work and possible occupations; more descriptive information, and more clarity about what information was factual and what was the doctor’s own opinion. The various comments made are summarised on an annotated version of the Capability Report. (Sections 5.1.2 and 5.2)

Clients had different reactions to being called for a PCA medical examination, but for many it generated anxiety which influenced their reactions when they were told about NDDP during the PCA. Some felt under pressure to express interest in NDDP for fear of jeopardising their benefit entitlement. Such concerns were less apparent where they were approached about NDDP by letter in advance of the medical examination, but more apparent where they were approached at the Medical Services centre. The manner in which they were approached, and subsequent comments made by the Medical Services doctor, could minimise these concerns but they sometimes remained. There were varied experiences of the PCA medical examination. The fact that there were questions about work was generally not surprising to clients, but some clients were concerned that the doctor had not reached a full understanding of their condition and had under-estimated its impact on them. (Sections 6.2 and 6.3)
Reaching firm conclusions about their own work-related capability was difficult for some clients, particularly since it was hard for them to think of physical capability without specific jobs in mind. Three groups emerged. One group were clear that work was not currently an option for them; the second felt they could do some work provided they found the right kind; but a third group found it difficult to know whether work was an option for them. A Capability Report seemed potentially to have a role to play in these latter cases. Similarly, some clients felt their Personal Adviser had obtained a full understanding of their condition and its impact but others felt this was impeded either by their own feelings about their condition or by the Personal Adviser’s approach. Again, a Capability Report might have more to offer in these cases. (Sections 6.4 and 6.5)

Clients approached ONE and NDDP with varied mindsets. Some were highly motivated to work, or were uncertain about their chances but keen to pursue all possible avenues. But a third group were either rather ambivalent about whether work was right for them or were clear that it was not. Some were able to make clear progress through the contact with their Personal Adviser, but others did not. This arose not only for people who did not feel work was an option but also for people who were highly motivated. Despite their motivation, their contact with their Personal Adviser had not helped them to address or overcome barriers to work. There were different reactions to the idea of the Capability Report. Some were rather lukewarm about it, and others did not feel it would have added anything in their own case or were concerned that the information might be inaccurate or limited. Others, though, thought that additional medical information might have been helpful to either the Personal Adviser or themselves, particularly if it gave a clear steer about whether and when work was viable and about possible directions. (Sections 6.6 and 6.7)

Discussion (Chapter 7) The research does not provide a clear message about whether the Capability Report should be retained, but its value seems to be contingent on changes to the form, to the mechanisms by which it is produced, and (in the case of ONE) to the environment in which it is used. (Section 7.3)

The accounts of clients and Personal Advisers suggest that the Capability Report can have a role to play. However, there are concerns that the type of information contained in it does not adequately meet their needs, particularly for a clear steer about whether work is viable, how it might be structured and possible vocational directions. This suggests that changes to the form will be needed if its value and use are to be increased. There may be scope to expand the coverage of occupational health issues, particularly if this is supported by further training, but Medical Services doctors are concerned about their expertise in this area. A switch to electronic production of the form would also seem desirable. (Section 7.1)
In terms of the operating context, there is clearly a need to enhance the work-focused service provided to sick and disabled clients within ONE, and to support this with training for Personal Advisers on working with sick and disabled people. Training and guidance on Capability Reports is also required for both Medical Services doctors and Personal Advisers, and there is a need for more liaison between the two groups so that doctors have a better understanding of the information needs of Personal Advisers. However, the different working practices of Personal Advisers, and their different conceptions of disability and of the needs of sick and disabled people, suggest that there will continue to be different views about the value of the Capability Report. Few Personal Advisers show the Capability Report to clients, and the extent to which it can be of use to the client except indirectly through the Personal Adviser is therefore very limited. Guidance is needed about whether it should be accessible to clients. (Section 7.2)

There are concerns about the PCA as the forum for inviting clients to participate in NDDP, and about the medical examination as the forum for gathering information for the Capability Report. The integration of capability in the medical examination itself seems reasonably unproblematic, but there are concerns about whether the assessment captures an accurate, and sufficiently detailed, picture of capability. There are also suggestions among both Medical Services doctors and Personal Advisers that the Capability Report should be used in a more targeted way and produced only for clients for whom work is a viable option; in the light of, for example, their motivation to work, the extent to which this is possible given their condition, local labour market conditions and broader assessments of employability. There might also be a role for using Capability Reports more among people who have moved from IB to Jobseeker’s Allowance after a PCA, or for Disability Employment Advisers to use them in their work with sick and disabled clients. (Section 7.2)
1 INTRODUCTION

The National Centre for Social Research was originally commissioned by the Department of Social Security (DSS) to carry out an evaluation of the Capability Report. However, responsibility for the study was taken over in June 2001 by the newly created Department for Work and Pensions (DWP). The aims of the study were to explore the processes through which the Capability Report is produced by Medical Services doctors, the use made of it by Personal Advisers in their work with sick and disabled clients, and how it can contribute to services to support sick and disabled clients in moving towards and into work.

The Capability Report was introduced as an enhancement to the procedure for assessing entitlement to incapacity benefits, to reinforce and complement the work of Personal Advisers within ONE and the New Deal for Disabled People (NDDP) Personal Adviser Service pilots (for an explanation of these services, see Section 1.1.3). The test for eligibility for incapacity benefits is designed to reflect the point at which a person should not be required to seek work as a condition of receiving benefit. But some people who satisfy this test might nevertheless be capable of doing some work, and indeed be keen to move towards or into work. The Capability Report was introduced to provide work-focused information about clients' impairment or condition and about their capability, to assist Personal Advisers. It is completed by Medical Services doctors (employed by Schlumberger SEMA Medical Services) at the Personal Capability Assessment, and sent to Personal Advisers working within either ONE or (until June 2001) the NDDP pilots.2

A copy of a Capability Report is reproduced in Chapter 5. The report is ten pages long and covers:

- the client's occupational history;
- a summary of their condition;
- aids and appliances used;
- review of changes and functional outlook;
- details of their mental health;
- other work-related issues including the client's own views about work;
- details of their physical and sensory capability;

2 The NDDP Personal Adviser Service pilots came to an end in June 2001, to be replaced by a national extension of NDDP drawing on experience with the pilots and the NDDP Innovative Schemes, but rolling neither model out as such. The ONE pilots continue to operate. Capability Reports continue to be provided to Personal Advisers in 10 of the ONE pilots, including those which became Jobcentre Plus Pathfinders in October 2001 (Calderdale and Kirklees; parts of Clyde Coast and Renfrew; and South East Essex).
The Personal Capability Assessment (PCA) replaced the All Work Test (AWT) from April 2000 as the main medical assessment for state incapacity benefits. It provides medical advice to the Benefits Agency decision maker on which the determination of eligibility for incapacity benefits is based.

The PCA involves consideration of the extent to which performance of certain specified everyday activities is constrained or inhibited by their impairment or condition. Medical Services doctors carry out a paper scrutiny of the questionnaire completed by claimants (the IB50) and of medical evidence obtained from the claimant’s own general practitioner (GP). This medical evidence will usually be in the form of either a report (IB113) or a medical statement (Med 4). If further evidence is required, they will call the claimant to a Medical Services centre for a medical examination at which they will interview the claimant and, if appropriate, conduct a physical examination. They then produce an Incapacity Report (form IB85) which is sent to the Benefits Agency decision maker. It is at this point that they will also produce a Capability Report (in areas where it is being piloted), which is sent to the Personal Adviser. The Capability Report is quite separate from the Incapacity Report and cannot be used by the decision maker in the determination of benefit entitlement.

The Capability Report was piloted until June 2001 in areas where either ONE or the NDDP Personal Adviser Service was in operation. It is still being produced in 10 of the ONE pilot areas.

ONE, which has been operating since June 1999, is an initiative designed to provide a single gateway for benefit claimants where both benefit entitlement and work options can be considered together. It is being piloted in 12 areas, where participation became compulsory for new and repeat claimants for incapacity benefits from April 2000. All new claimants must attend an initial start-up interview with a Personal Adviser to discuss benefit options and complete the appropriate forms. Several days later, clients must attend a work-focused meeting with a ONE Personal Adviser unless the Personal Adviser believes there is good cause for the meeting to be deferred or waived. Following the outcome of the PCA medical
examination and receipt of the Capability Report, clients approved for incapacity benefits are asked to attend a further compulsory work-focused interview to discuss their thoughts about work, barriers to work and – if relevant - options for work. Again, this meeting can be deferred if appropriate, for example if clients are severely ill or recovering from treatment. The intention is for the Capability Report to inform discussion at this interview. The Personal Adviser will provide advice and encouragement, help with job search and with applying for jobs, and can refer clients to other help or services within the Employment Service such as Disability Employment Advisers (DEAs) or elsewhere.

O N E brings together the Employment Service, Benefits Agency and Local Authorities at a single point of contact. As well as the 'basic model', there are two delivery 'variants'. In the call-centre variant areas, clients make their initial contact with the benefit system using the telephone before attending their work-focused meeting with a Personal Adviser at an office. In the private/voluntary sector areas, private and voluntary agencies have been invited to deliver O N E.

The N D D P Personal Adviser Service was piloted in six areas (with the service delivered by the Employment Service) from October 1998, and in a further six (delivered by selected private and voluntary sector organisations) from Spring 1999. Participation was entirely voluntary. It aimed to help people on incapacity benefits who wanted to work, and to help people already in work to retain their employment. In most areas it was delivered through local partnerships. Personal Advisers provided a similar range of activities to those working in O N E, but there was an emphasis on extending the range of services available to sick and disabled clients. The pilots came to an end in June 2001, to be replaced by a national extension of N D D P drawing on experience with them and with the N D D P Innovative Schemes.

Between November 1999 and March 2000 Capability Reports were completed on a voluntary basis in O N E areas. However, in April 2000 the Capability Report was introduced on a compulsory basis for people participating in the O N E service. A Capability Report is automatically completed for all Incapacity Benefit claimants who attend a medical examination with a Medical Services doctor as part of the PCA.

In the 12 N D D P Personal Adviser Service pilot areas, the Capability Report was in operation between September 2000 and June 2001. Since it was a voluntary service, the Capability Report was used as an opportunity to promote N D D P as well as to provide Personal Advisers with further information about clients’ capability. Three different approaches were tested:
Option A operated in nine areas, and involved clients being told about NDDP by a member of Schlumberger SEMA Medical Services staff if they attended a PCA medical examination. If they volunteered for NDDP, a Capability Report was prepared. The NDDP service was notified of the claimant’s interest in the service, and an interview with a Personal Adviser was arranged.

Option B operated in two areas, and involved Capability Reports being produced for all clients who attended the PCA medical examination, without the client being invited to volunteer.

Option C operated in one area, and involved clients being given written information about NDDP at the point when they were sent the IB50 questionnaire to complete. They were invited to complete a form if they wished to volunteer for the service. The Personal Adviser Service was notified of their interest, and the Capability Report was completed if they were subsequently called for a medical examination. If they were not called, a short version (the CR2) was completed from the Medical Services doctor’s scrutiny of the IB50 and the information provided by the client’s GP.

The objectives of this study were to review the operation, use and role of the Capability Report from the perspective of the three groups involved: Medical Services doctors, Personal Advisers in ONE and NDDP areas, and clients themselves. Specifically, the study has sought to explore:

- the completion of Capability Reports by Medical Services doctors, including items which are more or less difficult to complete, how it is integrated within the PCA medical examination and their comments on the format and content of the form;
- the various processes by which clients were told about the Capability Report and, where relevant, invited to participate in an NDDP pilot;
- Personal Advisers’ use of Capability Reports, its impact on the way in which they work with clients, and their comments on its format, content and style of completion by Medical Services doctors;
- clients’ understanding of the Capability Report, their experiences of its completion at the medical examination and perceptions of its use by Personal Advisers;
- whether and how the Capability Report assisted Personal Advisers to help clients to move into or towards work, and enhanced the service provided by ONE and the NDDP pilots.

The study was carried out using qualitative research, which is particularly suited to exploring the implementation and operation of new procedures. It was undertaken in three areas in which NDDP pilots operated: Bolton, South Devon and Eastern Valleys. Eastern Valleys used Option C to promote the NDDP pilot service. Option A was used in the other two areas. Option B was not included. The study was also carried out in three areas in which ONE operates: Calderdale and Kirklees, Clyde Coast and Renfrew, and Suffolk. Areas were selected to reflect diversity in

1.2 The objectives of the study

1.3 Design and conduct of the study

1.3.1 Overview of study design
models of ONE and providers of NDDP, as well as different areas of Britain and different types of labour market. The study involved:

- in-depth interviews with 13 Medical Services doctors; three were paired interviews to allow an exchange of views and reflections between two Medical Services doctors working in the same area, so a total of 10 interviews took place;
- in-depth interviews with 20 Personal Advisers, 8 Personal Adviser Managers or others with management functions, and one member of staff in an administrative function. Again, some were paired interviews and a total of 22 interviews took place;
- twenty-five in-depth interviews with clients about whom a Capability Report (or in some cases a CR 2) was completed, and who subsequently met with a Personal Adviser from either ONE or NDDP.

### 1.3.2 Sample selection

The Medical Services doctors were selected by liaison with local SEMA managers, and Personal Advisers in liaison with their managers. A principal selection criteria was that only Medical Services doctors and Personal Advisers who had at least some experience of Capability Reports should be selected. Thereafter, samples were selected to be as diverse as possible in terms of professional background, sex and (in the case of Medical Services doctors) full time and sessional staff. The clients were selected from the management information collated within ONE and NDDP, which identified clients who had seen a Personal Adviser after the Capability Report was completed and provided brief personal details about them. Those selected were sent a letter asking them to notify the DSS if they did not want to take part in the study. Final selection was made from those who did not opt out and was designed to ensure the sample was as diverse as possible in terms of characteristics such as age, sex, benefit receipt and condition, although little information about the latter was available.

Table 1.1 shows the profile of the study samples, and full details of the selection and approach procedure are given in Appendix 1.

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4 The Benefits Agency made the initial selection of the larger sample of clients, from which the research samples were purposively selected.
Table 1.1 Study sample profiles

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<tr>
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<td>- Incapacity Benefit</td>
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<td>- Jobseekers Allowance</td>
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1.3.3 Conduct of fieldwork

In agreement with the Department, fieldwork was undertaken between January and April 2001. Interviews were conducted using topic guides which listed key issues for discussion and relevant sub-topics, but probing and follow-up questioning were used to ensure that relevant issues, whether anticipated or not, were covered in full. Copies of topic guides and other study documentation are shown in Appendix B. Interviews with Medical Services doctors and Personal Advisers took place in their offices, and those with clients in their homes. Interviews were tape-recorded, with respondents’ permission, and transcribed verbatim for analysis. Clients were given a gift of £15 to thank them for their time.

It should be noted that the fieldwork was carried out at a stage where many of the key stakeholders, more particularly Personal Advisers and clients, had had only limited experience of the Capability Report. The reasons for this are clearly documented in the report. However, it should be borne in mind when considering the findings and suggestions for future potential uses for the Capability Report that some respondents were operating from low levels of understanding and appreciation of the intended role and purpose of the Capability Report.

1.3.4 Analysis and interpretation

The data in the verbatim transcripts were analysed using Framework, a method for analysing qualitative research data developed at the National Centre for Social Research and used widely in social policy research. The process, which involves transferring the data onto a series of thematic charts, is described in Appendix A.
The report discusses the views, perceptions and behaviours of each of the three study populations in turn. Chapter 2 looks at the Medical Services doctors, describing how they complete the Capability Report and integrate it within the PCA medical examination and discussing the issues it raises for them. Chapters 3 and 4 describe how Personal Advisers use Capability Reports. Chapter 3 describes levels of use of the Capability Report at the time of the fieldwork and discusses two sets of issues that help to shape this: understanding of the role of the Capability Report, and operational issues within ONE and the NDDP pilots. Chapter 4 then looks at Personal Advisers' information needs and how these shape a role for the Capability Report, and considers Personal Advisers' views of the Capability Report and the use they made of it. Chapter 5 provides more detailed coverage of the suggestions made by Medical Services doctors and Personal Advisers for modifying the Capability Report, with an annotated copy of a Capability Report to show the different views expressed. Chapter 6 looks at the Capability Report from the perspective of clients, exploring their experiences of the PCA medical examination, their contact with Personal Advisers in ONE and the NDDP pilots, and their views about the role and value of the Capability Report. The final chapter draws together key issues from across the three study groups and discusses their implications for the development and future role of the Capability Report.

The terminology used to describe the 'client group' varies between Chapter 2 and subsequent chapters. Technically, people are referred to as 'claimants' when they first make a claim for incapacity benefits and attend for the PCA examination. They subsequently become 'the client' of the Personal Adviser within the ONE or NDDP pilot service.

Throughout the report, the full range and diversity of experiences, views and practices, and of the factors that shape and underpin them, is highlighted. Qualitative research samples are not designed to be statistically representative, so that statements about incidence and prevalence cannot be made. Similarly, statistically discriminatory variables cannot be determined from qualitative data. However, the findings of qualitative research studies can be generalised to the researched populations provided that samples are purposively selected to reflect the study population, interviews allow full articulation of respondents' accounts, and the full range and diversity of responses are analysed and reported. Where relationships are described between, for example, views and practices, they reflect explanations explicitly given by respondents or derived implicitly from the analysis and interpretation of the data.

Finally, verbatim quotations from interview transcripts are used to illustrate key issues. Minor changes have occasionally been made to preserve anonymity.
2 MEDICAL SERVICES DOCTORS

2.1 Medical Services doctors' role in the Capability Report

This chapter explores the perspective of the Medical Services doctors on their role in the Capability Report. Generally, the Medical Services doctors interviewed were well disposed to the concept of the Capability Report, in principle at least. On the whole, they were also keen to produce Capability Reports that would be of maximum use to the Personal Advisers for whom they were intended. However, some felt frustrated that sometimes the process did not result in a report which they considered to be as useful as possible.

Medical Services doctors are employed by Schlumberger SEMA, which is contracted by the Department for Work and Pensions to manage the Medical Services doctors and medical staff who carry out assessments for disability and incapacity benefits on their behalf. The Medical Services doctors are either employed on a full-time basis by Schlumberger SEMA, or work part-time in a 'sessional' arrangement.

The full-time Medical Services doctors interviewed for this study had been conducting assessments for the then DSS for periods of time ranging from five to 19 years. Previously, most of them were working as GPs. Some, however, had previously worked as medical officers in the armed forces, police force or prison service. Others had had jobs in the health service, such as anaesthetist or obstetrician or as medical officers for companies or organisations.

The sessional Medical Services doctors interviewed typically worked six-eight sessions (equivalent to three-four days) per week for Schlumberger SEMA. The remainder of the time they worked as GPs or, in some cases, in other medical positions. The provision of the sessional Medical Services doctors was via Nestor Healthcare Group.

The work of the Medical Services doctors typically involved conducting medical assessments for various types of benefits, including Incapacity Benefit. The Capability Report was introduced as a new area of their work. However, in most cases the flow of Capability Report claimants was only a small part of their caseload, which meant that by the time the Medical Services doctors were interviewed for this study, many of them had completed fewer than ten Capability Reports.

2.1.2 Knowledge and training

The Medical Services doctors were aware that the purpose of the Capability Report was to inform Personal Advisers. However, knowledge of the way in which the Capability Report was actually used was more sketchy. This is discussed further in Section 2.3.
Training sessions on the Capability Report were provided for the Medical Services doctors. These were well received and were considered to be effective and professionally conducted. The Medical Services doctors described finding the training handbook particularly useful, and referred to it frequently.

The training was conducted around the time of the introduction of the Capability Report. The timing of the training sessions was found by several of the Medical Services doctors to be somewhat unsatisfactory. There were two reasons for this. Firstly, the trainers themselves had had very little experience of the Capability Report. Some of the Medical Services doctors therefore felt that although they were very good trainers, they were not fully conversant with the Capability Report process. Secondly, in some cases there was a considerable delay between the time of the training and the time when demand for the Capability Report started to materialise. The result of this was that by the time the Medical Services doctors came to conduct Capability Report assessments, much of the learning from the training course was beginning to fade.

When the Capability Report was introduced in 1999 on a voluntary basis it was added as a second component to the PCA medical examination. The examination therefore comprised both the assessment for Incapacity Benefit, recorded in the Incapacity Report (form IB85) and the assessment of capacity to work, recorded in the Capability Report (form CR1). In one NDDP pilot area, a shorter version of the Capability Report (form CR2) was completed from scrutiny of evidence supplied to the Medical Services doctor rather than from a medical examination.

The Medical Services doctors generally discussed with the claimant the format of the PCA medical examination. This involved enquiring whether they were aware of the Capability Report. Medical Services doctors' observation was that although claimants, in NDDP pilot areas in particular, were often aware of the Capability Report, this was not always the case. There was concern that in other cases, particularly but not exclusively in ONE areas, claimants had not had the Capability Report explained, or adequately explained, to them before the PCA medical examination.

There were Medical Services doctors who did not routinely tell the claimant about the Capability Report during the examination. This was largely because of fears that some claimants would react by becoming less open and might withhold information. However, other Medical Services doctors felt that it was very important that claimants were informed about the process in which they were participating. The descriptions given to the claimants were sometimes broad and included explanations of ONE or the NDDP pilots and the role of the Personal Adviser. Other Medical Services doctors gave descriptions which were limited to the format of the PCA medical examination, including the Capability Report.
The Medical Services doctors who described the format of the medical examination to the claimants, usually began by telling them about the Incapacity Report. They then tended to move on to explain that there was now also a second report, the Capability Report, which would also be filled in as a result of this examination. Some Medical Services doctors limited this introduction to an explanation of the two reports, and their differences, whereas others went on to describe how the Incapacity Report and the Capability Report went in different directions after the examination.

In outlining the Capability Report to the claimants, some Medical Services doctors explained that it was being completed for the Personal Adviser, others described how the Capability Report adopted a positive approach, or that it was in case the claimant was able to do any work. Some stressed that the Capability Report would not affect their benefit. The Medical Services doctors observed that some claimants were content with, or positively welcomed, participation in the Capability Report. However, it was the Medical Services doctors’ perception that there were also claimants who were suspicious and distrustful of the Capability Report and who remained very anxious that both participation in, and refusal to participate in, the Capability Report might represent a threat to their benefit. Medical Services doctors described how the claimants’ reactions to the explanation of the Capability Report ranged from rapid and strong defence of their incapacity for work, to a simple ‘yes doctor’ which one Medical Services doctor described as sometimes accompanied by an expression of incredulity.

Different Medical Services doctors adopted different approaches to the way in which they integrated the Incapacity Report and the Capability Report within the PCA medical examination. Some Medical Services doctors sought to ‘weave’ the two reports together in one process. Other Medical Services doctors tended to start by going through the Incapacity Report; only when that was finished would they turn to the Capability Report and ask the additional questions that were required. These were generally questions about the claimant’s occupational history, but also included questions about specific functions (such as whether the claimants wore glasses or were right or left handed), questions about aids and appliances used, about attitudes to work and about hospital appointments. In general, the Medical Services doctors did not conduct additional physical examinations for the Capability Report. However, sometimes there was a need to examine secondary or minor conditions which were not part of the specific condition investigated in the Incapacity Report. Part of the task of completing the Capability Report involved transferring information from the Incapacity Benefit form to the Capability Report. Because of the comparative familiarity the Medical Services doctors had with the process of completing the Incapacity Report, some expressed concern that they might forget the additional questions that they needed.
to ask for the Capability Report, although they did not say that this had ever happened.

There were few apparent difficulties in the PCA medical examination for the Medical Services doctors in combining a ‘mindset’ of both ‘incapacity’ and ‘capacity’ required in the Incapacity Reports and the Capability Reports respectively. Some were able successfully to disconnect the two approaches in their minds and found no particular problems. Others felt that separate ‘mindsets’ were not required - all that was required was to record the same information with a different slant.

The main differences which the Medical Services doctors described in the approaches they used for the two reports were that in the Capability Report they needed to focus more on work, and that the Capability Report encouraged retrospective reflection to a greater extent than did the Incapacity Report.

The Medical Services doctors were very aware of the requirement for consistency of information between the Incapacity Report and the Capability Report. For some, this was not problematic as they saw it as inevitable that the two would be consistent. Others however, saw this as something to be vigilant about, or felt the need to check back over the two forms, to ensure consistency. Some Medical Services doctors felt, for example, that inconsistency could occur where they mentioned problems in the Capability Report which had not been mentioned in the Incapacity Report.

2.2.2 Time

Thirty minutes was the amount of time which tended to be allocated in the scheduling of the PCA medical examination for the Medical Services doctors to conduct the Capability Report. The Medical Services doctors' accounts confirmed that in general, the Capability Report did indeed add approximately an extra thirty minutes to the duration of the medical examination. This meant that the total time that the Medical Services doctors spent on the medical examination was normally about an hour. Some Capability Reports could be completed more quickly than thirty minutes and others, particularly with claimants who had multiple conditions, took longer. On the whole, the Medical Services doctors felt that thirty minutes was usually adequate to conduct a quality Capability Report. It was suggested by some that the extra time allocated for the Capability Report provided a cushion for the Incapacity Report assessment, where more time pressure was experienced. Thus having an hour to complete both reports allowed the Medical Services doctors to be more thorough on the Incapacity Report assessment.
‘I think this is very useful having the Capability Report attached to an Incapacity Report, because very often we are expected to do the Incapacities by themselves very very quickly so we do perhaps do less than we would like. So doing it with this we are allowed adequate time to do it properly which is great. So personally, I would rather do these in conjunction with the Incapacities because you are allowed the right amount of time and you can actually do a good job on it.’

(Medical Services doctor, ONE area)

The one area of significant concern in relation to the timing of the Capability Report was to do with scheduling of the Capability Report completion. As described in Chapter 1, in Option A NDDP areas a member of staff asked the claimants when they arrived for a PCA medical examination, whether or not they would be interested in NDDP. This created problems for scheduling as it was not known in advance how many claimants would want the Capability Report and therefore how much time to allocate. The effect of this was wasted time for Medical Services doctors, or alternatively overbooking and resultant time pressures. Some Medical Services doctors described how in these cases they had had to take the forms home to complete, or had sent claimants away without having had a medical examination. This was a particular problem in outpost clinics, where there were no colleagues to offer help.

‘They are asked by the receptionist when they come through the door, ‘do you want this?’ And they can say yes or no... It is very bad for scheduling of course. Because if they say ‘yes we want it’ it adds a lot of time to our examination time. And if they say ‘no, we don’t’ of course we are sitting around doing nothing... The only way of dealing with it if they are overstaffed is to take them home and write them up later.’

(Medical Services doctor, NDDP area)

2.2.3 Evidence used in completing the Capability Report

The Medical Services doctors used multiple sources of evidence in completing the Capability Report. These included evidence from claimants as well as medical evidence.

An important part of the evidence which the Medical Services doctors used for the Capability Report, was their examination and assessment of the claimant. Part of this was the claimants’ responses to questions in the PCA medical examination which provided key information. The Medical Services doctors employed both direct and indirect questions to gather the relevant information from the claimants. This often involved using rather circuitous routes of questioning, or ‘slipping in’ questions, about attitude to returning to work for example, by way of other conversations.

The form IB50 provided a further potential source of evidence for Medical Services doctors to draw on in the Capability Report. Form IB50 is filled in by the claimant prior to the medical examination as part of their application for Incapacity Benefit. Some Medical Services doctors found
the IB50 to be a useful source of information and felt that it was a valuable way to gain an understanding of the claimant's perspective and an opportunity for cross-reference with the findings of their own assessment. Others found the IB50 to be of little use, particularly in cases where they felt that the forms had been filled out on the claimant's behalf by, for example, the Citizens' Advice Bureau.

Various types of medical evidence were also available to the Medical Services doctors. Sometimes claimants brought medication, hospital letters or appointment cards to the medical examination. In most cases the Medical Services doctors also had access to either a medical report (IB113) or a medical statement (Med 4) completed by the claimant's own GP. Where these had been completed carefully, the Medical Services doctors found the information useful. However, more commonly these forms had been completed with insufficient detail by the GP, and therefore proved to be of little or no use to the Medical Services doctors. The Medical Services doctors were generally of the view that it would not be realistic or reasonable to expect GPs to improve on the thoroughness of the form IB113.

The formal requirement on the Medical Services doctors is to complete the Capability Report based on medical evidence only. The Medical Services doctors interviewed fell into two groups in relation to their response to this. Firstly, there were those Medical Services doctors who endeavoured to stick rigidly to this requirement. Secondly there were those who, despite awareness of this requirement, nonetheless took into consideration broader factors in completion of the Capability Report. The Medical Services doctors within this second group were most commonly influenced by the claimant's age, especially if they felt that the claimant was nearing retirement age and in their view was unlikely to work again. However, some Medical Services doctors also took other factors into account. Caring for disabled or terminally ill relatives for example, or, as perceived by the Medical Services doctor, few signs of 'employability', were mentioned as factors that may be taken into account. The Medical Services doctors who fell into this second group tried to find ways to indicate on the Capability Report form their perception of the broader circumstances of the claimant which, in the doctor's view, influenced the claimant's capacity to work. These Medical Services doctors were aware that they were acting outside official policy in this respect and tended to explain their behaviour in terms of 'common sense' or of 'being human'.
Theoretically... that shouldn’t make any difference, in that I’m asked to assess that person’s capabilities as compared with somebody of the same age, gender, race... alright so theoretically it shouldn’t make any difference. Common sense, if I see a man of 64 who’s been digging roads all his life and has back pain, I’m not actually going to tell a Personal Adviser to train him to do office work for a year. I’m probably going to tell the Personal Adviser that there’s no way that this fellow can be helped, forget about him... How would I do that? ... I would be very strict in my criteria on which I chose limited residual function... because that’s a common sense approach.'

(Medical Services doctor, ONE area)

The Medical Services doctors had difficulty with the parts of the Capability Report form which required occupational health knowledge. They felt that this knowledge was necessary in order to fill in the form satisfactorily but that they did not have this type of expertise. This included knowledge about the nature of types of employment, types of workplaces, the tasks conducted in specific jobs and the feasibility of workplace adjustments. For these Medical Services doctors, filling in parts of the form (question 8 and particularly questions 9 and 11) was experienced as difficult and unsatisfactory. They felt that they tended to complete these parts of the form to a lower standard than they would have wanted. This was disappointing to some, who felt that these were very important and potentially useful parts of the Capability Report form.

'I always feel as though I’m skating on thin ice, because I don’t understand what people do in their jobs... I don’t understand what the work issues might be, and what the difficulties for the workplace might be. I have limited knowledge of workplaces. I don’t feel what I put contributes very much to the total effectiveness of the report. I think that what I put there... ... doesn’t help anybody basically. But I have to fill in the things. But I don’t really, I have no knowledge of the work issues to a certain extent, or I don’t know what the problems with the workplace may be... The suggestions I make are very primitive suggestions.'

(Medical Services doctor, NDDP area)

The Medical Services doctors questioned whether they were the most suitable group of professionals to be providing this type of information. Some felt that these parts of the form did not need a doctor to complete and that instead what some questions required was ‘common sense’ such as suggesting for claimants with repetitive strain injury that work tasks were rotated. Others felt that professionals with occupational health training such as an occupational health nurse would be better equipped to answer these questions. The Medical Services doctors clearly felt that their training had equipped them with a different set of skills from those required in these parts of the form. Their medical training had prepared them to make disease assessments, but not functional assessments. Their DSS training too had equipped them with a set of skills and knowledge which was different again.
‘Workplace adjustments [question 11] is very difficult for me, because remember I am a social security doctor basically, and although we have had some occupational health training, I don’t know how realistic it is to make the workplace adjustments.’

(Medical Services doctor, ONE area)

One of the Medical Services doctors interviewed also had another role in occupational medicine. He described how, because he visits workplaces, he is able to envisage individual claimants in specific jobs and specific workplaces. This, he felt, clarified his thinking and made the Capability Report much easier than it would have been if he was generalising with little specific knowledge.

2.2.5 Being positive about capacity to work

The Medical Services doctors had been briefed that in completing the Capability Report, they were required to describe the claimant’s condition and ability to work in ‘positive’ terms. Thus, rather than focusing on what the claimant could not do, they were to focus on what the claimant could do.

‘It’s basically taking a positive approach to the assessment. If you like, in a nutshell, looking at what the claimant can do rather than what they can’t do, which is a complete turnaround for the benefit system, complete turnaround.’

(Medical Services doctor, ONE area)

‘Say somebody can walk 100 metres, the positive spin is, this patient can walk up to 100 metres, which I think is no different from this patient can’t walk more than 100 metres, but they want the positive spin.’

(Medical Services doctors, ONE area)

There were some contradictions created for the Medical Services doctors by this, which are discussed in Section 2.3. However, in general the Medical Services doctors were very enthusiastic about this emphasis on the positive. This was largely because it provided a contrast with the approach taken in most other areas of their work, and was welcomed by most as a rewarding and satisfying way in which to work.

‘It’s awfully nice to sort of get away from this ‘we can’t do this, we can’t do that’ you know, it’s nice to hear what you can do.’

(Medical Services doctor, NDDP area)

2.3 Making the Capability Report more useful

As described above, in general, the Medical Services doctors were fairly happy both with the concept of the Capability Report and with their involvement in it. However, despite the general enthusiasm for the Capability Report, there were a number of ways in which they felt that their input into the process could be improved. These are discussed below.
As discussed earlier in the chapter, the Medical Services doctors were aware that the purpose of the Capability Report was to provide medical advice for the Personal Advisers. However, they were also conscious of an important gap in their own understanding which related to the Personal Advisers’ use of the Capability Report. This was of concern to the Medical Services doctors because, on the whole, they were making a genuine attempt to complete the Capability Report in a way that would be of most help to the Personal Advisers. They felt that a clearer understanding of the use of the Report would help them to appreciate what was and what was not useful to include.

There were a number of areas in which the Medical Services doctors felt that their work would benefit from a greater understanding. On a general level, they were aware that they had only a vague understanding of the ONE and NDDP systems generally, and that a clearer understanding of the process, of which the Personal Advisers and the Capability Report were a part, would help them better target their work. They also felt that they did not have a clear insight into the role and work of the Personal Advisers, such as the way they work with claimants and the help they can give them. More specifically, as mentioned above, they were particularly concerned that their own knowledge about the ways in which the Personal Advisers used the Capability Report was somewhat hazy.

‘We’re doing these things and we’re sort of shooting them off into the dark. We don’t really know what the Personal Advisers want from it. We’re assuming that what they… want to know [is] what’s wrong with the person… what the prognosis is… all about the limitations. But I don’t know, I mean maybe they don’t want to know that.’

(Medical Services doctor, ONE area)

In addition to wanting a greater understanding of the Personal Advisers’ use of the Capability Report, the Medical Services doctors also felt that better communications with the Personal Advisers would enhance the quality of their own completion of the Capability Report.

On the whole, feedback from the Personal Advisers was minimal. In the rare cases where Capability Report forms were returned to Medical Services doctors, it was most commonly as a result of poor legibility. Although there were Medical Services doctors who took a more functional approach to the production of Capability Reports there were other Medical Services doctors for whom this was important and who would like greater contact with, and feedback from, the Personal Advisers in order to help improve the quality of their Capability Reports.
Feedback on what they want I think would be [helpful]. Which things are most useful? Which are the most useful comments, and which are the least useful comments? If the PAs (Personal Advisers) said ‘We like to know about this’ or ‘we don’t like to know about that’, that would be very helpful. Because we could write screeds and screeds of stuff and they’re not interested... I’d like to be sitting in at that interview and see how they interpret one of my forms.’

(Medical Services doctor, NDDP area)

The type of feedback which the Medical Services doctors sought included both general comments on the usefulness of the content and style of the completed Capability Reports, as well as more specific feedback on particular questions or parts of the form. On a somewhat different level, some Medical Services doctors would also have welcomed feedback about particular claimants. Through the process of the Capability Report, the Medical Services doctors had been engaging with the possibility of work for certain claimants and some Medical Services doctors felt that it would therefore be both interesting and rewarding to hear whether or not the claimant had found work.

As described earlier, the Medical Services doctors felt that the ‘positive’ approach which they took in completing the Capability Report was both welcome and constructive. However, they had particular problems where they experienced a conflict between being positive and being what they perceived as ‘realistic’. Some of the Medical Services doctors felt that because of the requirement to present ‘positive’ information on the Capability Report form, what they finally wrote on the form in some cases did not wholly reflect the reality as they saw it. They felt concerned that they were giving a somewhat false impression to the Personal Adviser, or a partial picture.

‘You get the feeling that you’re not really telling the adviser all you want to tell him... there’s nowhere you can... express the feeling that you have about the person... the impression you have about what that person can do, with reasonable effort. Which would probably help quite a bit.’

(Medical Services doctor, NDDP area)

Furthermore, some of the Medical Services doctors felt strongly that it was inappropriate to be conducting the Capability Report for certain types of claimants whom they felt it unrealistic to envisage would work. Some of the Medical Services doctors felt that the Capability Report and the consequent discussions about work were unsuitable for claimants for whom work did not appear, in their view, to be a possibility. There was a range of reasons why the Medical Services doctors felt that it was unrealistic to go through the process of the Capability Report with certain claimants.
Firstly, the nature or severity of the medical condition of some claimants was such that the Medical Services doctors saw the possibility of them working to be totally out of the question, even ludicrous at times. Thus, what seemed like ‘going through the motions’ of the Capability Report felt wholly inappropriate.

The Medical Services doctors may also at times consider a Capability Report to be unrealistic or inappropriate for other claimant-related reasons. This could be the claimant’s situation, such as age or other personal or domestic circumstances. A case was described, for example, of a claimant who could speak very little English and whom the Medical Services doctor felt it unrealistic to assume would work.

A further reason why some Medical Services doctors felt that a Capability Report is unrealistic for some claimants is associated with the claimant’s attitude and motivation. This relates to both the attitude and motivation of the claimant generally and more specifically their attitude or motivation to work. Drug and alcohol abusers for example were referred to in this context, as were other groups who were considered by the Medical Services doctors not to be ‘job ready’.

‘I think that the main problem... is that the people who are coming to see us, they decide beforehand whether they’re going to work or not, and if they don’t want to work, there’s nothing anyone can do about it.’

(Medical Services doctor, N D D P area)

At times, some of the Medical Services doctors also wanted to include in their completion of the Capability Report their views on the realism of a particular claimant obtaining work given the levels of unemployment and conditions of the local labour market. Claimants with low skill levels and particularly those who were nearing retirement age fell into this category and some Medical Services doctors believed that in a competitive labour market, employers are more likely to give jobs to younger people.

‘But when you look at these files and you see somebody hasn’t worked for ten or twelve years, and they are late fifties, I mean I feel like writing on the front, you know, ‘don’t be silly,’ but I can’t do that.’

(Medical Services doctor, O N E area)

For some of the Medical Services doctors, the appropriateness of the Capability Report for certain claimants was a point about which they felt very strongly and which represented for them the biggest weakness of the Capability Report. It was seen as wasting people’s time and therefore money. But also it was seen as inappropriately or insensitively raising the hopes and expectations of some claimants.
We see some people, and we think, you know, this is a waste of time, and forty minutes later, we've finished and we think this was a waste of time for them, it was a waste of time for us, and it was a waste of time for everyone else. You almost feel that you want to write that in somewhere, not in that language, but to say, you know, this is such a chronic situation this patient's in, with the best will in the world they are not going to change their sickness behaviour, their sick role now, they've been like this for eight years, they are now in their late fifties, to expect what you expect is just not on. Just forget it. From my experience I'm telling you to forget it. But that's not how that system operates.

(Medical Services doctor, ONE area)

An issue was created for some of the Medical Services doctors about the expression in the Capability Report form of their own views about the reality of the prospect of work for specific claimants and the provision of an alternative viewpoint from that expressed by the claimant. The Medical Services doctors differed in respect to whether or not they expressed their own opinions in the Capability Report. While some Medical Services doctors did put their own views in the Report, others did not.

The Medical Services doctors are required to record their medical observations on the Capability Report form. However, although different from consideration of capability, some Medical Services doctors found that the nature of the form and the process of completing it made it difficult or unhelpful not to include their own perception of the claimant's chances of working. This could be influenced by medical or non-medical circumstances of the claimant and/or the doctor's assessment of the local labour market and a particular claimant's chances within it.

There were differences between the Medical Services doctors in relation to what they felt that they wanted to express in the Capability Report. However, most commonly, the type of views which they wanted to express were ones which would temper the accounts given by the claimant in the PCA, which fed into the Capability Report. The Medical Services doctors, for example, may have had doubts about the claimant's description of their condition and its impact, or have felt that the claimant's optimism or pessimism about their capacity to work was misplaced, or have identified inconsistencies in the claimant's account.

The Medical Services doctors also differed in their understanding of whether the expression of their own views in the Capability Report was formally encouraged or discouraged. Some were of the view that, differently from the Incapacity Report, the expression of their own opinions was welcomed in the Capability Report. Others felt completely the opposite and described feeling 'shackled' by not being able to express their own opinions.
Those Medical Services doctors who did articulate their own views in the Capability Report tended to do so because they felt that it would be useful to the Personal Adviser. There was a sense that without it the Capability Report would be giving the Personal Adviser an incomplete or inaccurate picture. In particular there was a concern that without it, the Capability Report would give a false impression of the claimant’s capacity to work. The Medical Services doctors felt that if, from their point of view, a claimant was very unlikely to work, then it might have been a waste of everybody’s time not to state that in the Capability Report.

Other Medical Services doctors were rigorous in ensuring that they did not convey their own views in the Capability Report. In most cases, this was either because they were aware that it was not the correct procedure and they were committed to abiding by the rules, or because they had concerns about consequences of possible objection from Schlumberger SEMA or claimants, if they did express their own views. The box for question 10 on the Capability Report form was most commonly used by the Medical Services doctors to express their own views. However, other questions were also used for this purpose.

Those Medical Services doctors who were convinced of the value of expressing their own opinions of the claimant’s chances of working, did not extend this to making recommendations about what claimants should do in relation to employment or to giving prescriptive advice. They were clear that this was beyond their remit.

The Medical Services doctors also had a number of comments about the specific wording or layout of the Capability Report, and about whether an electronic format would be preferable. These are addressed, with Personal Advisers’ comments on the same subjects, in Chapter 5.
3 THE OPERATING CONTEXT OF PERSONAL ADVISERS IN ONE AND THE NDDP PILOTS

The next three chapters of the report reflect the accounts of Personal Advisers in ONE and NDDP pilot areas. Chapters 3 and 4 explore the role of the Capability Report from the perspective of Personal Advisers. Chapter 3 examines Personal Advisers' levels of use of the Capability Report within the pilot areas at the time the fieldwork was conducted and explores how two key factors influenced the levels of use: the awareness and understanding which Personal Advisers had of the rationale for, and intended use of, the Capability Report; and the operational environment in which they worked. Chapter 4 then explores the extent to which the Capability Report was seen to bring 'added value' to Personal Advisers' work with clients and the impact which this also had on levels of use. Chapter 5 sets out comments from Personal Advisers on the style, format and content of the Capability Report and their implications for levels of use, setting these alongside the comments from Medical Services doctors.

As Chapter 1 described, the sample of Personal Advisers was purposively selected to reflect the views of people at different levels within the ONE or NDDP pilots. Interviews were conducted either with one individual or jointly with two or three individuals.

3.1 Levels of use of the Capability Report

A key objective of the study was to explore the use that Personal Advisers made of the Capability Report in their work with clients. However, an early and unexpected finding of the study for the research team was that Personal Advisers in both ONE and NDDP pilot areas had dealt with very few cases involving clients for whom a Capability Report had been received.

In the three ONE pilot areas, the figures provided to the research team showed that the number of clients with a Capability Report that had been seen by a Personal Adviser after the PCA was considerably lower than the number of Capability Reports that had been received in the offices. Whilst the number of clients seen in the Employment Service led areas had recently increased to around 50 in total, the numbers seen in the private sector led areas barely exceeded single figures in one area and was effectively nil in the other area. The reasons for this are explored in Section 3.3.1.

The NDDP Personal Adviser Service pilots ended in June 2001. At the time that the fieldwork was conducted, the actual number of Capability Reports being produced had been considerably fewer than expected. Also, the number of clients attending for an initial interview with NDDP had been far fewer than the number of clients who had expressed interest.
in the service and for whom a Capability Report had been carried out. In one (private sector led) area, only 26 clients had attended for initial interview out of 110 Capability Reports produced. In the other two areas, the numbers attending were only just into double figures. The reasons for the low take-up are explored in Section 3.3.2.

The low numbers of clients coming through had implications for the number of cases involving a Capability Report that any individual Personal Adviser was likely to encounter. A few Personal Advisers in both pilots had seen up to six cases at the time of the interview. More generally, Personal Advisers had seen one or two cases although some had not seen any.

A key finding of the research amongst Personal Advisers was how little information they generally had about the rationale for the introduction of the Capability Report and how Personal Advisers were expected to use it in their work with clients. There was also generally low awareness about the way in which the PCA medical examination was conducted, the process used to produce the Capability Report and the scope and levels of expertise of the Medical Services doctors completing it. Consequently, interviews with both Personal Advisers and Personal Adviser managers revealed a range of views, and a number of misconceptions, as to why the Capability Report had been introduced and how it was supposed to be used.

In the ONE pilots, Personal Advisers had varying levels of understanding as to why the Capability Report had been introduced. Some professed to be not at all clear why it had been introduced whilst others were aware that it was intended to provide Personal Advisers with information to inform their work with sick and disabled clients. It was also thought to have been introduced to indicate to Personal Advisers whether a client was capable of doing some form of work and to help focus clients’ minds on the option of work.

‘It was introduced to make sure that people are truly sick and identifying whether they are fit for work. It makes the distinction between 'fit for no work' and 'fit for some work'. If they are fit for some work, then they need help and guidance to see what they could do.’

(Personal Adviser, ONE area)

In the NDDP pilot areas, it was generally understood that the Capability Report was sent to Personal Advisers to assist them in identifying what clients would be capable of despite their disability:

‘It is a way of showing what they are capable of doing rather than just looking at them and saying they are not fit for work.’

(Personal Adviser, NDDP area)
It was also seen as intended to inform potential clients about NDDP and to encourage them to use the service. There was also a view that its ultimate purpose was to reduce expenditure on incapacity benefits by giving the PCA examination a more positive, ‘can do’ focus.

### 3.2.2 Intended use of the Capability Report

Views in both pilots about how the Capability Report should be used in dealings with clients were very varied. Some individuals, at both Personal Adviser and Personal Adviser manager levels, had a clear view of how they thought the Capability Report should be used to encourage clients to consider work as an option. (The ways in which Personal Advisers were using the Capability Report in practice are set out in Section 4.2). However, more generally people felt unclear about how they were supposed to use it:

‘From a Personal Adviser’s point of view, the whole system is so vague that people just don’t know what they are doing with the Capability Reports.’

(Personal Adviser, ONE area)

In NDDP areas in particular, some Personal Advisers could not see any clear point to using it. From their perspective, the information it contained had no ‘added value’ over and above what they were able to obtain from their work with the client.

NDDP Personal Advisers were quite clear that the Capability Report was intended for use with their clients, all of whom were on incapacity benefits. In the ONE pilot areas, where the service is delivered to the full range of benefit claimants, Personal Advisers, and sometimes their managers, displayed some confusion about which client group the Capability Report was intended for. Although some understood it was for clients on Incapacity Benefit, there was a widespread view that it was primarily intended to be used for clients who had been found ineligible for incapacity benefits at the PCA examination:

‘I see it as being for clients who ‘fail’ the PCA and end up on JSA. It must be them. If it was for people on Incapacity Benefit, managers would give us more time to look for jobs for them.’

(Personal Adviser, ONE area)

### 3.2.3 Understanding of how the Capability Report is produced

Lack of clarity about the rationale for and purpose of the Capability Report was linked to low awareness and understanding amongst Personal Advisers and their managers about the process whereby the Capability Report was produced. Although Personal Advisers were aware that Medical Services doctors produced the Capability Report, there was confusion about how it differed from the Incapacity Report and the nature of the evidence used to complete it.

Personal Advisers in both pilots were not always aware that two separate reports - the Incapacity Report and the Capability Report - were being produced at the PCA examination. They were consequently under the
impression that the Capability Report was being produced primarily for the BA decision maker but was now also being sent to Personal Advisers.

Personal Advisers were generally unclear about what evidence Medical Services doctors called upon for completing the Capability Report: for example, to what extent they were relying on the medical assessment itself and on evidence supplied by the client or from other sources such as the client’s GP. It was also not clear to what extent Medical Services doctors were being objective or putting their own interpretation on the evidence supplied.

A number of factors contributed to the generally low levels of awareness and understanding amongst Personal Advisers:

- Firstly, most of those interviewed had not been involved in the consultation process leading to the introduction of the Capability Report.
- Secondly, they felt they had received little more than basic training and guidance about why it was being introduced and how it was supposed to be used.
- Thirdly, there was little or no exchange of information between Personal Advisers and Medical Services doctors at the pilot project level.

A few of the NDDP Personal Advisers and managers interviewed for the study had been involved in developing the Capability Report during the summer 1999 trial. It was evident that this involvement had helped to raise their feeling of ‘ownership’ of the Capability Report and their awareness of ways of using it. Other Personal Advisers said they did not feel any sense of ‘ownership’ of the Capability Report. They tended to consider it just another initiative, of little intrinsic benefit to them, which they were supposed to implement without having had any input into the process. In the absence of any clear guidance, it was generally left to the discretion of the individual Personal Adviser as to whether, and how, it was used. Where the Personal Adviser could not see any clear value to it, it tended to be left to one side.

‘Part of the way Personal Advisers view the Capability Report arises from how it has been introduced. They do not have a sense of it being of value to them so they don’t tend to read them or feel the need to read them.’

(Personal Adviser manager, NDDP area)

Personal Adviser managers generally felt that the introduction of the Capability Report had been fairly ‘low key’. They felt that there had been little time to organise training, and indeed managers said that they themselves had received relatively little training or guidance. Consequently, the most that Personal Adviser managers had been able to do to prepare Personal Advisers for the introduction of the Capability Report had been to refer them to a training pack or guidance notes.
However, it was generally felt that the guidance notes themselves were not sufficiently detailed to provide the level of information needed for Personal Advisers to have a real understanding of how the Capability Report should be used and that Personal Advisers had often not read the guidance notes. In the ONE pilots, in particular, it was felt that Personal Advisers had had to get to grips with so much other information about benefits and other initiatives that reading the guidance notes had become a low priority for them.

Such training and guidance that had been given had been provided some way in advance of the arrival of the first Capability Report. Personal Advisers had therefore often forgotten about it and were surprised when the first Capability Report arrived:

'The first time I got a PCA [sic], it landed on my desk and I did not recognise it. I read through it but was a bit unsure what to do with it.'

(Personal Adviser, ONE area)

Where Personal Advisers or their managers had been involved in a consultation process prior to the introduction of the Capability Report, they had relayed some of the information gleaned through regular team meetings. However, it was generally felt that the profile of the Capability Report would have been significantly higher had specific training sessions been organised at the time of its introduction. It was suggested that a training session would have had much greater impact than reading the guidance notes in that it would have forced people to focus on the Capability Report and given them the opportunity to clarify any points which remained unclear. In some ONE pilot areas, sessions aimed at raising awareness of the Capability Report and providing clarification about its use were being planned at the time of fieldwork and were delivered shortly afterwards.

As a consequence of the low levels of training and guidance, Personal Advisers were left to form their own judgements about whether, how, and when, to use the Capability Report. These judgements tended to be based on their own assumptions rather than factual information, hence the understanding which had arisen in ONE areas that the Capability Report was intended to be used to help ‘JSA returners’ after the PCA rather than those clients who had been awarded Incapacity Benefit.

Where Personal Advisers were unsure of the nature of the evidence used for completing the Capability Report, they tended to have doubts about the PCA as an appropriate forum for assessing capability. This in turn led to a reluctance to place much reliance on the information contained in the Capability Report.
'There is a real need for Personal Advisers to be trained in what the Capability Report is and how it should be used. They need to explain the process by which the doctors do it and what evidence is used so the Adviser can explain the justification for the views to the client.'

(Personal Adviser, ONE area)

The perceived value of the Capability Report as a tool for working with sick and disabled clients was further diminished where it was mistakenly thought to be intended for the BA decision maker rather than the Personal Adviser.

The fact that there was very little liaison or exchange of information between Medical Services doctors and Personal Advisers at the pilot project level had a number of effects. Firstly, it left Personal Advisers feeling that they lacked information about the Medical Services doctors’ work with clients during the PCA and, secondly, it gave rise to a perception that Medical Services doctors lacked awareness of the information needs of Personal Advisers. Thirdly, in the absence of detailed information about how the Capability Report was produced, the principal source of information was feedback from clients themselves. Clients’ accounts of the way in which the Capability Report was compiled were inevitably tinged with the client’s own feelings about the PCA process and the outcome it had produced. Personal Advisers related a number of ‘horror stories’ from clients who had been for their PCA examination and been found fit for work.

‘They say things like ‘I went into the room and didn’t do anything and in the end the doctor found me fit’. The impression I get is that the PCA gets clients to trip themselves up. So the client can’t write but can carry shopping up the road.’

(Personal Adviser, ONE area)

Accordingly, Personal Advisers had concerns about the content and accuracy of the PCA which adversely affected their views about the credibility, and validity, of the Capability Report as a useful document for assisting them in work with clients.

Views about the advantages of greater liaison with Medical Services doctors were mixed. Some who felt they had a clear understanding of the Capability Report felt they had less need to understand the process by which they are completed. Equally, where the report was seen as being of little value there was little sense that liaison would improve its value. However, some Personal Advisers took the view that better understanding of how Capability Reports are produced might encourage greater understanding of how the information could be used to help clients.

Low awareness and understanding of the Capability Report amongst Personal Advisers and Personal Adviser managers had wider consequences in that they permeated the policy, administrative systems and working patterns of the ONE and NDDP pilots, as the following sections discuss.
3.3 Operational issues related to the ONE pilots

Levels of use of the Capability Report in the ONE pilots were affected by three interlinked sets of operational issues:

- Firstly, it was felt that the focus and priorities of the ONE pilots had left little scope for detailed work with clients on Incapacity Benefit. The twin pressures of time and targets meant that Personal Advisers focused on initial claims and on caseloading clients on Jobseeker’s Allowance.

- Secondly, there were issues around staff expertise, working ethos and staffing levels, which had implications for how staff worked with sick and disabled clients and for the scope which Personal Advisers had for using the Capability Report.

- Thirdly, the administrative systems set up within the ONE pilots also played an important role in determining levels of use.

3.3.1 Focus and priorities of the ONE pilots

Personal Advisers in ONE pilot areas referred to the fact that the role of the Personal Adviser in practice was very different from how it had been envisaged. It was understood that ONE had been set up to act as the Gateway for all types of clients to help them move closer to the labour market and, where possible, into jobs. The role of the Personal Adviser would be to work with a varied caseload of clients, each according to their needs.

In practice, Personal Advisers felt that the ONE pilots were driven by placement targets. Rather than being able to help all clients in their move towards the labour market, the main priority was to meet given targets for placing clients on Jobseeker’s Allowance into jobs. In the case of the private sector led pilots, the fact that funding was tied to meeting placement targets only increased the imperative to achieve them. Other targets, particularly for the number of new claims processed, put further pressure on any scope for working with clients on Incapacity Benefit. ONE Personal Advisers, who had expected their role to be akin to that of Personal Advisers on other Government programmes such as some of the New Deal programmes, now saw their role as closer to that of a New Claims Adviser.

Personal Advisers had therefore generally caseloaded very few, if any, clients on Incapacity Benefit. In order to meet their targets for Jobseeker’s Allowance clients, Personal Advisers were exercising wide discretion to defer calling Incapacity Benefit clients in for ‘trigger’ interviews after receipt of the Capability Report. This was underpinned, as the section below describes, by their perceptions of clients on Incapacity Benefit and their experiences of post-claim contact with them.

In the Employment Service led pilot area, management had recently altered the guidance about deferring ‘trigger’ interviews so that Personal Advisers were now obliged to call in all clients on whom a Capability Report had been done:
‘It is clear that Personal Advisers have not been applying their discretion properly. They have been applying their own culture and beliefs to the Capability Report and been deciding there was no point in seeing the client.’

(Personal Adviser manager, ONE area)

ONE Personal Advisers pointed out that it would not help work with Incapacity Benefit clients for placement targets to be set for ‘non-JSA clients’. They would be more likely to accord priority to other groups, such as lone parents, rather than Incapacity Benefit clients because they would be easier to place.

Since the fieldwork was carried out, operating targets have been introduced for ONE Personal Advisers to work specifically with Incapacity Benefit clients.

There was an evident reluctance amongst some ONE Personal Advisers to caseload clients on Incapacity Benefit which, it appeared, derived partly from the perceived pressures associated with targets and partly from their perceptions of sick and disabled people.

There was a recurrent view that the term Incapacity Benefit clearly implied ‘classified unfit for work’. It therefore seemed inappropriate, indeed intrusive, to oblige these clients to attend for an interview to discuss the idea of work so soon after the PCA examination. ONE Personal Advisers were concerned that this could cause anxiety and distress, particularly if the client’s condition would make visiting the service difficult and if clients felt that their benefit entitlement could be in jeopardy. For some ONE Personal Advisers, these views had been reinforced by their experience of clients’ reactions when they had contacted them to ask them to attend an interview. There was also a concern about the responsibility on Personal Advisers if the client’s condition were to deteriorate once they had found work.

Staff for the ONE pilots were drawn from a range of different agencies: from the Benefits Agency, the Employment Service, Local Authorities and from private sector agencies. They brought different levels of expertise and different types of working ethos with them. Whilst all staff were on a learning curve on joining the ONE pilots, this was especially true for private sector agency staff who had little or no relevant experience of working for a Government Department and therefore had more to learn than those drawn from the Employment Service or the Benefits Agency.

Although views were mixed, there was a general assumption that clients on Incapacity Benefit would be some way from work, and that intensive support from the Personal Adviser would be required to address a range of personal and work-related issues which were seen as very significant barriers to work. There were also very different levels of expertise in dealing with sick and disabled clients. While several staff with a Benefits
Agency background said that they felt comfortable working with this client group because they had been involved in dealing with claims for incapacity benefits, staff from other backgrounds often felt that they had little or no expertise to draw on in dealing with the client group. Although some advice and guidance on disability issues had usually been provided during the Personal Adviser training, it was felt to have been too limited in scope to have any impact on skills levels.

Policy guidelines for O N E require all clients to be called in for a ‘trigger’ interview following notification of the outcome of their PCA. However, based on their views about what was appropriate, and their sense of their own skills, Personal Advisers were often not calling clients on Incapacity Benefits to this compulsory work-focused interview. Some made no contact; others would have a short conversation on the telephone largely about benefits. If clients were called to an interview, it was often a short meeting which focused largely on benefits with little or no discussion of the idea of work – there were few references to cases where there had been more substantial interaction.

In some offices, clients on Incapacity Benefit were referred to one particular Personal Adviser who was considered to have some specialist skill or interest in dealing with the client group. In others, they were distributed amongst generic Personal Advisers on the basis of availability. However, this did not appear to have an effect on levels of work with clients on Incapacity Benefit since even ‘specialists’ were primarily dealing with Jobseeker’s Allowance clients and were constrained by the time pressures already mentioned. For the most part, the only substantial contact Personal Advisers were likely to have with clients involving a Capability Report was when a client had been found ineligible for Incapacity Benefit and was initiating a new claim for Jobseeker’s Allowance. Where there were any issues relating to the disability that needed resolving, Personal Advisers tended to refer them to a Disability Employment Adviser (DEA) who, it was thought, was more suitable for meeting client needs in terms of expertise, time and a less target-driven working environment. Indeed, there were some suggestions that the Capability Report would be more useful for DEAs than Personal Advisers.

O N E Personal Advisers sometimes talked about sick and disabled people as a whole being unlikely to be capable of work or motivated to work. However, they did, either spontaneously or with prompting, distinguish between different groups of clients on incapacity benefits in terms of their motivation and employability. Broadly speaking, it was felt that there was little that could be done for clients who were either totally unmotivated or were too incapacitated to work. By contrast, it was felt that there was a broad spectrum of other clients who, although unable to do work they had done in the past, might be able to do some work of another kind. However, motivation was felt to be key. Despite the fact that it was the policy of O N E, Personal Advisers expressed some concern
about the use of their time for carrying out compulsory interviews with people who were not required to look for work, and who appeared not to want to do so.

Issues relating to administrative systems and staffing levels also had implications for use of the Capability Report. Individual pilot areas had evolved their own systems for distributing and filing the Capability Report. In general, systems involved the Capability Report being sent to a specific office although there were cases of Capability Reports being sent to the wrong offices in some areas.

Once the Capability Report was received in the office, it was generally passed on to the Personal Adviser who had taken the initial claim. In one of the private sector led areas, administrative staff were unclear about what was supposed to happen with the Capability Report so simply filed it alphabetically and did not pass it on. However, the system has since been revised in the light of a policy presentation to managers so that the Capability Report will be held until notification of the outcome is received and then both will be passed on to the relevant Personal Adviser.

In the other two ONE pilot areas, Personal Advisers tended to record receipt on their electronic administrative system and file the Capability Report until notification of the outcome came through. In the Employment Service led area, Personal Advisers then read through the Capability Report before deciding whether or not to call the client in, looking for some indication that work might be of interest to the client. In the private sector led area, it seemed that the policy was to simply file the Capability Report if the client remained on Incapacity Benefit and to keep it on hold if the client was due to return to Jobseeker’s Allowance.

There were specific issues connected with the Capability Report being sent to, or held by, individual Personal Advisers. Under the call centre model, in one private sector led area, appointments were being made with a different Personal Adviser from the one who had received the Capability Report. It was then difficult for the new Personal Adviser to locate the Capability Report. Given the low priority attached to the report, Personal Advisers tended not to seek it out. In the other private sector led area, the high level of turnover amongst agency staff was affecting the ability of the service to provide clients with any continuity of Personal Adviser.

Finally, the Capability Report seemed also not to be used in Personal Adviser’s work with clients who were now on Jobseeker’s Allowance. It was felt that the time available for interviews with such clients was limited and, since Capability Reports were not easily accessed nor seen to be of high priority, they were not being sought. It was also said that clients moving to Jobseeker’s Allowance sometimes seek the initial meeting before the Capability Report has arrived in the office, and this too limited its use.
Personal Advisers in the N D D P pilots were operating in a very different working environment from those in the O N E pilots. The operational issues influencing levels of use of the Capability Report were therefore very different in nature. Firstly, Personal Advisers in N D D P did not operate under the same pressures as those in O N E. Secondly, the service was designed specifically for clients who were on incapacity benefits so Personal Advisers were able to caseload clients and work with them over a period of time. Thirdly, because the service was voluntary rather than mandatory they were, in theory, only seeing clients who were motivated to move into work.

It was generally understood that one of the objectives of the Capability Report was that it should be used as a marketing tool for the N D D P pilots to increase the number of clients coming forward to use the service. As Chapter 1 described, recruitment via the Capability Report was being carried out in two different ways in the three pilots. Under Option A, clients were invited in person to say whether or not they would like to use the service at the time of the PCA examination. Under Option C, the invitation was included with the appointment letter sent out by the Benefits Agency for the PCA. Client reactions to these recruitment initiatives are documented in Chapter 6.

In principle, Personal Advisers were in favour of initiatives that raised the profile of the service. However, in practice, the numbers of clients accepting the invitation to use the service through this route had been far fewer than expected in all three pilot areas. Of those who had accepted the initial invitation, a high proportion had subsequently declined an invitation from the service to come for an interview, or had made an appointment but not attended. Where clients had attended, they had often said that work was not currently an option for them or had seemed less enthusiastic than clients coming from other routes, so that there had been little contact beyond the initial interview.

With regard to Option A, Personal Advisers expressed concerns about the appropriateness of using a mandatory examination as the vehicle for a voluntary service. They felt that clients would very likely be under considerable strain at the prospect of possibly losing their benefits and would possibly be feeling resentful at being called in for the medical examination. Clients were, they thought, unlikely to be in a receptive frame of mind to consider a service to help them look for work. There was also a concern that, since the PCA was mandatory, any reassurances about the N D D P service being voluntary could well be disbelieved. There was a distinct possibility that some clients would only agree to see the service out of fear that their benefits could be affected if they did not:
It is not a good idea to pair the two. It is not voluntary to go for a medical; it is voluntary that they come here. It is a very stressful situation to introduce something that is voluntary and about helping them when medicals have a reputation for being unhelpful for clients. People say yes based on the fact that if they look cooperative they are more likely to keep their benefits.

(Personal Adviser manager, NDDP)

With regard to Option C, informing clients about a voluntary service as thought to be incompatible with an appointment letter for a mandatory medical examination. Again, there were concerns that clients would only be likely to contact the service out of fear of losing benefits. In both options, there were concerns about the quality of information that could be provided to clients about the service, the type of support available, and its voluntary nature. As Section 6.2.2 describes, these concerns were borne out by the accounts of some clients.

In response to their concerns about these issues, Personal Advisers tried to ensure that all clients making contact with the service were made aware, either by letter or over the telephone, that the service was entirely voluntary. However, the fact that there was a high drop-out rate once this was done tended to confirm the view that clients making contact via this route were doing so out of concern that their benefits might otherwise be jeopardised.

Overall, there was a perception that clients coming to the service via the PCA route were less likely to be motivated to think about work and, it was also suggested, were more likely to have more severe disabilities. They were, therefore, not regarded by Personal Advisers as the most suitable clients for the service since it was felt that spending significant amounts of time with clients, who are not ready to engage effectively with the service, would be a waste of resources.

3.4.2 Experience and working methods

The second set of issues relating to the operating context of the NDDP pilots concerns the experience and working methods of Personal Advisers. Personal Advisers in the NDDP service were working exclusively with sick and disabled clients who were on incapacity benefits. They felt that their depth of experience working with the client group had largely shaped their working methods, and it was unclear to them what the Capability Report could add. Although, as Section 4.2 describes, there were different working practices, Personal Advisers in NDDP were generally used to obtaining the information they needed about clients and their conditions through in-depth discussion with clients over some time. They had a range of further sources to which they could turn if more information, or a specialist assessment was required, but in practice these were generally not used routinely. For them, there was no obvious gap in information that the Capability Report was filling, and it was difficult for them to see what it could add.
This issue is discussed further in the following chapter, which explores the types of information used by Personal Advisers, whether and how they see the Capability Report adding to it, and how this helps to shape views about and use of the Capability Report.
4 PERCEIVED ROLE OF THE CAPABILITY REPORT FOR PERSONAL ADVISERS’ WORK WITH CLIENTS

This chapter examines the role which the Capability Report fulfils in meeting the information requirements which Personal Advisers have in their work with sick and disabled clients and their views about how it could be adapted and improved to meet them more effectively. Section 4.1 sets out the range of information needs that were identified as important for Personal Advisers in their work with clients and the sources used for obtaining the required information. Section 4.1 concludes with an examination of the extent to which the Capability Report was seen as able to provide or complement the information provided by other sources used. Section 4.2 investigates how those Personal Advisers who did make use of the Capability Report were using it: for what purpose, for what reasons and at what stage in their work with clients. Section 4.3 provides an overview of the extent to which Personal Advisers from both ONE and NDDP pilots see the Capability Report having a role in their work with sick and disabled clients in the future.

In order to understand Personal Advisers’ views about the value and role of the Capability Report, it is necessary first to understand the types of information that Personal Advisers say they require to help them in their work with sick and disabled clients. Three broad categories of information were identified:

- Firstly, Personal Advisers needed to familiarise themselves with details about clients: their personal history and situation; their motivation and aspirations.
- Secondly, there was a perceived need for comprehensive information about the client’s medical condition and its implications for the client’s ability to work.
- The third category of information identified was for employment-related information: specific information that would assist the Personal Adviser in helping the client to move into suitable employment.

Personal Advisers needed to have as much factual background information about the client as possible. This included information about both their personal circumstances and their work circumstances, particularly their skills, qualifications and previous employment. Personal Advisers in the ONE pilots placed particular emphasis on the value of information about the client’s motivation to work. As Chapter 3 described, this would have implications for the extent to which they might be able to help the client: given the pressures of placement targets and time constraints, the scope for meaningful work with clients who did not feel able or want to work would be limited.
In N D D P pilot areas in particular it was considered important to obtain as complete a picture of the client as possible in order to provide an effective service. For example, it could be important to find out about the person’s personal situation for an understanding of its effect on the individual’s levels of confidence. This, in turn, could have implications for the amount of support that the client would need from the Personal Adviser to become ready for work.

4.1.2 Medical information

Personal Advisers needed two types of what we have termed ‘medical information’. Firstly, they needed to gain a clear picture of the nature of the condition or disability and some indication about the likely prognosis whether the condition was likely to improve or deteriorate and the likely timescales. For instance, it was useful to know whether the person was able to sit or stand and, if so, for how long. Of particular interest was any information relating to mental health. It was not always immediately apparent to Personal Advisers if a client was suffering from a mental health condition. They wanted to know, for example, whether the person was likely to have ‘good’ and ‘bad’ days, whether there were any side-effects to any medication being prescribed, and whether there were any particular behavioural issues related to the condition. There was a view that this was relevant not only for their work with clients but also for Personal Advisers’ personal safety.

‘There is a specific need for background information on everyone with mental health problems. We see the client for the first time and we have got no medical history at all so we don’t know, for example, if they could be violent.’

(Personal Adviser, N D D P area)

The second type of medical information that Personal Advisers needed was about the implications of the client’s medical condition for work. This included whether their condition allowed any work, whether work could be undertaken without compromising their health, the amount of work that could be undertaken, and the specific types of vocational or occupational directions that were realistic given the client’s condition. It was important to establish early on whether work was, in fact, a viable option.

‘It would be useful to know whether the condition will improve or not as I would not necessarily know. I also would not know the effect which some conditions might have: what the client could and could not do and what dangers might result from work, for example where a client had a brain injury. I wouldn’t know if the person could drive or operate machinery as I don’t have the medical knowledge.’

(Personal Adviser, O N E area)

Some Personal Advisers, who stressed that they themselves did not have a medical background, said they needed the reassurance of medical evidence because they did not want the responsibility of placing the client in a job where they might come to harm.
In addition to information about clients and their medical condition, Personal Advisers welcomed any type of information that would assist them in placing clients into employment. For example, information which would help them to identify the particular barriers which the client faced with regard to employment and any possible ways of overcoming them. It was sometimes useful to have some form of assessment as to the types of workplace adaptations or additional equipment that would be needed for the client to be able to undertake work in a given employment situation.

It was also helpful for Personal Advisers to have information about the state of the local labour market and the types of employers who would be amenable to providing placements for disabled clients. This was of particular interest to Personal Advisers in the ONE pilots, many of whom had had little experience of trying to place a disabled client. It was sometimes, but less often, of interest to NDDP Personal Advisers, who had generally acquired this type of information through their experience of doing the job.

Personal Advisers used a number of different sources of information for their work with clients. The most important source of information, in both ONE and NDDP pilots, was clients themselves. For additional or supplementary information, Personal Advisers had variable degrees of access to external sources of specialist advice and support.

Views about the extent to which much, or almost all, of the required information could be obtained from the client were mixed. There was some consensus that for the most part clients were able to provide background information about themselves, their personal history and current situation, their motivation and aspirations as far as work was concerned.

However, Personal Advisers differed in their views about how far clients could give a reliable account of what they could and could not do. Some felt that on the whole clients knew better than any outside source what they were capable of. Equally, there were those who shared this fundamental view but qualified it by citing a number of limitations. Others had less confidence in the ability of clients to assess their own condition and were more concerned to compare and contrast the information obtained from the client with information from other sources. These Personal Advisers took the view that some clients were by temperament more "open" than others. It could be that they were not being completely honest with themselves or the Personal Adviser or that they might be...
reluctant to divulge the full picture of their condition: for example a client might talk about a bad leg but fail to refer to diagnosed schizophrenia.

Views about the ability of clients to assess the implications of their condition for the type of work they could do were mixed. Whilst some Personal Advisers thought that clients were best placed to judge what type of work they could do, others felt that they were not always able to tell what the effects of their condition might be in a work context. This was felt to be especially true where there was a problem with mental health. There was a need for information from an external source on the nature of the psychological barriers and how they might affect the client’s behaviour and ability in a work environment. In addition, some clients were felt by Personal Advisers to have unrealistic expectations of the type of work they could do. This could be the case where they did not fully understand the implications of their impairment, for example as a result of a head injury, or it might be due to other factors such as a long spell away from the labour market. Advice and guidance from an external source could be useful for promoting more realistic client expectations.

Views about the ability of clients to provide information about the type of work they wanted to do were also mixed. Personal Advisers felt that some clients simply did not know what kind of work they wanted to do and were not aware of what job options might be open to them. In these cases, Personal Advisers might be able to advise clients themselves or call on external specialist advice to assist in helping the client. It was also thought that an outside assessment was often better able to identify the most suitable types of workplace aids and adaptations than clients themselves.

It was stressed that an essential ingredient in accessing information from clients was a good relationship between client and Personal Adviser. The ability to access information from clients depended on staff expertise in facilitating the relationship and on the time available to the Personal Adviser. It was felt that clients needed to feel a sense of trust in order to ‘open up’ and it could often take several sessions before the client would feel sufficiently confident to do this. Staff in the ONE pilots frequently emphasised that they were lacking both in experience and in time for assessing employment options for sick and disabled people.

4.2.2 Other sources of information

The extent to which Personal Advisers were able to access advice and information from sources other than the client varied markedly between the two services. In the ONE service, as has already been mentioned, Personal Advisers did little caseload of clients on Incapacity Benefit and were likely to refer a sick or disabled client to the Disability Employment Adviser (DEA) rather than seek to work with the client themselves. They therefore tended not to seek additional information except, in exceptional circumstances, from the client’s GP. 
Within the NDDP pilots, Personal Advisers had access to a range of specialists and specialist agencies for medical or employment-related information. However, it was stressed that these were only required in relatively few cases, and that in most cases Personal Advisers were able to gain the information required from their meetings with clients themselves. The most common source of medical information was the client’s GP but Personal Advisers also described approaching other people with a close knowledge of the client’s condition: for example, a psychiatrist, community psychiatric nurse (CPN) or social worker.

In approaching GPs and other professionals involved in the client’s care, Personal Advisers sought different types of information. They might be seeking general information about the client’s health or about a precise area of interest such as details of the medication being taken and the possible effects on the client’s behaviour and performance.

Alternatively, they might be seeking an assessment of the implications of the client’s condition for the appropriateness of work generally, the right timescale for a return to work, or the particular area of work envisaged.

‘I had a client whose job was being kept open for him but it had a time limit. I needed to organize some funding for the client to go through functional rehab. I contacted the GP to see whether the timescale they had set was realistic for the person to return to work. The GP was responsive and confirmed that the timescale was workable.’

(Personal Adviser, NDDP pilot area)

Personal Advisers might also contact the client’s GP (or other key person such as a CPN) where they did not feel convinced that the client had provided the full picture and there was a risk that some factor might be overlooked which could adversely affect the client in a work situation. Some Personal Advisers stressed that they tended to seek medical advice and information from GPs and other key people because they themselves did not feel confident to make an assessment of the client’s condition and its implications for work. It was important to have evidence from someone with medical expertise, ideally with an ongoing relationship with the client, to avoid taking any steps that might make the client’s condition worse.

There was a general level of satisfaction with the reliability of the information contained in reports from a GP, and Personal Advisers mostly said that they would feel confident acting upon it. However, some queried the impartiality of the information that a GP would provide and felt objectivity might be influenced by the ongoing nature of the relationship between GP and client.
Personal Adviser was well equipped to do:

‘Staff here are well versed in looking at disabled people and their ability to go into work. They have been doing it for a long time, are pretty expert and work out really quickly where the client is coming from, how much they can cope with and which industry they should move into.’

(Personal Adviser manager, N D D P area)

Others seemed to have a greater need for some level of outside input. Personal Advisers in the N D D P pilot areas had access to occupational psychologists within the service or partnership providing the Personal Adviser Service. The extent to which clients were referred to occupational psychologists varied between the N D D P pilot areas: in one Employment Service led area, referrals appeared to be fairly routine, but in the other two areas they were used in more exceptional cases.

Referral to an occupational psychologist occurred for a number of different reasons. Sometimes it occurred because the Personal Adviser was at a loss how to proceed, for example where it was unclear what sort of occupational paths might be open to a respondent particularly if their previous occupation was no longer a viable option:

‘We sometimes refer people to occupational psychologists when the client has come from a certain employment background and we have no idea how to transfer their skills into another area of employment.’

(Personal Adviser, N D D P pilot area)

Personal Advisers also made a referral to the occupational psychologist if they had a sense that there were other background issues which might be barriers to work, but which the client seemed reluctant to discuss. Occupational psychologists were felt to be particularly skilful in eliciting detailed information about mental health issues:

‘A client of mine had a medical health problem so I referred him to the occupational psychologist. The client had told the psychologist everything he had taken months to tell me in one hour.’

(Personal Adviser, N D D P pilot area)

It could also be used in the case of a specific condition where the possible implications of work compromising a client’s health could be severe: for example, where the client had a heart condition or multiple disabilities.

Personal Advisers also referred clients to an occupational psychologist in order to obtain the opinion of a third party in cases where they felt that the client’s aspirations or expectations were unrealistic.

In the N D D P pilot areas, Personal Advisers were also able to refer clients for a more detailed Occupational Health Assessment (O H A) although different agencies were used in the areas. One area used one of the partner organisations in the private sector led consortium whilst another
had a contractual arrangement with Schlumberger SEMA Medical Services. As with occupational psychologists, key reasons for referral were to identify suitable work options based on an in-depth assessment, or for reassurance that work would not compromise the client’s health. One Personal Adviser had been able to organise an ergonomic assessment for a client during the placement which had proved very useful:

‘It can be useful to have an ergonomic assessment done on a Capability Report client when he or she does a placement. They really test the person and let them see what they can and can’t do. One man, who had wanted full time work, said after the placement that there was no way he could manage full time. But without the assessment, he would never have known it.’

(Personal Adviser, NDDP pilot area)

Personal Advisers had very diverse views about the value of the Capability Report, the role it had to play within the context of their information needs and the extent to which these needs could be met by clients themselves or by additional information sources. For many Personal Advisers in the ONE pilot areas, the views they expressed about the value of the information contained in the Capability Report was largely hypothetical as they had had little or no experience of using a Capability Report in their work with clients.

On the one hand there were Personal Advisers who felt that the information contained in the report could perfectly well be obtained from the client, provided that Personal Advisers had the time to do so. It was difficult for them to see what added value the Capability Report provided.

Others felt that Personal Advisers lacked medical expertise and were therefore not sufficiently qualified to understand medical conditions or assess the validity of client’s accounts of them. They saw value in additional information from the Medical Services doctor or in the doctor’s objective assessment of the client’s condition and its implications for work capability.

‘I have a client who had to go on to Incapacity Benefit because of his bad asthma. He then went back on JSA. It noted on the Capability Report that the client was only on limited medication which was why the asthma appeared worse than it actually was. If I did not have a Capability Report, I would have said it was shocking and lodged an appeal.’

(Personal Adviser, ONE pilot area)

There was, therefore, potential value in having the opinion of the Medical Services doctor as to whether the client was, or was not, capable of working; whether it should be full or part time work and, if possible, some indication of the most suitable form of work. This could then provide a good starting point for a discussion of the employment options available. It was considered especially useful for certain types of client:

4.3 Perceived value of the Capability Report as a source of information
for example those with a mental health problem which was often not immediately apparent, or for clients who could be job ready in the near future but not just yet.

Other Personal Advisers were sceptical about relying on information provided by the client. These Personal Advisers felt that the value of the Capability Report consisted precisely in the fact that it took the personal element out of the equation. They felt it was useful to have the view of an independent third party expressed in black and white. Apart from its value in acting as a shortcut to finding out about the client at the initial interview, it could be used for noting discrepancies between the views of the client and those of the Medical Services doctor, for challenging any unrealistic expectations and for exploring points, which the client had failed to mention.

‘The Capability Report can be useful for those with mental health problems. It can reveal things which the client has not necessarily volunteered: for example that they have difficulties relating to other people in a work setting.’

(Personal Adviser, NDDP pilot area)

It has already been established that Personal Advisers were generally not aware of the fact that Medical Services doctors used a range of evidence to complete the Capability Report: the IB50 questionnaire and GP notes as well as their own medical assessment and questions to the client. There were therefore doubts about how well the Medical Services doctors were able to form a realistic picture of the client after one meeting. This led to a perception that the Capability Report offered a one-off view of the client at a particular moment in time and was not able to reflect the fact that the condition may change in severity from day to day. These Personal Advisers therefore felt there was considerably more value to be gained from obtaining information from the client. Over time, they felt, the client would reveal far more about his or her capability than could be provided in the Report. Doubts about the reliability of the information contained in the Capability Report were increased where there was any conflict between the information provided by the report and that provided separately by the client’s own GP.

Where the Capability Report had been used in interviews with clients, views about the extent to which it had provided an accurate picture of the client differed. There were examples where it was thought to have reflected the client and the client’s condition very accurately. However, there were others where it was thought that the information had failed to indicate the severity of the condition or its likely impact on the client’s ability to work; equally, there were occasions when Personal Advisers felt the Capability Report had under-played the level of capability.

Whilst some Personal Advisers working in NDDP pilot areas felt at ease with what they saw as a type of ‘medical model’ used for completing the Capability Report, others felt that it sat uneasily with what they referred

4.3.1 Perceived reliability of the information provided in the Capability Report

4.3.2 The model used for completing the Capability Report
to as the ‘social model’ which they used for their work with clients. In their view, strictly medical information about the client’s condition and a medical assessment of its implications for work was of only minimal value for their work. By contrast, the ‘social model’ emphasised the importance of clients’ own accounts, perceptions and assessments. The starting point for these Personal Advisers was to find out what the client wanted to do and to explore the client’s perceptions of their capability, encouraging the client to reflect on this and, through discussion and perhaps also trial placements, to consider the feasibility of their goals.

Those Personal Advisers who used other sources of medical information, such as a GP report, generally felt that these were more useful in meeting their information requirements than the Capability Report. They stressed, for example, that GPs had an ongoing relationship with the client and were therefore able to supply a historical perspective to their information whilst the Capability Report could only provide a snapshot of a given moment in the client’s condition.

On the other hand, as noted in Section 4.1.2, other Personal Advisers took the view that the information from the GP might be less objective than that provided by the independent Medical Services doctor in the Capability Report. It was also said that the range of information contained in the Capability Report was more comprehensive than that supplied in GPs’ reports. Personal Adviser managers, in particular, felt that there could be a financial advantage to having medical information provided by the Capability Report in that it could save the fee for commissioning a report from a GP.

Whilst there was a perception that the Capability Report could indicate broadly the type of workplace activities that clients could do, it was quite widely felt that the information it contained was too general in nature to assist Personal Advisers in identifying specific work options for clients. For example, they felt it did not provide advice about: whether the client was likely to be able to do any work, how much work would be appropriate and how this could be structured, and the types of occupation that might feasibly and safely be considered; nor was it able to identify potential employers:

‘Clients come along expecting the service to find them work. But there is nothing on the Capability Report about what they could do in terms of employment. That is the real sticking point: what can the person do and which employer is going to provide that for them by taking them on?’

(Personal Adviser manager, NDDP pilot area)

Other specialist referral sources – occupational psychologists and services providing detailed occupational health or vocational assessment – were felt to provide more valuable information that involved a deeper consideration of the client’s own specific circumstances, interests and condition.
‘The Capability Report is just a health report about what the BA person thought the health position was. The occupational GP is specific. For example, if I had a client who had broken their back ten years ago and was suffering from osteo-arthritis, I would ask the occupational GP for advice on what type of job he could do. He might recommend that the client should not do bricklaying but could do plastering. We could then go from there and know that we would not be choosing anything that would be physically harmful to that person.’

(Personal Adviser, NDDP pilot area)

As noted earlier, Personal Advisers had generally seen few Capability Reports and were therefore not very familiar with its contents. Some identified certain types of information as being absent which were in fact covered by specific questions in the report. For example, it was sometimes claimed that the Capability Report failed to refer to the client’s motivation to work or a prognosis of how the condition was likely to develop. However, the requirement for more specific information about the implications of the client’s condition for the feasibility of work as an option and for appropriate work directions was a recurrent theme.

Chapter 3 has already established that Personal Advisers generally were making little or no use of the Capability Report in their work with clients and outlined the principal reasons why this was the case. In addition, the fact that Personal Advisers had busy schedules made them less inclined to read a document that they considered to be long, hand-written and couched in terminology with which they were not familiar, as the following chapter discusses.

However, despite the range of factors contributing to low levels of use, a few individual Personal Advisers in both pilots were using the Capability Report quite extensively in their work with clients. It is important therefore to establish what factors may contribute to these individuals finding ways of using the Report whilst their colleagues did not.

It was apparent that experience of disability issues was a factor in Personal Advisers’ willingness to make use of the Capability Report in their work with clients. Personal Advisers were drawn from a wide variety of backgrounds and had very different levels of expertise and experience when they joined the service. Some felt they had substantial experience of disability issues and that this had helped them to an understanding of how and why to use the Capability Report, despite the absence of a clear steer through formal training and guidance. Experience of disability issues had come about in several ways. For example, the Personal Adviser:

- had a Benefits Agency background which had involved extensive work with clients on incapacity benefits;
- either had a disability or had a relative who was disabled;
- came from a home environment with a strong medical bias.
However, it was also apparent that not all those with previous experience or personal interest were, in fact, using the Capability Report. Indeed, some felt that it was precisely their experience of working with disabled people that meant that the Capability Report had relatively little to offer them. Some in the NDDP pilot areas, for example, noted that when they had first begun to work with sick and disabled clients they would have valued something like the Capability Report, but that now they generally felt able to work without it.

4.4.2 Preferred working methods

More generally, whether or not Personal Advisers used the Capability Report in their own work with clients appeared to be influenced by a combination of their familiarity with disability and disability issues and their own preferred working methods. There was clearly scope, particularly in NDDP pilot areas, for Personal Advisers to evolve their own working style based on their experience, personal temperament and their preferred approach.

Two broad categories of working methods with clients were identified:

- A ‘client-led’ approach. Personal Advisers taking this approach included those with limited or no experience of disability and some with fairly extensive experience of disability. What distinguished their approach was a preference for seeing clients without any prior information, with a completely ‘open’ mind and without any preconceptions about them. They were primarily concerned with obtaining a full understanding of the client’s condition and situation from the client’s own perspective. They might use discussion and gentle challenging to encourage further reflection by the client, but their general stance was that clients were the best judges of their own capability. They were therefore more keen to encourage the client to learn and adapt their goals through experience rather than to rely on information obtained from elsewhere. Some Personal Advisers identified this approach with the social model of disability although others described it without relating it to any particular model or ideology of disability.

- A ‘multi-source’ approach. Personal Advisers adopting this approach tended to be those whose experience of disability and disability issues had led them to place more emphasis on the value of information from sources other than the client. Whilst these Personal Advisers saw the client’s perspective as important and wanted to understand it in detail, they also had a stronger perception of the limitations of evidence from the client. They were aware of factors that might cause clients’ evidence to be unreliable such as a reluctance to divulge information about mental health issues. They therefore saw value in external information to supplement it, or to provide an alternative ‘independent’ or ‘objective’ perspective to it, and they might sometimes use this information to question the client’s own perception of their condition or to encourage them to reflect further upon it. It was among Personal Advisers who described this ‘multi-source’ working method that the Capability Report was most likely to be used and seen to be of value.
4.4.3 Use of the Capability Report for work with clients

Where the Capability Report was being used, it tended to be used at two stages in work with clients. It could be read through in advance of meeting the client. Alternatively, or additionally, it could be used during the interview itself.

4.4.4 Use prior to interview

The most widespread use of the Capability Report was for Personal Advisers to acquaint themselves with details of the client and their condition in advance of meeting them. The main reasons for reading the report at this stage were: to find out from the medical evidence what the client was realistically capable of, to see what type of work the client might be able to do and to understand the likely effects of any medication taken or of the condition itself.

It was clear that Personal Advisers taking a multi-source approach often read the report quite thoroughly whilst the client-led Personal Advisers often just flicked through it or did not open it at all. In some cases, the Personal Adviser would look through the report on initially receiving it and then use it for mental preparation before the interview. However some Personal Advisers in NDDP pilot areas said that they were no longer reading Capability Reports when they came in, apart from just checking for any major problems such as drugs or attempted suicide, because so few clients were attending for interview. Now, they only read the report immediately before the client arrived for the interview.

It appeared that a number of Personal Advisers, from both services, limited their use of the Capability Report to preparation before the interview because they were not clear whether, or how, it should be used during the interview. A common area of confusion for Personal Advisers in both pilots was whether they were allowed to mention or refer to the Capability Report during their interviews. There was even greater confusion over whether they could or could not show the report to the client. Personal Advisers in a ONE pilot area reported that they had been expressly told that they were not to refer to or show the Capability Report during interviews with clients. In other areas, Personal Advisers had to rely on their own judgement and came to different conclusions. Some took the line that, under the Data Protection Act, clients had a right to see any document which was written about them. Others felt that the nature of the information contained in the Capability Report was unsuitable for showing to a client and could prove counter-productive in their dealings with them:

‘There might be things the client would not want to hear. For example, we could have the client saying that they have such and such an illness and the Capability Report saying things along the lines of there is nothing wrong with the client so that can be a difficult issue.’

(Personal Adviser, ONE pilot area)
Where Personal Advisers did use the Capability Report during their interviews with clients they used it in different ways and for a number of different purposes. A few Personal Advisers had reached the conclusion that, given the recent Data Protection legislation, clients were entitled to see their own Capability Report. In one case, it was shown, so that the client was aware of its existence, but not gone through in detail. In another, the Personal Adviser had used the report to check out with the client that the information it contained was correct.

Others had gone through the information contained in the report but without showing it to the client. In one case, it was because the Personal Adviser was not confident to take the report at face value so wanted to check it with the client’s view. In another, the Personal Adviser had gone through it point-by-point with the client although this was an approach that was largely discouraged by managers:

‘Clients should not feel they are undergoing a test. Some PAs use it as it is intended but others go through it as a checklist section by section which puts the client on the backfoot.’

(Personal Adviser manager, ONE pilot area)

For the most part, Personal Advisers had used the report as a third party view in the interview and this could be used in various ways. It could be used for raising issues with the client or for countering the client’s opinion if it appeared to the Personal Adviser to be unrealistic:

‘I only refer to the Capability Report if what the client says conflicts with what is in the report or where the medical view suggests that there could be difficulties. I used it for one girl who had cancer but wanted to work full time because of financial pressures. I incorporated what the report said about her starting part-time to build up stamina into my standard spiel about having a structured approach in the return to work.’

(Personal Adviser, NDDP pilot area)

Alternatively, it could be used to point out discrepancies in the information provided by the client:

‘I used the Capability Report once in an interview. The lady was going on about her arthritis so I said ‘according to the report here, there is nothing wrong with you’ to get a reaction from her. I then used to it talk through her arthritis and discovered that she had severe mental health problems.’

(Personal Adviser, ONE pilot area)

A third way in which the Capability Report was used was as a basis for negotiation. Where the client had accepted that the information provided about his or her capability in the report was accurate, the Personal Adviser could use this common understanding as the basis for a discussion of possible work options.
I had one bloke who said he was not impressed with his PCA and that the doctor had not listened to him. When I went through the report the chap said ‘bloody hell, he was listening then’. We were then able to move on from there using that agreed understanding as a basis.

(Personal Adviser, NDDP pilot area)

4.5 Views about the future role of the Capability Report

Personal Advisers were asked for their views about whether there was a role for the Capability Report in their work in the future. Views ranged along a spectrum from those who were broadly in favour of retaining the report to those who felt it should be discontinued. A prevalent view was that if the Capability Report were to be retained, it could only work effectively if a number of measures were put in place to support it.

4.5.1 Retention of the Capability Report

Those who were broadly in favour of retaining the report included a number of Personal Adviser managers from both ONE and NDDP pilots. From their perspective, the Capability Report had the potential to be a useful tool in the long run but that potential could not yet be fully evaluated because Personal Advisers had not been equipped with the skills to use it. There were suggestions that all parties involved with the policy and implementation should get together to reassess the Capability Report and the changes required for taking it forward. It was felt that the report had become devalued in the eyes of Personal Advisers because so little priority had been attached to it and it had been so little used. There was therefore an imperative to raise the profile of the Capability Report amongst Personal Advisers.

Those Personal Advisers who were in favour of retaining the Capability Report, even those who were currently using it in their work with clients, echoed the need for a reassessment of its role and function if it were to be retained. They felt there was little point in continuing with it unless Personal Advisers used it more widely.

A number of reasons were put forward for discontinuing the Capability Report. These strongly reflect Personal Advisers’ views about the value of the Capability Report. Those who were strongly committed to the ‘client-centred’ method of working with clients, particularly Personal Advisers in the NDDP pilots, preferred to rely on information from, and discussion with, the client. They were dubious about how the evidence obtained in one session at the PCA medical examination could be more reliable than that obtained from the client over a period of time. In their view, the reliability of the evidence was also likely to be suspect in that it was obtained at a mandatory medical examination. They felt that the client was more likely to reveal information that was not disclosed at the PCA medical examination through working with the Personal Adviser on a voluntary basis.

There were also questions about whether the Capability Report provided anything that could not be obtained from other sources. For example, it
was felt that the client’s GP could provide the same type of medical information, or more detailed information, as the Medical Services doctor. Indeed, there were suggestions that GPs would be better placed to compile the Capability Report since they had an ongoing perspective on the client whilst Medical Service doctors could not get a full picture in one session. There were also doubts about whether it would be cost-effective to train the Medical Services doctors to supply the occupational health expertise that Personal Advisers required.

4.5.2 Changes to the operational context

It was difficult for Personal Advisers to divorce their views about whether or not the Capability Report should be retained from the operational context in which it was being deployed. It was difficult for Personal Advisers to envisage a role for the Capability Report in the ONE service as it was currently being implemented. In NDDP pilot areas, the fact that recruitment to the service under both Options A and C was generally considered to have been ineffective, indeed counter-productive, also meant that continuing with the Capability Report was not regarded as a sensible option. It was felt that it had yielded very few clients and that those clients who had approached the service had often turned out to be the clients with whom it was difficult for the service to work: those who did not want, or were not able, to work.

4.5.3 Value for money

Finally, cost was an issue for both ONE and NDDP Personal Advisers. Doubts were expressed about the value for money of producing the Capability Report, even among some of those who were otherwise quite in favour of it or who were using it in their work. It was widely felt that the number of cases involving a Capability Report that had been seen in all the pilot areas did not really justify its existence. In addition, the amount of useful information it provided and the degree to which it was used by Personal Advisers in their work could not justify the time and money involved.

4.6 Support required to underpin a continuing role for the Capability Report

Personal Advisers and their managers felt that changes needed to be implemented in three key areas if the Capability Report was to continue to have a role. The changes related to:

- awareness-raising of the Capability Report with training to underpin it;
- specific operational issues related to the ONE and NDDP pilots;
- revisions to the content and format of the Capability Report.

4.6.1 Awareness-raising and training

Personal Advisers saw raising the profile of the Capability Report as a top priority if it were to be retained. It was generally felt that low levels of understanding had been a major factor contributing to the low levels of use within both services. Training was considered a key issue for dispelling misunderstandings at both the organisational and individual levels and for making Personal Advisers feel comfortable about using the Capability Report.
It was felt that training needed to be delivered on a face-to-face basis, such as a seminar or workshop, with written notes as back-up rather than purely through the written word. It should be targeted at three discrete areas. Firstly there was a need for Personal Advisers to have an understanding of why the Capability Report had been introduced. Secondly, Personal Advisers needed to understand the working of the PCA medical examination so that they would have greater understanding of the circumstances under which the Capability Report is completed. Thirdly, it was imperative that Personal Advisers received training in ways of using the Capability Report so that they could go on and develop their own expertise.

It was suggested that increased liaison between Personal Advisers and Medical Services doctors at a local level would help Personal Advisers to understand how the Capability Report is produced and would help the Medical Services doctors understand the type of information that was most useful for working with clients. It was felt that a degree of consultation and co-operation at the organisational level might help to ensure that the Capability Report became a more ‘user-friendly’ document for Personal Advisers.

4.6.2 Operational issues

It was felt that there would need to be a fundamental change in working ethos and working patterns within the ONE service before Personal Advisers could be in a position to use the Capability Report. Firstly, the nature of targets would have to be reappraised so that Personal Advisers would have an incentive to work with clients on Incapacity Benefit. Secondly, staffing levels would have to be adjusted to allow Personal Advisers sufficient time for work with sick and disabled clients. It was also suggested that Personal Advisers should have some discretion over which Incapacity Benefit clients they saw so that they could give full attention to those who were motivated to work and seen as more ‘job ready’. One suggestion was for Medical Services doctors to carry out a Capability Report only on those clients who they considered might actually be capable of doing some form of work.

The chief operational issue for the NDDP pilots was the need to reappraise the idea of using the PCA medical examination as a forum for recruitment. One solution suggested was to postpone the invitation to join the service until after the outcome of the medical examination was known. A letter could then be sent reminding the client that they had had a PCA medical examination and putting forward the option of receiving assistance if they wished to return to work. The perceived advantages would be that the client would be less anxious than at the medical examination and possibly more receptive to the idea of work. They would also feel under less pressure to accept the invitation if that was not what they wanted.

Part of the difficulty for Personal Advisers in NDDP was that so few of their clients had come with a Capability Report. There was a view that...
if the Capability Report was carried out on a greater proportion of clients, it would assume a greater importance for Personal Advisers who might, in turn, incorporate it into their methods of working with clients. It was even suggested that there could be advantages in having a Capability Report completed about all clients.

Finally, Personal Advisers made a number of suggestions for ways in which the Capability Report itself could be made more ‘user-friendly’. Chapter 5 examines the reactions to, and views about, specific features of the Capability Report from the perspective of both Personal Advisers and Medical Services doctors.
5  THE CAPABILITY REPORT FORM

This chapter discusses specific issues related to the Capability Report form itself from the perspectives of the Medical Services doctors and Personal Advisers. The chapter is in two distinct parts. Sections 5.1 to 5.4 synthesise the views of Personal Advisers and Medical Services doctors about specific aspects of the report: its style, format and content. In Section 5.5, the Capability Report form is reproduced and annotated with comments by Medical Services doctors and Personal Advisers about the content, layout and convenience of specific questions and parts of the form.

5.1 Views about the Capability Report

Personal Advisers stressed that, given the pressures of their job, it was important that the Capability Report should be ‘user-friendly’ and easily accessible to them so that they could obtain a clear, simple picture of the client. Although views about specific features of the report varied between individuals, there were a number of suggested ways in which the content, style and format of the report could be made more user-friendly.

The views of Medical Services doctors also varied between individuals. In some cases, the issues around specific features of the report were the same for the Medical Services doctors as for the Personal Advisers. However, there were additional issues for them about how to fill in the report and some suggestions for changes to how this was carried out.

5.2 Style and format of the Capability Report

5.2.1 Length and legibility

Some Personal Advisers found the Capability Report a very convenient document: easily accessible and easy to use. For others, issues around the length and legibility of the form diminished the ease with which they could use it. Length was an issue in that it was difficult for some Personal Advisers to read a document that was 10 pages long in the limited time at their disposal.

‘We only have a limited time to read and this is quite a few pages. It would take 10 minutes to read to do it justice’

(Personal Adviser, NDDP area)

Some would have preferred a much shorter document of two to four A4 pages, ideally consisting of five or six sections containing the essential information which could not be obtained from the client. Section 5.2 provides comments on the type of information considered to be of value to Personal Advisers.

Some Medical Services doctors too would have liked a shorter form, and were concerned that there was repetition on the current form (some felt, for example, that Question 10 encouraged repetition, whereas others found Question 10 very useful).
Legibility was a recurrent theme in the interviews with Personal Advisers. The Medical Services doctors completed the Capability Report form in hand-written text. Some Personal Advisers had found the doctor’s handwriting easy to read. However, the more general view was that doctors’ handwriting was difficult to read and this posed a number of problems. Personal Advisers were disinclined to persevere with the Capability Report where it took too long to decipher. It also prevented them from getting the full picture of the client if they could only access parts of the information. On occasions, Capability Reports had been deemed ‘unfit for purpose’ and had had to be returned for reworking.

5.2.2 Use of electronic format

Personal Advisers generally thought that it would be advantageous for the Capability Report to be supplied in a printed format which would, it was felt, be easier to read and therefore easier to assimilate, and would increase the likelihood of it being read and used. A possible option would be to have the Capability Report supplied in an electronic format which could then be printed out or read on the screen. This would have the additional advantage that it would be easily accessible by a number of people.

The Medical Services doctors also put forward their views about the possibility of substituting the current paper format for an electronic format. Some would definitely prefer an electronic format and saw a number of advantages to it. Firstly, it would facilitate easier transfer of certain basic client information, such as personal details, between the Incapacity Report form (IB85) and the Capability Report form. Secondly, it would make possible the introduction of more tick boxes and standardised answers, in turn making the form quicker and easier. Thirdly, it would result in a better quality of Capability Report produced for the Personal Adviser.

However, other Medical Services doctors saw a number of disadvantages to an electronic format. Doctors were not always familiar with, or comfortable using, computers. It required time to acquire or upgrade those skills and it would also take time to learn to use a new electronic version of the form. In the short term, at least, this would slow down the process of completing the Capability Report. Furthermore, they felt there was a risk that it would encourage the insertion of ‘stock’ or standardised answers which could adversely affect the quality of the report.

5.2.3 Use of language

Personal Advisers made a number of comments that the language and terminology used in the formulation of questions in the Capability Report and that used by Medical Services doctors when completing the report was different from the type of language that they themselves would use. Some Personal Advisers said that they associated this kind of language with what they saw as a ‘medical model’ of disability rather than with the ‘social model’ with which they were familiar. There were therefore issues around comprehension and accessibility.
A number of examples were quoted of where terms used were not comprehensible to Personal Advisers: at Question 4, the term ‘review of changes and functional outlook’; at Question 5, the terms ‘reduced and normal function’; at Question 11, the term ‘residual functional capacity’.

User-friendliness was further diminished for Personal Advisers where Medical Services doctors used what was perceived as abstruse medical jargon (or ‘gobbledegook’) for completing the report. What Personal Advisers said they wanted was direct straightforward information in simple, plain English. For example, rather than a reference to ‘nervous debility’, they wanted to know the nature of the problem and its direct cause, such as drugs or alcohol.

5.2.4 Layout and format

In terms of the layout and format of the report, Personal Advisers had mixed views about the relative merits of the tick boxes and the boxes for notes. For some people, tick boxes enabled them to obtain a quick overview of the client and the client’s condition without any extraneous detail. The client would then be able to supply the detailed information. On the other hand, it was widely felt that the descriptive information contained in the boxes for notes was often precisely the information that was of greatest use to Personal Advisers. There were suggestions for extra boxes at the end of the report: one to put forward the client’s view of their own condition and one for the Medical Services doctor’s view.

The same divergence of views was apparent amongst the Medical Services doctors. Some doctors, for example, had a preference for ‘tick boxes’ on the Capability Report, whereas others felt that the Report would be enhanced if there were more opportunity for free text. Others felt that parts of the form (particularly Questions 8 and 9) required more space to allow them to write more.

5.3 Content of the Capability Report

Section 5.3 gives detailed comments about the content of specific questions and parts of the report. Personal Advisers were unfamiliar with the legislative framework and operational context within which Medical Services doctors were obliged to work. Nevertheless, different Personal Advisers gave comments about the approach which they thought should inform the content of the Capability Report:

- Firstly, it would be extremely useful for the form to clearly indicate the client’s fitness for work: whether it was immediate or a long way down the line, or whether the client was unlikely to be able to work for the foreseeable future.
- Secondly, it would be useful to know the amount of work the client could do: full or part-time and the approximate number of hours.
- Thirdly, all the information given should be linked as closely as possible to employment: the effect of the condition and any medication on the amount or type of work the client could do.
A fourth point made by some Personal Advisers was for the information to give as much description as possible so that the Personal Adviser was not presented with a black and white picture but could see all the shades of grey in the client's situation.

Finally, it was useful for the Personal Adviser to be clearly told what information was purely factual and what was the opinion of the Medical Services doctor.

The following subsections set out the views of Personal Advisers towards the three types of information which the Capability Report provides: background information about the client (Questions 1 to 4); personal capability (Questions 5 to 7); and work-related capability and other work issues (Questions 8 to 11). Inevitably views were mixed about each section so the following is a synthesis of Personal Advisers' views. Views about the content tended to differ in accordance with Personal Advisers' preferred approach. Personal Advisers who preferred the 'multi-source' approach tended to be in favour of background information about the client and comprehensive, descriptive information wherever possible. Those who were 'client-led' tended to be more dismissive of the information about the client, and generally seemed to favour succinct comments to be used as pointers for them to pursue with the client.

5.3.1 Background information about the client (Questions 1 to 4)

'Client-led' Personal Advisers tended to make the point that the information contained in Questions 1 to 3 was precisely the information that they were able to elicit but in a less medical form. Other Personal Advisers felt that this type of information was helpful and particularly so for self-briefing in advance of seeing the client. It saved time at the initial interview and having the opinion of a doctor lent authority to the information. Any disparities with the client's account could then be registered and discussed.

It was generally felt that the information provided was made more relevant to the work of the Personal Adviser where the problems associated with the condition were related to employment. What Personal Advisers wanted to know was about the effects of the condition, and the effects of any medication or treatment, and their likely impact in the work situation: for example, if the client had been a scaffolder, that he was no longer able to cope with heights. Or alternatively, the impact of the condition on the client's dexterity on a computer in an office environment.

A number of Personal Advisers mentioned that the Capability Report lacked a prognosis of how the client's condition was likely to develop. It is possible that one reason for this was the language used for the heading at Question 4 ('Review of functional changes and outlook') which was considered to be the kind of 'medical jargon' that was off-putting to Personal Advisers. Knowledge about how the condition was likely to develop and information about any planned event, such as surgery, could then be passed on to any prospective employer with the informed consent.
of the client. However, vague comments such as ‘expected to make good improvements’ were not considered helpful: what was needed was something concrete along the lines of ‘the client is having an operation in two weeks’ time and will then be out of action for two months’.

The Medical Services doctors sometimes felt that it was time-consuming for them to access this background information and that some of it could be provided by others (see Section 5.4).

5.3.2 Personal capability (Questions 5 to 7)

As has already been made clear, the area of mental health was one where some Personal Advisers felt that they lacked experience and confidence. There was a general perception that to have a medical opinion was useful and that it was desirable to have as much, and as detailed, information as possible. So, for example at Question 5, the requirement was for as much descriptive information as possible, more particularly about how the condition was likely to impact on work: the nature of symptoms that were likely to appear; whether the person was capable of holding down a job; how far the client could interact with, or posed a risk to, work colleagues; and what the worst case scenario could be. It was also important to know the likely effects of medication on the client’s behaviour in the workplace: for example, whether the client might become drowsy or confused and what limitations it would place on the type of work they could do.

Although some felt it was useful to know, from Question 6, what the client saw as his or her barriers to work (for example, nearing retirement age or a history of unemployment), others felt that this was something that Personal Advisers would probe fully over time. Question 7 caused some difficulties for Personal Advisers. Firstly, Personal Advisers felt that they had no knowledge of the evidence on which the assessments were made. They therefore did not feel able to defend the information if the client refuted it. Secondly, the level of information was not regarded as sufficiently detailed: for example, it was important to know the length of time that the client was able to walk, bend or crouch and they felt they did not always get this information in the notes section. Finally, it was felt that the information should be geared to the impact on work: for example, if the Personal Adviser knew the exact nature of the problem which the client had with standing, it would then be possible to know which jobs to avoid.

The Medical Services doctors did not note significant problems with these sections.

5.3.3 Work-related capability and other work issues (Questions 8 to 11)

Personal Advisers for the most part considered information about work-related capability to be the most pertinent for their work with clients. It was valuable to know, for example, to what extent the client would be able to travel to and from the workplace. Equally, it was useful to know whether a client had come in looking rough and smelling of alcohol because of the implications for placing the person.
However, there was considerable scepticism over whether Medical Services doctors were qualified to make judgements of this nature. Firstly, Personal Advisers were unsure of the expertise which the Medical Services doctors had, particularly in the area of occupational health, and their ability to determine what workplace adjustments were required (Question 11). Secondly, the judgements made at Question 8 were often seen as hypothetical since they were made without regard to any specific work environment. For example, the ability to use a workstation could depend on a range of different factors depending on where the workstation was situated. Similarly, judgements about interaction and awareness were made without any empirical evidence obtained in a work setting.

There were some suggestions that Question 9 could be expanded since work-related health issues were a key information requirement for Personal Advisers and should be dealt with as fully as possible. There were some Personal Advisers who saw Question 10 as potentially very useful for obtaining the doctor's own view of the situation and for suggestions. One Personal Adviser had found it useful where the doctor had mentioned that his own assessment of the client's condition was not as bad as that of the client herself. Another had appreciated the observation that the client needed a new CV. However, where doctors did not complete the box fully, it was felt that its potential was not being realised.

The Medical Services doctors generally felt that the training they had received did not allow them to complete these sections competently and confidently (see Section 5.4).

5.4 Completing the Capability Report form

Some of the Medical Services doctors felt that it was not necessary for them to complete the Capability Report themselves. They felt that parts, or the whole of, the form could be delegated to others. It was suggested that the Personal Adviser, an occupational health nurse or the client could fill in parts of the form as well as, or better than, and more cheaply than, the Medical Services doctors. This was raised particularly in relation to Question 1, which was felt to be time consuming, and did not require the skills of a Medical Services doctor to complete, but also in relation to Questions 3 and 6.

Some Personal Advisers misunderstood the role and expertise of the Medical Services doctors who complete the Capability Report. In some cases, it was suggested that the client's GP would be better placed to provide detailed medical information than the Medical Services doctors even though GPs are not occupational health practitioners. It was also suggested that the information on work-related capability could be more employment-focused if the section was completed by someone with specialist occupational health training.
5.5 Annotation of the Capability Report form

This section reproduces a copy of the Capability Report annotated with comments made on specific questions by Medical Services doctors (in shaded boxes on the left-hand side) and by Personal Advisers (in boxes on the right-hand side).
CAPABILITY REPORT
Medical Advice to a Personal Adviser

This report has been compiled following a functional medical assessment for state incapacity benefit purposes.

1. Occupational History

<table>
<thead>
<tr>
<th>Type of work</th>
<th>From - To</th>
<th>Hours worked / wk</th>
<th>Reason for leaving</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medical Services
- Time consuming
- Can be difficult to obtain information from clients
- Difficult with clients who have had multiple, irregular or unofficial work
- Could be completed in advance by the client

PA comments
- Factual information obtainable from client in greater detail over time
- Useful information to know in advance: check out against client's account

<table>
<thead>
<tr>
<th>Main activities involved</th>
<th>Associated health problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

Are there any specific medical conditions associated with any previous employment?
If Yes give details in box below

Yes [ ]  No [ ]

Notes:
2. Summary of current picture
Include only current clinical conditions which have a significant impact on physical and mental function [include variability]

No other current medical conditions have a significant effect on physical, sensory or Current treatment which has a significant impact on function: [include beneficial and adverse effects]

3. Aids & Appliances in current use
To include spectacles, pacemaker, artificial limbs, wheelchairs etc.

None

4. Review of functional changes and outlook
Outlook to include any planned treatment. Please explain any likely change in client’s future functional capacity clearly indicating probable timescales wherever possible.

5. Personal Capability - mental health factors
N = normal function  R = reduced function
Please provide additional information below where you identify reduced function

<table>
<thead>
<tr>
<th>Completion of tasks</th>
<th>N</th>
<th>R</th>
</tr>
</thead>
<tbody>
<tr>
<td>(taking messages, house work, leisure activities, recognising and dealing with dangerous situations)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Daily living</th>
<th>N</th>
<th>R</th>
</tr>
</thead>
<tbody>
<tr>
<td>(dressing &amp; appearance, sleeping and use of substances)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coping with pressure</th>
<th>N</th>
<th>R</th>
</tr>
</thead>
<tbody>
<tr>
<td>(panic attacks, disinterest &amp; unexpected events)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Interaction with others</th>
<th>N</th>
<th>R</th>
</tr>
</thead>
<tbody>
<tr>
<td>(prefers own company social anxiety, disinterest, unable to go out alone etc)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes:

PA comments

Medical Services Doctors comments

PA comments

Medical Services Doctors comments

PA comments

Medical Services Doctors comments

PA comments

Medical Services Doctors comments

PA comments
### Overall level of mental health symptoms

Tick the most appropriate box (for full description of each group see Guidance notes for IB approved doctors).

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No problems to only mild symptoms.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No significant impairment of mental function.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Constant moderate symptoms which may require treatment.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Impact on mental functioning leads to day to day difficulties but no supervision required.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Constant severe symptoms.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Impact on mental functioning which may range from serious symptoms to a requirement for constant supervision.</td>
<td></td>
</tr>
</tbody>
</table>

### 6. Other work-related issues

Where appropriate, provide evidence relating to the client's own beliefs and expectations regarding their health and fitness for work.

<table>
<thead>
<tr>
<th></th>
<th>Medical Services Doctors comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Could be completed by the PA.</td>
</tr>
<tr>
<td></td>
<td>Experienced as a relaxed point in the interview, with different tempo.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PA comments</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&quot;Information mostly obtainable more fully from client&quot; [client-led].</td>
</tr>
<tr>
<td></td>
<td>&quot;Exactly the kind of 'soft information' required in advance of seeing the client&quot; [multi-source].</td>
</tr>
</tbody>
</table>

### 7. Personal Capability - physical and sensory factors

Please provide advice in relation to the following activities taking account of any aids or appliances which the client may use.

#### Mobility

Notes – where residual function is limited

<table>
<thead>
<tr>
<th></th>
<th>Walking</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fully effective residual function</td>
</tr>
<tr>
<td></td>
<td>Limited residual function</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Using stairs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fully effective residual function</td>
</tr>
<tr>
<td></td>
<td>Limited residual function</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Bending</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fully effective residual function</td>
</tr>
<tr>
<td></td>
<td>Limited residual function</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Crouching/Squatting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fully effective residual function</td>
</tr>
<tr>
<td></td>
<td>Limited residual function</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Posture</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Standing</td>
</tr>
<tr>
<td></td>
<td>Fully effective residual function</td>
</tr>
<tr>
<td></td>
<td>Limited residual function</td>
</tr>
<tr>
<td></td>
<td>Sitting</td>
</tr>
<tr>
<td></td>
<td>Fully effective residual function</td>
</tr>
<tr>
<td></td>
<td>Limited residual function</td>
</tr>
</tbody>
</table>
8. Work-Related Capability

Where you indicate a negative response please provide additional notes.

Preparation for work

Y ☐ N ☐ Able to travel to and from a place of work by public transport

Y ☐ N ☐ Able to prepare and present themselves appropriately for work.

Medical Services Doctors

Comments:

Lack of occupational knowledge can present problems with some parts.
Notes boxes too small.

PA comments

Managing work tasks

Y ☐ N ☐ Able to negotiate doorways, lifts, aisles or stairways in a work environment.

Y ☐ N ☐ Able to understand simple work instructions (verbal or written).

Y ☐ N ☐ Able to learn and undertake a variety of simple tasks similar to everyday activities.

Y ☐ N ☐ Able to see the shape, size, distance and motion of objects in a work environment.

Y ☐ N ☐ Able to grasp, handle and carry small objects.

Y ☐ N ☐ Able to use an office workstation in a way which is not limited by the client’s condition or its treatment.

Y ☐ N ☐ Able to drive or operate machinery in a way which is not limited by the client’s condition or its treatment.

Notes:

Medical Services Doctors comments

Lack of occupational knowledge can present problems with some parts.
Notes boxes too small.

PA comments

‘Managing work tasks’: hypothetical judgements.
Question marks about expertise of Medical Services doctors for making the assessments.
Definition unclear: ‘sedentary’, ‘stamina’. 

PA comments

Managing work tasks
Physical/mental stamina

Y ☐ N ☐ Able to sustain sedentary work (as defined) for at least 3 hours per day including any reasonable short breaks.

Y ☐ N ☐ Able to sustain mental concentration for spells of at least 3 hours per day including any reasonable short breaks.

Notes:

Interaction and awareness

Y ☐ N ☐ Able to communicate effectively in a work setting.

Y ☐ N ☐ Able to interact effectively with other people in the workplace.

Y ☐ N ☐ Would be aware of potential dangers to themselves or others in the workplace.

Notes:

9. Work related health issues

Bodily Systems include any musculoskeletal, cardiac, respiratory, skin, sensory and mental & behaviour problems.

Work issues include possible work demands, exposure, situations, pregnancy and infections.

<table>
<thead>
<tr>
<th>Bodily System</th>
<th>Work Issue</th>
<th>Problem for worker</th>
<th>Problem for workplace</th>
</tr>
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</table>

Medical Services: Doctors comments

Perceived as difficult and uncomfortable due to lack of workplace and occupational health knowledge.
Feedback would be welcomed here.
Boxes too small.

PA comments

Work issues: potentially the most useful information. Could expand the boxes.

Notes:

10. Other significant information

Please give below any other significant information about your assessment which may be of help to the Personal Advisor.

Medical Services: Doctors comments

Tends to be used either to describe particular circumstances for patient, or for Medical Services doctor to express own opinion.

PA comments

Not always filled in.
Useful box for doctor to give own opinion and make suggestions.

Notes:
11. Workplace adjustments

Please note any general workplace adjustments which might improve residual functional capacity.

Medical Services Doctors comments

Found difficult without workplace/occupational knowledge.

PA comments

'Residual function capacity': 'medical jargon'. Queries about doctors forming opinions without occupational health expertise. Should include client's views of adjustments required.

This form has been completed by a doctor approved by the Secretary of State for Social Security.

I have completed this form in accordance with the current guidance to Incapacity Benefit examining doctors as issued by the Benefits Agency. I can confirm that there is no harmful information in the report.

Doctor's name

Doctor's signature

Date
This chapter explores the role of the Capability Report from the perspective of clients. As Chapter 1 outlined, the study included in-depth interviews with 25 clients of whom 15 had had contact with the NDDP pilots and 10 with ONE. Most were on Incapacity Benefit; a small number in the ONE areas had been moved to Jobseeker’s Allowance following their Incapacity Benefit claim being disallowed as a result of their PCA medical examination.

The chapter begins by looking at clients’ awareness and understanding of the Capability Report. It then describes their experiences of the PCA medical examination itself, including the process by which clients are told about the NDDP pilots at that stage. The following sections look at clients’ feelings about work and particularly at how clear the occupational implications of their condition or disability are to them, and discuss how easy they found it to talk about their condition with their Personal Adviser, since these issues are relevant in assessing the role of the Capability Report. The chapter then looks at clients’ experiences of the service they used (either ONE or NDDP). The final section describes their views about the Capability Report and concludes with a summary of the factors which, from the perspective of clients’ accounts, appear to shape the need for, or role of, the Capability Report.

6.1 Awareness and understanding of the Capability Report

The Capability Report did not appear to be a particularly prominent aspect of ONE or the NDDP pilots for clients. None of the clients interviewed had seen their own Capability Report, nor had their Personal Advisers referred specifically to any of its contents. Whether or not they knew that a report had been completed about them varied. None of the clients interviewed in the ONE areas appeared to be aware that the Medical Services doctor had completed a Capability Report and there was no recollection of the term when it was mentioned by the research team. In the NDDP pilot areas, some clients similarly did not recognise the term or the idea. More generally, however, in NDDP areas they did recall mention of the Capability Report by the Medical Services doctor, although sometimes only after the term was used by the research team. They generally understood it as a form completed by the Medical Services doctor to provide medical or work-related information about them to a Personal Adviser, or to assess what they could do, and thus distinguished it from the Incapacity Report which they understood to be an assessment of what they could not do. However, the fact that awareness of the

5 In one NDDP pilot area, this may be because it was a CR2 that was completed. As explained in Section 1.1.4, the CR2 was completed by the Medical Services doctors from scrutiny of written evidence only in this area. Clients would not attend a PCA medical examination.
There were different reactions among clients when they were called to a medical examination. For some it was not their first, and they already understood its purpose, although this did not necessarily reduce anxiety about it, particularly if earlier experiences had not been positive. Some clients acknowledged the need for a PCA medical examination and were generally resigned to it, or were confident that they would be found eligible for Incapacity Benefit. Others, however, did not understand why a medical examination was required. They felt that it was unnecessary given that their own GP, and sometimes consultants and other professionals, could provide evidence that their condition was genuine. They felt it questioned their own integrity, particularly if they compared themselves with others who they felt receive incapacity benefits with less justification.

The PCA medical examination was generally anticipated with a high level of anxiety in both ONE and NDDP areas. Clients were concerned both about what the interview would involve and about whether or not it would result in losing Incapacity Benefit. There were high levels of anxiety even among people who felt it was quite clear that they were not fit for work and who were subsequently found eligible for Incapacity Benefit. For some, their concerns were exacerbated by receiving very little notice of the medical examination, by difficulties in getting to the Medical Services centre either because of their condition or because it was difficult to access by public transport, and by having to wait for some time in the reception area before they were called.

As Chapter 1 outlined, there were different ways in which clients were told about the NDDP pilots as part of the PCA process. In one of the study areas they were asked to complete a form if they were interested in NDDP. This form was returned with the IB50 questionnaire, and they may subsequently have been asked to attend a medical examination (Option C described in Section 1.1.4). In the other two study areas they were approached while they were in the reception area waiting to be called for the medical examination (Option A, see Section 1.1.4).

Being asked to indicate their interest by letter in advance of the PCA medical examination seemed to cause fewer concerns. Some clients responded positively because they felt the service might help them, or at least wanted to find out what was on offer. But others saw less value or relevance in the NDDP pilots and responded because they ‘had nothing to hide’.
There were more concerns where clients were approached at the medical examination. Three issues emerged here. First, as noted, clients were generally concerned about the examination and its outcome. They felt that they had enough on their mind and that it was not the right time to be asked to consider a service that would help them to move into work. They did not seem to consider the idea of a welfare-to-work scheme being raised in connection with the medical examination to be a contradiction necessarily, but felt that the examination was, on its own, enough to have to manage.

‘When (the person) came up … I don’t know, I like to know what’s going on and then I’m in control, and I didn’t know so I was worried … . My mind at the time was on what was going to happen, who I was going to meet, I wasn’t really interested in (them), they brought in this new dimension that I didn’t understand.’

(Client, NDDP area, muscular-skeletal condition)

A second issue was a perceived pressure to express interest in NDDP. Some people felt that it would be important to present oneself as someone who wanted to improve their situation and move forward into work, and assumed that failing to do so might jeopardise their receipt of Incapacity Benefit at some point in the future. Being asked about it in a public place reinforced this concern, and the fact that the invitation to participate was linked with the process of assessment for Incapacity Benefit meant they did not believe it was entirely voluntary.

‘You’re always afraid, the least little thing, they’re going to take your money off of you … . You always think, because as soon as you see ‘this won’t affect your benefit’ you think ‘hang on a minute, that’s not right, it will affect your benefit. If you don’t do what they suggest then it’s because you don’t really want to go back to work’ … . If it doesn’t affect your benefit, why is it coming in the same envelope?’

(Client, NDDP area, muscular-skeletal and mental health conditions)

Finally, there were also concerns about NDDP itself, and particularly a fear that it might result in being forced to take work before they felt ready to do so.

These concerns were generally expressed by clients who felt that the explanation they had been given about NDDP at the Medical Services centre was inadequate. People were happy with the discussion where it had clearly communicated that participation in the NDDP pilots was voluntary and would not impact on benefit receipt, and where they had been given a broad understanding that they would have a Personal Adviser who would work closely with them. But some felt that the information they were given was unclear or incomplete, that the person

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6 Participation in the national extension of NDDP is also voluntary.
communicating it had been unconfident or ‘shifty’, and the discussion rushed. Here, some people felt these issues had been clarified by the Medical Services doctor they subsequently saw who revisited the issue of NDDP at the beginning of the medical examination, but others remained unclear until they met with their Personal Adviser.

Where there were concerns about how they had been approached, some people felt it would be better for the issue of participation to be raised by Medical Services doctors, who were felt to have more time and to be able to give a clearer explanation. Others felt it should be left until they had been told the outcome of the PCA, and knew their benefit status and the Medical Services doctor’s view of whether work was viable for them.

Clients generally felt that their concerns about participating in the NDDP pilots had not influenced the way they had presented themselves at the PCA medical examination. However, it does appear that some opted into NDDP despite feeling that work was not viable for them because of concerns about compulsion, or with little real interest in the service. Under these circumstances, they generally had only one meeting with a Personal Adviser and seemed not to find their contact helpful or to make progress towards work. This echoes the concerns expressed by Personal Advisers (see Section 4.2) about the effectiveness of the PCA as a forum for recruitment to the NDDP pilots.

The duration of the medical examination, as recalled by clients, varied considerably from around 10-15 minutes to around an hour. Among those who had had previous examinations, some felt their most recent one was longer and involved a broader discussion, but others noticed no difference.

If the Capability Report is to provide a full and accurate account of the client’s condition, the manner and approach of Medical Services doctors and the extent to which they facilitate an open and full description of the condition and its impact are clearly important. Here, there were quite varied experiences. Some people were very positive about the Medical Services doctor they saw. They found them warm, kind, sympathetic and understanding. They felt the doctor had asked detailed and appropriate questions about the condition and its impact, and that their follow-up questions meant that a very full picture was given. They praised the way in which Medical Services doctors had seemed genuinely interested in them and their life, giving them plenty of time to talk and coming across as good and attentive listeners.

6.3 Experiences of the PCA medical examination
6.3.1 The conduct of the PCA medical examination

Accounts of Medical Services doctors (see Section 2.2.2) suggested that they generally allowed around an hour for the PCA examination where a Capability Report was involved. However, claimants were not necessarily present for all the time spent completing the forms.
‘She was really nice ... she put you at your ease .... She just sat and spoke to me, asked me how I felt, whether it’s better some times in the day than other times and things like that .... She was spot on actually, all the things she was asking .... She must have known a lot about (my condition) because of the questions she was asking.’

(Client, ONE area, mental health condition)

Others had found the encounter more matter-of-fact and were less personally impressed by the Medical Services doctor, but felt that they had been able to give a full account of their condition.

However, there was also a group of clients who felt that the Medical Services doctor would not have achieved a full and accurate understanding of their condition. This arose in a number of ways. It occurred where people felt that the Medical Services doctor had conducted a very limited investigation, particularly compared to the extensive tests they had had in hospital, or where they found Medical Services doctors impersonal or cold. Being asked questions curtly, having their answers cut off and not being able to elaborate meant that they were unconfident the doctor had fully understood their situation. This was particularly difficult for clients who found it distressing generally to talk about their condition, especially where it involved depression or anxiety, and in some cases these symptoms were not volunteered by clients.

‘I found it hard to explain my situation .... She never asked the questions I was expecting her to ask, like when do I get the most pain, why do I, where is the pain. All she did was looked through the notes and said ‘right, well, nothing wrong there, you’ve nothing there, nothing there’ and just writing comments down and then it was (the physical examination).’

(Client, ONE area, muscular-skeletal condition)

There was also concern that the nature of the questions and examination would have under-recorded the impact of their condition. Clients said, for example, that the Medical Services doctor had correctly established that they could walk upstairs but not that they could do so only slowly or infrequently, or that they could bend but only with pain.

‘You are either saying yes you can go up a full flight of stairs or no you can’t. There is no ‘yes if I am feeling well I can but tomorrow morning I may not be able to’ .... I tried to say ‘I do vary from day to day, week to week’, but it’s like banging your head against a brick wall.’

(Client, NDDP area, muscular-skeletal condition)

They were also uncomfortable when asked to do something that was at or beyond the limit of their capability – such as bending, stretching or turning. One man refused to, and felt angry he had been put in that position. Others said they had pushed themselves and tried their best, and one woman said she was crying and sweating for much of the examination because of the pain and effort involved. This echoes the
As Section 1.1 outlined, the medical examination when it incorporates a Capability Report assessment involves a greater focus on work. The fact that work was discussed was not generally mentioned by clients as surprising, provided it was raised in an open and straightforward way. Some said that they had mentioned work before the Medical Services doctor raised it, others that the earlier discussion about NDDP meant they were not surprised when the Medical Services doctor asked about their experiences and thoughts about work. One woman, however, found the discussion of capability – of what she could do rather than what she could not – surprising and felt she was being challenged by the Medical Services doctor.

At the same time, people were offended where they felt the Medical Services doctor’s response to their condition had been unduly negative. Some described Medical Services doctors telling them they would not be able to return to their previous work, and one woman described the doctor who conducted her PCA medical examination working through a form ticking boxes and saying ‘you can’t do that, you can’t do that, you can’t do that’.

People generally learnt the result of the PCA within a week or two, although some remembered having to wait much longer. Among the small number of people in our sample who were found ineligible for Incapacity Benefit some accepted this and acknowledged that they felt capable of at least some work. But there was anger and surprise where people felt that their condition meant they could not work, particularly if they had felt, during that medical examination, that the Medical Services doctor had recognised the reality of their condition or if they compared themselves with other, less ill, people who were on Incapacity Benefit.

The clients interviewed had different thoughts about work and its viability for them, and this could be a complex issue for clients in both ONE and NDDP areas. Assessing their own capability involved thinking about whether they were able to do any work, how much work they could manage, how to structure it (in terms of number of hours and days per week), and the types of job they would be able to manage. It was clearly difficult, for many, to come to firm conclusions about all these aspects. It was also difficult for them to consider individual aspects of capability in isolation: thinking about whether any work would be possible and how it might be structured, in the abstract, was difficult for people who did not have a specific vocational direction in mind as a viable option. This meant that thinking about the viability of work seemed to be particularly difficult for people who had not worked for some time. Similarly, if their condition meant they could not return to their previous occupation and were having to consider a substantial change such as from heavy
manual work to sedentary, non-manual work, it was difficult to be certain about the right direction. Some recognised that they would need to follow a different direction, but were uncertain about what that direction should be and felt very unconfident about moving on. Clients were also very concerned about how they would fare in a competitive labour market, particularly if they faced other challenges such as being older or having few or no formal qualifications, and found it difficult to separate these concerns from the issue of capability.

Assessing their own capability for work, then, was by no means straightforward for all clients. Within the sample, there were three broad groups.

The first group were people who were clear in their own minds that work was not an option because of their condition. They described conditions that were particularly severe and limiting in their impacts, and lives that were particularly restricted by pain, mobility constraints or psychological conditions. In some cases their own assessments were reinforced by what they had been told by GPs or other medical professionals, who had warned them against returning to their previous job or to any work at all. Some felt they would recover in the future and would be able to return to their previous work, but others found it difficult to imagine any work they could ever do.

The second group were people who were clear themselves that they could do some work now, provided they found ‘the right job’. They had a fairly clear general sense of what this would be, for example knowing that they could work part time, that it should be light or sedentary work, an un-pressurised environment, an understanding employer or locally based. Some were clear about the specific vocational direction they wanted to follow, but others had less formed ideas about this.

Between these two was a third group of people who were generally uncertain about whether work was viable for them at all, whether it should be full or part time work and what sort of vocational direction would be appropriate. Some expressed views that fluctuated during the course of the interview; others were ambivalent throughout. They described being unsure about what they could manage in their non-work lives and sometimes over-stretching themselves, or being uncertain about how their everyday capability would translate in the workplace.

‘I feel a bit better one morning so I give it a try, and then I suffer for it after and I think ‘oh, why did I do it in the first place’ … . Because you’re feeling you’ve got a bit more energy one day and the pain is not quite so bad you think ‘oh, I can get away with (doing) that today’ so you do it and then you think ‘I shouldn’t have done that’.’

(Client, NDDP area, muscular-skeletal and mental health conditions)
A number of factors seemed to influence how clear people were about their own capability. Some of these related to their particular disability or condition. It was easier for people to be clear that work was not an option if they had a more severe or limiting condition. Having a fluctuating condition, or several conditions, could create uncertainty, and people whose condition was new or who were still receiving treatment for it were unsure how much capability they would recover. The clarity of the information given by medical professionals was also relevant: some felt they had been given a clear diagnosis and prognosis and a good explanation of their condition, but others seemed not to have had this.

Their experiences of work were also relevant. Having worked at some point with their condition, either as it was developing or since its onset, could be helpful for them in understanding what they could or could not manage. But some people who had tried work and had to leave after a short time found this very unsettling, and their confidence in their ability to judge what was right for them seemed to have been shaken. People who had had a lot of contact with the labour market over the course of their lives felt this helped them to assess whether work was right for them, while those who had not worked for some time felt this contributed to their uncertainty. Finally, some people had discussed work as an option with other people, particularly their own GP, and been given clear guidance about whether or not it was viable.

These different experiences were very relevant to whether or not people felt a Capability Report might have been helpful in their case, as Section 6.6.1 explores further.

6.4.2 Assessing employability

Clients' different views about their capability for work, given their condition, were compounded by their sense of other barriers to work and of their own employability. As noted above, a particularly significant issue here was the difficulty of determining an appropriate vocational direction, and there were also concerns about how people would fare in a competitive labour market. There was a strong anticipation of reluctance on the part of employers to take on someone disabled or with a limiting condition, particularly if the individual was also approaching retirement age or had few formal qualifications. There were concerns about whether work would be financially disadvantageous compared to staying on Incapacity Benefit, particularly if only part-time work was seen as viable, and concerns too about whether it would be possible to return to benefits if work proved not to be manageable. Clients were also often very unconfident about the process of applying for work and about whether they would be able to hold down a job, and nervous about letting an employer down and exposing themselves to risk.
6.5 Discussing conditions and capability with Personal Advisers

The previous section explored how far clients have a clear understanding of their condition and its impact on their capability for work. Also of relevance to the role of, or need for, a Capability Report is the question of how far clients are able to discuss their condition, and its implications for their capability for work, openly and fully with Personal Advisers.

In general, both in ONE and NDDP areas, clients felt they had been able to give their Personal Adviser a full and clear account of their condition and its impact on their life and their capability for work. Clearly, their own understanding of it is relevant here. But so too is the manner of their Personal Adviser, and the quality of the relationship that develops between Personal Adviser and client. Some clients were very positive about the approach that their own Personal Adviser took, and felt it had assisted them in talking openly and fully about their condition. Although the sample sizes are small, this emerged particularly, although not exclusively, in NDDP areas. They praised Personal Advisers who had seemed understanding, sympathetic, and genuinely interested in and concerned about them. They felt it had been important that Personal Advisers had devoted a significant portion of the first interview to talking about the condition and its impacts, asking questions and giving the client time to talk at their own pace. Meeting the Personal Adviser more than once had been very important in building this rapport and trust. It had also sometimes been helpful where Personal Advisers had mentioned their personal experience of a similar illness or disability, or their previous employment experience of disability generally.

‘It didn’t matter that I wasn’t going to see a doctor ... or that (the Personal Adviser) didn’t know about me because he wanted me to tell him, which was fine, which was better really ... He tried to find out what I could do, what I was prepared to do, what I would be able to do ... I mean he took another hour to do this, but he was ... interested in me, he wanted to know me as a person. He was a very skilled guy, I mean it was so easy the way he did it.’

(Client, NDDP area, muscular-skeletal and other conditions)

In other cases, however, clients felt that they had not been able to communicate a full account of their condition to the Personal Adviser. Some clients said there had been no discussion of their condition at all: this arose in ONE areas among clients on Incapacity Benefit as well as those on Jobseeker’s Allowance. Others – both in ONE and in NDDP areas - described more perfunctory discussion, with the Personal Adviser asking no detailed or follow-up questions. This was particularly frustrating to clients who had more complicated or unusual conditions which they felt needed fuller explanation. Even where there had been more discussion of their condition, there were reports of Personal Advisers subsequently making unrealistic or inappropriate suggestions which clients felt indicated a lack of understanding.
Again, clients' own feelings about, and ability to talk about, their condition was important. Some felt their health or disability was a very private and personal matter and were reluctant to talk about it in detail, or felt their interaction with their Personal Adviser was affected by their own lack of confidence or experiences of depression. This meant they gave only minimal details of their condition, or did not volunteer information about some aspects such as depression and anxiety.

‘Well, we touched on (my condition), yes ... . She was nice, I thought she cared ... . It was only a little chat ... . It’s a personal thing ... . I’m not just going to chat about it. I did have a problem or whatever but I wasn’t going to pour my heart out. I don’t mind telling people but I’m a private person and, you know, my doctor would have a job getting it out of me.’

(Client, NDDP area, muscular-skeletal and other conditions)

The concerns about work outlined in the previous section were reflected in the range of reasons for participating in the NDDP pilots, and in different responses to ONE. Some people were highly motivated to work and sought either general advice about work and appropriate vocational directions, or specific help for example with training or getting a placement. Others felt that work was a long shot but were keen to explore any possible sources of help. But those who were much more uncertain about work or had reached the conclusion that it was not viable seemed less happy to be involved with ONE or NDDP. They had responded to a request to attend a meeting with a ONE Personal Adviser because they suspected that to refuse would jeopardise their benefits, or else to prove that they were not claiming fraudulently. They similarly joined NDDP because they suspected that it was important to secure their benefits or to demonstrate that they were genuine. Again, this echoes Personal Advisers' feelings about clients' reasons for attending interviews.

These different responses to participation were, to some extent, reflected in different patterns of interaction with ONE and the NDDP pilots.

Experiences of ONE and the NDDP pilots were quite diverse. Within the sample, there were three broad patterns of interaction.

6.6 Experiences and impacts of ONE and the NDDP pilots

6.6.1 Participating in ONE and the NDDP pilots

6.6.2 Patterns of interaction with ONE and the NDDP pilots
Second, there was a small group who felt they had received significant help and had made real progress towards or into work. Within our small sample, everyone in this group had had contact with N D D P rather than with O N E. They spoke very highly of the service and of their Personal Adviser. They had valued help such as discussion of job options; access to training or a placement; offers to contact former employers; advice about benefits and particularly about the 52 week linking rule which would smooth their return to benefits if work was not sustainable, and general support, encouragement and a boost to their self-confidence.

The remaining people all felt that they had not made any progress through their contact with the service. This group included people in O N E and in N D D P areas. In the O N E areas, some had moved to Jobseeker’s Allowance following the PCA, and their contact with O N E seemed to be limited to signing on, with little or no discussion of job options or help towards work. In other cases (in both O N E and N D D P), it was the client’s own decision that work was not an option, at least not now (a view that they sometimes said was expressed also by their Personal Adviser), or the client remained uncertain or ambivalent about work despite their meeting with a Personal Adviser.

However, this group also included clients who were more certain that they wanted to explore the possibility of work and who were disappointed that their contact with either O N E or N D D P Personal Advisers had not been more constructive. The areas where their needs seemed not to have been met included not being given advice or information about appropriate vocational directions; interest in training not being followed-up; interest in voluntary work not being followed-up, or actively discouraged on the grounds that this would jeopardise benefit entitlement; and feeling that Personal Advisers did not have sufficiently close contact with local employers to be able to help the client find an appropriate job.

Some clients, in both O N E and N D D P areas, had found their Personal Advisers somewhat unsympathetic and unsupportive. Where clients had had contact with more than one Personal Adviser (in both O N E and N D D P areas), or also with a Disability Employment Adviser (in O N E areas), this could be unsettling. The offices where O N E was delivered were occasionally felt to be distressing because of the behaviour of other clients, or more generally because of the ambience or the physical environment. This had sometimes discouraged continued contact.

These experiences may, to some extent, reflect clients’ own continuing uncertainty about whether work really was an option. However, there were also cases where clients seemed highly motivated to work or to move towards work, but felt their contact with the service had not

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8 However, the numbers involved are very small and the study sample was not designed to be statistically representative, and this should be seen as an issue for further investigation rather than as a conclusive finding.
ultimately been helpful. These comments echo Personal Advisers’ descriptions of the low priority given in ONE areas to clients on Incapacity Benefit, but they also suggest that not all clients in NDDP areas received a full service.

As Section 6.1 outlined, none of the clients in the study sample had seen their own Capability Report. So that there could be some discussion of whether a Capability Report might be a useful tool in their own case, the research team gave a brief description of the key issues covered by the Capability Report and sometimes gave the client a blank copy to consider and comment on.9

There was generally no concern about the idea of having a Capability Report completed, although this was sometimes expressed somewhat defensively by clients who said they had ‘no problem’ or ‘no objection’. There was some interest in seeing their own Capability Report, both to check its accuracy and because clients thought they would find useful information or views in it, but people did not generally seem to be concerned that they had not been given an opportunity to see it. One woman who felt the Medical Services doctor had been negative about her capabilities said she would not want to see her own Capability Report as she felt it might be discouraging.

There were different views about whether or not a Capability Report would be helpful to their own contact with ONE or with the NDDP pilots. The view that it might be useful was sometimes expressed in a somewhat lukewarm way, by clients who said things like ‘it can’t hurt’. Others were keener on the idea and felt that it would be useful for the Personal Adviser to have more information about, and a better understanding of, their condition and capability. It was sometimes difficult to get a clear sense of what they felt this would have added to what they themselves told the Personal Adviser. They thought that the Medical Services doctor’s account might be more thorough, might include details that they may not have given, and might give medical information or use medical terminology that could help the Personal Adviser. It was said that details might be missed by clients, particularly if the Personal Adviser was not good at eliciting information. There was also a view that a Capability Report would have provided the Medical Services doctor’s confirmation to the Personal Adviser that the client did, indeed, have the condition they had reported, thus proving that they were genuine and honest – an issue that emerged as a concern even where people’s receipt of Incapacity Benefit continued after the PCA, and indeed where they had been receiving Incapacity Benefit for several years.

9 The research team had to make a judgement, in each interview, as to whether showing the respondent a blank copy of the form would be a useful prompt for continued discussion. For example, this was not done where it was felt that the respondent’s views had already been articulated in full and that showing the form was unlikely to reveal more. It was also not done where there were time pressures, or where there were concerns that a respondent might not be able to read or assimilate a lengthy form.
‘It goes into quite a lot of detail so (Personal Advisers) would know exactly how it would affect you … . Yeah, I think it would be useful. I think it is good that it has been done by the doctor. They know that you’ve seen a professional person about it, they know that they’ve gone through it in detail with you. (They could just ask you) but they don’t know if it’s the truth, I suppose, some people may tell lies. But if you’ve seen a doctor and been examined thoroughly … it probably gives them a better idea really.’

(Client, N D D P area, muscular-skeletal condition)

One woman said that she herself had mostly thought about what she could not do rather than what she could, and hoped the Capability Report would therefore give a more balanced assessment of her capability. It was also thought useful for the Personal Adviser to have this information in writing, and as a document they refer to later, particularly by clients who had complex or unusual conditions.

‘I went through (my condition) with her but … whether she took it all on board and could remember everything is another matter. If she’d had a file in front of her that explained everything that (the condition) is, and how it affects people, then yes, she’d probably be at an advantage then. Because I was telling her things that she didn’t know and explaining it to her. If I asked her now, she probably wouldn’t be able to remember. She probably sees that many people.’

(Client, O N E area, muscular-skeletal condition and sensory impairment)

Where people found it difficult or uncomfortable to talk about their own condition, they thought that the Capability Report would have been helpful, particularly to avoid repetition if they had seen more than one Personal Adviser.

Finally, there was also an expectation that the Capability Report would have provided occupational health or vocational guidance, which it was thought would have been useful to both the client and their Personal Adviser. Here, clients felt that the Medical Services doctor would have been able to give their own opinion about whether work (and whether full-time or part-time work) was viable and could safely be done, or that they would have been able to suggest suitable jobs.

It was stressed, however, that the Capability Report should not replace the Personal Adviser getting to know the client well and listening to the client’s own views about their capability and the viability of work.

There were others, however, who felt that the Capability Report would not be a useful resource in their own case. Here there were three issues. First, some clients felt that it would not have added to the information they were able to give the Personal Adviser themselves, and emphasised that they had been able to give much more detailed and useful information when they had met their Personal Adviser. They stressed that they had
a clear understanding, themselves, of what their capabilities were. They could see no value in the Personal Adviser also receiving this information from the Medical Services doctor through the Capability Report.

Second, as Section 6.3.1 suggested, there was concern about the accuracy of the information in the Capability Report, given that it was collected at the medical examination. Clients felt that the Medical Services doctor had not been able to get a full insight into their condition and its impacts, either because the medical examination was not long enough or because the investigation was not sufficiently in-depth. There were also concerns that a single interaction with the Medical Services doctor can misrepresent the fluctuating nature of some conditions and their impacts, and that insufficient weight is given to the fact that a client may be able to, for example, walk or climb stairs, but only infrequently or with pain or discomfort. Some clients felt that it would be more appropriate for the Capability Report to be completed instead or additionally by their own GP or consultant, who would have a fuller understanding of their condition and its impacts. It was also said that the form is not sufficiently detailed to allow Medical Services doctors to record variability in capability.

‘(Medical Services doctors) don’t know you well enough. They only see you for something like half an hour every six months, and it’s not the same one ... . I think it would be far more appropriate for your own doctor (to complete the Capability Report) ... . Your own doctor knows your condition and has your files and knows you more personally than (a Medical Services doctor) that doesn’t know you from Adam.’

(Client, ONE area, mental health and other condition)

Finally, there was some doubt as to whether Medical Services doctors have enough experience of occupational health and vocational guidance to understand the implications of medical capability for capability in the workplace, to be able to suggest how much work would be manageable, or to allow them to suggest appropriate jobs. Here, there was a suggestion that the Capability Report should be completed by Personal Advisers from careers services.

6.7.2 Summary of possible role of Capability Report

To summarise, the accounts of clients suggest that the Capability Report most clearly has a role to play where clients are uncertain about how their condition impacts on their capability, where they find it difficult to report its impacts to their Personal Adviser (either because of their own hesitation or because of the manner of the Personal Adviser), or where for some reason the Personal Adviser does not appear to give sufficient weight to collecting information about their condition and its impacts. There is interest among some clients in Capability Reports giving a clear indication of the Medical Services doctor’s view about whether any work is possible and whether this should be full- or part-time, but others feel they can assess this themselves.
Capability Reports appear, from the perspective of clients, not to be of value where the client is able to give a full account of their condition and its impact, or where the client is clear that work is not an option and not interested in considering the issue further at this stage. In other cases, it is possible that a Capability Report might have provided useful information, but its value was limited because of the existence of other significant barriers to work, which were not always being addressed by ONE or NDDP. In particular, there are a number of clients for whom vocational guidance – suggestions of specific types of occupation that would be manageable and realistic given their condition, work experience, interests and qualifications – would appear to be a significant need.

The following chapter draws together key issues from the three study populations and discusses their implications for the future role of the Capability Report.
At the time of the fieldwork there was varied but generally low usage of the Capability Report among Personal Advisers in their work with sick and disabled clients. This is explained both by issues connected with the form itself and the extent to which it meets Personal Advisers’ information needs, and by the wider system in which it operated within ONE and the NDDP pilots. This section summarises these issues and discusses their implications for the development of capability reporting as part of the IB medical assessment and for the structures and systems required to support its use.

From the clients’ accounts, the Capability Report appears to have a role to play where the client cannot themselves give the Personal Adviser a full account of their condition and its work implications – either because they themselves do not have this knowledge or because some aspect of their interaction with their Personal Adviser inhibits full discussion. For some, there was a rather vague sense that additional information might be useful, and the idea of a clear steer about work options was particularly valued. Others, however, felt they were able to discuss these issues fully with the Personal Adviser without requiring information from elsewhere.

Among Personal Advisers, views were again mixed. Some felt the Capability Report provides useful background information about the client, their condition and how it affects them. A third party view was sometimes seen as helpful to highlight discrepancies in the client’s account, as reassurance that work could safely be considered, and as a basis for discussion and negotiation with the client of the way forward.

Among both groups, however, there were concerns about whether the information in the Capability Report has sufficient depth, whether it adds enough to what can be generated by discussion between client and Personal Adviser, and whether any additional information needs are not better met by other sources, particularly GPs.

There is a general concern that the type of information provided in the Capability Report does not sufficiently address Personal Advisers’ key information needs. There remains a need for more information about whether the client would be able to work, how work should be structured, and the types of occupation that would be appropriate. There are different levels of understanding among Personal Advisers about the role and skills of the Medical Services doctors, but some question whether Medical Services doctors can provide the information they require, and believe that specialist referral, for example to an occupational health specialist, is more appropriate. Among the Medical Services doctors themselves, there
are again mixed views. Some would welcome the opportunity to communicate more directly in the Capability Report their own assessments about whether work is feasible or safe, how it should be structured and possible occupational directions, but they have concerns about how well equipped they are to provide this information.

This evidence suggests that some changes to the form will be required if confidence in it is to be increased and its value and use widened. First, consideration should be given to whether there is scope to improve the coverage of work-related information. Clearly, the extent of occupational health expertise among Medical Services doctors will place constraints on this. However, there may nevertheless be scope to maximise their input through greater clarity in question wording and perhaps through greater specificity (given the difficulties Medical Services doctors highlight in talking about work in general) particularly if this is supported by more in-depth training. Second, other modifications to the form and its mode of completion may help to widen its use. Electronic completion and an emphasis on clear, jargon-free language – in both question formulation and the way it is completed by Medical Services doctors – would be helpful. Greater clarity about the information sought in some questions would be valued by Medical Services doctors and Personal Advisers. There are mixed views among Personal Advisers about the length of the form: some would like it reduced to key information that they could not obtain from the client; others would like more detail in some areas and, for example, space for including the Medical Services doctors’ own views. Generally, Personal Advisers see questions which have a direct relevance to work as being key, but Medical Services doctors find these the most difficult to complete.

It is clear, however, that there are also issues relating to the broader operating context in which the Capability Report is used which have implications for its role and value, and there is a need for consideration of changes here to support the use of the Capability Report.

First, there is clearly diversity in the extent to which work-focused advice is made available to sick and disabled clients in the ONE areas. In general, however, other priorities underpinned by operating targets mean that there can be little scope for Personal Advisers to provide in-depth support to sick and disabled clients who want to move towards or into work. Faced with considerable pressure on their time and competing priorities, Personal Advisers seem to focus their work on other client groups. They have a discretion to defer trigger interviews with Incapacity Benefit clients after they receive the Capability Report, but seem to be exercising this more widely than was intended, and somewhat unevenly. Personal Advisers’ own perceptions of sick and disabled people, and their confidence, experience and sense of expertise in working with them, clearly play a part here. This suggests that a substantial refocus is required if Capability Reports are to be more widely used by Personal Advisers in
their work with clients on incapacity benefits, which will need to be supported by further training in disability equality issues and in how to help sick and disabled people who want to move towards work.

The Capability Report also potentially has a role to play in Personal Advisers’ work with clients who move to Jobseeker’s Allowance following their PCA, and other research suggests that Employment Service Advisers sometimes find it difficult to know how to work with this group. However, the Capability Report seems currently not to be being used extensively by Personal Advisers here.

Further training and guidance on Capability Reports is clearly required, for both Medical Services doctors and Personal Advisers. Among the Medical Services doctors, there is a lack of clarity about some aspects of completion of the form, particularly whether their own views should be recorded, whether it is seen by the client and on specific questions where they are unsure about the type of information sought. More generally, however, Medical Services doctors need a better understanding of how Personal Advisers work with sick and disabled clients, how they use the Capability Report, and the type of information they find helpful within it. Personal Advisers need guidance about the intended role of the Capability Report, the client groups to which it is relevant, and how they can use the Report to inform their work with sick and disabled clients. They also need a better understanding of the evidence drawn on by Medical Services doctors in completing the form and of the PCA more broadly. There is clearly a need for more liaison and collaboration between Personal Advisers and Medical Services doctors, particularly so that Medical Services doctors can understand the information needs of Personal Advisers. Initiatives to tackle these issues were beginning to be set up at the time of fieldwork in some areas.

Guidance, discussion and greater liaison may help to support the use of the Capability Report. However, it seems likely that the different working approaches of Personal Advisers will continue to influence whether and how they use it. These different approaches, which can be described as ‘client-led’ and ‘multi-source’, revolve around the centrality given to the client’s own perceptions of their condition and of the appropriate way forward. They seem to be underpinned by different ideologies or perceptions of disability. This suggests that the Capability Report will continue to be used to varying degrees, and in different ways, by different Personal Advisers.

Few Personal Advisers currently show clients their Capability Report, and thus it is only indirectly through its impact on Personal Advisers’ work with clients, that it can provide information which might motivate clients in considering work, or help shape their thoughts about appropriate

7.2.2 Training, guidance and liaison

7.2.3 Personal Advisers’ working methods and ideologies of disability

7.2.4 Accessibility of the Capability Report to clients

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work directions. There is uncertainty among both Medical Services doctors and Personal Advisers about whether it is permissible or desirable to make the Capability Report accessible to clients, and varied practice. Among clients there is some interest in seeing the Capability Report, particularly if it provides medical or work-focused information that would be of use to them. However, there are likely to be some tensions between the provision by Medical Services doctors of frank and full information and accessibility of the Capability Report to clients, and this is an issue on which guidance and clarification is needed for Medical Services doctors and Personal Advisers.

There are a number of concerns about the PCA as the forum both for inviting clients to participate in the N DDP pilots and for completing the Capability Report. In relation to recruitment to the N DDP pilots, there are concerns about how easily a voluntary programme sits within the compulsory context of the PCA. The linkage between the PCA and the N DDP pilots, particularly in Option A, where clients were approached directly at the Medical Services centre, appeared to undermine or confuse the voluntary nature of N DDP as well as adding to the stress and anxiety of clients. From the accounts of clients and Personal Advisers, it is clear that some people opted into the N DDP pilots out of a sense of compulsion or more general obligation, and this could lead to ineffective engagement with the pilots. It seems likely that this could have become problematic for the pilots if it had become more widespread. There was clearly a need to improve the way in which clients were approached about N DDP, but it may have been impossible to remove these concerns completely as long as the linkage with the PCA remained.

There are fewer concerns about the integration of the capability assessment in the PCA itself. The Medical Services doctors seem broadly happy with conducting both elements, and clients generally seem comfortable with the discussion of work provided it is raised in an open and straightforward way. However, there are concerns among clients and Personal Advisers about whether the PCA captures a full and accurate picture of the client’s condition and its impact on them, particularly where conditions are complex or fluctuating. Confidence in the system might be improved by more liaison between Medical Services doctors and Personal Advisers, helping Personal Advisers to gain a better understanding of how PCAs are conducted and the evidence drawn on. More explicit coverage in the Capability Report of variation in capability and the effects of conditions might also help. There seems also to be a need for improvements in some Medical Services doctors’ interaction with clients. Again, however, it may be impossible to remove these concerns altogether, and a preference for medical information to be provided by patients’ own GPs is likely to remain.
A number of difficulties are identified which relate to the fact that the Capability Report is completed for all clients having a PCA in ONE, and was completed for all who opted into NDDP in the NDDP pilot areas.

Medical Services doctors find it somewhat frustrating to complete the Capability Report for clients who they feel are highly unlikely to move into work, either because of the nature of the condition or because of broader issues around their employability and local labour market conditions. They are sceptical about the value of the Capability Report in these circumstances and are concerned that it raises unrealistic expectations among clients. The need to present a positive picture is seen to add to this, where Medical Services doctors feel it results in a partial or false image. Some Medical Services doctors try to address these issues by communicating their own views, but are unsure whether this is encouraged or not. More guidance in these areas would be helpful.

Personal Advisers, too, in both the NDDP and ONE pilots, had mixed views about the value of Capability Reports where clients would need substantial support to move into work, and particularly where clients themselves do not consider work to be a viable option or one that they want to pursue. There were concerns about whether this is an efficient use of Personal Adviser time and about the anxiety they feel it causes to clients, particularly in ONE, given that the subsequent interview is compulsory. Within the sample of clients interviewed there were clearly some who did not consider work, or moving towards work, to be an option for them, and for whom engagement with either ONE or the NDDP pilots was unproductive or stressful.

These issues raise questions about whether the Capability Report would be more useful and effective if its use is targeted, so that it is completed only for those clients where the likelihood of effective engagement with a Personal Adviser is greatest. One option might be for the Capability Report to be completed by Medical Services doctors in a separate session, after the PCA and the subsequent work-focused interview, for clients who are interested in work and where the Personal Adviser thinks the additional information would be helpful. This clearly has cost implications - an additional session would need to be funded, although fewer Capability Reports would need to be completed - but may lead to more effective use of the Capability Report.

If the Capability Report is to remain a part of the PCA, there is scope for improvement in the systems surrounding its completion and in the broader services within which it operates. There needs to be greater clarity for Medical Services doctors about the value and role within the Capability Report of their assessments of the likelihood of work, and a better understanding of the ways in which Personal Advisers work with sick and disabled people. Providing better information to Incapacity Benefit
claimants about the requirements on them within ONE and more guidance and training for Personal Advisers, particularly in ONE, about ways of working with sick and disabled people may make their engagement with clients more effective. Clarity about the circumstances under which compulsory work-focused interviews can be deferred may be required, as well as more training in how to conduct interviews using a Capability Report. As discussed above, there was also a need to improve the way in which clients in the NDDP pilot areas were told about the pilots, and to consider how their voluntary nature could best be protected in the compulsory context of the PCA. It should be noted, however, that these issues would need to be looked at afresh in the context of the national extension of NDDP, which draws on experience with the Personal Adviser Service pilots and Innovative Schemes, but rolls neither model out as such.

There might also be a role for using Capability Reports more among people who have moved from IB to Jobseeker’s Allowance after a PCA, or for Disability Employment Advisers to use them in their work with sick and disabled clients.

7.3 Conclusions

The research findings provide a general picture of diverse views about the value of the Capability Report. The Medical Service doctors are generally broadly comfortable with its inclusion in the PCA - indeed some welcome it warmly. Clients do not raise objections to the concept, and again some see it as being of value. Among Personal Advisers there are more diverse reactions. Some find the Capability Report useful, have incorporated it in their work with clients and would regret its absence. Others see no value in it and regard it largely as an irrelevance. In the NDDP pilot areas, some Personal Advisers saw the Capability Report as a method of recruitment to the service that could be counter-productive. What is clearer is that, if it is to be retained and its use and usefulness to be increased, changes will be required to the form, to the systems surrounding its completion, and in the case of ONE to the wider context in which it operates. However, these changes alone will not remove the tensions between the compulsory nature of the PCA and the voluntary status of job-search and work for people on Incapacity Benefit.

A final issue, which permeates the interviews with Medical Service doctors, Personal Advisers and clients, is an underlying concern about employers’ attitudes and approaches to recruiting sick and disabled people and about how these clients fare in a competitive labour market. Ultimately, the effectiveness of the Capability Report, and of the services within which it operates, will be dependent on the success of broader initiatives that address employer behaviour as well as those that help sick and disabled people themselves.
This appendix provides detailed information about the research methodology used during this study and elaboration on Section 1.3 of the report.

The study was qualitative in nature and based around in-depth interviews with the three key stakeholder groups involved with the Capability Report: the Medical Services doctors who draw up the report; Personal Advisers who make use of it in their work with sick and disabled clients; and the clients themselves. In-depth interviews were chosen for this study as the most suitable vehicle for providing detailed personal accounts of experiences of, and views about, the Capability Report.

The study was undertaken in six areas which were individually selected with respect to the diversity of the models of ONE and the NDDP pilots and to represent different regions of the country and different types of labour market. The three ONE areas were selected to reflect the three delivery variants outlined in Section 1.3 of this report: the basic model, the call-centre model and the private sector led model. The three NDDP areas were selected according to whether they were led by the Employment Service or by private and voluntary sector organisations and on the basis of the approach used for promoting the service to clients. Employment Service or private sector led areas were selected according to whether they were led by the Employment Service or by private and voluntary sector organisations. The precise distribution of the number of interviews across the six pilot areas is given in Table A.2.

The study was undertaken in six pilot areas which were selected to provide a broader range of experiences of, and views about, the Capability Report. In the event, it was decided to include only the two options which required the client to volunteer for the service: Options A and C.

The interviews with clients were all individual interviews although some part-time employment service doctors were also interviewed individually. In-depth interviews were carried out with a wide variety of service doctors and a proportion of interviews carried out with medical service doctors and personal advisers. The greater number of interviews with clients were individual interviews. The number of interviews with clients is given in Table A.2.

### Table A.1  Study areas

<table>
<thead>
<tr>
<th>Area</th>
<th>ONE Pilot</th>
<th>NDDP Pilot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clyde Coast</td>
<td>Employment Service led</td>
<td>Employment Service led</td>
</tr>
<tr>
<td>Renfrew</td>
<td></td>
<td>Private sector led</td>
</tr>
<tr>
<td>Calverdale</td>
<td>Call-centre model</td>
<td>Call-centre model</td>
</tr>
<tr>
<td>Kirklees</td>
<td></td>
<td>Private sector led</td>
</tr>
<tr>
<td>Suffolk</td>
<td>Private sector led</td>
<td></td>
</tr>
<tr>
<td>Bolton</td>
<td>Employment Service led</td>
<td>Option A</td>
</tr>
<tr>
<td>South Devon</td>
<td>Private sector led</td>
<td>Private and voluntary sector led</td>
</tr>
<tr>
<td>Eastern Valleys</td>
<td>Employment Service led</td>
<td>Option C</td>
</tr>
</tbody>
</table>

The table shows the number of interviews carried out in each area. The number of interview participants is given in Table A.2.
A total of 100 interviews was carried out with medical service doctors who had been involved in completing Capability Reports and the sample was monitored by the research team to ensure diversity in terms of age, gender and professional background. The original intention had been to conduct interviews with 20 or more personal adviser managers in each study area. The sample was monitored by the research team with feedback on the sample and issues affecting the use of the Capability Report.

A.2.3 Client sample

The client sample was obtained from management records collated by the ONE and NDDP pilots which identified clients who had been seen by each of the ONE and NDDP pilots. The sample was then extended to include a larger sample of clients treated in other areas.

<table>
<thead>
<tr>
<th>Group</th>
<th>Total</th>
<th>Total</th>
<th>Total</th>
<th>Total</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Clyde</td>
<td>Calderdale</td>
<td>South</td>
<td>Eastern</td>
<td>_valleys</td>
</tr>
<tr>
<td>Clients</td>
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<td>2</td>
<td>2</td>
<td>2</td>
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<tr>
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<td>0</td>
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<td>0</td>
</tr>
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<td>0</td>
<td>5</td>
<td>5</td>
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<tr>
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<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Personal Adviser</td>
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<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Medical Service</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

Table A.2. Sample composition by study areas
A.3  Screening and recruitment

A.4  Conduct of the fieldwork

Appendix B.

Copies of the opt-out and the confirmation letters are given in full in Appendix B. A confirmation letter was sent to all respondents who were invited to participate in the study. The letters were sent by first-class post to each individual respondent. Interviews were carried out with Medical Services doctors to allow members of the research team to gain a comprehensive understanding of the process used by Medical Services doctors to complete the Capability Report.

The interviews were conducted in a number of fieldwork areas, with Personal Advisers and clients, and with Medical Services doctors. The interviews were recorded and transcribed verbatim.

The interviews generally lasted between 1 and 1½ hours. The interviews were conducted in a number of fieldwork areas, with Personal Advisers and clients, and with Medical Services doctors. The interviews were recorded and transcribed verbatim.

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Advisers were invariably held at the relevant ONE or NDDP office. Clients were interviewed in their own home and were given £15 in recognition of their help with the study. In cases where clients knew little or nothing about the Capability Report, the interviewer provided a short oral summary of how and why it is produced and showed a blank copy of the report form. A blank copy of the Capability Report form was used to show to respondents in the interviews with Medical Services doctors and Personal Advisers to elicit their views about its content and format.

Verbatim transcripts of the interviews were analysed using 'Framework', an analytic tool devised by the Qualitative Research Unit at the National Centre and subsequently adapted for computer use. The key topics and issues which emerge from the data are identified through familiarisation with transcripts. Following this a spreadsheet was set up consisting of a series of worksheets (or charts) within which data from each transcript are summarised and entered. The context of the information is retained and the page of the transcript noted, so that it is possible to return to the transcripts for further analysis. Each transcript is seen containing a set of 'fields' of information, with the column headings relating to key themes emerging from the data. Each raw data field is seen containing a set of 'fields' of information, with the column headings relating to key themes emerging from the data. Each raw data field is seen containing a set of 'fields' of information, with the column headings relating to key themes emerging from the data. Each raw data field is seen containing a set of 'fields' of information, with the column headings relating to key themes emerging from the data. Each raw data field is seen containing a set of 'fields' of information, with the column headings relating to key themes emerging from the data.
FIELDWORK DOCUMENTS

APPENDIX B

Topic guide for interviews with Medical Services Doctors

Topic guide for interviews with Personal Advisers

Topic guide for interviews with Clients

DSS opt-out letter for clients

Introduction letter for clients

Confirmation of appointment letter for clients

Topic guide for interviews with Medical Services Directors
1. INTRODUCTION
   • The National Centre
   • The study
   • Timing, confidentiality, tape recording
   • Any issues that the respondent would like to raise

2. BACKGROUND
   • Brief details of respondent’s role for Medical Services
     - how long in post; full or part time post
     - what they were doing before
     - any specialism in occupational health
   • Details of the arrangements for conducting the PCA at their centre
     - how many doctors involved
     - how many assessments do they carry out per week
     - how many Capability Reports have they carried out personally so far
   • Brief description of their catchment area for carrying out PCAs

3. THE CLIENTS
   • Whether their clients for the PCA are ONE or NDDP clients
   • At what stage the Capability Report is mentioned to customers
     - how raised, and by whom
     - what is said
     - response of customers
     - impact on expectations, state of mind, response to PCA
   • Do clients understand what the Capability Report is about
     - have clients seen a PA/ do they recognize the term ‘Personal Adviser’
   • How explicit are they about the Capability Report when describing the PCA to the customer
     - reasons for the approach taken

4. ASSESSMENT OF CAPABILITY
   • Whether they treat the PCA as one medical assessment or treat Incapacity and Capability separately
   • How is the assessment of Capability incorporated within the PCA
     - whether they ask additional questions if so, what are they
     - whether any additional physical assessment
     - to what extent is the process prescribed or left to their discretion
   • How different is the style of questioning used around Capability cf. to that used for Incapacity
     - how direct they can be in the questions they ask
     - is the style of questioning prescribed for them
     - how far are asking about work in their questions
     - do clients understand what is being asked
   • How much extra time does the Capability assessment add to the incapacity assessment within the PCA
     - does this have any effect on the way they conduct the PCA
5. COMPLETING THE CAPABILITY REPORT

- When is the Capability Report completed: during or after the PCA?
- How easy or difficult is it to elicit the information needed/fill in the Capability Report, e.g.
  - for particular types of customer or impairment
  - for particular questions of parts of the Capability Report
- What evidence do they draw on for completing the Capability Report:
  - Probe for use of the following:
    - customer’s answers to the questioning
    - doctor’s own interpretation of customer’s answers (any guidelines about using this?)
    - observation of the customer
    - medical examination
    - IB50 questionnaire
    - medical evidence: do they need more from GPs/specialists
- To what extent are they drawing on factual information or inference/opinion
- What do they think about the Capability Report:
  - how full and realistic a picture does it paint
  - how useful is it (whether useful for everybody or not)
- What do they think Personal Advisers need from the Capability Report:
  - how does this influence the way they complete the Capability Report
  - do they ever have any feedback from, or contact with, Personal Advisers
  - do the Personal Advisers ever send the Capability Report back for further clarification

6. FORM AND CONTENT OF THE CAPABILITY REPORT

- Go through the Capability Report with the respondent section by section to elicit their views about the questions and their approach in answering them. Standard probes:
  - How useful is the question
  - What evidence do they draw on
  - How could the question/section be improved

7. USE OF CR2

- When do they complete the CR2
- What do they use to complete it
- Does completing the CR2 raise any specific issues
- How relevant do they think the information is likely to be for PAS:
  - how might it be improved

8. REFLECTIONS

- How far do broader issues influence the way they fill in the Capability Report, for example:
  - e.g. employability, age circumstances, motivation and labour market
  - customer’s attitude/approach to the PCA exam
- To what extent they have to adapt their mental approach and way of completing the report when switching from the Incapacity Report to the Capability Report:
  - how far are they trying to make the Incapacity Report and the Capability Report consistent
- How comfortable are they with the Capability Report as part of their role:
  - whether it requires specialist occupational health knowledge
  - does it impact on the Incapacity Report
  - does it impact on customers’ attitudes to the medical examination/relationship with the doctor
- How adequate was the training and guidance they received about the Capability Report:
  - any other type of information/guidance they would like to have had
  - how much do they refer to the manual

9. SUGGESTIONS FOR THE FUTURE

- In what ways do they think the Capability Report could be improved:
  - design, layout and length of the form
  - content of the form
  - format (e.g. electronic format)
- Are there any ways in which they would like to see the current system for assessing Capability changed or improved, for example:
  - ways of informing customers about the Capability Report
  - assessment procedure
  - liaison with Personal Advisers, GPs, etc.
- Any overall suggestions for how Capability could be assessed more effectively
The aim of the interview is to ask Personal Advisers to focus on their use of the Capability Report in their interviews with clients and the extent to which the report is being used by advisers to encourage and assist clients on Incapacity Benefit to look for work. It is helpful to encourage Personal Advisers to use examples of current, or recent, cases to illustrate the points they make. In the case of "matched interviews", the interview should focus on the process used by the adviser in dealing with that specific case.

1. INTRODUCTION
   - The National Centre
   - The study
   - Timing, confidentiality, tape recording
   - Any issues that the respondent would like to raise

2. BACKGROUND
   - Details of organisation running the scheme [NDDP or ONE]
     - private or voluntary sector; Employment Service; BA; LA; call centre
   - Details of respondent's role
     - length of time in role
     - details of previous roles
     - whether has specialism in disability or other (e.g. occupational health)
       - types of client, including non disabled
   - Number of cases they have dealt with that have involved a Capability Report

3. AWARENESS AND UNDERSTANDING
   - Why do they think the Capability Report was introduced
     - reasons for their views
     - principal sources of information
   - How clear are they about the process whereby the Capability Report (CR1) is produced by Medical Services doctors
     - in what cases CR1s are and are not produced
     - amount of liaison with the doctors
   - How do they think the CR is supposed to be used
     - for which categories of client (e.g. those who have been awarded Incapacity Benefit or those who have not and have returned to JSA); reasons for their views
     - how do they think Personal Advisers are expected to use Capability Reports
   - Views about information and preparation for using the CR
     - how much information were they given; how was this communicated
     - details of any training and guidance they received; how satisfactory
     - views about what else they would like/need
   - What do they see as their role in their work with disabled clients
     - is it easier to work with some types of impairment than others; which/why
   - What types of information do they need in order to make their assessment of the client's work options
     - how far did they get this before the Capability Report became available (or do they get it now when a CR is not available for a client)
     - how easy is it to obtain information from clients
     - how realistic are client expectations

4. RECEIVING THE CAPABILITY REPORT
   - How and when do they receive the Capability Report
     - what happens when they receive it, and why
     - how many meetings held with clients before/after the CR arrives
   - How long after receipt of the Capability Report do they call the client in for interview
     - is this before or after the client knows about the result of the Incapacity Benefit assessment
     - does the PA receive the CR early enough for it to inform the interview; views about whether timing is right
   - Do they see everyone who has had a Capability Report
     - if not, how does the decision come about
   - How aware are clients of the Capability Report
     - whether clients give feedback about their experience of the medical examination (PCA)
5. USE OF THE CAPABILITY REPORT

- How far are they able to make full use of the Capability Report in practice
  - examples of how they do use it as they are expected to
  - reasons why are unable to do so
  - main constraints on their ability to use as intended

- What use do they make of the Capability Report once they receive it
  - is it something they merely glance at or does it play a more central role in their dealings with the client; why
  - what effect does the CR have on the way the interview is conducted
  - do they show the report to the client; why/why not

- At what stage does the Capability Report get raised with the client
  - have they already broached the subject of a return to work with the client at that stage
  - responsiveness of clients to having the issue raised

- Level of use of Capability Reports
  - circumstances in which use/choose not to use
  - factors affecting extent of use
  - whether used for subsequent interviews; how
  - whether potential for greater use/how use might be increased
  - which areas of the CR are most/least helpful

- Examples of where the report has actually shaped their work with the client
  - how and why

6. MATCHED CASES ONLY

- Brief background about client:
  - age, work history, impairment
  - initial thoughts about work

- Point when CR received by PA
  - whether any earlier contact with client; issues covered; relationship with client

- Capability Report: go through CR completed for client
  - PA’s comments on information provided
  - how closely matched PA’s own perceptions/client’s views
  - how useful, how far added to what could have or did find out in other ways

- Use of Capability Report:
  - whether PA showed CR to client
  - client’s reactions or thoughts

- Impact of Capability Report:
  - impact on their understanding of client’s impairment and its implications (eg whether work suitable, appropriate direction, appropriate structure of job/support)
  - impact on quality of support and advice they were able to give
  - any influence on client’s motivation to work or views about appropriate direction
  - any influence on way in which PA worked with client and outcome of work

7. SPECIFIC FEATURES OF THE REPORT

*Go through the report with the respondent section by section. For each section, ask them how they could/should use the information in working with the client. Where possible, ask them to illustrate their answers with examples*

- Views about
  - the formulation and purpose of the question
  - the relevance of the answers provided
  - how helpful for them in their dealings with the client; extent to which adds to what they already know
  - how could be improved
What impact has the Capability Report had on:
- their understanding of the client’s impairment and its implications for work
- the quality of support and advice they are able to give to the client
- their ability to place the client in suitable work

What impact has the Capability Report had on:
- client motivation to look for suitable/realistic work
- the relationship between client and adviser

Whether any problems around the Capability Report, e.g.
- timing
- administration
- appropriateness to this client group

Are there any ways in which they would like to see the current system for assessing Capability (nb. not incapacity/benefit entitlement) changed or improved, for example
- ways of informing customers about the Capability Report
- liaison with Medical Services doctors, GPs, etc.
- whether any remaining gaps in their need for occupational health guidance; how might be filled

Any overall suggestions for how the Capability Report itself could be improved

Overall, how satisfied are they with the way the CR forms are filled in
- how well the information matches with their own perceptions with what client says
- degree of variability between Capability Reports/doctors
- examples of helpful and unhelpful modes of completion by Medical Service doctors
- whether any unfit for purpose/particular problems (e.g. legibility)

Do they ever send CRs back to MS doctors for ‘rework’
- whether they get returned
- if returned, how far the CR has been changed/improved

Views about the design, layout and length of the Capability Report
- suggested improvements

How useful would it be if the Capability Report could be supplied in an electronic format
- what would be the likely advantages/disadvantages
- how far it would help to sort out any current problems associated with hard copies (for example, access, storage, flexibility of use)
- likely impact on ways personal advisers would use the CR

8. USE OF CR2 [EASTERN VALLEYS PILOT only]

Experience of using a CR 2

How useful is it
- comparison with usefulness of CR 1

9. APPRAISAL OF THE CAPABILITY REPORT

Details of training or preparation received for dealing with NDDP/ONE clients and the Capability Report
- views about how suitable, sufficient and timely the training was
- whether other/more training would be useful

Views about the idea of having a Capability Report
- advantages and disadvantages
- usefulness for filling any gaps in information

What impact has the Capability Report had on:
- their understanding of the client’s impairment and its implications for work
- the quality of support and advice they are able to give to the client
- their ability to place the client in suitable work

What impact has the Capability Report had on:
- client motivation to look for suitable/realistic work
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- ways of informing customers about the Capability Report
- liaison with Medical Services doctors, GPs, etc.
- whether any remaining gaps in their need for occupational health guidance; how might be filled

Any overall suggestions for how the Capability Report itself could be improved
The aim of the interview is to explore clients' awareness of, and attitudes towards, the Capability Report, both within the context of applying for Incapacity Benefit and within the context of their involvement with a Personal Adviser under ONE/NDDP. In addition, the interview will seek to elicit the impact of the Capability Report on clients' motivation to look for work and their expectations of the types of work they might undertake.

NB. There will be diversity in how visible or distinctive the Capability Report is to clients and questioning will need to be flexible in response to this.

1. INTRODUCTION
   - The National Centre
   - The study
   - Timing, confidentiality, tape recording
   - Any issues the respondent would like to raise

2. BACKGROUND
   - Age, household composition
     - work/benefit circumstances of others in household
   - Education and employment history
     - age left school; qualifications obtained; details of any subsequent training/quals
     - whether currently working or not: type of work
     - type of work done in past
     - reasons for leaving: whether their disability was the main reason for leaving
     - whether they expect to work in the future: reasons
   - Details of sickness of disability
     - type of impairment; duration
     - prognosis
   - Benefits situation
     - which benefits they are currently receiving (all benefits)
     - had their benefits situation changed recently: if so, why

3. FINDING OUT ABOUT ONE/NDDP
   - Establish whether currently/recently been seeing a Personal Adviser
     - how many interviews have had with the PA
     - when first saw the adviser (how long before or after start of IB claim)
     - details of how they came to see the adviser
   - Establish name of service / location if known: ONE or NDDP
     - how did they hear about it
     - how well informed do they feel about the service: who provides service, aim of service, requirements of them do they feel that it is compulsory or voluntary
   - When made contact with the service, was this purely about benefits or were they considering work
     - whether wanted to work, felt could work
     - type of work considering
     - type of help or support that might be useful

4. APPLYING FOR INCAPACITY BENEFITS
   - When did they apply for incapacity benefits
     - was this their first claim for incapacity benefits or a repeat claim
     - did they receive any help with the application from the PA, or not
   - When did they have their medical (PCA) test to assess their claim for Incapacity Benefit
     (explain that some people are seen by doctors from Medical Services as part of claim; mention MS location; did this happen to them)
     - whether any previous/subsequent experience of medical test/All Work Test/PCAs expectations of what would be involved
     - understanding of purpose
   - What they were told by receptionist/doctor about PCA
     - how this relates to expectations
   - Experience of PCA
     - how long it lasted
     - how they felt about questioning and examination: whether seemed appropriate, relevant, any discomfort
     - whether the medical assessment seemed fair and appropriate
     - views about manner and approach of doctor: what did they think the doctor was looking for
5. NEXT STEPS

Explain to respondent that sometimes a Capability Report is done and sent to the Personal Adviser, after the medical examination and since the Capability Report was produced.

- When did they hear the outcome of their claim; what was it?
  - reactions to the outcome
  - effect on them

- How long after the medical examination was their next interview with the PA?
  - was there any discussion at that interview about the Capability Report/their medical examination?

- Types of issues discussed at that interview:
  - benefits: did PA know outcome of PCA and was this discussed?
  - about work and appropriate work directions
  - how to progress towards/look for work
  - reactions to discussing these issues
  - implications of their impairment for work

- Number of visits/contacts with PA since then
  - issues discussed
  - whether any help provided in looking for work: details

6. IMPLICATIONS OF IMPAIRMENT FOR WORK

- Review any implications they feel impairment has for:
  - type of work they could do
  - structure of work (eg full time, part time, number of hours)
  - specific job choices (location, environment, pay)
  - anything they would want employer to know
  - any aids or adaptations they would want

- How far they felt the PA understood the implications of the impairment:
  - perceptions of PA’s understanding of disability (generally and their own in particular)
  - how far PA’s perceptions and approach were appropriate and matched/differed from their own views
  - any information sought by PA (from them, from GP etc.)

- What effect the PA’s understanding had on:
  - the relevance and usefulness of any advice given by the PA
  - their thoughts about work, progress, any action taken

7. THE CAPABILITY REPORT

Explain to respondent that sometimes a Capability Report is done and sent to the Personal Adviser.

- Whether any specific mention of a Capability Report by PA:
  - what was said
  - what understood content, format, purpose to be
  - whether they understood who completed it

- Did they see it, get a copy of it (show copy of blank report)

If client did not see Capability Report: give brief description or show copy

- Whether they recall any mention being made of the Capability Report

- How would they have felt about the doctor filling this in about them
  - how would they felt about the PA having this information
8. REFLECTIONS

- What do they think about the idea of a Capability Report?
  - usefulness for them/the PA
  - any reservations about the concept: what and why

- What types of information should be in the Capability Report; why

- How do they see their future
  - anything they would particularly like to do
  - how likely are they to do any work: what and why

- Finally, do they any further suggestions for improvements to:
  - services to help people move into work
  - the way the medical assessment (PCA) is conducted
  - the Capability Report

If client saw Capability Report:

- Content of Capability Report
  - type of information covered
  - how accurate, how close to their own perceptions of self
  - how useful
  - whether was information they gave could have given to PA

- Whether/how Capability Report was used by PA
  - was it referred to: in a specific session / more generally
  - did the PA go through it section by section

- What help was Capability Report to them / to PA
  - perceptions of how might have influenced what PA said/did
  - impact on their own thoughts about work
  - most/least useful areas of coverage
  - what would need to change for it to be more useful

- How useful could this have been to them / PA
  - what difference might it have made
  - most/least useful areas of coverage
  - overall advantages / disadvantages suggestions
Experiences of people receiving Incapacity Benefit

I am writing to confirm that the Department of Social Security has commissioned the National Centre for Social Research to carry out a study amongst people who receive or have recently applied for incapacity benefits. The study will be looking at people's views about the process of applying for incapacity benefits and the advice and help provided by personal advisers once the application has been made.

The research will provide valuable information to inform government policy about addressing the needs of people applying for incapacity benefits. The study will be conducted in confidence and the name of people taking part will not be known to the DSS.

The £15 you receive for taking part in an interview is a token of appreciation for your help with the study.

Yours sincerely

Jeremy Vincent
Research Officer

London WC2N 6HT
1-11 John Adam Street
4th Floor, The Adelphi
Department of Social Security
Social Research Branch
I am writing to ask for your help with a study that is being carried out amongst people who receive incapacity benefits. The aim of the study is to hear about people’s experiences of claiming the benefit and any follow-up contact they may have had with local advice services. Some of the people we are contacting may have seen a personal adviser from a service offering advice about applying for incapacity benefits. The service may have had concerns about their help, so this does not affect your benefits. Everyone who is interviewed will be given £15 as a small token of thanks for their help. This does not affect any benefits received.

The interviews will be carried out by the National Centre in strictest confidence. No information, which might identify you in any way, will be passed to the Department or to anyone else.

We hope you will decide to take part in the study. If however you do not wish to take part, please contact us before Friday 16th February. You can write to Robin Legard at the National Centre, or ring him on 020 7250 1866. Alternatively you may call Jeremy Vincent at the National Centre on 020 7962 8847.

Yours sincerely

Robin Legard, Jane Lewis, Kit Ward

The research team

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Ref No «Serial_number»/P.6021
e-mail  r.legard@natcen.ac.uk
Direct line  020 7549 9554

1 February 2001

Dear «Gender» «Surname»

Experiences of people receiving Incapacity benefits

1 February 2001
February 2001

Dear «Gender» «Surname»

Experiences of people receiving incapacity benefits

Thank you for agreeing to take part in an interview for this study. I confirm that the interview will take place at your home on at and will last about one hour. 

The interview will be carried out in strictest confidence. No information which might identify you in any way will be passed to the Department or to anyone else. Everyone who is interviewed will be given £15 as a small token of thanks for their help. This does not affect any benefits received.

The aim of the study, which is being carried out for the Department of Social Security, is to hear about people’s experiences of applying for the benefit and any follow-up contact they may have had with local advice services. Some of the people we are contacting may have seen a personal adviser from a service offering advice about applying for benefits or about considering work.

We look forward very much to meeting you.

Yours sincerely

Robin Legard, Jane Lewis, Kit Ward

The research team

«Gender» «First_Name» «Surname»

«Address1»

«Address2»

«Address_3»

«Address_4»

«Postcode»

February 2001
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