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Can I take this opportunity to express my outrage at a system which privatises the bureaucratic exclusion of genuine claimants for disability support to which they are entitled by virtue of their contribution to the public purse over long and productive working lives. Had I imagined that taking my particular appeal to Tribunal would mean it could be considered on its merits and not gauged against some [in the words of The Government’s own advisors] ‘mechanical’ and ‘not fit for purpose’ process, then I would have done so, but I know full well that the nodding of sympathetic heads will not allow me to achieve some ludicrous target of 15 points based on whether I can raise at least one arm above my head and not having an aversion to using public transport.

When a daily tabloid trumpets that ‘75% of all claimants on disability benefit are ‘scroungers’’ it is surely only endorsing successive Government’s public spin. Clearly ATOS has deemed me a ‘scrounger’.

Yesterday I attended my bi-annual Oncology Clinic at The Royal Orthopaedic Hospital in Birmingham. In passing, I related to my consultant the findings of the ATOS professional who conducted my review. I told him how I had been assessed as having 70% abduction of my damaged shoulder/upper arm without the good doctor bothering to leave the comfort of his chair to actually examine me. That my consultant could only shake his head in disbelief says everything. The actual rotational ability of my shoulder struggles to make single figures. As pointed out in my appeal letter, this particular ATOS professional could not tell his abduction from his elbow. Not that it would have made any difference of course. Upper limb disability and 24/7 pain is still only worth 0 points. An aversion to using public transport may have gained me a point had I chosen to play that particular game – the honest don’t of course. My consultant also made it clear that I was in for a lifetime of pain and discomfort that only amputation could remedy. Maybe the DWP would prefer that I agree to a lifetime regime of opiate-taking just to switch from one benefit to another.

It is a scandal that hundreds of thousands of able-bodied young adults are allowed to remain on disability benefits because successive Governments have neither the jobs, training opportunities or another world war to occupy them, whilst people like me are thrown onto JSA and told that after six months their benefit will stop. It is equally a scandal that adults who have never contributed, or contributed very little, to the public purse are granted civic parity with those who have worked long and prudent lives and who,
when illness strikes before retirement, are told that their private pension pots are to be means-tested. Some incentive to plan for retirement!

If the ATOS experience is one that is to be repeated within the creeping privatisation of the NHS, the beneficiaries of this brave new world will not be the ‘customers’, but rather the shareholders based in Dubai or Boston.

*March 2011*
MR JOHN HEEPS
YM672384C

ATOS MEDICAL  27/10/2010

I wish to appeal against this decision on the grounds that:

1. my ongoing pain and discomfort at this stage of my recovery will render me a less than an effective and productive addition to the workplace

1.1 It was made clear to the HCP at the outset that pain was my major issue, yet this is not remarked upon in the summary. That would be understandable if there were no clinical evidence to substantiate this declaration, but there demonstrably is. My ability to squat once or lay down on the couch once were achieved in spite of the pain in my shoulder. My shoulder is in a permanent state of dislocation because there is no surgical procedure available to replace the muscle and ligament removed during surgery to enable the head of the prosthesis to engage with the shoulder cuff. The most comfortable position for my arm is resting at my side or at 90 degrees to the vertical. I have been provided with a surgical harness which provides some psychological support, but in truth little that alleviates either the pain or the dislocation.

I have been assured that with time, physio and hydro-therapy that the pain will diminish as the operation heals and other muscles in the shoulder strengthen and compensate, but as my consultant says ‘will have only very limited function’. This disability will not prohibit a return to a career in Information Technology or indeed any office-bound occupation as there is voice-activated software available to work hands-free, pain however will. The summary states that I use a computer at home for a hour at a time, but does not say that this restriction is due to pain. My own setup is not ergonomically correct and unless the keyboard is on my lap, am forced to type and perform other functions one-handed.
2. the non sequitur of a final judgement upon my condition

2.1 The judgement that ‘my disability amounted to a ‘**moderate impairment of the shoulder**’ is not the logical inference that can possibly be drawn from the clinical record, my declarations as summarised by the HCP or the demonstrations of my physical difficulties.

‘**It was also noted that Mr Heeps had difficulty using a pen in their right [my dominant] hand, but appeared to have no difficulty getting out and handling papers with both hands**’.

What is being said here? If the writer is stating that the latter activity in some way qualifies the degree of difficulty of the prior activity and of the shoulder, it is a misdirection. I can use my lower limb, elbow to fingers. I can remove and insert papers in an inside jacket pocket as long as the hand is not required to reach head height. Writing, and using the lower arm for other restricted activities are entirely different. As I have discovered, writing is primarily a shoulder movement. As demonstrated to the HCP this involved a clumsy mechanical performance of physically lifting the right arm by the wrist onto the paper and guiding it across the page. This describes **‘difficulty using a pen’**.

The HCP seems to have come up with the equation:

\[
\text{functioning elbow + non-functioning shoulder [0 directional rotation]} = \text{‘moderate impairment of right shoulder’}
\]

This inference was either a moment of temporary illogicality or my integrity was being questioned. I’d rather it were the first.
I speak as a carer for a disabled relative, about to be put through the transfer from Incapacity Benefit to ESA who has grave concerns about this whole process, and the impact on the disabled community, who are suffering as a group from a distinct lack of protection from government and a duty of care. Their human rights are being eroded, which is a sad and worrying state of affairs for a modern civilised country to be connected with. We should be cherishing those that need our help, not traumatising them by threats and punishments. If all the people currently living independently in the community are forced into institutions by these measures, how will this government be seen by others, and where are all these institutions? I don’t want to see disabled people begging on street corners in this country, or on back-wards of hospitals, don’t let this government take away their dignity and rights, and turn back the progress made.

1. The whole process from start to finish is almost designed to terrify the most vulnerable people who receive the initial notification letters and forms. Disabled and sick people should not be put under such strain, and speaking as a carer who is anticipating this process i feel terrified too. So much is at stake, for people who are only just coping now. The support offered i believe will be very patchy, and with so many people being reassessed together there will not be enough time to look after everyone, even if it were the intention.

2. The WCA is designed I believe to catch people out, and vulnerable people will very often say things that can be misconstrued or perverted to fit the tick-box culture of the WCA. Atos are paid by results and the results they seek are to get as many people off benefits as possible, their judgements and techniques are tarnished by profits, they have no interest in the person in front of them, they do not know the person’s history, they are computer driven operatives, well-paid and detached from human misery. The centres of examination are processing plants for the vulnerable to be led through and out the other side, impersonal and scary places for people both physically and mentally to be put through.

3. People would have more confidence in the system if it was not run by a money making enterprise like ATOS, and that evidence was taken from a claimants, records, medical history, GP reports, other medical people involved with the claimant, carers both from outside agencies and their own personal carers , and more importantly from the person themselves, who knows better than anyone, if they have any hope of working again. Many more people should be exempt from this process, and should be told that as soon as possible so that they can stop worrying, which in many cases is causing their condition to worsen.

4. Appeals should be much more straight forward and quicker, people shouldn’t be left for weeks not knowing their fate. As soon as an appeal is lodged, they should know how long they will have to wait for a decision. Their benefit should remain intact in every regard, until the appeal is resolved. Then the decision should be given
in clear language and as positively as possible, with as much help as required for the individual and their carer as possible.

5. The whole ESA benefit is deeply flawed even Professor Gregg has said this. More people need to be in a safe place, not enough people are in the support group, and those in the WRAG groups are placed in a deeply insecure and stressful situation. Not fit to work but having to jump through hoops, and then after a year dumped on JSA, losing benefits and support, and who knows the roof over their heads too. Constant re-assessment is cruel and costly, people can never relax, always having to prove their disability or illness, for fear of losing benefits. The disabled community should not be put through this terrible ordeal, they should not be lumped together and treated as if they do not have special needs e.g asking a blind person if they are still blind is the ultimate cruelty.

6. I believe the national roll-out should be halted, until everyone is satisfied with the findings of this investigation. I also believe that ESA should be scrapped and the existing benefits in place for disabled and long-term sick should be left in place essentially, but reviewed in a totally different and fairer way.

March 2011
It would appear to myself that the WCA would be seen to be fairer should more consideration be given to medications that are being taken by claimants on a regular basis.

It is commonly accepted by the medical profession that the gold standard for treatment of severe pain is Morphine and Fentanyl...

Paragraph A3..It is common practice in the medical profession that the administration of the aforementioned drugs is not taken lightly and it follows that it would be right to assume that patients receiving these drugs for pain control are indeed suffering with conditions that exhibit severe pain.

The WCA does not give adequate protection for people who are suffering great pain and as such it fails both the DWP and the claimant, this being the case it could be argued that the WCA is not fair/just in this instance.

It would be reflective of a caring and fairer WCA if provision was given for persons who are taking strong analgesia medicines to be found to satisfy the WCA on the grounds that notwithstanding their disability/illness that by the taking of such medicine they would be a liability in the workplace by virtue of the effects that the medicines would have on their mental/physical performance.

The above mentioned criteria are in my opinion sound in basis and deserve to be implemented without further consultation, they are in fact common sense and to ignore them would leave people open to serious injury in the workplace when it could be argued that people on such strong medicines should not have been in such a position in the first place. The question of liability would in my opinion hover tentatively over the heads of those in a position to order such instances to occur.

I therefore respectfully submit to the committee that great thought be given to this matter in the interests of fairness and in the name of humanity, given the named medicines are given for severe pain I see no reason whatsoever why an individual should be forced to undergo the WCA and be found fit for work and consequently put their health and that of others at serious risk.

In conclusion the following medicines are in my opinion reasonable indicators of serious pain/conditions, Morphine, Fentanyl, Pethidine, Temgesic, Methadone, Diamorphine, these all assist in the relief of severe pain ...although not exhaustive weaker medicines such has Tramadol do not qualify. It is a common belief of the layman to believe Tramadol is as strong as Morphine when in actual fact it is only for moderate pain at best.
It has been my pleasure to submit this suggestion to the committee in the hope that changes for the good of all can be made to the WCA and confidence restored to the end user ...it just cannot be right that people suffering severe pain be ignored and found fit for work ...the Government has a duty of care to look after those that are in need of assistance whilst at their most vulnerable in their lives, I trust that they will not be found wanting.

March 2011
Written Evidence submitted by Dr Sarah Campbell

Summary:
I was a new ESA claimant in March 2010. My main problems with ESA have been as follows: inaccessible format of the ESA50 medical form, unnecessary reassessment just months after the initial decision and a basic error on ATOS’s part leading to removal of the benefit with no warning.

Inaccessible format of form:
The initial ESA50 form I am required to fill out has no accessible electronic format. I am unable to write and so have to ask someone else to fill it in, which given the personal nature of the questions is very embarrassing. It took 3 hours to fill in the first time with someone copying my answers I had typed out on my laptop. This would cost me £30 if I employed my carer to do so, and would take away 3 hours of care as social services do not provide for this sort of thing in my care package.

It is also a huge task for me to undertake. Everything else has to be put on hold. It took me over a month to fill out the form and was totally exhausting. I got into trouble from other government bodies for not filling in their forms as I was unable to do more than one at a time. For example I was late with my records for direct payments specifying care receipts and was told that care could be withdrawn as a result.

Reassessing support group claimants months after their award:
I was put into the support group without difficulty. However incredibly, despite having an incurable and progressive condition and despite having since been awarded indefinite both High rate care and mobility DLA, I was called for reassessment just 5 months later. It is impossible for my situation to have changed. All this can do is cause stress and problems for the claimant and waste time and money.

Withdrawal of benefit with no guarantee of reassessment due to ATOS error:
I was sent a new ESA50 to fill in. Although I sent the form in plenty of time, I received a P45 to be given to my new employer the day after it was due with no letter of explanation. I discovered that my ESA had been stopped with no warning. I eventually found that they claimed never to have received my form.

Rather than find out why, they had declared me fit to work and stopped my benefit from one day to the next. I am allowed to send in the form again and the decision maker can then decide if my reason for its lateness is satisfactory. If so my case will be reopened. If not, then I have to start a whole new claim. In the mean time I have no money coming in.

It is astonishing that non receipt of a form through no fault of their own means that a severely sick and disabled person can have their only source of income cut off and be declared fit to work with no guarantee that their reassessment will continue.

March 2011
I work in General Practice assisting patients with social problems, which includes assisting with Benefit claims and related issues. I am well aware of the points system, but even I find the ATOS report long winded and confusing when I am trying to check and explain to patients what the assessment is saying about their ability under the various headings. It seems like it is written to confuse.

I also wonder if there could be a highlighted sentence in the refusal explaining that although some people have medical problems the government wants to help as many as possible back into work suitable for them. Many people I see are angry at being assessed as having no problem, particularly when they have been getting IB and have had no change in circumstances. They don't understand it.

The current jobs market doesn't help, for claimants feel if most people can't find work what is the likelihood of them getting it.

March 2011
Written evidence submitted by Peter Higginson

1. The government has appointed a private healthcare body, ATOS ORIGIN to undertake the disability assessments of the long-term sick from February 28th 2011.

2. It’s important to notice that whilst these interviews are called medicals, they are in fact functional observational tests to determine whether claimants are telling the truth on their ESA50 claim forms. The model for the software used on the ATOS computers is taken from insurance company interviews to disprove the validity of a claim for disability, and the onus upon the examiner is to discover the functionality that the claimant *does have* on the day, rather than the history, testimony and description of their illness by their GPs and Consultants.

2b. With a fluctuating condition like schizophrenia, a highly medicated patient will undoubtedly pass the functionality test because the descriptors require there to be a psychotic break in communication or evidence of harmful behaviour on the day of the interview in order to score any points. Any testimony as to the effects of stress, changes in mood, and the appalling nature of the infrastructural pain of schizophrenia, is marked as not relevant on current evidence (94% of trialled claimants were passed fit for work).

3. If the patient demonstrates his psychosis however then the session can be ruled invalid because of the failure of the claimant to understand the process. Or it cancelled on safety grounds. So there is a *double-bind* written into the base of the tests for the mentally ill.

4. Over the next three years the DWP will test 1.5 million claimants on these grounds, of whom approximately 500,000 have a severe and enduring mental illness. You can see how there is a potential here for a disaster in mental health services as patients’ benefits are cut by up to 80% and they are sent to the Job Centre to look for work they cannot do, or that does not exist.

5. The danger with severe mental illness is that when patients are faced with double binds coupled with punishing sanctions, they naturally turn to suicide or contemplate violence as a solution to the impossible problem.

6. In my own case I will almost certainly pass the medical because I cannot demonstrate my condition without coming off the medication and letting
the psychosis I bear manifest itself. This would represent a serious
danger of harm to myself and others, and is heavily contra-indicated by
medical practice. So I am frightened as I contemplate this problem,
which actually represents a ‘psychotic’ proposal to the claimant.

March 2011
I am writing to give my personal experiences of the WCA, ATOS and the way my claim was proceed by the DWP Jobcentre plus.

1) I have now undergone two WCA, the first in 2009 and the second in November 2010. Both were carried out by nurses who I feel did not have adequate knowledge and understanding of mental health difficulties.

i) The First assessment lasted aprox 20min and I was asked questions about my physical ability to perform tasks, I was also asked about any emotional, cognitive or behavioural difficulties. I answered the questions in as much detail as possible while showing the assessor documentation to back up what I was saying. I found a lot of the questions to be very misleading, ie, I was asked if I had an active bank account in which my benefits were paid in to, I answered yes to this question as my money went in to my account rather than receiving a giro as I am not very good at managing my money. My answer to this question was used against me to say that I had no difficulties managing my finances.

I received my results of the WCA and scored 0 points, I them went to appeal and within apox 15min I was awarded 15 points and was then awarded the full benefit.

From the line of questioning in the WCA I feel it is impossible to get any points for the descriptors because when you try to answer a question the assessor scrutinises your answers. For example, when I was asked if I could prepare a meal for myself I

ii) My second WCA took place in November 2010, the assessor was a nurse and the assessment took aprox 30min. I was asked the same questions relating to physical and mental ability for completion of tasks and again many misleading question. For example, I was asked if I see my GP for any treatment, I said that I saw my GP twice weekly to pick up persecutions and to review my progress as my GP was in the process of changing my antidepressants as my old ones had been discontinued. This was used as evidence that I could cope with social situations as I left the house to do this. I was asked if I had any contact with friends or family, I said that my dad came to see me once a week make sure I was generality ok. This was used against me to show that I could cope with social situations. I was also asked if I had a bank account and if I had an address where I received post, this was used as evidence that I had no difficulties managing my affairs. As I did last time, I provided evidence to support my claim. The assessor refused to look at it saying that it wasn't important. This has been used against me stating that I did not provide supporting evidence.
explained about my paranoia with using the cooker and fear of forgetting it is on and burning food or myself. I added that I used microwave meals and get take out. The assessor questioned me saying things like "but you are physically capable aren't you and I'm sure you could make a sandwich if you really needed to?" I had to answer yes to this because I am physically capable; it is mental health reasons that stop me. I scored 0 points for this assessment and I am currently waiting for appeal. I have been told that I might not be seen until August but my representative is going to see if I can get seen sooner. I honestly don't know what I would do if I didn't have help, this has already caused me a huge amount of stress.

iii) I found the attitude to the assessor from ATOS to be very confusing. On one hand, when I was giving my history my condition and what caused it, she was very sympathetic, saying that she was very sorry to hear what I had been through. When I told her that I was really worried about the outcome of the assessment because I had failed the last one and had to go to tribunal, she was sympathetic and said that she understood how traumatic the experience can be for people with mental health problems but that there was nothing she could do about it as see is in no way involved in the process. On other occasions I found her to be very uncaring and felt that she didn't understand me. I was feeling very nervous at the assessment and very self conscious so had my hood up, she asked me to take it down and I explained how I was feeling and that I was sorry, she was very sharp with me and it upset me. She hardly looked at me throughout the whole assessment and even provided a description of me in the written assessment that was inaccurate, in my opinion, proving that she wasn't paying attention. I explained to her at the beginning of the assessment that I get very flustered and find it difficult to put what I mean in to words when I am under pressure, even after telling her this she was very pushy when asking questions and seemed to just want to get it done as soon as possible without taking my needs in to consideration. I would have appreciated it if she had taken her time more and let me put more time in to my answers so she could get a better picture. I have a lot of phobias and beliefs that many people would find strange when I am having a really bad time, for example, I have a fear of vomit that stops me being around anyone who might be sick, I also have a problem with thinking that people are angry with me so avoid speaking to people on the phone. I felt that the assessor didn't take these things seriously and many weren't included in the written assessment. I think things like that should be looked in to because they do impact my ability to work and engage in social situations.

iii) My overall experience of the process has and still is very bad. I strongly feel that the WCA is not fit for purpose and is letting a lot of people down. This whole thing is causing me a huge amount of stress which is making my condition worse and as a result I worry that it will take longer for me to be in a position where I could get a full time job. Like many people who suffer from mental health problems and physical
problems I want to work, it's just that at this moment in time I am not ready. I have pushed myself too hard in the past and kept going with a job when everyone around me new I was too ill to work just so I didn't have to go through the system again. Each time I do this I end up in a much worse position, having a breakdown and having to try and build myself back up again. Each time I fail a WCA and have to go through the appeals process it knocks me back further from my goal of being fit enough to find work in the future. The WCA needs a serious overhaul, I can only speak from my experiences of going through it with a mental health problem (GP thinks I have BPD) and it is not a nice one. My problems are fluctuating, I might be really happy and hyper one day, not really looking out for myself and doing stupid things that might get me in to trouble, another day I might be so low that I can't move and want to kill myself, another day I might be slightly psychotic and want to hurt myself in strange ways, it is very rare that I have a day when I am completely ok and "sane". The WCA needs to take this in to account, it is not fare if my assessment happens to fall on a day when I am coping relatively ok and how I feel other times is not taken into account. I also think that evidence provided by GPs and other health professionals should be taken in to account. My GP knows a lot more about what I go through on a regular basis that a nurse who sees me for 30min. I think it is important for the assessors to have some background knowledge of the conditions affecting the claimant they are assessing. It is like getting a random person off the street to assess someone with a complex neurological condition, the results aren't going to be accurate. I also think that the time between assessments needs to change. I had my previous tribunal in March 2010, I was then called in for another assessment in November. If the DWP had looked at my records they would have seen that it would have taken a miracle drug for my condition to have got better in that time and there are some people who are being reassessed every three months. This practice waists tax payers money, it would be far more efficient for someone from the DWP to look over the claimants file and assess whether or not their condition is likely to have changed, for example, if a claimant has MS or an inoperable brain tumour, the likelihood of their condition getting better is very slim.

2) From my experience, the decision making process is not adequate. The decision is only made from the ATOS assessment which is not accurate and the questionnaire that the claimant has filled in. You should be allowed to submit evidence from medical professionals to back up your claim. I think the thing that frustrates me the most is that once a decision has been made that isn't in your favour, you are told you can submit supporting evidence to show why you think the decision is wrong but the DWP do not send you a copy of the report, so you don't know what questions you are challenging. When I submitted my appeal to be looked at again I requested a copy of the assessment so I could put together some good supporting evidence, but after a month I received a letter saying the decision could not be changes and that I did not send in any supporting evidence. I had not received a copy of the report so I feel this was very unfair. It would be nice to at least
be given a chance to defend ourselves. I think it is wrong that if you request information from the DWP they do not have to send it to you, how is anyone suppose to put forward a case when they are not allowed to see what they are challenging. What I would like to see in the way decisions are made is:

i) A questionnaire that is suitable for all types of illness and disability. The questions need to be more rounded so that you are not excluded if your condition doesn’t fit a question 100% you are not excluded. For example: Part 1 question 11 Staying conscious when awake :- I suffer from dizzy spells and vertigo caused by anxiety so most of the time when I stand up I get a white fuzz over y eyes and nearly fall over, this can be hazardous when crossing roads etc. I had to answer no to this question because it says that it is specifically for conditions like epilepsy where you have a fit or blackout or go in to diabetic shock, what I experience is not on the list. Part 2 question 18 Going out:- In the second part of this question it asks if you feel you cannot go out even if someone is with you, you can only answer yes or no. I had to answer no to this question as I do not feel like that all the time; my condition varies so there are many times when I feel I cannot go out without another person with me. The way this question is worded means that if you have a condition that varies you have to answer no and therefore, loose points. There are also any questions that are very misleading, I had someone fill in the questionnaire for me and they were confused. For example, In part 2 of the questionnaire, the questions start of asking if you can do things with the options usually, it varies and not very often, then on question 15 the wording suddenly changes, asking if you have difficulty doing things with the same options. For someone who has difficulties filling in forms this tactic of changing the wording for the question is very unfair and may lead to any people ticking the wrong box. I am dyslexic so if it wasn’t for the person helping me rereading the question just to make sure, I would have picked the wrong box. There are also only 10 sections for mental health which quite frankly is not enough, mental health very complex and cannot be assessed with such few questions.

ii) I think the WCA needs to be more thorough. People are different and a condition is not going to affect two different people in the same way. Some ailments are quite easy to assess, like if someone is a quadriplegic or is blind, but others are far more complex and would need a more in-depth assessment. From the side of mental health I think more time should be given to gain an accurate history and understanding, also claimants should be given more time to explain how being in a working environment would affect them. Variations in mood and behaviour should be looked at more thoroughly and on an individual basis rather that asking set questions. I know that the whole thing is done via a computer program and that is going to be difficult to change but I think a lot can be done with choosing the right person to carry out the assessment. If an assessor has got good training with a variety of mental health conditions, having a good amount of time with the claimant to properly discuss the way their condition affects them should aid them in filling in the questions on the system adequately. From my experience there have been a lot
of problems with the assessor not fully understanding what the claimant is trying to say and this is worsened with the feeling of being rushed.

I don't really want to muddy this up but I truly think that the assessments need to be carried out by professionals who are unbiased and are carrying out the assessments to gain an accurate account of how a claimant is affected by their condition and not more concerned about numbers and deadlines, as I truly feel that that is ATOS's main focus. I find it very disheartening that ATOS healthcare are using methods for assessment brought forward by Prof Mansel Aylward, head of research at Unum Provident in Cardiff. This is the same company that was sued in America in 2002 for $31.7 million for running "disability denial factories". Again, I am sorry for bringing this up but it just worries me a lot.

3) I have been through the appeals process twice now, the first time I was successful and the second is ongoing. The first time I was quite happy with the way things were run, I waited about three months for my appeal to be heard and even when I had difficulties the staff were very helpful and supportive. I received all the information I asked for in good time and when my appeal was heard a decision was made very quickly. The people who heard my appeal were patient and listened to what I had to say.

The appeal I am going through currently is unfortunately taking a lot longer; I have been told that this is due to a high number of appeals being heard at the moment. Although I am having to wait they were very prompt in sending me all the relevant information and including details of organisation who I could contact for help and advice. In all I am happy with the way this is run.

March 2011
In October 2010, an initial letter was received by Mr. G. (my patient), requiring that he make contact, or risk his benefits being stopped. Mr. G. who has an extensive history of Paranoid Schizophrenic Illness, became very anxious about the process from this point, until its eventual resolution in January 2011.

By 5th November 2010, he and I had completed the form, and posted them off. In the form, we made explicit that:

i) His illness means that he requires assistance to communicate with people he doesn’t know well;

ii) his illness and its treatment mean that his day starts around mid- to late morning;

iii) I would attend any appointment with him.

He received an appointment for 08:50am on 23rd November.

Mr. G. contacted me, and I contacted the relevant agency on his behalf to reschedule the appointment with reference to the previously described information. A new date could not be arranged at that time because of their diary constraints. I was advised to call back on 21st/22nd November.

I called back on the 22nd November, and was informed that any rescheduling information could not be shared with me because of the Data Protection Act. Eventually, and following an impasse, this was resolved and a new appointment agreed for the 16th December at 11:00am.

Arrived with Mr. G. at ATOS Aberdeen at 10:45am-(we’d been told to arrive ten minutes ahead of the appointment time)-in blizzard conditions. The waiting area was full of others who’d been there for more than an hour. We were finally seen at 12:15pm having had no explanation for the delay, and having to request that the heating be increased in the waiting area.

The medical assessment lasted for one hour, and appeared to consist predominantly of the doctor transcribing information from the original assessment form, onto the computer.

Mr. G. was contacted in January 2011 and informed that he’d transferred from Incapacity Benefit to Employment and Support Allowance (Support Group)-much to everyone’s relief.

April 2011
In 2008 the previous Labour government introduced a new benefit for the sick and disabled called the Employment Support Allowance (ESA). The new benefit replaced two existing benefits for new claims on its introduction but at its heart were two major differences. First, was a new test called the Work Capability Assessment (WCA), to determine eligibility for the benefit and for the majority of claimants, called the Work Related Activity Group (WRAG) there was to be a new regime of personalised support and engagement to help people back to work (which I designed). The new regime initially applied only to new claimants but this week existing claimants are starting to be re-tested under the new WCA test and may potentially be reclassified as Fit for Work.

There are two major reasons why getting this transition process right is critical. First, this is a large and vulnerable group and thus the introduction of the new benefit eligibility test has the potential to cause huge anxiety and distress to people. Many, especially those with mental health problems, may well fall into the sizable crack between ESA and JSA (unemployment benefit) and end up destitute, homeless or worse. Second, those denied access to the benefit are likely to end up on unemployment benefits which are not designed to help sick people back to work. Under the new Work Programme providers are paid to get claimants into sustained work are divided into three groups, the first are mainly adult unemployed who receive help after 12 months claiming benefits. Here the payment to a provider for getting them into work for a year will be of the order of £3500. Those “being found fit for work” and hence signing on as unemployed rather than disabled will normally be allocated to this group, although if they were previously claiming Incapacity Benefit they will get the help after 3 months. For those on ESA the package of support starts immediately and providers will be paid about £14,000 if they get someone into work for two years. Getting the sick and disabled in the right category thus matters greatly in terms of the chances of helping them into work. Those on unemployment benefits with significant barriers to work may well be ignored by providers as offering little hope of a pay off given the high investment needed to get them back to work.

Given the imperative of getting people into the right category, common sense would suggest the Government should move slowly and check at each stage that any changes were working. So starting with new claimants makes sense and a five year review process was specified in the original legislation I believe. Yet the developments so far have been deeply flawed. Concerns with the WCA test emerged in late 2009/early 2010 with strong reports of major problems, especially around individuals with cancer, mental health problems and variable conditions. It also emerged that a huge number of cases were going to appeal, jamming the system, and often being overturned. The Government responded with changes to address these issues, but there
were no subsequent checks that the problems had been dealt with. In fact, the cries of anguish continued unabated. In the summer of 2010, Prof. Malcolm Harrington was commissioned to undertake the first major review and it was quickly apparent that he saw the need for extensive changes to the process of the decision making after the test was undertaken. Furthermore, the DWP was also internally reviewing the medical test. Yet the first trial of the WCA test on existing disability claimants went ahead in Burnley and Aberdeen on the old test and the old decision process. So now as the medical test goes national the new regime outlined by Harrington and the DWP internal review is being implemented with no prior testing. The Government claims these changes have fixed the earlier problem and undoubtedly the Harrington Review will have made a difference, but surely it should be tested and checked before being applied nationally. It is baffling why the trials in Burnley and Aberdeen were not delayed just 4 months to test run the new regime. Likewise it is clearly essential to track the progress of those denied access to the new benefit, especially among those previously claiming Incapacity Benefits, to study what is happening to them. Are they moving to JSA, getting jobs or suffering acute deprivation without any financial support? By tracking people according to what conditions they are presenting with, we can assess which conditions are not being picked up well, if groups fail to move into work. But again no such research or tracking is apparently being undertaken.

The process seems to have been characterised by undue haste, a lack of testing and immediate assessment. It may be that this derives from a view that those denied benefit will be healthy and undeserving of support, rather than emphasising the risk of vulnerable people being treated inappropriately. This has become an interactive process of changes being followed by a chorus of complaints, revision, a wait to see if complaints diminish, and further revision when they don’t. The current national roll out will not be the end regime but just the latest iteration in my view. This is no way to introduce such a fundamental reform affecting so many vulnerable people.

March 2011
Written evidence submitted by the North West Mental Health and Welfare Rights Group

The North West Mental Health and Welfare Rights Group was established in 1998 for Welfare Rights Advisers who deal mainly with people with mental health problems and meet regularly to discuss issues pertinent to this client group. The NWMHWR group is made up of a number of organisations across the North West (e.g. from Sheffield to Liverpool), including Local Authorities, CABx, Voluntary Agency’s, Health Trusts, Housing Associations etc. It is the only known such group nationally, with people from other areas on the mailing list for minutes, information etc e.g. Broadmoor Hospital advice workers. The aim of the group is to share knowledge, information and good working practices in the specialist area of Social Security Benefits and Mental Health.

This report has been compiled and agreed by the group, with individuals providing examples of difficulties experienced by their clients.

- Communication

We welcome the fact that it has been recognised that measures need to be put in place to explain the migration process to vulnerable customers. However, we hope that it will also be recognised that any form of communication may be a source of stress for customers with mental health problems. We hope that DWP will take into consideration some of the barriers faced by this client group such as anxiety about talking over the telephone, feeling intimidated by people in authority, language problems, literacy problems and lack of insight into their mental health problems.

It is important for DWP staff to remember when giving decisions over the phone that decisions are complex, at times controversial, and carry a right of appeal. They need to be mindful that the information needs to be conveyed in a fair and neutral way, so that customers are not dissuaded from appealing.

The lines of communication should be consistent so that advice workers can correctly advise people on what to expect during the process.
There is no reference in the descriptors to self harm/suicidal actions, psychosis or severe self neglect. The previous PCA did not include this on the presumption they would be covered by the Severe Mental Illness (SMI) exemption – although this was not always the case in practice. Most people with a severe mental illness have a [enhanced] CPA (Care Programme Approach) with intensive support from Mental Health Services and are not in a position to undertake work related activities, which could cause deterioration in their mental health with associated hospital admissions.

**Example:**
A was on CPA with bi-polar and had multiple incidents of deliberate self harm. WCA assessed her to be ‘normal, adequate, no ideas of self harm, good insight’ and awarded 0 points. First-tier Tribunal placed her in the Support Group.

**PROPOSAL:** include self harm/suicidal actions, psychosis, or being under an [enhanced] CPA in the Support Group criteria.

Many people with severe mental illnesses spend periods in psychiatric hospital after either voluntary admission or under section of the Mental Health Act or remain in community under intensive support of a Mental Health Crisis Team to prevent hospital admission. A WCA is often arranged within weeks of discharge, when the person is still trying to re-establish themselves and become stable in the community and needs time to do this to prevent deterioration and re-admission.

**Example:**
C had psychiatric hospital admissions 11/08-02/09 and 09/09-12/09 when received ECT causing memory problems. Attended WCA medical 02/10 and Disability Analyst assessed treatment as ‘average strength’ and failed the assessment.

**Example:**
D has paranoid schizophrenia with psychosis, receiving anti-psychotic depot injections, under the care of a Consultant Psychiatrist, weekly CPN visits and discharged from psychiatric hospital 1 month prior to WCA. CPN accompanied to WCA. Disability Analyst awarded 0 points, First-tier Tribunal put in Support Group.

**PROPOSAL:** people discharged from psychiatric hospital/ under Crisis Team are put into the Support Group for initial 3 months after discharge.
Some people with mental health problems are discharged from hospital under a Community Treatment Order or under section 117 After Care, with ongoing intensive input from Mental Health Services.

Example:
E was detained in hospital under section 3 Mental Health Act and discharged on a Community Treatment Order. Underwent WCA less than 3 months after discharge and assessed by Disability Analyst as having a ‘mild mental health condition’ and awarded 0 points. DWP Decision Maker returned this to ATOS to query and ESA85 returned with assessment changed to ‘moderate mental health condition’, but still given 0 points. First-tier Tribunal placed in Support Group.

PROPOSAL: people discharged from hospital under a Community Treatment Order or S117 of the Mental Health Act are put into the Support Group

Exemptions
There is no exemption for people with SMI, or in receipt of Highest Rate Care Component (HRCC) of Disability Living Allowance (DLA) (as previously was under PCA for Incapacity Benefit). This means people who may need a high level of supervision; monitoring and support to enable them to live in the community have to attend medicals, often in busy cities, some distance from their home. Many such claimants living in the community do not have any warning of or are unaware of any relapse in their condition until they reach crisis point. This can happen at any time or may be due to a claimant ceasing their medication as they feel they are better.

Example
F has severe depression with psychosis (aural and visual hallucinations day and night), panic attacks and insomnia. F is under a Psychiatrist, receiving anti-psychotic medication and in receipt of HRC of DLA. F’s CPN accompanied F to WCA. Disability Analyst assessed claimant as having mild mental health problems and awarded 0 points. First-tier Tribunal allowed appeal on evidence without requiring oral submission from claimant.

PROPOSAL: people with SMI or in receipt of HRCC of DLA should be exempt from the WCA and placed into Support Group.

Mental Health Champions
Where someone has a lack of insight into their condition and does not think they are ill, Disability Analysts often take the claimant’s word at face value, without the time to undertake a more in-depth assessment to reveal their actual problems.

Example:
G has paranoid schizophrenia but does not accept this, stating she only has stress. Disability Analyst assessed her as having anxiety and depression with good insight into her illness and failed WCA.

Example:
H is delusional, hears voices, has severe paranoia and thinks he was kidnapped and kept locked in his own house for 3 weeks (was in psychiatric hospital) and discharged just prior to WCA. But has no insight, thinks he is well and shouldn’t be on benefits, trying to sue hospital over wrongful admission. Disability Analyst awarded 0 points.
Although we welcome the proposal from Professor Harrington’s review of the WCA that a Mental Health Champion for each ATOS assessment centre has been implemented, we are concerned that this role has been given, at least in our local area to a member of Jobcentre Plus staff on top of their other duties.

**PROPOSAL:** Community Psychiatric Nurses to be recruited by ATOS to be the Mental Health Champion in each area. This champion could assess claimants with mental health problems, give training on mental health to their colleagues and spread good practice.

**Delivery**

Claimants report experiences of Disability Analysts’ lack of interest, rudeness, not listening to their answers, cutting them short when trying to qualify/explain their answers, not looking at them whilst asking questions but just typing into the computer.

**Example**

L attended medical where the Assessor diagnosed client with hearing problems despite all the medical evidence indicating mental health and learning difficulties. No history of hearing impairment. Client has difficulties with communication due to mental health and learning difficulties.

**PROPOSAL:** Disability Analysts are provided with further training on Customer Care and given more time to undertake medicals.

**ESA 85 Reports**

ESA85 design fault in ‘drop down’ boxes and multiple reference to an absence of the most severe symptoms e.g. ‘no rocking movements’ purporting to indicate there is little problem present.

**PROPOSAL:** ESA85 be adapted so that the Disability Analysts cannot just cut and paste the same information to justify each descriptor, but give individual reasons for their decision on each descriptor.

**Exceptional Circumstances**

There is often no evidence that the Disability Analyst and Decision Maker have given any consideration to Exceptional Circumstances such as substantial risk to the mental or physical health of any person if the claimant were to be found capable of work (ESA reg 29) e.g. due to deterioration in mental health/increase in self harm/suicide risk/hallucinations/psychiatric hospital admission.

**Example**

M was found fit for work. No account was taken to the ongoing treatment from Mental Health Service Providers to the detriment of the clients mental health. Mental Health providers have been extremely worried about possible relapse.
PROPOSAL: Decision Makers should demonstrate they have considered Exceptional Circumstances and if not applied give a full explanation as to how this decision has been made and what evidence was taken into consideration.

Assessment Centres
Where people with mental health problems cannot travel to distant busy cities for the WCA (e.g. Manchester) it is difficult to arrange/get agreement for a taxi or a domiciliary assessment. There are no disabled parking facilities at the Stockport venue. These factors increase the risk of benefit being stopped due to non attendance at the medical.

Example:
N completed an ESA50 requesting a Domiciliary with reason. No contact appeared to be made with GP or Care Co-ordinator. Despite this he was still asked to attend a medical in person. Eventually after several letters and calls a Medical Assessor attended his home. Assessor was invited to his room because he very rarely leaves his bedroom. This was declined and Assessor had a brief conversation with N’s Dad. As a result of this visit N was placed in the Work Related Activity Group and asked to attend a further medical again in person.

PROPOSAL: more local centres where WCA’s can be carried out.

Fluctuating Conditions
Where someone has a fluctuating mental health condition e.g. bi-polar disorder, which can involve severe low and high moods, a one off WCA assessment cannot reflect this condition and its effects on the claimant. The ESA50 is very hard for a claimant with such a condition to complete the answers depending on what part of the cycle they are currently in. For example the distinctions between often / frequently/ for the majority of the time on the ESA50 are often meaningless to claimants.

Example
Q was in a heightened state of mood, believing he was invincible. He completed the ESA50 without any help. Unfortunately in this state there was little insight into his illness believing he was well and subsequently was found fit for work.
PROPOSAL: ESA50 wording should be changed to reflect fluctuating conditions. Disability Analysts are given more training in fluctuating conditions, and where diagnosis suggests this e.g. bi-polar, be particularly aware of taking a snap shot picture of the claimant’s difficulties.

Equality Considerations
People from some cultures can have difficulty voicing and describing mental health problems due to associated stigma/ lack of appropriate language/words, and these can therefore be missed at the WCA.

Example
T, a female Asian client was assessed by an Asian male Doctor despite requesting a female. She felt he was biased towards her due to cultural differences and found it difficult to be open with him about her mental health problems.

PROPOSAL: Disability Analysts are trained in cultural issues in relation to mental health and are given more time to undertake the medical in order to do a full assessment.

• Decision-making Process
Consideration should be made for whether ESA Reg 29 applies (exceptional circumstances).

It would be good if there was training for all decision –makers on common mental health conditions and symptoms so that they can spot cases where it is useful to request further medical evidence from client’s G.P ,C.P.N etc

It would be good if D.Ms had directions to fully scrutinise ESA85s in order to pick up on inconsistencies.

• Appeals Process
We welcome that it has been recognised that the appeals process is very lengthy. We would like to point out the extra stress that this causes claimants with mental health problems. The prolonged uncertainty, and hardship caused by living on a lower income throughout the process, carries a real risk of relapse, and possible hospital admission, for some claimants in this group. We welcome that steps have been taken to increase the number of appeals that can be revised on reconsideration, but hope that this will be taken a step further for the migration process, by ensuring WCA medical reports are as accurate as possible, and Decision-Makers are empowered to collect further evidence when necessary.

We would like the DWP to understand that it can be very difficult for claimants to gather their own supporting evidence for an appeal. Busy GPs sometimes have a policy of not supplying tailored evidence requested by patients, and sometimes there is a charge.

We are concerned that some vulnerable claimants will still slip through the net of the appeal process, and will then need to sign on for Jobseeker’s Allowance. The added pressure of conforming to a Jobseeker’s Agreement could have a very negative impact on a claimant’s mental health condition.
• **Outcome of Migration**

Claimants who find that they do not meet the criteria of the WCA are likely to find themselves on Jobseekers’ Allowance long term. Today’s labour market is very competitive, and it is hard to see how someone who has been too ill to work for a long time can compete when there are so many healthy and able-bodied jobseekers with more up to date skills around. Sadly, the future looks bleak for many of those transferred from Incapacity Benefit to Jobseeker’s Allowance.

The proposal to time limit contribution-based ESA for those in the Work Related Activity Group to one year fundamentally changes to nature of the Welfare State. This change will leave many who don’t qualify for income-based ESA without any income of their own. This undermines that principle of the Welfare State as a system that gives financial security to those who pay into it. We are likely to see an increase in the number of appeals for claimants seeking to be put in the support group, because there is so much more to gain by this decision. This will increase the backlog of appeal waiting for a hearing at a time when it is expected to increase already.

Claimants that don’t qualify for income-based ESA because of a partner’s income will lose their financial independence because of this proposal. This will disproportionately affect women, and could have a damaging effect for those in abusive relationships.

*March 2011*
Written evidence submitted by Carole Rutherford

1. Executive Summary

- The process of communicating with adults with autism is seriously flawed and no reasonable adjustments are being made to enable adults with autism to communicate effectively throughout the process.
- The literature provided by Jobcentre plus for adults with additional support and communication needs does not include anyone who has a diagnosis of autism therefore having diagnosed communication impairment.
- The assessment process even before the process has officially begun is having a negative and lasting impact on the emotional wellbeing of adults with autism.
- Adults with autism require support from the first point of contact to enable them to communicate effectively.
- The Works Capability Assessment was not designed with autism in mind. The assessment process is therefore flawed making it almost impossible for an informed decision regarding the capability of an adult with autism to seek or maintain employment to be made.
- Very little regard appears to have been paid to Section 20 of the Equalities Act.
- Correct and appropriate must be offered to any adult who is deemed to be either fit to work or who is placed in the Work Related Activity Group.
- The training and the content of the training received by the Atos assessors is a huge cause for concern.
- The roll out and continuation of these assessments should cease until Local Authorities and Health Authorities have had the time to appoint lead professionals and establish the groups that have been suggested they establish within the strategy.

Area of Interest

2. I am the mother of two autistic sons’ one adult and one child and I have been living with autism for 23 years. I am and have been a parental supporter, supporting families who are living with autism nationally and locally where I live for ten years. I have firsthand experience and awareness regarding the Works Capability Assessments process and how it is impacting on the lives of families and adults living with autism. I am an advisory group member of the All Party Parliamentary and I was a member of the External Reference Group who acted as an advisory group to the Department of Health while they were drafting the adult’s autism strategy. I was part of the Health Chapter.

I am willing and would welcome giving oral evidence to this committee as part of this Inquiry.

3. As the parent of an adult son with Aspergers Syndrome and Keratoconus which is a complex and degenerative eye condition I have many concerns about the assessment process. My son is at the moment in receipt of Incapacity Benefit I have tried to find out as much as I can about the Works Capability Assessment and the process leading up to the
assessment. The only written material that I can find displayed on the Jobcentre plus website is a factsheet for customers with additional support and communication needs. I had hoped that this factsheet would inform me what support was available for my son. The factsheet does not mention autism. I find it incredible that a factsheet that states that it has been produced for adults who have additional support and communication needs does not mention a condition that is diagnosed using a triad of impairments, two parts of which are communication and socialisation.

3.1 At the moment my son is only aware that he is going to have to have an assessment to see if he is fit to work through news articles that he has read and watched on TV. Many of the articles that are being printed in the papers are fairly negative and are painting people on benefits as being scroungers and people who want something for nothing. My son has become very distressed by the news articles which have added to his extreme stress and anxiety. My son is fully aware of his own limitations and his awareness of these limitations already impacts negatively on his self esteem and self worth.

3.2 Adults with autism do not cope well when they are in a continual state of flux not knowing what is going to happen to them and not knowing when. The anxiety of not knowing when or what will happen during an assessment is having a negative impact on my son’s emotional wellbeing and is exacerbating all of his other anxieties and his OCD tendencies. My son has asked me to find him someone to speak to about his increasing levels of anxiety. This is however not as easy as it might sound because my son has an IQ over 70 which have thus far ruled him out of services and provisions in our Local Authority.

3.3 My son requires help in all areas of communication both written and verbal and this support will need to be offered in advance of the whole assessment process.

4. I do not believe that the Works Capability Assessment was designed for adults who are on the autistic spectrum. I have huge concerns about the assessment which is by its design a tick box assessment from which the adult scores points towards their capability to seek and maintain employment. I do not believe that that Works Capability Assessment if fit for purpose to be used as a tool to measure the works capability of adults with autism.

4.1 Autism is not always a standalone condition. There are many co morbidities that go hand in hand with autism. Adults with autism can struggle to understand their own condition and any co morbidities that they have. My son is one such adult and despite his high IQ has huge problems communicating effectively. Stress and anxiety both impact on my son’s ability to communicate. His literal understanding of both written and spoken communication impairs and there is often a deficit of shared meaning and understanding between my son and the person who is trying to communicate with him.

4.2 Adults with autism may also have other none related medical conditions as well as their autism. We have been told that my son is one in one million people who will have a diagnosis of an Autistic Spectrum Condition and Keratoconus. The two conditions do not sit well together and have had a profound effect on my son’s life and seriously impact on my son’s capability to carry out basic life skills. To date we have
found no one other than Mr Jordan, who as well as being an optician specialises in the perceptual problems experienced by those on the Autistic Spectrum, who understands the impact that having these two conditions have on my son’s life. Who will be able to provide supportive evidence detailing the impact that these two conditions have on my son’s life should he need to provide it?

4.3 There are huge question marks hanging over the training and the quality of the training that has been received by the Atos professionals who are carrying out the Works Capability Assessments. Autism is complex condition and one that requires a considerable amount of autism specific training over a long period of time before the complexities of the condition can be fully understood. It can take months and even years before a diagnosis of autism is given. The diagnosis is often given by a team of people who have all been specially trained in the field of autism. It is therefore difficult to believe that one distance learning module can in any way reflect the complex and specific nature of autism and enable an assessor to make an informed decision about the person they are assessing.

4.4 I feel that very little regard has been paid to the Equalities Act and in particular section 20 of the Act which speaks of making reasonable adjustments for anyone who has a disability. I have not heard of any reasonable adjustments being made for adults with autism who have a recognised communication and socialisation impairment. Although adults are in some areas are being advised to take someone with them for their assessment, the people who are accompanying the adult usually a parent or carer, is not being allowed to help the adult to communicate.

4.5 In order to qualify for ESA in a work-related activity group the adult being assessed has to gain more than 15 points. Making oneself understood is covered by a physical descriptor, descriptor 6. This makes no sense at all to me. The Guidance given to the assessor must include adults who have impaired communication due to a non-physical disability such as autism or a learning disability otherwise how are these needs going to be assessed?

4.6 The part of the assessment for understanding and comprehension falls under descriptor 7 which is again a physical descriptor and therefore in no way take into account anyone who had autism which is not diagnosed as a physical impairment.

4.7 If my son is going to be assessed for his capability to work I think that that assessment should reflect his condition and how it impacts on his life.

5.0 I find it difficult to accept that an informed decision can be reached regarding the capability of an adult with autism to seek and maintain employment using an assessment that does not have descriptors that reflect the condition. If my son is going to have his capability to work assessed it should be done using an assessment that was designed with autism in mind.

5.1 I believe that the assessment process must be taken into consideration the history of the person who is being assessed. Many adults with autism have been failed throughout their childhood and have never been able to access services and provision that might have enabled them to actively seek and maintain employment. My own son has not been seen by any autism specific professionals since being signed off by Children’s Services when he was
16 years old. My son will be 24 in July of this year. A failure by the system to meet the needs of children and adults with autism has resulted in limiting their capacity to do many things including seeking and maintaining employment.

6. I have grave concerns as to who will be able to support adults who find themselves in an appeal situation having had no access to support, services or provision for many years. Who will be able to provide supportive evidence for these adults?

7. The outcome of the migration process is likely to have a profound effect on some adults with autism who find themselves being declared fit to work or placed in the Works Related Activity Group. There is a dearth of understanding and qualified professionals nationally who can support adults with autism. Adults who are deemed to be fit to work or placed into the Works Related Activity Group will need a considerable amount of support to adapt to a significant change in their lives. Adults with autism often find change very difficult to negotiate and cope with. The Adults Autism Strategy ‘Fulfilling and Rewarding Lives’ has yet to impact on the lives of adults with autism. Local Authorities are still getting to grips with the strategy and the implications that the strategy has for them. Cuts are being made right across the Local Authority and Health Authority spectrum and there is a sense of hopelessness within the autism community that the changes that were both much needed and long overdue will not now happen without some considerable lobbying from the community itself. Questions are being asked about what support if any is going to be available for adults with autism, especially those who have Aspergers Syndrome and High Functioning Autism if they are deemed to have the capability to work.

7.1 Very little if any thought appears to have been given to adults who find it difficult to cope with uncertainty. When rolling out an assessment that is meant to be assessing the capability of a person to work, I would have thought it best practice to first of all take into consideration the nature of the condition that the disabled person has, and how they are likely to be affected by the news that they will have to have an assessment. No regard appears to have been given to the way in which an adult with autism in particular might react to this news and how it might affect their emotional wellbeing. Uncertainty creates anxiety and stress and the longer the uncertainty remains the greater the level of anxiety.

8. I believe that the roll out of the Works Capability Assessment has been very badly timed for adults with autism many of whom are isolated and unsupported within our communities, who have yet to be identified and added to the data which Local Authorities should now be collecting in line with the Autism Act. Given that Professor Harrington is in the process of completing his second review of the assessment process, and that many people have voiced their concerns about the assessment process being flawed. I also understand that three national charities that were assisting Professor Harrington with his review have now totally disassociated themselves with the review. I have many concerns that Local Authorities and Health Authorities have not had the time to appoint lead professionals and establish the groups that have been suggested they establish within the strategy.

9. **Recommendations**
• The literature available through Jobcentre Plus must include adults with autism who have a diagnosed communication impairment.

• Every adult with autism must be offered an independent advocate or communicator to enable them to communicate effectively thought the entire assessment process. This offer must include adults who have a diagnosis of Aspergers Syndrome or High Functioning Autism.

• The Works Capability Assessment should cease until the Adults Autism Strategy has had the opportunity to be taken on board and embedded in Local Authorities.

• Any assessment method which is assessing the capability of an adult with autism must reflect the complex nature of autism.

• All assessors must receive appropriate and on-going autism specific training which covers autism and its many co-morbidities, and how autism can present. The training should be delivered by an appropriate and accredited trainer.

• A past history and as much information about the adult as can possibly be obtained should be included in the assessment process to ensure than an informed decision about that adult is reached.

• Supportive evidence provided by parents and carers where an adult has not been in receipt of provision or serviced should be admissible and should be included in relevant information about the adult.

• A lack of service provision and support for an adult does not mean that that adult is without need. This is a more a reflection on the lack of services and provision available to adults with autism than the adult themselves. The lack of service provision and support for adults needs to be recorded.

April 2011
Written evidence submitted by West Oxfordshire Citizens Advice Bureau

Firstly, please let me say that in the main I support the welfare reform and the theory behind the proposed changes. I do recognise the need for Government to save money but feel that short term spends to ensure this process is smooth will inevitably shorten the process, thus saving more money long term...... (arguably - it is not an exact science)

- The Department’s communications to customers going through the assessment and whether the information, guidance and advice provided by the Department and Jobcentre Plus is effective in supporting customers through the process.

  Clients who have been in receipt of benefit for a number of years AND who have limited understanding through mental capability will with disregard the letters sent OR worry endlessly. Key groups in receipt of IB who have recognised mental health issues such as anxiety/depression/learning difficulties etc could, arguably be assisted with personalised (one-to-one or suitable group presentation communication). An expensive option, but maybe one that could be achieved through volunteer organisations set-up for this sole purpose. It maybe that the same individual mentors the client through the whole process (though arguably training and therefore further expense) may be required.

- The Work Capability Assessment including: the assessment criteria; the service provided by Atos staff; the suitability of assessment centres; and customers’ overall experience of the process.

  It has been proven (and backed up by the independent review - Outcomes date Nov 2010) that the present Work Capability Assessment procedure is inadequate; non reflective of clients true issues; and often found to be completely untrue when evaluated for the purpose of appeal. A key weakness being that of ATOS staff and as a result the overall experience by a client who has been through the assessment. ATOS professionals are felt to be removed, ill-educated and have a pre-disposed objective ; to fail clients irrelevant of what issues present themselves or the evidence in hand. For physically disabled clients the process is a huge challenge on so many levels. The main one being is the lack of consideration to the variable nature of pain and the impact of repetition etc. For clients with mental health issues and learning disabilities the procedure is overwhelming and for many extremely distressing - profound by the 0 score at the end of it.

- The decision-making process and how it could be improved to ensure that customers are confident that the outcome of their assessment is a fair and transparent reflection of their capacity for work.

  There needs to be open lines of communication at every step of this process. ATOS/Decision Makers/The Tribunal to not communicate adequately if at all. There is no transparent reflection because the questionnaire scoring does not reflect the true picture (always) of the issues presented by a client. Improvements may include better training and communication between the Government Assessor and the client GP OR/AND more involved recognition of the views of medical/professions that have a history of involved with the client. At the moment, any evidence is disregarded and a client can be found fit for work after full support from medical consultants superior to that of the ATOS assessor. There is a need for mentors for those who have recognised mental health issues. A mentor to not only ensure that the clients welfare is preserved but also that a fair picture is taken by ATOS and communicated effectively to the decision maker and so forth.

- The appeals process, including the time taken for the appeals process to be completed; and whether customers who decide to appeal the outcome of their assessment have all the necessary guidance, information and advice to support them through the process.

  The appeals process is timely costly and avoidable in main cases if a full picture is taken and medical evidence taken in confidence from professionals who know the client well. The appeal process is overwhelming for clients who genuinely do have the issues that mean that they are eligible for the benefits. I do realise that the appeal successfully works to disencourage disingenuous clients - but
there needs to be a balance. There is a real worry that with a present 6000 per week caseload that the appeals services will not manage the influx of cases that are bound to ensue through the migration from IB to ESA. I do see many positives in the new WCA but with the weakness at ATOS level there will inevitably be many clients that must unnecessarily go through the appeals process. The information put forward to clients needs, in many cases, to be followed up by independent professional people so that the content is fully understood. The telephone calls that have been taking place have muddled clients and actually, in some cases, been seen to encourage them to apply for JSA while on the line after misguidance by the telephone adviser - whether intentional or not - this is a serious concern with many possible negative connotations. Funding for CAB’s to engage with clients throughout the migration process could help.

- The outcome of the migration process and the different paths taken by the various client groups: those moved to Jobseeker’s Allowance, including the support provided to find work and the impact of the labour market on employment prospects; those found fit for work who may be entitled to no further benefits; those placed in the Work Related Activity Group of the ESA, including the likely impact of the Department’s decision to time-limit contribution-based ESA to a year; and those placed in the Support Group.

There are many positives to this proposal. I do see that the welfare state is for families/individuals who are facing hardship and there must be some methods of limiting funds going where it is not needed for life’s necessities. This will take time for people to adjust to and with early Financial Capability intervention to minimise damage to household budgets could be manageable. But it needs, especially in the early stages, needs to be managed with support networks in place. £420 less pcm per household can impact hugely of standard of living, especially in the current economic climate. While the principle behind this part of the reform is sound care will need to be taken.

- The time-scale for the national roll-out for the migration process, including the Department’s capacity to introduce changes identified as necessary in the Aberdeen and Burnley trials.

With present appeals taking up to a year from lodging to outcome, it is very optimistic to assume that the migration is achievable within 4-years. Yes it will be managed by date of reviews and therefore numbers involved in the process staggered, there are still adequate numbers to create huge operational issues. IF the WCA is better, this would assume that ATOS is completely sorted out AND ALL of the recommendations promised by the DWP to be implemented following the review (outcomes Nov 2010), and realistic numbers of appeals (in number of clients) are lodged it is still difficult to realistically envisage that the migration will be completed when there is already a massive backlog of unresolved cases awaiting outcomes. Improve the system - improve the training and all levels of the process - provided funding to quality organisations with well trained individuals to support clients (who need it) through the process and the time-scale will be reduced, but 4-years…..?

April 2011
I have been attempting to get a reassessment of my ESA as my conditions have now worsened but after having rung them consistently for weeks and not received the promised paperwork I gave up. That was months ago. They now claim I have the paper work and that I count as on the appeals process. This meant that when I needed to apply for a crisis loan I was not eligible for one as they didn't recognise my benefit as being active despite the fact it was. I had to make a very confusing round of phone calls to different parts of the DWP trying to figure out what was going on and what to do about it. This took all in all about 2 hours to sort out.

Additionally when I was applying for ESA and DLA both parts of the DWP, during the initial application process they handled paperwork incredibly badly. ESA failed to inform me that my doctors note was not the right kind and kept telling me to get a doctors letter or note rather than the required medical certificate. DLA claimed that they had not received letters from consultants and doctors of mine despite the fact that I saw evidence to the contrary with both my consultants and GP. Both of these things caused huge delays to my applications and also meant that I was denied some of my back pay because it was seen as these issues where my fault not theirs.

I have attended my own ATOS meeting and that of friends to support them. In both my own and the appointments I attended with friends the ATOS doctor did not look at us, he stared persistently at his computer screen. The only time during my interview with him that he looked at me was when he came to the section about mobility and was about to ask to examine my mobility and then he finally noticed my wheelchair. With one friend who also has mobility issues he caused her such physical pain that she was in tears and yet she had to go to appeal as he scored her 0 on all of her mobility factors. Another friend of mine who has many mental health problems that make it impossible for her to work was told that she is liar by the ATOS doctor when she told him about her psychological problems and when I attempted to defend her we were told that anyone who claimed purely because of psychological problems was a liar and trying to cheat the system as psychological problems cannot be proven or measured. This particular friend was however lucky that her psychiatric nurse dragged her back down there the same day to confront the same ATOS doctor and after 20 minutes of stern talking to about the errors of his ways as well as the reality of my friends condition and her treatment plan the ATOS doctor conceded that indeed it was a genuine case.

I now fall into the category of those who need support in returning to work. Against all advice I am looking for a job because I feel very pressurised into doing so despite the fact that you are told in 'work focused interviews' that you do not have to look for work if you are not ready the under lying message is still the same, that you are a waste of resources because a doctor who cannot get a job in a normal practice or hospital has said you are fit to work. I personally cannot move my arms very high due to sub luxation in my shoulder, I am in a wheelchair as I have two knees that are displaced permanently and the rest of my joints are deteriorating due to severe and degenerative hyper-mobility, This is not recognised by ESA as a serious condition due to the severity of my condition being rare with hyper-mobility - usually they just laugh and tell me how lucky I am to be double jointed and bendy - and this is coupled with a very poor immune system and M.E. which makes it impossible for me to work as other people could if at all. I feel pressurised into finding a job which I know I could never possibly hold down. At first I felt pressurised into finding any job at all and am now being pressurised into finding jobs that are full time which I certainly cannot do.

April 2011
As Chairman of the Allerdale (West Cumbria) branch of the Multiple Sclerosis Society, I am particularly concerned with the assessment criteria used in the Work Capacity Assessment.

MS is a very serious and disabling condition of the nervous system causing widely differing symptoms, many of which – nerve pain that does not respond to pain killers and extreme fatigue – are invisible. It is also characterised by fluctuating periods of relapse and remission.

As you will know, there is no cure for this degenerative condition for which there is no predictable course – the uncertainty of which causes much anxiety. In addition the efficacy of disease-modifying drugs for symptom control differs from person to person.

For these reasons, any assessment carried out on a single occasion cannot result in a reliable judgement on the person’s ability to sustain paid work. Unfortunately for those wish to try, attempts to make the most of a remission period by working hard to catch up either in a job or in the home, so often result in MS fatigue and a relapse into return of symptoms which are either more severe or spread to another part of the nervous system.

People with MS find that stress plays a large part in the course of their illness (as, indeed, in other illnesses) and the manner in which the assessment is carried out needs to be monitored by staff who have experience enabling them to understand the problems and anxieties faced by people with fluctuating degenerative disease.

March 2011
Written evidence submitted by NAT

Summary

NAT is the UK’s leading charity dedicated to transforming society’s response to HIV. We provide fresh thinking, expert advice and practical resources. We campaign for change.

NAT is a member of the Disability Benefits Consortium (DBC), the national coalition of over 40 different charities and other organisations committed to working towards a fair benefits system.

This submission is also supported by George House Trust, the largest HIV Social Care Charity in the North West of England.

We would like to submit evidence on the following aspects of the migration from Incapacity Benefit to Employment and Support Allowance:

- The Work Capability Assessment (WCA) does not adequately assess the physical and mental health barriers to work experienced by people living with HIV. Those who carry out the WCA have poor knowledge of HIV, leading to inaccurate decisions.

- Decision-making on ESA claims almost exclusively follows the recommendations of the Atos healthcare professionals (HCP), and disregards the medical evidence provided by specialist HIV clinicians.

- Appeals for ESA claims still have a high success rate, and this is especially the case when people living with HIV have expert advice and support. However, the scale of the migration and cuts to advice services will mean that not everyone will be able to access this support in future.

- The outcome of the migration for Incapacity Benefit claimants living with HIV will in many cases be poverty: either because they are found ‘fit for work’ and without access to further benefits; or because they lose access to contributory ESA (work related activity group) if they fail to find work within twelve months.

The Work Capability Assessment

1. NAT supports the principle behind the Employment and Support Allowance (ESA), to provide support for those who are not able to do any work, while providing extra support to those who may be able to work in future, if given the right help. However,
the Work Capability Assessment (WCA) is failing to correctly identify among people living with HIV those who:

- are ‘fit for work’ (not entitled to ESA)
- have ‘limited capability for work’ (work-related activity group- WRAG)
- have ‘limited capability for work-related activity’ (support group)

2. In 2010 NAT carried out a review of the experiences of people living with HIV of the Work Capability Assessment (WCA).

   We found that the WCA does not take into consideration the main barriers to work experienced by people living with HIV. The result has been that individuals with serious physical and mental health problems are found ‘fit for work’.

The assessment criteria

3. There are no opportunities during the WCA to provide information on key HIV clinical markers, such as CD4 count. Although these markers do not measure the full experience of living with HIV, they can be important indicators of poor health and immune deficiency, which should indicate to a decision-maker that the claimant has limited capability for work (or work-related activity).

4. NAT is aware of cases where people living with HIV who have CD4 counts below 50 (an indicator of serious ill health), who were also suffering from opportunistic infections and illnesses, have scored no points on the WCA. These cases tend to win at appeal, on the basis of ‘special circumstances’ rules which had not been considered by either the Atos assessor or the DWP decision-maker during the assessment process.

5. The WCA is also poor at assessing the impact of fluctuating symptoms. As a long term condition affecting many aspects of physical and mental health, HIV is characterised by the presence of multiple and often fluctuating symptoms. A survey by NAT of 265 people living with HIV found that the main fluctuating symptoms experienced by people living with HIV are fatigue (57%); depression and/or anxiety (55%), gastro-intestinal problems (48%) and neuropathy (nerve pain) (33%).

6. When introducing the WCA, the DWP expressed concern that the previous assessment for incapacity benefit had allowed for some “double-counting”, where multiple descriptors appeared to measure the same activity (in particular some around mental health). But the points system introduced in response through the WCA has an opposite problem: it is possible to be considered to have real problems with two completely distinct types of activity and still not pass the WCA.

7. For example, someone living with HIV may have a combination of serious side-effects related to their essential (life preserving) HIV medication. As shown in the

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survey responses, diarrhoea is one common side effect (and currently the only of the main fluctuating symptoms to be at all considered by the WCA). They may also experience pain while walking, because lipodystrophy (redistribution of fat deposits, associated with some HIV drugs) has left their feet without natural padding. In this situation, they would score the following under the WCA:

Risks losing control of bowels or bladder so that the claimant cannot control the full evacuation of the bowel or the full voiding of the bladder if not able to reach a toilet quickly- 6 points

Cannot walk more than 200 metres on level ground without stopping or severe discomfort- 6 points

As they have only scored 12 points, the claimant would be found ‘fit for work’, despite having two significant health-related barriers to work. In this example, the two impairments have the potential to interact directly so that one exacerbates the impact of the other. It should be kept in mind that the individual may also experience additional symptoms not currently captured by the WCA, such as fatigue or nerve pain.

**The service provided by Atos staff**

8. NAT has had numerous reports from welfare rights advisers and their clients of poor knowledge of HIV among Atos staff, who ignore the medical evidence provided by HIV clinicians because they do not understand the relevance.

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

10. In one illustration of the significant knowledge gap among HCPs, an HIV-specialist benefits adviser took a case to appeal, in which the claimant’s side-effects from HIV treatment were a key source of difficulty in finding or staying in work.

The HCP present at the hearing responded that, as the claimant’s CD4 count was at an acceptable level, “why don’t they just stop taking [the medication]?" The claimant’s HIV-specialist benefits adviser tried to explain the serious health consequences of interrupting treatment, which would include a decline in CD4 count, but the judge told her to “please be quiet.” As the HCP was a doctor, the judge took his opinion over that of the benefits adviser.

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4 Strict adherence to anti-retroviral treatment is absolutely essential to successful HIV treatment. As well as negatively affecting the health of the individual, poor adherence to treatment can lead to the development of drug resistance, which has serious public health consequences.
11. NAT is aware that people living with HIV are not alone in experiencing an attitude of disbelief from Atos HCPs. However, this is particularly distressing for people living with HIV, many of whom will have had bad experiences discussing their HIV in other settings. HIV remains a stigmatised condition in the UK. For a claimant living with HIV, who may be trying to explain issues relating to their mental health, or side-effects of their treatment, a dismissive attitude is likely to make them disengage with the benefit assessment process, including the pursuit of their right to an explanation or appeal of any decision.

12. Welfare rights advisers and organisations who support people living with HIV report that the stress associated with the WCA process can have a real impact on the health of someone living with HIV:

“The introduction of ESA and the push for people in receipt of sickness benefits to return to work means that we are increasingly receiving calls from clients who are worried about their entitlement and are feeling anxious that they will be asked to return to work when they are not ready - for instance because their condition varies so much and/or they have not worked for some time. We should not underestimate the effect this has on HIV positive claimants’ ability to cope with their medication, and their general wellbeing.’

- HIV-specialist benefits adviser, London

Recommendations

13. People living with HIV going through the WCA should be asked relevant questions about their health including CD4 count or other indicators of immune function; any side-effects of treatment they may experience; and if they experience fluctuating symptoms such as fatigue, pain and gastro-intestinal problems.

14. The Committee should seek clarification on why DWP and Atos have so far refused to improve the HIV training provided to staff and contractors.

Decision-making

15. According to DWP’s guide on the WCA, the decision maker will "carefully consider all the evidence", including "the completed customer questionnaire, the information provided by their doctor and the advice of the approved healthcare professional". However, despite the weight of knowledge and experience clearly lying with the specialist clinician who is expert in the condition, the weight of evidence in the decision comes from the generalist HCP, who may have absolutely no specialist training in the condition.

16. At present, the interpretation of evidence provided to an ESA claim is extremely narrow. Evidence from doctors is discounted because it does not explicitly and directly address one of the activities covered by the WCA descriptors. In one case a

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psychiatrist had to make multiple representations about a patient’s Post Traumatic Stress Disorder before it was finally accepted at appeal as evidence of incapacity for work.

17. The most recent ESA statistics show that only 3% of claims found eligible for WRAG were ‘reconsiderations’ – cases where the Decision Maker had decided against the Atos recommendation, or had requested a re-assessment by Atos.  

18. NAT supports Professor Harrington’s recommendation of the first Independent (Harrington) Review, that the DWP must focus on “Empowering and investing in Decision Makers so that they are able to take the right decision, can gather and use additional information appropriately and speak to claimants to explain their decision”.

Recommendations

19. The Committee should seek clarification on the progress of the implementation of the recommendations of the Independent Review of the WCA by the DWP, including Professor Harrington’s recommendations on decision-making.

Appeals

20. There is a fairly consistent 40% success rate for ESA appellants overall. It is also clear that claimants who receive help with and representation at their appeal from a welfare rights adviser do even better - one London HIV organisation has a 100% success rate at appeals.

21. However, with the greater volume of claims expected due to the migration, there will not be the capacity for HIV benefits specialists to support everyone who has an unfair claim through the appeals process. Many HIV organisations also face a loss of funding from social care and local authorities. In addition, the loss of Legal Aid funding for welfare advice will seriously reduce access to information and support from expert organisations like Citizens Advice Bureau.

7 Ibid.
Outcomes of migration

Those found eligible for ESA - WRAG

22. NAT strongly opposes proposals in the Welfare Reform Bill to limit contributory ESA to 12 months for those in the WRAG. The loss of the key out of work benefit (a loss of £91 per week) at an arbitrary point will exacerbate the existing high levels of poverty among people living with HIV. Between 2006 and 2009, one in six people currently accessing HIV had to access emergency cash support from one national charity (the Crusaid Hardship Fund) to pay for essentials. Living in poverty seriously compromises the ability of people living with HIV to meet their health-related needs. This includes the very basics such as travelling to medical appointments, heating their home to prevent respiratory infection, and regularly eating nutritious food to ensure the success of their treatment regime.

23. Physical and mental health problems related to HIV do not come with a time limit. As already illustrated above, claimants must show substantial physical or mental impairment before they are found eligible for ESA in the WRAG.

24. In addition, HIV remains a stigmatised condition in the UK, so people living with HIV still face social, as well as health-related, barriers to work. Research shows that unemployment among people living with HIV may be as high as 50%. One in five people living with HIV who are in work have experienced discrimination in either their previous or current job.

Those found ‘fit for work’

25. NAT is extremely concerned that some people living with HIV who are found ‘fit for work’ and are also found to not be entitled to further benefits will be left in poverty (see comments above).

26. NAT is also concerned that those Incapacity Benefit claimants who are found ‘fit for work’ and then move onto Jobseeker’s Allowance will not receive the support they need to move into work. The need for extra support is a common theme among people living with HIV who wish to work, but aren’t quite fully job-ready at present. For example, one survey respondent said that he needed “some support to work”, because “although I have applied for jobs I never get interviews. I have ongoing memory and concentration problems and would need help with this.”

27. For people living with HIV, stigma is still a day-to-day issue, and while many employers are proactive in creating a stigma-free workplace, this is not the case for all. And while it is unlawful to discriminate against someone in recruitment or the

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9 NAT. 2009. *Working with HIV.*

workplace on the basis of their HIV, they can still face more subtle barriers - those based on informal and unspoken expectations about employee behaviour, flexibility and attendance (including sick leave). People living with HIV may also face real barriers of confidence and self-esteem due to past experiences, or fear of stigma in the future. These barriers can be overcome with specialised support and help, but such support will not be available to the Incapacity Benefit claimants who are found ineligible for ESA.

National roll-out and timeline of the migration

28. NAT welcomes the ongoing reforms recommended by Professor Harrington in his first year review of the WCA, the Government endorsement of these recommendations, and the programme of work Professor Harrington has already outlined for the second year. However, we question the decision to go ahead with the national roll-out of the migration while these Harrington reforms are still being implemented, and further recommendations are yet to be made.

29. We are particularly concerned by the Government’s decision to implement the recommendations of the Internal Review of the WCA, which were consistently and strongly rejected by disability organisations, including those who had been consulted in the review process. The new ESA Regulations, which will bring in the changes to the WCA as recommended by the Internal Review, require a major change to the assessment process at the same time as the migration will be rolled out.

30. The introduction of the new ESA Regulations will be costly for DWP, and may lead to claims of unfair assessments, as ESA claimants will be subject to different rules depending on when they are assessed. In addition, the changes are likely to be superseded in the near future when the recommendations of Professor Harrington’s second year review are implemented – these will included proposed changes to better reflect mental health and fluctuating conditions in the WCA. For these reasons, disability organisations, including NAT, have repeatedly called for an annulment of these Regulations (please see Appendix for previously published briefing).

Recommendations

31. The Committee should seek information from the Department for Work and Pensions on how Jobcentre Plus offices will be prepared to meet the needs of disabled people who are moved to Jobseekers Allowance following the migration, including:
   - Staff training in the social dimensions of disability and the sensitivities associated with stigmatised conditions like HIV.
   - Staff training in equalities legislation, especially those aspects of the Equality Act 2010 relating to the rights of disabled people in recruitment and employment
   - Resources to provide disabled people with the extra support and training they may need to overcome barriers to work.
32. The Committee should seek clarification on the following aspects of the provision to time-limit contributory-based ESA (WRAG) to 12 months:

- What will happen to claimants who reach the 12 month limit of contributory ESA (work-related activity group) but do not qualify for means-tested ESA?
- What evidence did the Government use to decide upon the 12 month limit for ESA?
- Has the Government considered the additional difficulties faced by people with stigmatised conditions such as HIV, in trying to find work within 12 months?

33. The Employment and Support Allowance (Work-Related Activity, Action Plans and Directions) Regulations 2011 should be annulled. Any changes to the WCA should be left until the second year Independent Review of the WCA reports.

April 2011
Appendix: Previously published briefing

The Disability Benefits Consortium (DBC) is a national coalition of over 40 different charities and other organisations committed to working towards a fair benefits system. Using our combined knowledge, experience and direct contact with disabled individuals and carers, we seek to ensure Government policy reflects and meets the needs of all disabled people.

Background
The Work Capability Assessment (WCA) is the test used to determine eligibility for Employment and Support Allowance (ESA) and operates using a set of descriptors. Each descriptor has a number of points attached to it and if an individual scores 15 points either across a range of descriptors or on a single descriptor they qualify for ESA. Following an internal review carried out in 2009/2010 the Department for Work and Pensions (DWP) plans on introducing changes to these descriptors that will tighten the criteria for ESA. We are concerned that this review was carried out too early in the life of ESA to be based on meaningful evidence, that the revised descriptors fail to meet the aims of ESA and that these changes are premature as further revisions to the descriptors are expected following the more comprehensive annual reviews commissioned by the DWP.

We are therefore asking that these regulations (S.I. 228) be annulled.

Compliance with the Welfare Reform Act 2007
The test for ESA is meant to identify “whether a person’s capability for work is limited by his physical or mental condition” (Welfare Reform Act 2007, 8.1). However, the new descriptors will in practice identify only those individuals incapable of any work, not those with a limited capability.

Internal review
The internal review that produced these revised descriptors was based on very limited evidence and failed to consult widely. Whilst DBC members were involved in the review they were concerned about the thoroughness of the review and clearly stated that they did not support its findings.

Restricting access to ESA
The internal review of the WCA was announced in July 2008,\(^{11}\) three months prior to the introduction of ESA itself and with the express purpose of reducing access to the benefit.\(^{12}\) Despite the high than anticipated numbers of people being found “fit for work” (70% compared to the predicted 51%) the revised descriptors proposed by the review will reduce access by a further 5%.

Social Security Advisory Committee
The Social Security Advisory Committee (SSAC) received over 160 responses to their consultation on the revised descriptors and has recommended that “the Department does not proceed with the remaining proposed changes to the descriptors until these have been reconsidered in the light of the findings of the independent review of the WCA and the experience of the trial of the migration of IB customers to ESA”.

Further revision of WCA descriptors – Independent WCA Review
As part of the DWP commissioned independent review, work is currently being undertaken to revise descriptors to take better account of non-physical impairments and fluctuating conditions. If further changes are then made to the WCA this would lead to confusion amongst staff delivering the benefit and an unequal system with eligibility varying according to when people applied.

Chemotherapy
The regulations will improve the WCA for those waiting for, or between courses of, chemotherapy and we would welcome separate regulations to introduce these much needed amendments.

Impact of proposed descriptors
Below are some examples of the impact of the proposed new descriptors:

- An individual who “cannot mount or descend two steps even with the support of a handrail” could now be classed “fit for work”.
- Someone unable to stand at a workstation for more than ten minutes could now be deemed “fit for work”.
- The descriptors for turning star headed sink tap have been removed, consequently there is no functional assessment for the ability to turn or rotate the hand despite this representing a form of manual dexterity vital in many workplaces.
- Three different categories of descriptors looking at motivation, concentration and reasonable time to complete an action have been collapsed into one single descriptor, meaning significant areas of function are excluded from the new assessment, for example, although depression is just one impairment, it may affect functioning in multiple areas of a person’s life and the WCA needs to reflect this.

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\(^{11}\) Department for Work and Pensions (2008) ‘No one written off’
\(^{12}\) Ibid: 3.11 … We expect that, following the planned review, the proportion of ESA claimants who will be assessed as able to look for a wide range of jobs straight away and eligible for JSA by the time they complete the WCA at around the three-month point, will rise by around 10 percentage points.
• The ability to get about and cope with change will no longer be assessed in terms of frequency, which will impact negatively on people with variable or fluctuating conditions.

• The changes remove all lower-level descriptors in some categories, for example, there are now no six point descriptors within manual dexterity, making it hard for people with multiple impairments to qualify.
Written evidence submitted by the Low Incomes Tax Reform Group

1. Executive Summary

1.1. We welcome this inquiry into the migration from incapacity benefit (IB) to employment and support allowance (ESA) as it allows us to reiterate concerns about how the migration process impacts on the tax liabilities, tax credit entitlement and passported benefits position of a migrated claimant. We are particularly concerned with those former invalidity benefit (IVB) claimants who, on migration to CBESA, will lose their transitional tax protection.

1.2. So far, despite our repeated requests, neither DWP nor HMRC has given adequate guidance to those in the migration process, despite the potentially serious consequences on their household income.

1.3. We therefore urge the Committee to press DWP and HMRC for commitments to:

- Work together to provide adequate guidance to individuals caught up in the migration process, particularly those former invalidity benefit (IVB) claimants for whom tax and tax credits matters need to be carefully considered. This is because the transfer from their formerly non-taxable IB to taxable contributory ESA could have serious financial impacts on their household income;

- Ensure that processes are in place to issue correct PAYE codes to all individuals moving from a hitherto non-taxable benefit to one which is taxable;

- Work together to identify those former IVB claimants who are also claiming tax credits and write off any tax credits overpayments which have arisen as a result of the departments’ contributory error, ie their failure to provide adequate guidance as to the potential tax credits consequences of the migration;

- Ensure that the impact on passported benefits is also adequately explained;

- Consult with the Committee and stakeholders on their staff guidance, in particular ensuring that HMRC staff deal sympathetically and speedily with claimants who may come within the tax net for the first time in many years.

2. Introduction

2.1. About us
2.1.1. The Low Incomes Tax Reform Group (LITRG) is an initiative of the Chartered Institute of Taxation (CIOT) to give a voice to the unrepresented. Since 1998 LITRG has been working to improve the policy and processes of the tax, tax credits and associated welfare systems for the benefit of those on low incomes.

2.1.2. The CIOT is a charity and the leading professional body in the United Kingdom concerned solely with taxation. The CIOT’s primary purpose is to promote education and study of the administration and practice of taxation. One of the key aims is to achieve a better, more efficient, tax system for all affected by it – taxpayers, advisers and the authorities.

2.2. Our response

2.2.1. We welcome this opportunity to comment on the inquiry into migration of incapacity benefit (IB) claimants to employment and support allowance (ESA). There are many organisations which are better placed than us to comment on the work capability assessment, decision-making and appeals processes and overall outcomes for claimants. Our response will therefore focus on how the migration process interacts with the tax and tax credits systems.

3. Background

3.1. Transitional protection for invalidity benefit claimants

3.1.1. Incapacity benefit was introduced in April 1995 as a replacement for invalidity benefit (IVB). One of the crucial differences between IVB and IB is that the former was non-taxable, whilst the latter is primarily taxable.

3.1.2. IB has 3 rates:

- Short term-lower rate which was non-taxable (paid for the first 28 weeks of a new claim – not available since the introduction of ESA in October 2008)
- Short term-higher rate which is taxable
- Long term rate which is taxable

3.1.3. In order to give protection to those moving from non-taxable IVB to taxable IB in 1995, transitional tax protection was given meaning that their IB, although long term, is non-taxable. This protection is given under Section 663 Income Tax (Earnings and Pensions Act) 2003.

3.2. Interaction with tax credits

3.2.1. The tax credits system generally follows the tax system when determining what counts as income for tax credits purposes. If income is taxable it will normally be income for tax credits purposes (although there are some exceptions) and if non-taxable it will not be included as income.
3.2.2. For IB, tax credits follow the tax treatment and therefore both the short term-lower rate and long term IB for those previously in receipt of IVB are not taken into account as income.

4. The impact of migration to ESA on tax and tax credits

4.1. The tax position

4.1.1. Those IB claimants who successfully meet the requirements will be migrated to contribution-based ESA (CBESA) which is a taxable benefit.

4.1.2. It has been confirmed that there will be no transitional protection for those currently in receipt of non-taxable IB (old IVB claimants) and therefore they will move from a non-taxable to taxable benefit.

4.2. The impact on claimants

4.2.1. The explanatory memorandum to the ESA transitional regulations\(^1\) states that ‘the Government will ensure that no customers whose benefit rates are higher than the ESA rate will experience a cash reduction in their benefit on migration to ESA, by transitonally protecting their existing level of benefit’. In addition, in went on to say that ‘Anyone receiving Housing Benefit and Council Tax Benefit at the point of migration will not see a reduction in overall benefit income as a result of migration due to transitional protection in Housing Benefit and Council Tax Benefit’.

4.2.2. Whilst this commitment was welcome, we pointed out in our evidence to the Social Security Advisory Committee’s review of these regulations, that it is still possible for some claimants to be worse off as a result of migration by virtue of a hitherto non-taxable benefit becoming taxable. As well as decreasing net income due to an increase in tax payable, in turn it could lead to a substantial reduction in tax credits and the loss of passported benefits.

4.2.3. In a discussion about the Employment and Support Allowance Regulations 2008 in the House of Lords it was said\(^2\) that most claimants who receive only CBESA will not be liable to tax because their income is likely to be under the personal allowance. However, the documents provided by DWP to SSAC\(^3\) show that DWP estimate 50,000 claimants will be affected by the loss of transitional protection with an average income tax liability of £1,000 a year. The rationale given for this is that ‘these will be customers with the highest incomes, the vast majority of whom are already liable for tax’.


\(^{3}\) http://ssac.independent.gov.uk/pdf/employment_and_support_allowance_regs.pdf
4.2.4. Given that the personal allowance for 2011-2012 is set at £7,475, many claimants who have income over this amount, for example because they have a small occupational pension or because they do ‘permitted work’, may well already pay tax but to say they are on the ‘highest incomes’ is not accurate given that we are talking about people in relative poverty. The impact of the increased tax bill, which could be around £19 per week for someone with a small private pension and CBESA, should not be underestimated.

4.3. **The tax credits position**

4.3.1. Tax credits play a crucial part in reducing child poverty, supporting families with children and helping low-income workers move into and remain in work.

4.3.2. At present, tax credits rules broadly follow the tax system. Therefore, if income is taxable it is generally counted as income for tax credits and if it is non-taxable it is generally not counted as income for tax credits. Under the current tax credits rules, those who receive non-taxable LTIB (former invalidity benefit claimants) do not have this counted as income for the purposes of their tax credits claim.

4.3.3. However, if these claimants are moved to taxable CBESA it follows that their CBESA would become income for tax credits. For most claimants on low incomes, this would eventually mean a loss of tax credits of 41p for every £1 of CBESA income.

4.3.4. In 2007, we wrote to Lord Kirkwood outlining our concerns about the transfer of claimants to ESA and particularly about the implications for tax credits. As a result of that letter, DWP replied stating that ‘the likelihood of people on low incomes facing loss of tax credits as a result of receipt of contributory ESA is limited when you consider that, as with the current system, people will not receive both Employment and Support Allowance and Working Tax Credit at the same time as the qualifying conditions are mutually exclusive’. It went on to conclude that ‘this means that the people facing receipt of ESA and withdrawal of tax credits at the same time would be those with children’.

4.3.5. As stated to SSAC in our response to their consultation on the ESA regulations, we believe that presumption is incorrect because it is indeed possible in some circumstances to receive both ESA and Working Tax Credit (WTC). Although admittedly this is generally not possible in the case of those on LTIB moving to ESA, it is possible that claimants of LTIB (non-taxable) will be part of a couple claiming WTC jointly. It follows therefore that in such cases there will be an increase in the joint household income when there is a change from non-taxable to taxable benefit.

4.3.6. For example, let us consider a couple with no children where one partner works 32 hours per week in a low-paid job, and the other is on LTIB (non-taxable). Their WTC award will presently be based only on the employment income of the working partner. If no transitional protection is given, when LTIB is converted to CBESA under the current rules it will be classed as income for tax credits purposes, thus eventually resulting in a significant reduction in the tax credits award. Based on 2011-2012 rates of ESA, if CBESA is paid at £94.25 per
week, loss of tax credits could be as much as £2,010 per year or about £39 per week. Whilst there may be no loss from ESA, there is a substantial loss of WTC as a result of the transfer from IB to CBESA.

4.3.7. We acknowledge the role of the disregard in tax credits, so that the impact of the change from non-taxable LTIB to CBESA may not be seen immediately where claimants' awards are based on previous year income. However, in the second and subsequent years (applying the current rules) the income from CBESA will have to be taken into account. For tax credits claimants who are already paid their tax credits on an estimated current year basis, any change in income would impact on their award immediately and may create an overpayment.

4.4.8. Similarly, low-income families with children may also see a fall in tax credits where a parent moves from non-taxable IB to taxable CBESA. This will run counter to the Government’s broader child poverty agenda.

4.5. **Passported Benefits**

4.5.1. Tax credits often act as a gateway for entitlement to certain passported benefits. For example, exemption from NHS health costs can be given if you receive:

- Child Tax Credit (CTC) and your gross annual income used to calculate your tax credits award does not exceed £15,276; or
- CTC and WTC and your gross annual income used to calculate your tax credits award does not exceed £15,276; or
- WTC including a disability or severe disability element and your gross annual income used to calculate your tax credits award does not exceed £15,276 per annum.

4.5.2. As well as receipt of WTC or CTC (or both) there is often an income criteria attached to passported benefits. Claimants moving from non-taxable LTIB to taxable CBESA will see a rise in household income that may cause them to lose valuable passported benefits because they no longer meet the criteria.

4.5.3. Although other benefits can also act as a gateway to certain passported benefits, CBESA is not a benefit which normally gives rise to such entitlements. For example, receipt of CBESA would not give automatic exemption from NHS health costs. A family which loses passported benefits as a result of their tax credits income rising after transition would not be able to use CBESA to keep their passported benefits.

4.5.4. As we have shown, the transition from a non-taxable to taxable benefit can have serious financial consequences both in relation to a fall in tax credits but also the potential loss of related passported benefits.

5. **Administrative concerns**
5.1. *Importance of good administration*

5.1.1. In light of the potentially severe impact on a claimant’s tax and tax credits position, it is absolutely crucial that accurate information is given to claimants so they understand how the migration will impact upon them.

5.1.2. We stressed this in our submission to SSAC in 2010, and urged DWP and HMRC to address the administrative issues linked to tax and tax credits and to ensure that claimants have adequate information about the impact of the migration on their tax and tax credits position.

5.1.3. Unfortunately, as the pilot exercise has ended and migration has rolled out nationally, neither DWP nor HMRC seems to have adequately addressed these concerns.

5.2 *Administration and tax*

5.2.1. Although the letters we have seen indicate that HMRC will be in touch with claimants, such contact is said to be in the context of income tax. But we have seen no evidence that there is a co-ordinated programme to ensure that HMRC will provide individuals with an accurate PAYE code at the point of migration. A failure to do this may add a tax underpayment to an already confused and unsatisfactory position. We would ask the Committee to obtain the appropriate training materials provided to HMRC staff to ensure that they are equipped to understand the nature of the migration issues and to deal sympathetically and speedily with former IB claimants who may come within the tax net for the first time in many years after losing transitional tax protection.

5.3 *Administration and tax credits*

5.3.1. There appears to be little, if any, joint working between DWP and HMRC despite the clear necessity for it. As far as we are aware, the letters that are being sent to claimants by DWP in relation to migration do not contain any reference to tax credits. This needs to be corrected immediately.

5.3.2. At the time of writing this evidence, we have had no information from HMRC as to how they are dealing with those migrating from non-taxable IB to taxable ESA despite several requests.

5.3.3. The HMRC website contains no specific information about the change, neither can we find any reference in HMRC’s series of tax credits leaflets. Those that are migrated mid-year are unlikely to appreciate the need to inform HMRC for tax credits purposes, due to the lack of information give to them by either government department, therefore it is possible that an overpayment could be building up. We urge HMRC to give a commitment that they will write off any overpayments that occur in these circumstances and that they undertake an exercise, with DWP, to identify those affected and write off the overpayments without the need for the claimant to dispute.
5.3.4. For those who are not impacted immediately, due to the £10,000 income disregard in tax credits, HMRC need to have processes in place to ensure that claimants who have been migrated from non-taxable to taxable income are identified so that their tax credits for 2012-2013 are based on correct income. As well as updating their materials immediately, they need to be pro-active in contacting claimants. It is not acceptable to rely on the claimant to understand the relevance of the change from IB to ESA for tax credits when neither DWP nor HMRC has given them any information.

5.3.5. DWP also need to ensure that their letters are amended to include information about a potential loss of passported benefits.

April 2011
1. About us
As the largest organisation of blind and partially sighted people in the UK, RNIB is pleased to have the opportunity to respond to this consultation.

We are a membership organisation with over 10,000 members who are blind, partially sighted or the friends and family of people with sight loss. 80 per cent of our Trustees and Assembly Members are blind or partially sighted. We encourage members to be involved in our work and regularly consult with them on government policy and their ideas for change.

As a campaigning organisation of blind and partially sighted people, we fight for the rights of people with sight loss in each of the UK’s countries.

During the next five years we want to tackle the isolation of sight loss by focusing on three clear priorities:

1. Stopping people losing their sight unnecessarily;
2. Supporting blind and partially sighted people to live independent lives; and
3. Creating a society that is inclusive of blind and partially sighted people.

We also provide expert knowledge to business and the public sector through consultancy on improving the accessibility of the built environment, technology, products and services.

Question 1
The Department’s communications to customers going through the assessment and whether the information, guidance and advice provided by the Department and Jobcentre Plus is effective in supporting customers through the process.

1.1 The main requirement for visually impaired people is the provision for alternative formats, if initial contact with customer is made via inaccessible measure (standard letter) renders the process will be flawed.

Recommendation 1
Throughout the assessment process information should be available and supplied to visually impaired claimants in an accessible format.

Question 2
The Work Capability Assessment including: the assessment criteria; the service provided by Atos staff; the suitability of assessment centres; and customers’ overall experience of the process.

2.1 Despite the fact that blind and partially sighted people have a different impairment, face a different challenge in adjusting to their impairment, and require different aids and equipment the regulations conflate sight loss and hearing impairment within a single descriptor.
2.2 Activity 7 refers to both verbal means and non-verbal means. RNIB interprets this to mean that you may not obtain 15 points as long as you could communicate by one or other of these means. Consequently with respect to the first descriptor - "Cannot understand a simple message due to sensory impairment" a claimant may not obtain 15 points if they could hear a message even if they couldn't see it or if they could see a message even if they couldn't hear it. The ATOS guidance for health care professionals implementing the WCA makes it clear that this descriptor is aimed at the deaf blind community or people who have a hearing impairment.

2.3 Page 82 of the guidance states, "A person who is deaf who cannot hear a shout at beyond 1 metre (80db loss) with macular degeneration to the extent that their vision is moderately impaired such that they have 6/24 vision, and can only read N16 print with a magnifying glass is likely to have “significant” problems. A person who is deaf (80db loss) and has 6/24 distance vision but can read N16 print with their normal spectacles is likely to have “some” problems."

2.4 The only descriptor specifically linked to sight loss (in the ATOS guidance) is the activity "Navigation and maintaining safety, using a guide dog or other aid if normally used - Activity 8." This descriptor too is unworkable in practice.

2.5 Descriptor 8(a) "Unable to navigate around familiar surroundings without being accompanied by another person due to sensory impairment" raises the problem that if the surroundings are familiar to a claimant it is likely that such a person could already navigate them and thus would not qualify for 15 points.

2.6 The descriptor 8(b) "cannot safely complete a potentially hazardous task such as crossing the road without being accompanied by another person due to sensory impairment" raises the problems of the fact that the descriptor is likely to be taken very literally in assessments. If the road has a formal crossing, has audio signals that would have met the Best Value Performance Indicator and other standards for accessibility it might not be a problem to cross. Alternately if the crossing is being dug up, there is rat running traffic or there are no accessibility features then it might be a very large problem indeed. It may be safe to assume that only the blind or partially sighted person concerned is the appropriate judge of whether a task is hazardous or not.

2.7 In respect of the descriptor 8(c) "Unable to navigate around unfamiliar surroundings without being accompanied by another person due to sensory impairment there are no points currently inserted though the implication is that 9 is the score.

2.8 Many blind and partially sighted people's vision is affected by the light condition and consequently their ability to see fluctuates through the day. Our own experience of the ATOS assessment is that people are being assessed for being able to complete the minimum level of activity only once and in the optimum of conditions.
2.9 The wider problems with all the descriptors affecting people with sight loss are that they are supposed to be assessing impairment functionality in the workplace but none of the descriptors apply to an actual work environment. The descriptors assume that the problem for people with sight loss is simply travelling to work and whether they constitute a safety hazard to themselves or others once there.

2.10 There is an implied assumption that all employers have enlightened attitudes to the employment of disabled people and have also made all reasonable adjustments to their policies, premises and equipment, this is unlikely because the disability discrimination legislation is reactive and not proactive in the responsibilities it places on employers.

2.11 The previously used descriptors correlated with work based activities e.g. visual acuity (reading & communication), field of vision (navigation, orientation & safety) and ability to recognise people/workmates (expressive and receptive communication). The tabled regulations contain proposed descriptors that do not correlate with a work setting. This leads to the inevitable conclusion that when taken into account with the suspension of the Work Focused Health Related assessment the system has been reduced to a medical and not social model of disability.

2.12 There has been considerable support for those people like ourselves who are critical of the WCA descriptors. Professor Harrington’s first review identified the need to "look at "improvements that could be made" (p 630, The Social Security Advisory Committee referred to particular groups "being poorly served by the design and operation of the WCA" (paragraph 1.2). Finally the Merits Committee wished to see “fully appropriate” descriptors brought forward.

Recommendation 2
We welcome DWP’s recent offer of improved guidance with respect to the interpretation of the descriptors on communication and navigation and in order to reflect the challenges faced by blind and partially sighted people.

The RNIB Group would also wish to see either the retention of the existing descriptors or the impact of sensory loss reflected in new descriptors.

2.13 In addition to our concerns regarding the nature of the assessment we also have some specific concerns relating to the service provided by ATOS staff. Our staff has reported instances of blind and partially sighted clients enduring some spectacularly bad assessments, these have prompted us to complain on several occasions to ATOS senior management.

Recommendation 3
In particular we are concerned that systemic failures occur because lessons learnt from the appeal process are not fed back into the assessments or the process for conducting the assessments via JCP decision-makers. Consequently we recommend that ATOS be asked to report on how their work is modified to redress poor practice identified by the appeal process.
2.14 All the ATOS assessment centres should be expected to be fully accessible to disabled people. Many assessment centres are not fully accessible for example our staff in Exeter have reported one WCA having taken place at a customers home as the assessment centre was not wheelchair accessible. In addition our staff have reported that even the signing in process is on occasion not accessible. The absence of disabled parking spaces at the centre in Stockport sparked media coverage, see http://menmedia.co.uk/stockportexpress/news/s/1417282_blue-badge-row-hits-new-centre

**Recommendation 4**
These reports lead us to question whether ATOS have audited their centres and procedures to ensure consistency of provision for disabled people's access. In order to demonstrate that they meet their obligations under equality legislation ATOS should be asked to make publicly available access audit reports for all their assessment centres.

**Question 3**
The decision-making process and how it could be improved to ensure that customers are confident that the outcome of their assessment is a fair and transparent reflection of their capacity for work.

3.1 ATOS medical reports are often erroneous; our staff reports one example where a visually impaired and diabetic customer's report stated that he had had the pulse in his feet tested. His GP was astounded, as he has not tested for a pulse in patient's feet for many years. This case is currently pending appeal.

3.2 Available evidence from staff supporting blind and partially sighted claimants suggests that many decisions are absurd and illogical. For example a service user registered blind, diabetic and also a double amputee in a wheelchair was found not to have 'limited capability for work'. Following a lengthy appeal process the customer was placed in the support group. During this process the claimant moved from a position of securing less than 15 points to scoring 59 points.

**Recommendation 5**
We are supportive of the recommendations that emerged from Professor Harrington's review. We recommend that given that the Government has indicated its support for these recommendations that a timetable for their introduction is now published and made publicly available.

In addition we recommend that the DWP decision making standards committee be asked to independently review the customer journey through the WCA.

**Question 4**
The appeals process, including the time taken for the appeals process to be completed; and whether customers who decide to appeal the outcome of their assessment have all the necessary guidance, information and advice to support them through the process.
4.1 Appeals are taking many months and in some cases over a year, for example one customer’s appeal process lasted 16 months. During this appeal no advice or guidance was provided by DWP. Our staff has reported that only at appeal is specialist medical information such as a certificate of visual impairment being taken into account.

**Recommendation 6**
Claimants with a visual impairment should be invited to bring any additional medical evidence including a certificate of visual impairment with them to the assessment. The LiMA software used by Atos assessors should be altered to ensure that assessments are able to capture the significance of this additional medical evidence.

**Recommendation 7**
It shouldn’t be necessary for claimants to have to write to DWP for a copy of their own assessment report. ATOS reports in suitable accessible format should be shared with claimants as a matter of course.

**Question 5**
The outcome of the migration process and the different paths taken by the various client groups: those moved to Jobseekers Allowance, including the support provided to find work and the impact of the labour market on employment prospects; those found fit for work who may be entitled to no further benefits; those placed in the Work Related Activity Group of the ESA, including the likely impact of the Department’s decision to time-limit contribution-based ESA to a year; and those placed in the Support Group.

5.1 The number of our clients likely to be migrated stands at 16,470 of whom 5940 are female, 10,530 are male and the remainder unknown. Our clients represent 0.77% of the total IB caseload. IB/Severe Disability Allowance caseload for working age - ICD categorisation diseases of the eye and adnexa, as of February 2010 (last available update).

5.2 With respect to ESA claimants the picture is as follows - (from Table 10 of 5.3 of "Employment and Support Allowance Work Capability Assessment by Health Condition and Functional Impairment" DWP, dated October 2010 using the same ICD classification).

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Numbers</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placed in the support group</td>
<td>200</td>
<td>4.8%</td>
</tr>
<tr>
<td>Placed in the work-related activity group</td>
<td>1300</td>
<td>31%</td>
</tr>
<tr>
<td>Did not complete the assessment</td>
<td>1400</td>
<td>33%</td>
</tr>
<tr>
<td>Still in progress</td>
<td>100</td>
<td>2.4%</td>
</tr>
<tr>
<td>Found fit for work</td>
<td>1400</td>
<td>33%</td>
</tr>
</tbody>
</table>

4200 of our clients in total
5.3 We are concerned firstly by the high proportion of claimants not completing the assessment and it is our hope that the reasons for this will be determined through Professor Harrington's next review. Secondly we are perturbed by the very high proportion of our clients that have been found fit for work with the possibility that these people will neither obtain work nor employment support to find work. These people will instead be placed on Job Seekers Allowance where they will face a tougher conditionality regime.

5.4 We are also concerned at the impact of the time limiting of contributory ESA for the people in the Work Related Activity Group. The Shaw Trust, a welfare to work provider, has stated that it doesn't help to rush ESA claimants or place unrealistic demands on them. Many blind and partially sighted people require longer term support. Recent analysis on the Pathways to Work Programme (January 2011) reveals that only 12% of clients with "diseases of the eye" were able to find employment within one year of joining the programme. Consequently we are concerned that many blind and partially sighted claimants will be affected by the time limiting of ESA. The effect will be to force them onto JSA where they will receive less support to find work and face a tougher regime of conditionality. The impact will be to reduce the income of many by up to a third and leave them with a significantly lower standard of living.

5.5 The RNIB Group recently obtained findings from research conducted by the University of Birmingham, into the impact of the recession on the employment rate of blind and partially sighted people. The research shows that since September 2008 there has been an 8% fall in their employment rate. This research highlights the vulnerability of our clients to the current recession and the challenges they face in obtaining and retaining work.

**Recommendation 8**
The proposal in the Welfare Reform bill to time limit contributory ESA for those in the Work Related Activity Group should be abandoned.

5.6 Finally we would highlight a gap in provision existing between the Pathways to Work Programme ending and the new Work Programme beginning. Disabled clients in the work related activity group would be left without employment support at a time of very high and rising unemployment.

**Question 7**
The time-scale for the national roll-out for the migration process, including the Department’s capacity to introduce changes identified as necessary in the Aberdeen and Burnley trials.
unresolved dispute over Professor Harrington's recommendation that claimants should have the right to have additional medical evidence taken into consideration (such as a Certificate of Visual Impairment) and ATOS own willingness to modify the LIMA software to achieve this.

**Recommendation 9**
There ought to be consistency of treatment for all those being migrated and we would therefore endorse the SSAC recommendation that the IB migration be suspended until the WCA is fully revised and the LiMA software suitably modified to reflect this.

April 2011
Written evidence submitted by Citizens Advice Scotland

Summary

- 207,000 people in Scotland claim Incapacity Benefit. The majority of these claimants will be reassessed in the next three years, involving over a thousand re-assessments each week in Scotland.

- ESA has arguably been the most concerning issue for bureau advisers in the last two years. Advisers regularly report of clients with significant health problems who they feel are inappropriately found fit for work.

- The Tribunals Service and citizens advice bureaux have been overloaded by a massive caseload of ESA appeals. Figures in January 2011 showed that 31,800 ESA appeals in the UK were cleared at hearing in Quarter 3 of 2010/11 – around 2,600 a week.

- The underlying principle of ESA is that sickness benefits claimants that have a capability for work are supported into employment. However, the reality appears to be that claimants are being moved from one benefit to a less expensive one, or dropping out of the welfare system altogether.

- Independent research has found that only 13% of those found fit for work are being supported into sustained employment. ESA is being hastily rolled out to a vulnerable section of society before it has been shown to meet its aim of supporting people into work.

Introduction

1. ESA has quickly become a significant issue for citizens advice bureaux in Scotland, both in terms of the severity of its impact on clients and the pressure this places on bureau resources. In particular, welfare advisers report of many clients with serious health conditions who have been found fit for work, including clients with Parkinsons Disease, Multiple Sclerosis, terminal cancer, Bi-polar disorder, heart failure, strokes, severe depression, and agoraphobia.

2. It is important to note that CAS – and many groups that support people who live with disabilities across Scotland – support the principle that those who have a capability for work should be helped into suitable and sustainable employment. Our concern, and that of welfare advisers, is that ESA is failing to meet this principle: that it is failing to adequately assess many clients, failing to help former claimants to find employment, and may simply be moving claimants from one benefit to another or out of the system altogether.

The Work Capability Assessment (WCA)

3. Clients and advisers have reported a range of issues with the WCA, including problems with the assessment descriptors and healthcare professionals who do not appear to be listening to the claimant or who distort their answers. Following the introduction of the assessment in October 2008, it has quickly become one of
the biggest sources of complaints from bureaux clients. Based upon the experiences of their clients, welfare adviser concerns about the WCA include:

- **The WCA is often rushed**, and can last just 20 minutes, leaving claimants with the impression that they have not been properly assessed
- **The yes/no format of the assessment is too narrow**, leaving little opportunity for the client to explain their condition
- **The health care professionals often fail to listen or interact with the client**, which can lead to mistakes and a failure to properly assess conditions
- **The descriptors often do not cover a client’s condition**, especially mental health conditions, and are not based on ‘real world’ capabilities.

4. A number of welfare advisers detailed the problems that clients had reported to them regarding the inadequacies of the assessment and the conduct of the health care professionals:

   “I can tell them [clients] word for word exactly what they are going to say to me, “I was only in for 20 to 25 minutes, they just asked me questions, they never looked at me or examined me…” I myself have attended two of these medicals so I know what people tell me is the truth.”

   “I have had many comments from clients about the Health Care Professionals who carry out medicals. They do not appear to listen to their answers, they do not look up from the computer screen, everything is rushed with clients given no opportunity to try and explain their situation. Also there are many comments about the medical report stating things that had never been said.”

   “Many clients are complaining about the medical assessment: many feel that they are not being listened to; that the medicals are rushed; that their words are being taken out of context; and that the questions asked do not relate to their particular disability. This seems to affect people with mental health problems especially.”

5. The assessment itself is often very stressful and upsetting for clients, with some reporting that the WCA has had an adverse impact on their health. A bureau reported anecdotally that one client who was initially found fit for work was eventually put into the Support Group after her condition significantly worsened as a result of the stresses of the assessment process. A bureau adviser stated what the assessment process entailed for bureau clients:

   “It is fair to say that claimants always feel the process is making every condition worse.”

**The decision-making process**

6. Clients have little faith in the assessment and decision making process. The problems experienced at the assessment – including rushed appointments and healthcare professionals who do not appear to be listening to the claimant –
mean that clients are likely to feel that they have not been properly assessed and that therefore the decision that they have received is incorrect.

7. This problem is compounded by the decision letters that clients receive, which are often full of technical jargon and fail to explain to the client why the decision has been reached. Without a clear understanding of why ESA has been refused, and a feeling that their assessment was inadequate, many clients feel that the process has failed them and that their only recourse is to appeal. Advisers explain the problems with decision letters:

“The decisions, in some cases, consist of one or two comments made on the medical report and do not give claimants a clear understanding of why they have been refused.”

“…to the ordinary man in the street they are just a lot of legal jargon and illegible medical reports from Atos that they cannot really make head or tail of.”

8. A number of clients have complained that their supporting medical evidence has been ignored by DWP decision makers who have effectively ‘rubber stamped’ the recommendation from the WCA. This medical evidence is then often used to successfully appeal the decision. The Harrington Review found that decision makers follow the advice of the medical assessors in 98% of cases. We strongly support Professor Harrington's recommendation that the DWP decision maker take a far more active role in making decisions based on both the assessment and the supporting medical evidence.

The appeals process

9. The Tribunals Service and citizens advice bureaux have been overloaded by a massive caseload of ESA appeals. Figures in January 2011 showed that 31,800 ESA appeals were cleared at hearing in the UK in Quarter 3 of 2010/11 – around 2,600 a week.¹ The DWP had originally estimated that 21,000 appeals a year would reach an appeal hearing.²

10. DWP figures show that around 40% of ESA appeals are found in favour of the claimant. More than 11,000 assessments were overturned at appeal in Quarter 3 of 2010/11.

11. The high number of ESA appeals has had a huge impact on the time and resources of citizens advice bureaux. Welfare advisers estimate that up to 70% of their time is taken by ESA claims, mostly appeals, with prepartion for each appeal taking an average of five hours of adviser time. Welfare advisers are representing clients at hundreds of ESA tribunals each year:

² Impact Assessment of the ESA Regulations 2008 (DWP March 2008)
“In a normal year, I deal with up to 250 appeals on average… but I’m now at the
stage where at this precise moment, I had had 520 appeals come through by books
since April. I’m overloaded and the Tribunal Service is overloaded.”

“The appeals process: - this is now taking a ridiculous amount of time and resources
which this country cannot afford and will only get worse.”

12. The pressure on the Tribunals Service has resulted in a significant wait for
clients before they have their appeals heard. The experience of advisers is that
appeals are taking around 6 to 9 months to come to a hearing causing
considerable financial worry and stress to claimants:

“It’s unreasonable to expect claimants to wait 6 months before their tribunal hearing
and for a decision – stressful for claimants.”

“…the 6-month wait for an appeal to be heard does not do the claimant's health any
good at all.”

13. Despite changes made by the Department to reduce the number of appeals
made, it is likely that the re-assessment will cause another surge in ESA
appeals, placing significant additional pressure on the Tribunals Service and the
advice services supporting these claimants.

The outcome of the migration process

14. The performance of ESA thus far, and the significant press attention devoted to
it, means that many Incapacity Benefit claimants are aware of the upcoming
reassessment process. For some, the impending migration is a source of
significant worry and may be making health conditions worse. A welfare adviser
explained how one client viewed her upcoming reassessment:

“A client phoned in a very distressed state. A friend of hers had told her to telephone
the CAB. She is on Incapacity Benefit and is very fearful about the changes she is
hearing about that could affect her benefit entitlement. She said she wanted to be
dead and last weekend thought of overdosing… She cried a lot and there were
pauses. Tried to reassure her and not to worry about what may or may not happen.”

15. The effects of the reassessment process on the health of claimants – even
before an assessment has taken place - must therefore not be underestimated.
There is a risk that long-term IB claimants may not understand the significance of
the reassessment or be unable to cope with the process. In these circumstances,
claimants may fail to respond to communications or fail to attend medicals. One
possible outcome of the migration process is therefore that thousands of
claimants will drop out of the system altogether and be denied the support that they should be entitled to. It is imperative that these people are supported in the process and not written off.

**Fit for work**

16. The Department estimated that around 23% of IB claimants would be found fit for work in their reassessment. Initial estimates from the pilots in Aberdeen and Burnley found that 30% of IB claimants had been found fit for work. This would suggest that up to 50,000 IB claimants in Scotland will be found fit for work by 2014 – around 45 for every day of the next three years.

17. The stated aim of ESA is to support those on sickness benefits with some capability for work back into the workplace. However, it appears that the majority of former claimants are not being supported into sustained employment. An independent review of ESA customers published in December 2010 found that only 13% of those found fit for work in their Work Capability Assessment have been helped into sustained employment. The majority of those found fit for work either live on reduced benefits or rely on the income of a partner instead. 61% of those found fit for work are neither in employment or receiving JSA. These findings suggest that the ESA process is not achieving its stated aim.

18. It is likely that long-term IB claimants – who have already been deemed unfit for work and who are likely to have a poor employment history – will face even more barriers to work and will need significant support to overcome them. It is imperative that substantial targeted support is provided for former IB claimants in the new Work Programme. The alternative is a risk that these former claimants will be ‘creamed and parked’ by back to work providers.

19. Many former IB claimants will be ineligible for JSA if their partner has an income or if they have savings. Anecdotally, many claimants who are found fit for work are dropping out of the benefits system altogether and relying on the income of their partner to get by.

20. The result of these issues could be a group of people with health problems who are not in employment or supported in the benefit system. Far from supporting people into work, the outcome of the migration process could be to move sickness benefit claimants on to a less expensive benefit or out of the system altogether.

**The Work Related Activity Group (WRAG)**

21. In the recent pilot phase of the national reassessment, 39% of IB claimants were placed in the WRAG group. While we have previously argued that far too few claimants were being placed in this group – about half of the Government’s

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initial estimate – proposed changes to the WRAG group will have a substantial impact on the claimants placed in this group.

22. Those placed in the Work Related Activity Group (WRAG) will have a time limit of 12 months for claiming contributory ESA. If they have not found employment by this point, they will be moved to income based ESA or moved off the benefit altogether. Around 700,000 people in the UK will be affected by the change by 2015-16 – around 280,000 would lose entitlement to ESA after 12 months. The average loss (for those those losing out) would be £51.85/week (£2,700/year) if they do not find employment.\(^5\) Research undertaken for the DWP\(^6\) found that 31% of claimants in the WRAG group did not expect to ever return to work.

23. Assuming that the figures from the pilot in Aberdeen and Burnley apply to the rest of the country – 30% fit for work; 39% placed in the WRAG group – then the above figures would suggest that 30% of claimants would be moved off sickness benefit after their assessment and a further 12% moved off ESA after 12 months. All told, the Government is estimating that more than 4 in 10 current IB claimants (around 75,000 claimants in Scotland) will be moved off sickness benefits within 12 months of their assessment. Whilst it would be a significant boost to the economy and to these people’s lives if they found rewarding and sustainable employment, only a small minority would find sustained work if current trends continue. The remainder would claim JSA or drop out of the benefits system altogether.

The time-scale for the national roll out

24. 207,000 people in Scotland claim Incapacity Benefit. The majority of these claimants will be reassessed in the next three years, which will involve over a thousand re-assessments each week in Scotland. This is a major exercise for the DWP and Jobcentre Plus, both of whom are concurrently being asked to cut their spending.

25. There is a major worry that the national reassessment is being rushed and pushed through in an ad-hoc fashion. Any learning from the pilots that have taken place in Aberdeen and Burnley has a very short time to be fed into the national reassessment – there was one working day between the end of the pilot and the start of the national reassessment.

26. On top of this, the Government are attempting to combine changes recommended by the Harrington Review with its new ESA regulations. The multiple changes, and the haste at which they are required to be introduced, do not suggest a settled system with which to launch such an ambitious national roll-out.

27. We are also concerned that the haste at which the national reassessment is being pushed through will potentially leave Jobcentre and ATOS staff unable to cope with the rapid changes. Jobcentre staff will soon be expected to help

thousands of customers with health problems and poor employment histories prior to the Government’s proposed Work Programme coming into place in the summer. We are worried that the rapid changes that are being pushed through will negatively impact on claimants in the national reassessment.

28. Welfare advisers expressed their concern about the speed and scale of the national reassessment:

“If I am right in thinking it is expected to be completed by 2014, I think this is ambitious and I am concerned the right decision for claimants may be compromised because of the rush for the migration to be completed. I expect disaster for our clients.”

“It appears that the DWP are unable to cope with the number of cases. I’ve had clients who have been waiting more than 12 months for an initial medical – and with 1 million plus IB claimants to reassess this will only get worse.”

29. The speed of the national reassessment is likely to place huge demand on the services of welfare advisers in citizens advice bureaux. Bureaux currently deal with around 1 new issue each year for every 3 ESA claimants in Scotland – if this trend is repeated for IB claimants in the reassessment, bureaux could expect to deal with almost 70,000 new issues on their behalf. This welfare adviser explains her expectations:

“We are awaiting this process with trepidation as we expect our workload to increase substantially.”

30. It is also worrying that the Work Programme will be introduced some months after the national transition from IB to ESA has started. It is expected that 10,000 Work Capability Assessments of IB claimants will be undertaken each week from April 2011 with an expected 23% of claimants found fit for work.⁷ This is on top of the 20,000 new ESA claimants that are currently being found fit for work each month. Therefore, it is highly likely that tens of thousands of claimants – many of whom will face significant barriers to work and pose serious difficulties for JCP staff – will be found fit for work and encouraged to apply for JSA before the Work Programme is in place. These claimants may not receive the support to enter the job market that they deserve and were promised.

Conclusion

31. ESA is a benefit without a good record of assessing capability for work correctly or for improving outcomes for claimants. Rushing it out one working day after the end of the pilot, and at the same time as implementing new regulations and recommendations from a major review, is a huge risk and has the potential to impact negatively on some of the most vulnerable groups in society. Many former claimants will receive support and return to employment – and this is to be welcomed – but there is a significant risk that the majority of former IB claimants will find themselves in a worse position, both in financial and health terms, than their current situation. This is contrary to the aims of the exercise.

April 2011
Written evidence submitted by Oxford Welfare Rights

Oxford Community Work Agency (OCWA) is a local charity which has been providing specialist advice on social security benefits for over twenty years. OCWA is funded by Oxfordshire County Council and Oxford City Council. OCWA’s services are provided through:

Oxfordshire Welfare Rights (OWR) – which provides ‘second tier’ advice in social security law including tribunal representation, a telephone consultancy service to other statutory and non-statutory agencies and training courses. The service covers Oxfordshire (and under separate funding a telephone consultancy service for Hampshire Citizens Advice bureaux).

Barton Advice Centre (BAC) – which provides a ‘front line’ advice service primarily for residents of Oxford City and surrounding area. This service includes specialist welfare benefits and debt advice work.

SUMMARY

- The Work Capability Assessment (WCA) process including the statutory test is not fit for purpose.
- The migration process should be suspended until such time as there has been a quantifiable improvement in the application of the WCA.
- There is considerable scope to reduce the cost to the public purse of poor decision making and the consequent volume of appeals.
- The ‘limited capability for work related activity’ criteria should be further revised to take account of claimants with severe limitations including those previously ‘exempt’ from the PCA.
- Claimants should not be treated as not having limited capability for work and benefit stopped immediately following an initial failure to attend a WCA examination.
- The WCA must include a process by which appropriate evidence from the health professionals treating the claimant is obtained.
• Healthcare Professionals and decision makers should receive additional training on the proper application of the statutory criteria and case law.

• The DWP and the Tribunals Service should be required to produce a submission and list a case for hearing within a statutory time limit.

• There is significant scope for the DWP to improve the process of revision and the quality of such decisions.

• Monitoring of the appeals process and appeal outcomes is required.

• The permitted work higher limit rule should be amended to make provision for claimants who do not have the capacity to undertake ‘full time’ work.
INTRODUCTION

1. In our submission the WCA process, including the statutory test itself, is not fit for purpose and the migration process should be suspended until such time as there has been a quantifiable improvement in its application.

2. There is considerable scope to reduce the cost to the public purse of poor decision making and the consequent volume of appeals.

3. It is our experience that the most significant problem with the application of the WCA is the limited accuracy and appropriateness of the medical opinion provided by ‘healthcare professionals’ (HcP) on form ESA85.

REPRESENTATION AT WCA HEARINGS

4. In the period from August 2009 (first hearing) to 31st March 2011 we have represented 157 claimants at a first tier tribunal hearing\(^1\) following a decision that they were ‘fit for work’. 94% of those appeals have been successful. This reflects our previous experience under the PCA from its introduction. We believe this demonstrates that there are significant problems with the application of the WCA.

MIGRATION

The Department’s communications to customers going through the migration process.

5. We welcome the more proactive approach to the WCA process the department intend to apply during the migration process.

6. We are concerned that in practice:

- The process will not be sufficiently responsive to individual claimant’s needs and circumstances, for example, those with a significant mental health condition.

- Staff may be constrained by following a question and answer style script during telephone or face to face contact.

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\(^1\) Excluding hearings which did not reach a decision.
• Staff may not have sufficient understanding of the statutory and administrative processes.

• Staff may not have sufficient awareness of incapacity and disability issues, be sensitive to individual claimants needs or have the necessary skills to enable them to ‘tease out’ relevant information.

• How claimants who were previously accepted as exempt from the PCA will be dealt with, as many will have had no prior experience of the PCA process and will have significant limitations on their capacity to engage in the migration process or work related activity.

• Following a decision that a claimant does not have limited capability for work the emphasis may be unduly placed on claiming alternative benefits and work seeking.

• Claimants may not be given clear and accurate information about their right of appeal, the appeal process or entitlement to receive benefits as ‘incapable of work’ pending a tribunal hearing.

7. Following a decision that a claimant is ‘fit for work’ it is our experience that claimants are often given inaccurate information by staff at local Jobcentre Plus offices. For example, that the claimant cannot continue to receive ESA pending an appeal hearing and must claim JSA instead (or vica versa).

8. Similarly claimants who have been found fit for work but have made an appeal are being advised by staff at the JSA new claims contact centre that they cannot claim JSA because they have an outstanding ESA appeal. What is absent in each scenario is a clear and accurate explanation of a claimants options and what action they need to take.

Migration of claimants exempt from the PCA

9. Particular difficulties may arise for claimants who are currently exempt from the PCA. Only a limited number of such claimants are likely to be found to have limited capability for work related activity (the Support Group) because of the more restrictive criteria. However, they are unlikely to attain a capacity to work in the foreseeable future.

**Case example**

Mr H had a diagnosis of schizophrenia. He lived in supported accommodation. He was previously accepted as exempt from the PCA. At his most recent PCA examination the HcP’s opinion was an award of 0 points under the physical criteria and 8 points under the mental health criteria which was confirmed by a decision maker. A tribunal found that he remained exempt from the PCA due to a ‘severe mental illness’.

A complaint was made to Atos Healthcare about the failure of the HcP to explore his symptoms and the impact of the condition. The complaint was upheld at the Independent Tier of ATOS Healthcare’s complaints procedure.

10. If significant numbers of claimants who were previously exempt from the PCA are found only to have limited capability for work this may lead to a perception that the process of migration is unfair and will bring the WCA process into further disrepute.

11. **Recommendation:** The ‘limited capability for work related activity’ criteria should be further revised to take account of claimants with severe conditions (including those exempt from the PCA) who are unlikely in practice to be capable of engaging in work related activity, and who have little prospect of obtaining and maintaining work in the foreseeable future.

**FAILURE TO ATTEND**

12. It is appropriate that claimants should ultimately suffer sanction if they fail to attend a WCA examination when directed. However, the current provision is harsh. It is unlikely that significant numbers of claimants wilfully fail to attend. Reasons for failing to attend are varied but are often linked to the claimant’s health condition, a misunderstanding of the process or administrative problems at DWP or Atos Healthcare.

13. Whilst there is some protection within the ‘good cause’ provision,$^3$ in practice there are long delays in the determination of good cause by decision makers. This means claimants are left without benefit for considerable periods. If good cause is not accepted there will be a further delay while a new claim for ESA (or JSA) is made and processed and a new date for a WCA is set. Frequently claimants in this situation are left reliant on Crisis Loans for income.

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$^3$ ESA Reg 38(2).
14. There is significant scope for DWP to be proactive and establish why a claimant has failure to attend, and where appropriate offer a further appointment, before they are treated as not having limited capability for work. A claimant should only be treated as not having limited capability for work where their failure to attend is wilful.

15. **Recommendation:** Claimants should not be treated as not having limited capability for work and benefit stopped immediately following an initial failure to attend a WCA.

THE WORK CAPABILITY ASSESSMENT

16. Migration will commence at the same time that significant changes to the WCA criteria are introduced. Whilst we note that government has agreed to implement the recommendations of Professor Harrington’s first review of the WCA⁴ there will not have been time to implement many of the recommendations or for them to have 'bedded down'.

17. We suggest that the forthcoming changes to the statutory test will not lead to a significant improvement in the quality and accuracy of WCA assessments until issues of its inadequate application are addressed.

Revised ESA50 questionairre

18. We note that a revised version of the questionnaire ESA50 will be introduced alongside the revised WCA. The new version repeats the shortcomings of previous versions including a failure to include questions which relate to all of the points scoring criteria within an activity (for example, activity 2(b) - ‘standing & walking’ - 9 points). This means that at the earliest stage appropriate information to address the statutory test may not be gathered.

Additional medical evidence

19. The WCA process repeatedly fails to obtain evidence that properly addresses the WCA criteria.

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20. GPs and other healthcare professionals are likely to be best placed to provide detailed evidence regarding a claimant’s capabilities. The form ESA113 is inadequate for this purpose as the questions are neither specific to the claimant or the WCA criteria.

21. **Recommendation:** a process by which appropriate evidence from the health professionals advising the claimant is obtained must be introduced into the WCA process.

**Application of the WCA**

22. The WCA is not designed to be a ‘snap shot’ test. It should be applied with reference to a claimant’s ability to carry out an activity with ‘reasonable regularity’.\(^5\) Similarly the effects of, for example, pain, discomfort, fatigue, side effects of medication etc. should be taken into account.

23. **Recommendation:** HcP’s and decision makers should receive additional training on the proper application of the statutory criteria and case law.

**Claimants’ perceptions of WCA examinations**

24. The majority of our clients comment, both to us and before a tribunal, on the way in which the HcP conducted the PCA or WCA examination. Their comments can be summarised to include:

- HcP did not listen to what I had to say / did not allow me to fully answer the questions.
- Spent the whole of the interview looking at a PC screen and using the keyboard.
- Asked leading questions and would only accept a yes/no answer – for example, ‘you don’t have a problem with this do you?’
- Asked only general questions about daily life and did not explain or ask questions about the specific activities in the statutory test.
- Concentrated on my physical health (clients with conditions affecting mental, cognitive or intellectual functions).

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\(^5\) ESA Reg. 34, C1/95(IB), CSIB/17/96, CIB/14587/96 etc.
• General perceptions that the HcP was disinterested in the individual, dismissive of the effects of their condition and were rushing through the assessment.

THE APPEALS PROCESS

Delays

25. It is our experience that the considerable delays that had developed since the introduction of ESA with the processing of WCA and PCA appeals by both Jobcentre Plus and the Tribunals Service have recently begun to reduce.

26. In our experience during 2010 PCA/WCA appeals took on average in excess of six months to reach a hearing with the length of delay being similar at both the Jobcentre Plus and Tribunals Service stage.

27. There must be concern that delays will increase again as a substantial numbers of claimants migrating from IB/IS enter the appeals process later in 2011.

28. We note and commend the recommendations of the Administrative Justice and Tribunals Council (AJTC) recent report - *Time for Action - A report on the absence of a time limit for decision makers to respond to social security appeals.*

29. **Recommendation:** DWP and the Tribunals Service should be required to produce a submission and list a case for hearing within a statutory time limit.

Revision of a WCA decision by a decision maker

30. In our experience only very rarely will a decision be revised by a decision maker following submission of a revision application which includes further medical evidence. There appears to be a culture within DWP that ‘the appeal has been made, let the tribunal decide’. This means that many claimants unnecessarily endure the stress and delay of the appeals procedure.

31. **Recommendation:** There is significant scope for the DWP to improve the process of revision and the quality of such decisions.
Repeat WCAs, failure and appeal – the ‘revolving door’

32. We are currently assisting claimants who had ‘failed’ their first WCA assessment, had been successful on appeal and have now been found ‘fit for work’ under a subsequent WCA. Accepting that some claimants’ conditions and capabilities may change, there would appear to be no procedure within the WCA process that takes account of the outcome of a previous WCA decision or appeal.

33. We have assisted many individuals through the cycle of failed PCA and success at appeal on numerous occasions over a period of years.

34. Whilst it is appropriate that claimants are re-assessed periodically under the WCA the period between assessments must be sensitive to their medical condition. Proper account must be taken of possible improvement in a claimants ability to undertake the prescribed activities and the extent to which undertaking work related activity is likely to have any impact on their move toward being ‘work ready’ and therefore the frequency at which the WCA should be applied.

35. The repeated ‘cycling’ of claimants through the WCA and appeal process will bring the WCA into further disrepute.

36. **Recommendation:** detailed monitoring of the appeals process and outcomes is required including:

- Delays
- Revision of decisions subject to appeal
- Reasons why original decisions are overturned on revision or appeal
- Outcomes for claimants previously within the PCA exempt categories.

**Case example**

*Mr B has a visual impairment. He was scored 9 points (activity 9D) by a HcP confirmed by a decision maker. He appealed against this decision. Medical evidence from his consultant confirmed his loss of visual fields was 75% and that the condition was degenerative. The appeal was allowed on this evidence without Mr B having to attend.*

*Within weeks of the tribunal’s decision he was again assessed under the WCA and only awarded 6 points (9E). He again appealed. DWP refused to revise the decision stating that it preferred the opinion of the HcP to that*
of his consultant. His second appeal was allowed without him being required to attend.

PERMITTED WORK

37. The therapeutic value of work, paid or unpaid, is well understood. However, the permitted work rules are structured on the assumption that claimants who are receiving benefit but undertake some part time paid employment will progress from ‘out of work’ benefits to ‘full time’ work within a relatively short period.

38. Claimants undertaking paid work within the permitted work higher limit (PWHL) rule are currently faced with a ‘cliff edge’ after 52 weeks. At that point they either have to be both capable of and able to obtain an increase in their working hours or give up permitted work.

39. Many claimants undertaking PWHL are not capable of increasing their working hours because of their condition. However they do not require support within the supported permitted work (SPW) rule in order to maintain that work. Having to give up the work after 52 weeks in order to retain benefit entitlement can be detrimental to their health and undermine their long term prospects of increasing their working hours.

40. **Recommendation:** The permitted work higher limit rule should be amended (in advance of the introduction of Universal Credit) to make provision for claimants who are not ready to undertake work in excess of 16 hours per week.

Case example

The following case illustrates issues outlined above for claimants who are exempt from the PCA and/or are undertaking permitted work.

*Mr B (age 42) was employed as a motor technician. He had a brain haemorrhage (aneurysm) in 1998. He was awarded Incapacity Benefit and Income Support. He was able to return to some very limited paid work with his employer under the then ‘therapeutic earnings’ rule. The work he undertook was being provided by an extremely supportive employer and was of very limited ‘commercial’ benefit to them.*
He continued with this work following the introduction of the permitted work rules. Following maladministration of the permitted work rules by DWP his awards of IB & IS were terminated in May 2010.

As a result of this termination he made a claim for ESA. He attended a WCA medical examination in June 2010 and the opinion of the HcP was an award of 6 points under the physical activities. This was confirmed by a decision maker. Mr B appealed against this WCA decision.

It was not possible to establish from DWP whether he had previously been treated as exempt from the PCA although he had never been required to attend a PCA examination. Medical evidence confirmed that he would have met the exempt criteria throughout the period of his IB/IS award but that he did not meet any criteria to be placed in the ESA Support Group (limited capability for work related activity).

His appeal was allowed by a tribunal and he was placed in the work related activity group.

As a result Mr B is required to attend Work Focused Interviews and will be faced with giving up his higher rate permitted work after 52 weeks. Medical evidence confirms that his condition will not improve and he will not be able to undertake work in excess of 16 hours per week. He is working for a very supportive employer and does not require additional support from an outside agency to enable him to continue in this work.

To enable him to continue with permitted work (which is clearly of significant therapeutic value to him) after the 52 week period it is necessary to find an organisation to support his work so he fits within the ‘supported permitted work rule’ even thought such support is not required in practice.
I have to write in relation to the inquiry into the Work Capability Assessment. Regarding the assessments, I think it's appalling that people who've gone through the appeals process and have had their original WCA overturned, then have to go through it all again, in a matter of weeks or months. I've heard this happens in many cases and I think this amounts to harassment of disabled people by the DWP and I hope someone files for a Judicial Review to stop the DWP from getting away with it because I think it amounts to what is known as Wensbury Unreasonable in legal terms.

This brings me onto cutting legal aid for benefits cases. I'm totally cynical about this. There are great injustices already going on and the government are paving the way for further injustice to prevail. It's a nasty move and this means that legal aid funded workers who help people fight their benefit cases will also disappear. The figures show that those with representation do better than those without. Many disabled people will be denied representation and so will be dealt a double injustice.

I have recently been sent an email by a disabled advisory group to state that the ESA test is to get even harder from April 2011. They cite an example in the training manual of people being able to make a cup of tea, wash or dress as being passed as fit for work. This is an outrage. My 83 year-old mother can do these things. Is she to be bullied into work as well? Relating back to the high success rate of claimants having their ESA decisions overturned on appeal, by making the ESA test even harder to pass, fewer will win on appeal a) because of these ridiculous extra hoops disabled people are expected to jump through and b) the cuts to legal aid for benefits cases will ensure this, so that the government can then turn round and meet their targets, rather than meeting the needs of disabled people. In any case, I understood that Professor Harrington's report had called for a better, more sensitive ESA, that was to take account of fluctuating conditions, mental health problems, the assessment process and so on. I see little evidence of this in the new training manual. As it is the test is demeaning and degrading and doesn't look at the impact of disability as a whole but rather breaks it up into meaningless tasks, for example, if somebody can bend down and pick up a coin from the floor, regardless of the fact that a person is supposed to be able to do repeatedly and without pain, otherwise they are deemed not to be able to do it at all. But time and time again, ATOS don't abide by their manual. Surely they are the ones who should be more accountable with such a high error rate? Yet they are being rewarded financially in spite of their appalling failure rate and in spite of the fact that their related company UNUM were found guilty of illegal practises in the US and ran 'disabled denial factories'. The WCA test has been declared unfit for purpose even by its own designer.
Yet in the new manual we have terrifying paragraphs which show little understanding of how illness and disability impacts on the lives of those who suffer – it’s not a case of ‘if you can do this, you can therefore work’ - basic living and survival is on a completely different level than being able to have the stamina and consistent good health required for work. In the DLA consultation, it was at least recognised that disabled people are ‘experts in their own condition” and yet here we have pseudo-science propounded in the WCA manual. Here are some examples:

1) “A clinician does not routinely consider the functional restrictions or disabling effects of the medical conditions that they treat. They must take into consideration that the clinician may have no specific training in assessing disabilities in their medical education, and may have considerable difficulty in giving an accurate assessment or forming an opinion in relation to the functional restrictions experienced by their patient.”

“Atos Healthcare practitioners are specifically trained in the assessment of disability. By evaluating the clinical history, the physical examination and informal observations in the light of the claimant’s daily activities, the medical disability analyst is able to provide an accurate and consistent assessment of the functional restrictions. This assessment is based on the HCP’s medical training and expertise, and a body of established medical knowledge and opinion. The HCP is able to advise the DM on restrictions arising from the disabling condition(s).”

It is absolute nonsense and a complete arrogance for ATOS to think they know more than a highly-trained GP who has studied medicine and been in practise, often for years.

2) “Signs which are inconsistent with purely organic pathology include”:

a) “Overreaction to examination” – everybody reacts differently. Claimants may have been abused, how can such generalised statements fit all? It is ludicrous

b) “Diffuse rather than localised tenderness” – people with fibromyalgia have sore and painful points all over their body, that’s a symptom of fibromyalgia!

3) “It is usually only possible to observe the claimant standing for short periods of time but even these are of value in your report, e.g.

“I observed him standing for 3 minutes only during my examination of his spine but he exhibited no distress and this, in conjunction with my clinical examination recorded below, would not be consistent with his stated inability to stand for less than 30 minutes. He may need to move around to ease spinal discomfort but..."
would not need to sit down." As always, this opinion should be reinforced by typical day examples of standing ability."

Again, this is absolute nonsense. There’s a world of difference between 3 minutes and 30 minutes, Anybody who has lower back problems knows just what a strain it puts on the back to have to stand for 30 minutes.

These are just a few examples in the manual which were jaw-droppingly shocking. Also, there is little reference to fluctuating conditions, yet these are the very people who stand to lose the most, where fatigue, stamina and pain are the main symptoms, eg MS, ME, fibromyalgia, lupus, anxiety, bipolar, depression, schizophrenia etc. Furthermore, the assessment is completely anti-women, there’s no mention of women who have abnormal periods and pain to such an extent that it affects their lives every month.

The government also keep chanting the mantra that the welfare bill has ‘spiralled out of control’ which again is misleading. A lot of the evidence shows this not to be the case, and any increase in spending was as a result of increased pensions and increases in housing benefit and JSA (as a result of the housing boom and then the world recession). ESA actually went down during the same period. Now we hear that the latest unemployed figures have hit 2.3 million, and those most likely to get a job are men over 50 working in the private sector. This isn’t looking good for women, young people, and public sector workers, nor those with a disability. Furthermore, we learn that the DWP are putting pressure on Job Centres to sanction people to meet their targets. Let’s make no bones about what this means, it means people are losing their money, having nothing to live on, they’re in danger of losing their homes, if not their lives and will ultimately cost the health service more in the long run. It is madness and kow-towing to the Tory press who are inciting disability hatred with their vicious and largely untrue reports against the poorest and most vulnerable in society.

The money this country spends on out-of-work benefits as a proportion to income is actually the lowest in the world, lower than the States and many third world countries, and still the government wants to continue a campaign which is becoming dangerously near that of Nazi Germany, where the disabled were among the first to be targeted. In terms of the market-based economy, if we are not financially viable we are dispensible, and compassion goes out of the window. I am ashamed by the monetarist values of this country, where those that ‘can’ will be catered for, and those that can’t will be beaten, bullied or left to rot. The mark of a civilized society is measured by how it treats its weakest members. In the not so distance past, child abuse or rape weren’t taken very seriously, now we look back on those days with horror and disbelief. One day, too, future generations will look back with disgust and abhorrence about the way we treated our disabled people and how it was allowed to happen.
I urge you to do all within your powers to stand up and speak up for all disabled people before it’s too late.

April 2011
1. I would like to raise my concerns about the government's proposals to change people over from long-term Incapacity Benefit to ESA.

2. The medical assessment itself is unfair and does not accurately reflect a person's ability to carry out full-time employment. They are often carried out by 'health care professionals' who do not understand complex conditions. These medical assessments should be carried out by fully trained doctors and where a person has a specific illness the doctor should be knowledgeable about it. There are many descriptors which are so ambiguous that they allow the DWP to find people 'fit for work' when clearly they are not. For example just because a person can pick a light item up once, or can reach above their head with both arms once does not make them fit to work.

3. There are many, many examples of people who have been wrongly assessed by these so called professionals. We have heard news reports about people who have brain tumours, and cancer and have been found fit for work. We have heard about people who have started the appeal process, only to die before even getting a Tribunal date. They must have really been fit to work!!!

4. Probably the most unfair proposal is the one to limit Contribution Based ESA to 12 months, essentially treating it as a means-tested benefit and not an illness based entitlement. This will affect all previous claimants migrating from Contribution Based Incapacity Benefit. In effect, what the government is saying is that if the claimant has a partner who works then they should keep them financially. This is grossly unfair as these claimants have paid into the National Insurance system for many years whilst working, so why should they be punished because they have a partner who is prepared to go out and work.

5. Claimants of income based Incapacity Benefit which is payable through Income Support and Income based ESA, are in effect rewarded for not having worked. In the majority of these cases their partners will also not be working so the government is encouraging people to be lazy in order to protect their benefits. At the same time the government is punishing genuine hard workers, by inflicting the financial burden of their partners living expenses on to them.

6. Likewise, people who have worked for many years and have paid into a private pension or occupational pension will be punished. Never mind the fact that they have already been taxed on the pension contributions, whilst working and then taxed on the pension itself once they were too ill to work, they now also face the extremely unfair likelihood that their ESA will stop as the government decide to means-test it. This is absolutely disgusting, another example of the government picking on the vulnerable members of our society.

April 2011
Written evidence submitted by CarerWatch

This evidence is presented by CarerWatch – a group of unpaid family carers. We also have many members with long term disability. We are an internet group and continually consult with our members. In particular we have written this evidence in open consultation with our members.

Firstly we would like to state that we have never seen such anxiety and distress amongst our members as that being caused by this migration from IB to ESA. The government has caused this distress and we ask the Select Committee to use their best offices to get the government to relieve this distress with extreme urgency. We are sure you understand that undue stress is detrimental to most health conditions.

You ask that we focus on certain questions.

1. *The Department’s communications to customers going through the assessment and whether the information, guidance and advice provided by the Department and Jobcentre Plus*

2. Our members have not yet experienced assessment. We can only say that our members are terrified by the reports that they hear from the media. The government has caused this perceived threat and we cannot understand why no government minister either in the last government or this government steps forward to offer reassurance to our members. This seems a complete failure of the duty of care.

3. *The Work Capability Assessment including the assessment criteria the service provided by Atos staff the suitability of assessment centres and customers’ overall experience of the process.*

4. Again our members have not as yet experienced this assessment. From what they have heard it fills them with dread.

5. *The decision-making process and how it could be improved to ensure that customers are confident that the outcome of their assessment is a fair and transparent reflection of their capacity for work.*

6. This is the crux of the problem. Our members perceive the WRAG to be a nasty group where people are bullied and harassed and effectively required to work. Our members need help back to work if they want it but they also need safety and security. They do not understand why threats and sanctions will be put on them. Their fear is of the WRAG which they do not think meets their needs.
7. The intrinsic nature of the WRAG is never clearly defined or explained. Professor Paul Spicker says in his recent book that the WRAG was originally intended as a rehabilitation group for people with conditions that were expected to get better.

8. But our members will not get better and rehabilitation is not appropriate for them. It says clearly in the Welfare Reform Act that anyone who is allocated to ESA has a condition which makes it unreasonable to require them to work. Our members have long term conditions and so will always have a condition that makes it unreasonable to require them to work.

9. And yet if they are allocated to the WRAG the time limit, the conditionality, the pressure in the WRAG is effectively requiring them to work. A DWP impact statement actually says - http://www.dwp.gov.uk/docs/esa-time-limit-wr2011-ia.pdf

"It was never intended that ESA for those in the Work Related Activity Group (WRAG) should be paid for an unlimited period to people who, by definition, are expected to move towards the workplace with help and support. Government intervention is required to help ensure that ESA is paid for a temporary period for those placed in the WRAG, thereby encouraging a return to work and stopping people being trapped on benefits for a lifetime."

10. So people in the WRAG are actually only in a halfway house on their way to being required to work. This is illogical as they have been assessed as having a condition that makes it unreasonable to require them to work. Is the WRAG for people who it is unreasonable to require to work as it says in the Act or is it a group for people who will be forced to work? This has to be clarified before a test can be devised to allocate people to the WRAG. The problem is not with the test. The problem is with the unclear nature of the intrinsic concept of the WRAG.

11. What is worse is that getting back to work is to be achieved by means of time limits, threats and sanctions. This is causing the fear.

12. People with long term disability will never be the same as fit unemployed people. Mr Grayling continually tries to equalise conditions between JSA and the WRAG on grounds of fairness but this is not fair. People with disability have extra difficulty and need extra consideration.
13. They will always have barriers to work – physical, social, emotional, practical. That does not mean that they cannot work and hopefully many of them can. The idea of supporting them with help to work is excellent and ESA could have been an excellent program of help. Unfortunately by introducing threats, sanctions, conditionality and time limits ESA is now riddled with fear.

14. The Support Group does not rule people out of work. People with even the severest of conditions may be able to find and keep work. Stephen Hawkins comes to mind. Help should be offered to absolutely every one with disability. But not threats and sanctions. No contractor or advisor has walked in the shoes of the person with disability whom he is advising. Any perceived non compliance may always be due to the condition. No sanction can ever be known to be fair. The idea of conditionality and sanctions being applied to people who are not fit for work can never be fair.

15. In conclusion - the allocation to the WRAG for long term conditions is therefore illogical and until it is made clear why some people are to be harassed and not others we can’t discuss how to manage the allocation in a way that is clear and transparent. We simply do not believe that any government minister in this government or the last has given a convincing explanation as to why someone who is never going to be fit to be required to work should be harassed and threatened and effectively required to work.

16. The appeals process, including the time taken for the appeals process to be completed; and whether customers who decide to appeal the outcome of their assessment have all the necessary guidance, information and advice to support them through the process.

17. If the grounds for treating the two groups differently are not clear to us then the allocation is not transparent and the grounds for appeal are also not transparent.

18. The outcome of the migration process and the different paths taken by the various client groups: those moved to Jobseeker’s Allowance, including the support provided to find work and the impact of the labour market on employment prospects; those found fit for work who may be entitled to no further benefits; those placed in the Work Related Activity Group of the ESA, including the likely impact of the Department’s decision to time-limit contribution-based ESA to a year; and those placed in the Support Group.
19. We do not accept that the WRAG is a safe place for anyone who has a long term condition where it is not reasonable to require them to work for the reasons given above. It’s no wonder when less than a third of existing IB claimants made it to the support group in the pilots that there is a climate of fear about the WRAG.

20. The time-scale for the national roll-out for the migration process, including the Department’s capacity to introduce changes identified as necessary in the Aberdeen and Burnley trials.

21. We don’t believe the division into Support and WRAG is logical or meaningful for long term conditions so obviously we don’t think that ESA should be rolled out until it is made fit for purpose. It would take so little to make ESA fair and transparent and an excellent program of help. Simply place every one who has a long term condition that meets the criteria of ESA in the Support Group and offer them help. Concentrate the help on people who want it whatever the severity of their condition. If people were not so terrified of being allocated to the WRAG they would have the confidence to try things that might fail. Currently they will be frightened to ‘have a go’ in case they are moved to the WRAG or JSA. Fear and threats are just no help to people with disability. Fear of the WRAG is demotivating and counter productive.

Leave the WRAG as a rehabilitation group.

Summary

CarerWatch are dismayed by the alarm and fear the roll out of ESA is causing our members. CarerWatch do not think ESA is fit for purpose and think the roll out should be halted until it is made fit for purpose. The Act says that any one allocated to ESA has a condition which makes it unreasonable to require them to work. If this is a long term condition they will always have barriers to finding and keeping work and they should be allocated to the Support Group.

The WRAG is a half way house to being time limited and sanctioned and forced off benefits. It is effectively requiring people to work which is illogical. The WRAG should revert to its original role of a rehabilitation group for people who will get better

With this one change ESA could become an excellent initiative to help people work and once the fear is removed people with long term disability might take a more positive approach and take a few risks to try and work.

April 2011
Written evidence submitted by Julia Cameron

Summary: My concerns as a person with long-standing ME/CFS facing the WCA.

1. I receive IB and am waiting to receive the letter calling me to be assessed for ESA. I have been unable to hold down a paid job since contracting severe ME in 1989, but when I got sick I had already been working only 3 or 4 days a week for many years because of ongoing fatigue and susceptibility to viruses. I found this was the only way I could keep myself afloat. My GP didn't seem to know what to do with me when I had a period of post-viral fatigue in my early twenties, so after that I pretended to myself and everyone else that there was nothing wrong with me and that it was a choice to work part-time. But it wasn't - I already had a form of chronic fatigue syndrome. Thirteen years later the sudden and severe downturn which became ME made me literally too sick to get out of bed and I had no choice after many months of no improvement but to give up my job. After a couple of years of severe illness my condition improved somewhat but I never became well enough to hold down paid work, and I deteriorated again 12 years ago. I will be 60 next year and have realised that over the last few years I am continuing to go downhill, despite having tried more or less every possible treatment for my condition, the few available on the NHS and many alternatives. Of course, worrying about losing disability benefits does my health no good at all.

2. Four years ago, after some private treatment made me a little better for a while, I started a very part-time voluntary job in an office. It was a great job for me as it was with an organisation whose aims I supported and it used some of my old skills. It was very local, entirely sedentary and only 7 hours a week, but even this had to be split between two days as I can never be active for more than a few hours even on 'good' days and must always sleep or at least rest horizontally in the afternoons for at least two hours. If I try to get away without this my condition rapidly gets a lot worse. I loved the job and thought I could cope with it for those few hours, in fact I initially hoped it might be a stepping stone to longer hours and maybe eventually a paid part-time job. But sadly, over the next 3 years my condition deteriorated further. Even working half a day twice a week was too much for me to sustain on a regular basis and eventually, very depressingly, I had to accept I must give the job up. I have spent the following year trying to repair the damage done to my condition - I have not fully succeeded. So my health, which was already very poor, is now worse than it was 4 years ago, because of attempting the most part-time work.

3. Despite this, reports about the way the WCA is carried out make me concerned that I might fail it, because on brief examination I can appear 'normal'. But with M.E my major problem is post-exertional malaise and extreme fatigue, which means I might be able to do something at the time, but will pay for it by hours or even weeks in bed depending on the degree of exertion. Even what would appear very mild exertion to most people can leave me so ill I go into a sort of stupor and am unable to speak. When you see me looking 'normal' it is because I have managed my very limited energy extremely carefully so that I can be functional for short periods of time. This is something I and disabled people with a variety of impairments have had to learn to do, and the degree of planning and organisation that it takes is mostly invisible to and unappreciated by outsiders.

4. I can't think of anything I would like more than to be able to work again, and I wish this and all governments understood that most unemployed disabled people would like nothing better than to earn their own living. We are not 'work-shy scroungers' as depicted so unpleasantly these days in the media - as a trustee of a local organisation of disabled people I know my concerns are felt by many
others. But even when I am fit enough to do some work-related tasks no employer on this planet would choose to employ someone like me, who can at best do so very few hours a week, and not even those on a regular basis. My condition means I often relapse quite unpredictably, and when I get a cold, let alone flu, I take many weeks to recover, months in some cases. If I push myself at those times I simply get sicker and recovery takes longer. I am someone who does not need to be 'encouraged' to work, rather, pushing myself to keep on working despite illness has led to my current situation. And in an economic system in which employers must make a profit and local authorities stick firmly to budget, I would never be a useful employee.

5. As more and more news comes out about the functioning of the WCA, the two types of ESA, and people being sanctioned and losing benefits entirely I am becoming even more worried, and the worry is worsening my health. If I qualify for ESA I am concerned about being deemed able to work at some future point, despite my age and the severity of my illness, and being put into the work-related activity group. As I am not well enough to undertake 'work-related activities' on a regular basis I am scared that I might be then be sanctioned and lose all benefits. If, god forbid, I was put onto JSA I simply would not have enough money to live on. The extra costs to me of being disabled are substantial and not covered by my existing benefit level, let alone if I lost £30 or £40 per week. If I were required to expend energy regularly looking for work my health would quickly take a further downturn. Combined with increased money worries and I could easily end up back in bed 24/7 and needing much more personal assistance. For which local authorities are now introducing charges, so yet more money problems. Some disabled people are talking of suicide in this kind of situation and I can entirely understand why. I hope and pray the government will see sense before forcing large numbers of IB claimants onto JSA or requiring us to undertake 'work-related activities' as disaster looms for many of us if the government does not change course.

April 2011
1. Executive Summary:

ACT NOW (Autism Campaigners Together) have many concerns about the migration from Incapacity Benefit to Employment Support Allowance including the Work Capability Assessment:

- Reasonable adjustments are not being made for adults with autism who have a diagnosed communication and socialisation impairment in line with Section 20 Part 5 of the Equalities Act.
- No support in the form of an advocate or communicator is being offered at the first point of contact by Jobcentre Plus for claimants with autism.
- The Jobcentre Plus factsheet for adults who have additional support and communication needs excludes adults with a diagnosis of autism. No reference to autism is made in the factsheet.
- The Work Capability Assessment descriptors do not reflect the complex nature of autism.
- Adults with autism are being inappropriately subjected to an assessment using a method that does not allow the complexity of autism to be accurately assessed.
- Parents and carers are not being allowed to help their adult children communicate during their assessment.
- The proposed changes to the descriptors will have a detrimental impact on people with an autistic spectrum condition.
- It must be recognised that many adults with autism have been failed throughout their childhood by both education and health services, impacting on their ability to seek and maintain employment.
- Adults who have been cast adrift without provision and services since leaving Children’s Services will have no supportive evidence to produce if they are asked to do so.
- Assessment Centres are not meeting the sensory needs of adults with autism.
- The distance learning autism training received by the ATOS assessors is woefully inadequate.
- Adults with autism will only feel confident with the assessment process when the method of assessment reflects their complex, specific and individual needs.
- The DWP does not inform adults about the emergency rate which can be accessed if adult finds themselves in an appeal situation which we believe is neglectful.
- The national roll-out for the migration process is we believe premature.

2. Area of Interest:
ACT NOW (Autism Campaigners Together) is a campaign group which was formed specifically to raise awareness regarding the impact cuts to Local Authority budgets and the changes to benefits, including assessments, will have on the autism community throughout the UK. ACT NOW has 10,000 supporters who actively feed into the campaign via our 23 Regional Co-ordinators who oversee our 10 regional groups and our groups in Scotland, Wales and Northern Ireland.

The core group members of ACT NOW include:

Carole Rutherford (Campaign Manager) has two sons with autism and is an advisory group member of the All Party Parliamentary Group for Autism. Carole was a member of the External Reference Group who acted as an advisory group to the Department of Health while they were drafting the Adult Autism Strategy.

Anna Kennedy (PR) has two sons with autism, founded and runs Hillingdon Manor and Baston House School. Baston House School is a community college for people aged 16+ offering vocational training from two sites in west London, a residential home for those attending the college, a specialist support outreach service and a thriving social networking club for young people. Anna and her team have created the largest range of specialist facilities in Europe.

Teresa Catto-Smith (Administrator and Scotland Co-ordinator) is a full time mum to 6 children (one is autistic, one is dyslexic & dyspraxic) and is an autism campaigner. Teresa runs her own support networks, Autism in Scotland and Lothian Autism Network, which are used by nearly 1300 people via Facebook.

Mavourneen Moore (Information Officer) has a teenage son with autism, works full-time in a pharmaceutical company and is an autism campaigner. She also volunteers for Braintree Mencap as vice chair of the executive committee and for Mencap Senior Gateway club.

In October 2010 ACT NOW published an impact assessment supported by 6000 people. The assessment included contributions from 2949 members of the autism community.

ACT NOW would welcome the opportunity to give oral evidence to the committee.

3. Our concerns:

The Job Centre Plus Factsheet ‘Reassessment of Incapacity Benefits /Support offered by Job Centre Plus for Customers with additional support and communication needs’ excludes anyone who has a diagnosis of autism which is a recognised communication impairment:

3.1 The factsheet gives specific information for customers for whom English is not their first language, customers who are visually impaired and customers with hearing and speech impairments and was issues by JCP in February 2011. It fails to mention communication impairments.

3.2 The factsheet states ‘Customers will receive a letter from Jobcentre Plus telling them that their benefit is being reassessed. Jobcentre Plus will then call the customer to discuss how this change will affect them and to answer any questions.’ Adults with autism will need to be offered support and the opportunity to access an advocate/communicator before the phone call takes place. The offer of support should be made in writing and in advance of the phone call from Jobcentre Plus and questionnaire being sent to adult for completion.
3.3 The factsheet continues: ‘During this telephone call the customer will be asked if they have any additional communications needs.’ Adults with autism require an advocate/communicator to be present with them when the phone call is made as without the right support they may be unable to identify their own communication needs and share that information. Being unable to identify and label how their disability impacts on their lives is one of the problems that adults with autism face daily.

3.4 While we acknowledge that Jobcentre Plus will support a customer’s right to have representation an adult with autism has to be made aware of this at the first point of contact. Arrangements then need to be put into place to ensure that support is offered in the form of either an independent trained advocate or someone who the person with autism is comfortable with and who they are happy to help them to communicate effectively.

4. The WCA is based on medical and social models of disability and the descriptors in no way reflect the complexities of autism. Adults with autism are being inappropriately subjected to the WCA and the impact of their disability is being assessed by a model that does not allow the complexity of autism to be accurately assessed.

4.1 In order to qualify for ESA in a work-related activity group the adult being assessed has to gain more than 15 points. The way in which it is currently proposed to change the descriptors we believe will have a detrimental impact on people with an autistic spectrum condition. The descriptors take no account of communication difficulties, verbal or non-verbal, due to mental impairment. We believe this to be a critical error within the assessment. Communication and comprehension are essential in the workplace.

4.2 ACT NOW argues that autism does not fit into either model of disability given it is a neurological condition, often hidden and varies greatly in how aspects of the numerous traits can affect each individual. Children and adults with autism are often more disadvantaged as a group and presented with even greater barriers than most.

4.3 Adults with autism do not always have any specific medical complaints making it difficult to identify physical or social barriers unless a complete profile and history of the person is completed. This must include evidence from carers and guardians. We have been told by Chris Grayling that this information will be considered as "secondary evidence" because most medical people do not have the ability to assess the extent to which someone is disabled by their condition.

4.4 ACT NOW believes that an automatic offer of support for every adult with autism, on the basis of their diagnosis and access to an independent advocate, supporter or ‘communication assistant’ must be made at the first point of contact by JCP/DWP. This must apply to all adults who have a diagnosis of autism irrespective of their communication abilities. It is essential that their communication difficulties and differences, their communication 'styles' and their preferred methods of communication are taken into account and reasonable adjustment made. (To meet Section 20 part 5 of the Equalities Act.)

4.5 Duty to make adjustments E+W+S(1): “Where this Act imposes a duty to make reasonable adjustments on a person, this section, sections 21 and 22 and the applicable Schedule apply; and for
those purposes, a person on whom the duty is imposed is referred to as A.(2) The duty comprises the following three requirements. (3) The first requirement is a requirement, where a provision, criterion or practice of A’s puts a disabled person at a substantial disadvantage in relation to a relevant matter in comparison with persons who are not disabled, to take such steps as it is reasonable to have to take to avoid the disadvantage. (4) The second requirement is a requirement, where a physical feature puts a disabled person at a substantial disadvantage in relation to a relevant matter in comparison with persons who are not disabled, to take such steps as it is reasonable to have to take to avoid the disadvantage. (5) The third requirement is a requirement, where a disabled person would, but for the provision of an auxiliary aid, be put at a substantial disadvantage in relation to a relevant matter in comparison with persons who are not disabled, to take such steps as it is reasonable to have to take to provide the auxiliary aid.

4.6 While we acknowledge that adults are sometimes encouraged to take someone with them during their assessment/interview parents, carers and relatives are feeding back to ACT NOW that they are not being allowed to help the adult with autism to communicate. Adults with autism require so much more than moral support at these interviews. We are aware that adults are extremely anxious in the build up to an assessment. Anxiety, sensory and behavioural issues can continue to impact on the adult for sometime after the assessment.

4.7 We are also hearing of people attending for assessment only to be told upon arrival (or after a wait) that their assessment is cancelled. Travelling and waiting are both areas of daily life that cause most people with autism massive anxieties.

4.8 One parent carer contacted ACT NOW to tell us that her daughter was very upset and crying during the assessment, the assessor then said “no, look me in the eye when I’m talking” – this is bullying/intimidating behaviour and very distressing for someone with autism. This young woman (and her mother) has not recovered emotionally despite being awarded ESA; she now lives in fear of the next assessment.

4.9 Assessment centres, and the rooms themselves, take no account of the sensory processing impairment a person with autism has, regardless of how able they appear to be. The environment is harsh and unfriendly – to all attendees. We are also hearing from people who have been kept waiting for at least an hour prior to an assessment – this is cruel and causing more anxiety.

4.10 The process of the WCA begins with a written questionnaire and because all forms of communication are impaired, adults with autism require support to enable them to fill it in. A literal interpretation and understanding, which is a part of the condition, is making the questionnaire (any questionnaire) very difficult for adults with autism to complete. One adult who contact ACT NOW supported his questionnaire with 192 pages of supplementary evidence which Job Centre Plus refused to read. This led to the adult becoming extremely stressed and medical help had to be sought for the adult.

5. There must be some weight given to those adults who have for a number of years been without support and provision and so will not be able to produce any written evidence which documents the difficulties that the adult has because of their autism. Some adults have been totally unsupported
since leaving Children’s Services and so have effectively been failed by the system. These adults are often isolated within our communities and are especially vulnerable. There is nothing within the current system that takes into account the fragility of these adults.

6. Training on Autistic Spectrum Conditions should be mandatory for all ATOS assessors not optional as it is at present – there are many stereotypical misconceptions about autism banded about by many, including professionals. The ability to access vital disability benefits should not be based on stereotypes. The subject of autism is covered within a self directed learning module ‘Learning Disabilities and Autism’ this module is presented as a DVD. Not everyone who has autism has an associated learning disability; this is something that is all too often overlooked when training is being carried out. Even where there is a learning disability present autism plays a large part in how that adult will present.

7. At the moment only 15% of adults with autism are in full time employment. This is opposed to 48% of adults with other disabilities being in full time employment. While some adults with autism do want to work and are capable of being in employment, it must be recognised that for some adults with autism living an independent life without employment will be a positive outcome too. Being able to live independently is something that should be a higher priority than employment for some adults with autism.

7.1 For this reason ACT NOW believe it is essential that adults with autism (and others with similar disabilities) who try to seek and maintain employment and for whatever reason fail are not penalised or given a ‘sanction’. Autism must be categorised as a high risk group, recognising that adults with this disability often find it difficult to seek and maintain employment – often because of the culture and social problems they face in the workplace.

8. Adults with autism will only be able to feel confident that the decision making process and the outcome of their assessment is a fair and transparent reflection of the capacity to work, when the method of assessment that is being used to assessment actually reflects their complex and specific needs.

9. Unless adults with autism have the necessary support, which they will require from the first point of contact by Jobcentre Plus, some adults are likely to be daunted/put off by the appeals process.

10. There is an emergency rate of Employment Support Allowance (or Income Support if this is an old claimant) that the DWP will give until their tribunal makes a decision. The payment is only slightly less per week than ESA/IS. If the adult wins their case they receive a full back payment. The DWP does not tell claimants about the emergency rate, which we believe is neglectful.

11. For those adults who have been continually failed by both education and health services throughout their childhood, the move to the Work Related Activity Group of the ESA could prove to be an extremely traumatic experience with the outcome being that those adults, many who are without services and provision, will reach crisis point.

12. ACT NOW does not agree with the decision to time-limit contribution ESA to a year and for those placed in the Support Group. This shows a failure to recognise that some adults will not be ready to
seek or maintain employment within a year of being eligible to claim ESA. This is especially so for adults who have a lifelong condition like autism. There must be some method of separating people with disabilities who may recover from their disability/illness/injury who could well be ready to seek and maintain employment within a 12 months period and those for whom this will not be possible.

13. The timescale of the national roll-out for the migration process is we believe premature to say the least. It would appear to be imprudent to continue with a national roll out of a system that is at the moment under review for the second time and only weeks away from that report being published.

14. ACT NOW is extremely concerned that the charities who were working on the Harrington Review, one being the National Autistic Society have now unanimously dissociated themselves from the internal report.

15. ACT NOW Recommendations:

- Adults with autism will require support to enable them to communicate effectively throughout the whole process of assessment no matter how able they appear to be.
- Support must be offered to adults at the first point of contact which should be in advance of the commencement of the assessment process. Every adult with a diagnosis of autism should be offered an independent advocate communicator or access to a communication system that best meets their needs.
- Any assessment which is used to decide if an adult with autism is capable of working must reflect the complex nature of the condition.
- All of the needs of the adult must be taken into account including their specific sensory needs and reasonable adjustments must be made for that adult in line with section 20 of the Equalities Act.
- It must be recognised and documented that some adults will be unable to provide supportive evidence from professionals involved in their lives if required to do so. Many adults have been without provision and services and without any contact with professionals after being signed off from Children’s Services. This is especially so for adults with Aspergers Syndrome and High Functioning Autism.
- Supportive evidence from parents, carers and people who know the adult well must be deemed to be acceptable in situations where an adult has not been able to access professional support.
- It is essential that the history of adults with autism is taken into consideration. Many adults with autism were failed throughout their childhood by both education and health. The failure to meet the needs of children and adults with autism is now well documented and has been at the heart of several Government inquiries.

April 2011
Written evidence submitted by Elina Rigler

1. Summary
I have lived with a chronic illness for almost 20 years and am currently receiving Incapacity Benefit. Having participated in programmes such as Pathways to Work on a voluntary basis, I possess first-hand experience of the barriers to work faced by those with limiting long-term illness.

I do not believe that the system is working properly in its current form, and I am concerned that the migration of IB claimants onto ESA has begun before all the necessary changes to the Work Capability Assessment have been implemented.

My more general concern is that the IB reform is based on questionable assumptions about illness and employment, and is therefore likely to fail, causing a good deal of suffering to claimants. Specifically, the system does not take account of the real-world impact of chronic illness on an individual’s ability to work or chances of finding work.

2. The time-scale for the national roll-out for the migration process
Like hundreds of thousands of other IB claimants, I am extremely apprehensive about the impending ESA reassessment. I suffer from the kind of chronic, fluctuating illness that is insufficiently captured by the WCA descriptors, and my worry is that I will be assessed by a poorly trained HCP with little understanding of my health condition.

The Government is aware that there are serious problems with the WCA; for instance, the Harrington review acknowledged that the WCA doesn’t adequately measure the full impact of chronic, fluctuating conditions on the individual’s capability for work. Professor Harrington has now set up a working group to review the WCA in relation to conditions such as ME/CFS, MS, arthritis and Parkinson’s disease.

The trouble is that the DWP is pressing ahead with the migration from IB to ESA while ignoring many of the well-known problems with the WCA and only gradually implementing Harrington’s recommendations for improvements. Worse still, a new version of the test has just come into force that is even less capable than the old one of measuring the real impact of chronic illness and will make it even harder for claimants to qualify for ESA.

It is unfair and irresponsible to start reassessing IB claimants using a test that everyone knows is seriously flawed. This is likely to lead to even more appeals and cause more hardship and anxiety to claimants. Moreover, those who are reassessed first, before all the recommendations have been acted on, will be placed at a distinct disadvantage.

3. Reality vs. Rhetoric
The IB reform is presented as a progressive measure empowering sick and disabled people to work. The problem is that the reform is not grounded in reality, but is based on the following highly dubious assumptions:

- The impact of complex medical conditions can be assessed by a tick-box questionnaire;
- the ability to carry out simple tasks indicates the ability to hold down a job in the real world;
- almost all illnesses are transient or can be easily managed;
- a stick-and-carrot approach is needed to get sick and disabled people off benefits;
- employers are willing to take on those with special employment needs, including long-term IB claimants, and
- sick and disabled people are able to compete with millions of able-bodied unemployed people at a time of rising unemployment.
I believe that many of the serious problems with the ESA/WCA stem from this lack of realism and that the system will continue to malfunction until the Government starts addressing these more fundamental issues.

3.1 Improving the Work Capability Assessment and the decision-making process

Improving the WCA requires much more than tinkering with the descriptors. ATOS assessors and DWP decision makers should not rely too much on the crude and rigid point-scoring system, but need to take into account all medical evidence. They should also use their common sense when assessing someone’s work capability; specifically, they should ask the question: does this person have any realistic prospect of finding and sustaining work, given the nature of their impairment?

The DWP is keen to emphasise that the WCA aims to identify accurately what people can do, rather than write people off due to their impairment\(^2\). These are noble sentiments and we should indeed focus on people’s abilities, and not on their disabilities. But there is a difference between what should be happening in an ideal world and what actually is happening. Unfortunately, we live in the kind of world where people with certain types of impairments are not employable in the mainstream job market; in particular, employers are generally not willing or able to accommodate the needs of those suffering from chronic, fluctuating illnesses.

Employers take it for granted that you are able to carry out ‘activities of daily living’, and they are not interested in your ‘good’ days. What they want to know is whether you are able to sustain, regularly and reliably, the kind of high level of mental and physical activity required for even part-time work. This is what the test should assess, and not your ability to walk short distances, raise your arms or press a button.

Too many sick and disabled people will continue to be wrongly declared fit for work until the assessment process starts taking into account how an individual’s illness or disability affects their capability for work in the real world.

3.2 The outcome of the migration process

3.2.1 For those moved to Jobseeker’s Allowance

The Government has frequently claimed that the new system is stopping people being ‘trapped on benefits’. However, there is no evidence that those failing the WCA are moving into work; in fact, they are more likely to be languishing on JSA or to have dropped out of the system altogether.

Indeed, according to the report published by the Institute for Employment Studies, only 13% of those placed in the Fit for Work group had found jobs by the time they were interviewed at least 6 months later, and nearly 60% were neither working nor looking for work (probably because they were unfit for work)\(^3\).

It is particularly cruel to push long-term IB claimants onto JSA and expect them to compete with millions of healthy people in an increasingly cut-throat job market. It is a well-known fact that employers are not willing to take on sick and disabled people; for instance, a recent study suggests that only 8% of employers would consider employing former IB recipients\(^4\).

Those forced onto JSA will lose up to 30% of their income. Although they have been deemed fit for work, most have significant health problems. They may find it hard to comply with the tough JSA regime and risk being sanctioned and losing even more benefit. Moreover, claimants who are not entitled to means-tested benefits can lose 100% of their independent income after six months.

It is not clear to me why being ‘abandoned’ on IB is regarded as a bad thing, but it is acceptable to abandon sick and disabled claimants on JSA at a significantly reduced income, or to simply abandon them, without any benefits.
3.2.2 For those placed in the Work Related Activity Group

Despite their severe health problems, claimants in the WRAG are forced to undertake work-related activities under threat of financial sanctions. It is a good idea to offer sick and disabled people a chance to discuss work opportunities with a personal advisor, but threatening them with sanctions is not only cruel, but also counterproductive. It is likely to cause them stress and anxiety, thereby aggravating their condition and delaying their recovery.

It should be remembered that many people in this group are suffering from long-term or life-long conditions. The ESA regime seems to be predicated on the assumption that even those with chronic or degenerative conditions, who may have been ill for decades, will miraculously recover within a short period of time and be able to find work.

Because of this kind of magical thinking, even those in the Support Group are liable to be subjected to frequent and unnecessary reassessments. Some chronically ill claimants are wrongly found fit for work and have to undergo the lengthy and stressful appeals process. They may eventually win their appeal, but then, only a few months later, may be called in for another assessment and forced to go through whole process again.

Time-limiting contributory ESA to one year means that many people will lose 100% of their benefits and will in effect be punished for being chronically ill and unable to work, or unable to find appropriate work. This is mainly a cost-cutting measure, but is also justified by the totally unrealistic assumption that most claimants will be ready to return to work within a year and by the dubious idea that throwing seriously ill people off benefits will ‘incentivise’ them to work.

3.3 ESA is punitive

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

If the Government truly believed that most of us are responsible adults who are keen to work, they wouldn’t impose on us such a punitive regime and such a draconian eligibility test. If they really wanted to support us into paid employment, rather than simply move us off benefits, they would listen to our views and take note of our experiences.

Sick and disabled people do want to work and they don’t generally object to welfare-to-work programmes. But such programmes need to offer non-coercive support and a safe place for those with health problems to explore the possibility of doing some paid work. Above all, claimants should not be penalised financially if they are too ill to work or, through no fault of their own, cannot find suitable employment.

3.4 Supply vs. demand side of labour

Contrary to the DWP rhetoric, it is not the current benefit system that is stopping people like me from working, but the nature of our impairment and the lack of suitable employment opportunities. The new benefit regime is unlikely to improve our situation; in fact, I fear that under ESA most of us will be significantly worse off financially, under permanent pressure, hence in poorer health and even further away from work than before.

Like tens of thousands of other chronically ill people, I have skills and qualifications, I am highly motivated, and don’t need financial incentives to work. Unfortunately, my illness severely restricts the kind of work I can do: because of the variability of my condition, I am unable to work regular hours and do not, therefore, fit into the mainstream job market. I might be able to do some very part-time work if I were allowed to choose when, where and how to work. Having taken part in the Pathways to Work and other back-to-work programmes as a volunteer, I know that jobs offering such a high degree of flexibility are virtually impossible to come by. My personal advisors had no idea how to help me: they could offer me job-searching tips, but they couldn’t wave a magic wand and create jobs tailored to my needs.
Indeed, social scientists and disability activists have been warning all along that the IB reform is unlikely to succeed as it focuses almost exclusively on individuals’ work-readiness and fails to take into account the myriad social and environmental barriers to work that sick and disabled people face even in boom years.

But Government policies continue to ignore the fact that neither sticks nor carrots can get people like me into work if there are no jobs we can apply for and if employers cannot be persuaded to hire those with special employment needs. Of course, it is much easier to deal with an individual’s (supposed) deficiencies than to tackle socio-structural barriers, make radical changes to working practices, or influence employers’ attitudes, but social policy should be based on reality and not on wishful thinking.

I find it worrying that the Government is planning to move hundreds of thousands of people off disability benefits, despite being fully aware that previous welfare-to-work programmes have only been able to help a small minority of claimants find work\(^5\). They don’t seem to care that most former IB claimants are likely to either become long-term unemployed or drop out of the system, falling into the chasm between welfare and work.

4. Conclusion
No one would object to ESA if it were capable of achieving its stated aims. There is, however, no evidence that the system is supporting people into work or lifting them out of poverty. It is much more likely to push them further into poverty, causing them a good deal of stress and affecting their mental and physical health\(^6\).

April 2011

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This response to the inquiry is primarily from a Welfare Rights perspective and should be regarded as such; our main concern in drafting this document has been to highlight the effect that the changes will have to our clients and the people of Middlesbrough.

It is within the remit of the Welfare Rights Unit to advise, help and represent Middlesbrough residents at all stages in the process of claiming welfare benefits from initial form filling to appeals to the lower and upper tribunals.

The most recent figures from the DWP show 8000 Middlesbrough residents in receipt of Incapacity Benefit.

These claimants fall into three groups:

1. People who have claimed IB/Invalidity Benefit due to ill health and are paid contribution based benefit (not means tested).

2. People receiving Income support due to incapacity (means tested).

3. People who have been disabled since childhood and are paid IB/Invalidity Benefit due to incapacity in youth at the same rate as those on contribution based.

Each set then falls into two sub groups:

1. Social Care Users.

2. Non-Social Care Users.

We have defined the sub groups because in particular the Social Care Users claims/reassessment will have an impact on Social Care.

Any claimant being migrated over to ESA will have been on an incapacity related benefit for a minimum of three years. For a significant number of claimants this will be more than 5 or even 10 years.

Anyone claiming since October 2008; will have claimed ESA. The only exception will be a small number of claimants who would have reclaimed IB following a period in work their incapacity being linked back to their previous claim.

A number of claimants will be reaching state retirement age within the 3 years that migration is anticipated to take and some people will have returned to work, we would estimate that between 2000 and 2500 claimants will be reassessed a year.

This begs the question; who will help all these people if they need it?

Our organisation currently is working to capacity and advises 12 people a day on the telephone (max 2964 per year) and has 8 outreach appointments a day (max 1976) to
help people fill out forms etc. There are other providers such as CAB but they are also working to capacity and have had to cut staff numbers due to cuts in funding. Legal Aid does not cover costs for form filling or appeal representation and it has been proposed that Welfare Benefits be taken out of the scope of Legal Aid.

The pilot studies carried out by the DWP showed that 30% of people who were reassessed failed to reach the threshold for ESA. The pilot study was carried out using the old work capability assessment. The new assessment criteria have a reduced number of criteria from which claimants can achieve the relevant points. The level of disability that has to be demonstrated to achieve points has also been increased. We therefore feel that the number of claimants who fail to qualify for ESA will be significantly higher than the 30% in the pilots.

When the migration of claimants from IB to ESA was mooted and the legislation passed it was for a transition from IB to ESA. Now however the goal posts have changed and it is proposed that claimants on contribution based ESA will only receive the benefit for a year if they are placed in the work related activity group.

We are concerned that the migration of IB claimants to ESA constitutes retrospective legislation as does the intention to limit the amount of time that existing claimants will be entitled.

Statistically disabled people remain out of work for longer than those that are able bodied, those that have been out of work for more than two years are statistically unlikely to find work unless they receive a substantial amount of help.

What will happen to the claimants who are found fit for work but do not qualify for means tested benefits such as JSA or Pension Credit? There is a risk that their households will become low-income households their spouse’s salary or their ill health pension being the only income coming into the household. Pensions paid due to ill health retirement were historically low due to the fact that they would be topped up by incapacity benefits. These families may have significant problems meeting their housing costs particularly if they have a mortgage on their property.

Historically someone retiring early would be advised to take a larger lump sum and smaller weekly payment. This was prudent financial planning if taking ill health retirement. The reduced weekly payment also reduces the tax burden on the individual if they were to re-enter employment.

Someone in work can make adjustments and provision for ill health; these claimants who have been ill health retired for some time cannot do this.

There has been very little information put into general circulation with regards to the changes and the implication they hold for this group of claimants. This group are also the least likely to have accessed services such as ours.

This group are also the most likely to be dissatisfied with the process. They see the IB as being a right due to their having worked and paid national insurance contributions. The writer has had numerous clients she has advised on appeals due to not reaching the threshold of the personal capability assessment. They have felt very let down that benefit
was withdrawn because they felt that NI was a type of insurance against being unable to work due to ill health “private insurance could not be stopped like this”.

Claimants receiving income support because of incapacity for work will not suffer the same financial consequences if found capable of work, JSA means tested is paid at the same rate as IS. We are however concerned that they will struggle to comply with the regime of JSA.

Claimants entitled to incapacity in youth are often amongst the most disabled in society, they are also more likely to be clients of social care. They are unlikely to have had regular reassessments of their IB, it will have been reviewed on an occasional basis or not at all.

Some will have the local authority as their appointee and as such the migration process will have an associated cost implication and be time consuming to local authority staff.

Some will have parents or relatives as appointee who may not appreciate the importance of the ESA50 when it arrives.

We have already had cases where clients have come to us when ESA has been stopped due to appointees not appreciating the importance of the client attending the medical. The length of time (up to 12 weeks) that it takes for another medical to be arranged can cause considerable financial problems. We have seen clients in supported living schemes go into considerable arrears with their housing costs.

We are unable to comment on the department’s communications because we know that they have been updated and we have not seen the final copies. Also a significant amount of communication is proposed by telephone.

From experience with the current ESA regime we would say that the DWP and ATOS need to look at the previous medicals and information held on file. They cannot rely on the information in the ESA50, people with learning difficulties or mental health problems often adopt a coping strategy where they say everything is OK. They also do not list all of their problems.

The writer was recently successful at appeal for a service user with a learning difficulty. The ESA50 had been sent to her address and filled out by a friend “because the service user could not read and write”. The friend who also had a slight learning difficulty completed the ESA50 in barely legible English and went to the medical with her friend. The client did not want to bother her social worker so did not ask for help. The assessment process does not routinely involve requesting information from GP’s or Social Workers, it is purely based on the ESA50 and the medical assessment. At assessment the interview was very quick and our client told the EMP they could do everything and did not have any problems. The DWP did not change the decision on review. On the morning of the appeal we received a phone call to say that we did not need to attend as the Tribunal had decided to make the award based on the papers.

The writer has had similar experiences with clients who have mental health problems; again they adopt a coping strategy of telling the EMP that everything is OK. Their appeals are successful but at the cost of considerable distress and financial hardship to the client. One client became so stressed by the appeals process and the thought of
going to appeal that her incidences of self-harm increased. We have submitted additional medical evidence of such quality that revisions of the secretary of states decision should have been made prior to the appeal date, such as statements from health care professionals that the claimant poses a significant risk of harm to the people around them, that there condition is so bad that it would pose a serious risk to there health if they were to be found fit for work.

We have also had cases where even though Examining Medical Practitioner was given details of all the medication that the claimant was on they failed to identify all of the medical conditions that the claimant was suffering from. Most significantly a highly depressed claimant who was taking a significant cocktail of anti viral medication was not identified as being HIV positive. Something that the claimant was too embarrassed to tell her.

For a case to get as far as an Appeal Tribunal carries with it a significant cost to the Tribunals Service and to organisations such as us. This could be avoided if the original decision was made based on adequate and relevant medical evidence. A simple Examining Medical Practitioners report based on a 45 minute interview is often not enough.

Clients that have been reassessed for ESA have been shocked that their previous medicals have not been made available to the EMP and are not used in the decision making process.

The biggest improvement to the decision making process would be to routinely write to the Medics and Social Care Staff detailed on the ESA50. This would have a cost implication but would lead to savings by the reduction in appeals and healthcare cost due to the trauma caused by wrong decisions.

We are also concerned that the DWP may be actively discouraging people from appealing or not telling claimant when they speak to them on the phone. The DWP should welcome appeals and deal with them expediently and fairly.

The Harrington Review made a number of recommendations and we are concerned that these are not being implemented. The DWP committed to a two-year process and yet the new Work Capability Assessment is being implemented without the two-year review that was built into the implementing legislation that brought about Employment and Support Allowance.

This whole process when considered in conjunction with the massive changes that are proposed to the entire benefits system and process is going to overwhelm both claimants and advise providers.
I am enclosing a copy of an advice leaflet that our unit has produced; this has been outdated already with regard to contribution based ESA. We would however ask that you compare the advice that we are giving to that that the DWP has produced and consider the difference in the actions it will prompt from claimants.

We would be happy to send a representative to answer any questions that the Committee may have of advisors that work at “the coalface” so to speak.

April 2011
SUMMARY

I set out, from my direct experience, why I believe the DWP’s medical assessments are not suitable or indeed safe for people suffering from severe depression.

1. Just before Christmas 2010 I went to the accident and emergency department of my local general hospital St. Thomas’s. I had been feeling very depressed since about July that year when my contract with an independent production company was not renewed.

2. I had been struggling to pay my credit card bills that were carrying debts of around £25,000. I had racked up this amount in an attempt to pay my way in terms of my mortgage and service charges and other outgoings including an annual interest rate of approaching 30 per cent on the two credit cards I had. As a freelance TV producer it was common to be unemployed for long periods.

3. By the time I arrived in the A&E my thoughts were extremely gloomy and I was seriously contemplating taking my life.

4. I had made one previous serious attempt to kill myself in 2007. Again the triggers had been debt and unemployment.

5. I had been treated in 2007 by the CREST team at Guy’s Hospital.

6. In order to be seen by the crisis team again I needed to be referred by either my GP or the hospital’s consultant psychiatrists.

7. I received exemplary treatment from the staff at the York Clinic where the CREST team is based.

8. On the 24th December I signed on for ESA with the DWP.

9. The doctor at Guy’s issued a medical certificate confirming I was unable to work.

10. Over the next 8 weeks I was in the care of the CREST team, the local community mental health team and my GP.

11. I had been prescribed an SSRI anti-depressant.

12. I applied for help with my housing costs. I began to receive the assessment rate of ESA of £63 a week.

13. My GP continued to issue medical certificates confirming I was not fit to work. I was also referred by my GP for ACT. I am currently waiting to find a practitioner.

14. I had stopped functioning on a day to day basis by August 2010.

15. I was failing to take care of myself and found carrying out the most basic of tasks impossible.

16. My post remained unopened and bills unpaid. I became reclusive and started to drink heavily as a self-harming strategy. I bought a car tow rope and attached it to a beam in my flat ready to end my life. Thoughts about killing myself filled my mind constantly.

17. My hair and my beard grew long and I looked, and no doubt behaved, like King Lear.
18. I had little money and was living on a diet of baked potatoes and whatever Lidl’s had reduced in the local shop. My daily trip to Lidl’s, my fridge was broken, was the only time I left the flat prior to seeing the doctors at St Thomas’s.

19. By December I had decided it was time either to end it or to get help. It was listening to Mr H talk about his cancer and remembering Alastair Campbell saying that however bad things appear they do get better. I had experience of this from 2007. I knew that people were there to help.

20. I started seeing three of my friends once a week. They were supportive and encouraged me to see the CREST team again.

21. My recovery started soon after I was referred to the CREST team. I saw members of the team on a regular basis. I was referred to the local CAB to help with my debts and a claim for benefit.

22. My landlord’s solicitors took me to court for unpaid service charge and a county court order was granted. I had missed the deadline for submitting a defence as I had not opened my letters for weeks. I was issued with a summons for possession of my flat. I had debts totalling in excess of £35,000.

23. In March 2011 I was called for a medical assessment by the DWP. I had one previously in 2007 when I had been claiming incapacity benefit. On that occasion I had passed it.

24. At this time my mood was stable. I was waiting the outcome of my claim for help with my housing costs. Waiting and also trying to buy food on the money the state was giving me was praying on my mind. Most days I was still thinking of killing myself.

25. At the assessment the doctor went through, as he explained, a checklist of questions, many of which were not relevant to me as I was suffering from a mental illness. I tried to explain, as best as I could, the symptoms I had including my recurring thoughts of suicide.

26. I was told that someone else would determine if I was fit to work. They would take into account what the doctors who had treated me had to say.

27. Dr M told me, however, that he did not have any information from my GP in front of him. I understand despite asking for permission to see my medical notes no one from the DWP has approached my GP.

28. The doctor also appeared slightly irritated if my explanation did quite fit the question on his computer screen. The test appears to me to be a snap shot and it is not best fitted for those with mental illnesses like mine.

29. In the event I scored no points despite telling the doctor about the state of my flat and my neglect of myself and my affairs and my gloomy moods.

30. The doctor then took my blood pressure and listened to my heart.

31. I was extremely anxious that if I failed the assessment I would not get the help with my housing costs.

32. I made another attempt, unsuccessfully, to take my life by swallowing 30 + pills.

33. Within a few days I received a letter from the DWP explaining that I had failed the medical assessment. No one at the DWP was able to tell me why.

34. My GP has been reviewing my care on a fortnightly basis. I explained what had happened. Perversely for some reason the whole episode made me
reassess my life. I stopped drinking and now the medication appears to be working.
35. I have started to manage my affairs. My mood is very much better.
36. My GP continues to issue medical certificates as she believes recovery from mental illness takes time and is pendulous. She says I should not be under any unnecessary pressure even though my mood is much improved.
37. I have checked the government website for information about the medical assessment and found that there is an exceptional circumstances clause. I would argue that my case is covered by this clause and have appealed the DWP’s decision to stop my ESA.
38. From my experience I think the medical assessment is not suited to deal with people with severe depression or other mental illnesses where there are peaks and troughs. I had not been asked about the impact a rejection from the medical assessment might have. Nor were my doctors’ asked for their advice.
39. I do not believe I am overstating it to say that people lives are being put at risk. If I had taken a few more pills or if they had been a little more potent I would not be writing this to you today.

April 2011
Written evidence submitted by Advice Services Coventry

The ASC partnership was formed in 2005 and includes:
- Age Concern Coventry
- Coventry Benefits Advice Line
- Coventry Cyrenians
- Coventry Refugee Centre
- Coventry & Warwickshire Family Mediation
- Coventry Citizens Advice Bureau
- Coventry law Centre
- Midland Heart
- Holbrooks Community Care Association
- Coventry Student Union Advice Centre
- Willenhall Advice Centre
- Wood End Advice & Information Centre

ASC is a partnership of agencies who are classified as providers of independent advice services.

Summary

As the migration of people from Incapacity Benefit to Employment and Support Allowance has only just started we are keen to share the evidence we have seen from people trying to claim employment and support allowance, which we believe will be of value to the committee.

As the evidence illustrates there are major failings with current processes which will significantly impact this migration and we would recommend all migration activity to cease until these issues have been successfully resolved.

Evidence from our clients illustrates key failings with:
- Medical Assessments carried out by ATOS.
- Decision makers do not look at all the medical evidence.
- DWP processes – inadequately trained staff, poor record keeping.

Client 1 – 01/04/2011

1. Single unemployed male – transferred from JSA to ESA when he became ill. Client hospitalised, suffering from Gliblastoma (brain tumour) and is receiving radiotherapy.

2. On initial call by Citizens Advice to DWP to chase the clients claim, the caller was advised that a claim had been established and the client now needed to submit a sick note. Citizens Advice made a follow up call 4 days later to chase MI12, advised that we had been given the wrong information and that a claim had not been established and sent for
processing because it was incomplete. Further visit by Citizens Advice to the client in hospital had to be made to complete a new claim form which has delayed payment further.

3. This client has had a very poor service from the DWP when he needed help and support the most whilst he is in hospital. There should be a dedicated team to deal with very sick people; no extra effort has been made for claimants with life threatening illnesses.

4. ESA has been a place for a long time now and we still see cases like this where DWP staff do not know what they are doing.

Client 2 – 01/04/2011

5. Female client lives with partner, diagnosed with secondary breast cancer and had to give up work as a result. Client is having intravenous chemotherapy but has been asked to complete an ESA50 in order to claim ESA.

6. Client had also recently been turned down on her DLA application but this decision was overturned following the withdrawal of the appeal by the Disability Benefits Unit (DBU).

7. A very poor service has been provided to the client by the DWP. The medical evidence provided does not appear to have been taken in to consideration in order to make the appropriate decision. This client experienced additional stress during an already difficult time and apart from her own health issues, her mother recently died.

Client 3 – 08/04/2011

8. Male client diagnosed with cancer of the pharynx in November 2009 which is now terminal. A DS1500 has been issued and a claim for ESA was made over the telephone by our adviser as the client has speech difficulties due to his illness.

9. The ESA worker was advised that our client has been issued DS1500 but continued to discuss with our worker the fact that the client would be asked to attend work focussed interviews and medicals. This was questioned by the adviser who again said that a DS1500 had been issued and that the client should be placed in the Support Group. Client has not returned yet to say which group he has been placed in.

Client 4 – 08/04/2011
10. We had been assisting this male client with a terminal brain tumour for some time. He had claimed ESA using a DS1500. However, when he died his wife came to the bureau and it was discovered that he had not been put in to the Support Group but paid the basic rate. We are waiting for ESA to telephone back to discuss this.

11. This poor administration at a time of upheaval in a household is not acceptable. The correct information had been provided and yet again a poor incorrect decision made. The household income was very low during our late client’s illness and now extra work has to be carried out unnecessarily.

Client 5 – 08/04/2011

12. This female client with a terminal brain tumour made a claim for ESA following her SSP entitlement using a DS1500. Almost immediately an ESA50 was sent to the client for completion.

13. Our adviser contacted the manager of medical referrals at ESA who looked into the situation. He came back saying this was issued in error and should not have been. He was very apologetic and said it would be withdrawn.

14. Once again, our client was subject to poor administration by ESA and caused extra distress and stress at an already difficult time.

Client 6 – 08/04/2011

15. This female client suffers from a condition called Cyclothymia which is a mild form of Bi Polar Disorder. She takes medication and is under the care of the Caludon Centre, University Hospital Coventry and Warwickshire. She was informed that as of and including 03/03/11 she was not entitled to ESA as she scored nil (0) points for mental health descriptors, following a medical assessment. This seems very unusual given that our client has specialist medication and psychiatric support. Our adviser completed a GL24 and drafted a supporting letter. Whilst our client is awaiting her appeal the ESA will be paid at the basic rate. When ESA was not awarded her Housing Benefit and Council Tax Benefit were withdrawn. These should now be reinstated pending the appeal.

Client 7 – 23/03/2011

16. Female aged 50, in receipt of DLA – low rates care and mobility lives alone in social housing bedsit.
17. Failed Limited capability for work assessment for ESA, scored nil points for mental health. Client suffers from bi-polar disorder and has recently been discharged from NHS mental health unit after a 2 month stay. Client receives support from a social worker and NHS mental health support worker. We are supporting this client to appeal this decision.

April 2011
Executive summary

- We welcome the Committee’s inquiry into the migration from Incapacity Benefit to Employment and Support Allowance, in particular the focus on the Work Capability Assessment and the timing of the migration from Incapacity Benefit, both of which we have significant concerns about.

- Neuromuscular conditions are a set of rare and very rare conditions affecting 71,000 people across the UK. Atos Healthcare are the company contracted to carry out the Work Capability Assessment. Because neuromuscular conditions are so rare, Atos healthcare professionals are therefore unlikely to have come into contact with more than a handful of such patients in their careers and will have little knowledge of the conditions.

- We therefore strongly support Professor Harrington’s recommendation that greater weight is given to medical professionals who have expertise in rare conditions so that the assessor can fully understand the impact of these complex, multi-system disorders on a claimant’s capacity for work.

- We are concerned that the current Work Capability Assessment does not accurately assess an individual’s capability for work and does not take into account the significant barriers they may face in finding and retaining employment.

- As our research has revealed, people with neuromuscular conditions face significant barriers in finding work, from physical access to the workplace through to the attitudes of some employers. Public transport is also often inaccessible for people with neuromuscular conditions, presenting a further barrier to employment for these individuals. An assessment which fails to take into account these barriers cannot accurately assess a person’s capability for work.

- We therefore recommend that the Government takes additional time to consider these issues and fully implements the recommendations of Professor Harrington’s review before moving ahead with the migration from Incapacity Benefit.

Introduction

1. The Muscular Dystrophy Campaign represents the 71,000 people in the UK with muscular dystrophy or a related neuromuscular condition. There are more than 60 different types of muscular dystrophy and related neuromuscular conditions, many of which are low incidence, orphan conditions and indeed some are very rare and are regarded as ultra orphan. Neuromuscular conditions can be genetic or acquired and, with the exception of a couple of acquired conditions, there are no known effective treatments or cures.

2. We endorse the recommendations to improve the Work Capability Assessment (WCA), following the independent review carried out by Professor Malcolm Harrington. We are very concerned that the WCA could make it harder for people with neuromuscular conditions to claim the Employment and Support
Allowance (ESA) to which they are entitled. Furthermore, we are very concerned that the changes implemented as a result of the internal review could make the process even more difficult for people with neuromuscular conditions. We believe that further consideration should be given to the structure of the WCA before full-scale migration from Incapacity Benefit begins.

3. While the government estimated that 49 percent of people undergoing the WCA would be refused ESA, placed on Jobseeker's Allowance and expected to find work, in fact the actual figure is 69 percent. It is also estimated that one in three ESA are appealed, and that 40 percent of these appeals are successful¹.

4. We agree with Professor Harrington that: "the WCA is not working as well as it should"² and support his call that greater weight should be given to evidence provided by medical professionals experienced in the particular condition affecting the person undertaking the assessment.

Professor Harrington's review of the WCA
5. During Professor Harrington's review, we had shared our concern that people with serious neuromuscular conditions are being incorrectly assessed as being fit for work, as a result of a flawed assessment system carried out by health professionals with little or no experience with rare neuromuscular conditions. Many GPs may only see one patient in their whole career affected by a neuromuscular condition, and it is therefore unlikely that the Atos Healthcare professionals (who are contracted by the Department for Work and Pensions to carry out the WCA) will have experience in these conditions.

6. The lack of knowledge about neuromuscular conditions is highlighted in the Department for Work and Pension's Disability Handbook, which is produced by the Department's Health and Benefits Division with help from experts involved in patient care for Disability Living Allowance and Attendance Allowance Decision Makers. The section on muscular dystrophy comes under child conditions and contains a number of very serious inaccuracies about neuromuscular conditions. For example, the section on Becker muscular dystrophy categorically states that the condition does not affect the heart. This is simply incorrect – cardiomyopathy is a very serious complication of Becker muscular dystrophy. Furthermore the Handbook incorrectly describes the severity of muscle disease, providing misleading information for assessors, and needs to be revised and corrected as a matter of urgency.

7. Given that this is the type of information is also provided to the healthcare professionals carrying out the WCA, we are likely to see incorrect decisions being made. We therefore welcome the recommendation that greater weight is given to evidence provided by medical professionals, in particular neuromuscular care advisors, who have expertise in rare conditions so that the assessor can fully understand the impact of these complex, multi-system disorders on a claimant's capacity for work.

The challenges of getting work for people with neuromuscular conditions

8. The WCA currently fails to take into consideration real-life context - it does not measure the availability of accessible and appropriate work, only functionality for theoretical jobs, and does not recognise that for many disabled people who are able to work, it can be almost impossible to find, obtain and retain employment, due to inaccessible workplaces, transport and employer attitudes.

9. The Muscular Dystrophy Campaign’s Trailblazers Young Campaigners Network is a group of young people with neuromuscular conditions campaigning for social inclusion for people with disabilities. As their report, Right to Work, reveals, there is a severe lack of appropriate employment opportunities for people with disabilities, who also face a poor understanding of disability among employers.

- Three quarters of Trailblazers think the job application process puts disabled people at a disadvantage
- 70 per cent of Trailblazers believe their job applications have been rejected because of how employers view their disability
- Three quarters of Trailblazers feel physical access to the workplace is a major barrier to finding a job
- One in seven disabled graduates (average age 26) says they have never been in paid employment.

Trailblazer 1 is a member of the Muscular Dystrophy Campaign’s Trailblazers network, a group of young people aged between 16 – 30 who fight against the social injustices experienced by young people living with muscle disease or a related condition. Trailblazer 1 is 25 and lives in Lancashire. He has Spinal Muscular Atrophy.

“One of my biggest worries was the financial side of things. I have good days and I have bad days with my health, which is why I needed to try and find a part-time placement with a certain level of flexibility. I have spinal muscular atrophy and things get harder and harder. The problem is that once you’ve been taken off Incapacity Benefit there is a six-month period before you can get it again. So if things got difficult and I leave an employer, it’s extremely difficult to get another job and impossible to get back onto the same income replacement benefit. It’s a "Catch 22" situation. You want to work but the employer can’t deal with disability, so you lose your job and you can’t go back on disability benefits.”

10. Whilst we welcome the intention of ESA to support those who can work to find employment, the evidence above demonstrates that significant barriers to finding a job continue to exist for people with neuromuscular conditions. Professor Harrington has recommended that further research should be carried out to "understand whether the assessment could and should incorporate more 'real world' or workfocused elements." We support this recommendation, but urge the Government to carry out this research as a matter of urgency.

Trailblazers 2 and 3 explain some of the difficulties they have experienced when looking for work.

Trailblazer 2 from Edinburgh:
In effect, employers are able to discriminate on the grounds of disability with a justifiable cause. This would not be the case on the grounds of race, gender or sexuality. But they are excused on the grounds of disability. The law has no teeth to actually encourage the appointment of new disabled employees, but the DDA is a welcome step if you were to become disabled whilst at work.”

Trailblazer 3 from Birmingham:
“I sent in a prospective CV (in which I did not disclose my disability) to a company, and received a phone call a few weeks later. I was asked to come in for an interview, but when I enquired about wheelchair access the person said they would find out and call back, but never did!”

11. The changes recently made to the WCA as a result of the internal review have led to significant simplification of the descriptors which make them less able to identify the barriers an individual may face in finding work.

12. For example, the internal review of the WCA argued that “individuals who use a wheelchair to mobilise, if working in a fully accessible area, are therefore not limited in their capability for some types of work” 3. This fails to take into account that many workplaces are not accessible to wheelchair users and some smaller firms will not be required to make reasonable adjustments to make their workplaces accessible.

13. In addition, public transport is often inaccessible to wheelchair users, further limiting the number of jobs available to them. In the End of the Line report, Trailblazers found, for example, that in one in three bus journeys and one in four train journeys they were unable to board the first vehicle to arrive due to factors such as a lack of staff or space for disabled passengers. On the London Underground, only 22% of stations are accessible to all wheelchair users, and of these only 1.5% (or four) of accessible stations are in Zone 1 (central London). The WCA is meant to identify ways in which a person’s impairment may impact on work opportunities. Whilst using a wheelchair does not prevent someone from working, as these examples show, it does significantly limit the work options available and the assessment needs to reflect this.

Conclusion
14. As we set out above, we have serious concerns about the current ability of the WCA to accurately assess an individual’s capability for work. The Atos healthcare professionals carrying out the assessment are very unlikely to have details, or any, knowledge of neuromuscular conditions and the WCA itself fails to take into account the significant barriers people with disabilities face in finding and retaining employment.

15. With these concerns in mind, we believe that the time-scale for beginning the migration from Incapacity Benefit is too fast. We recommend that the Government take time to review the current WCA more fully and implement Professor Harrington’s recommendations before moving forward. Without taking this time to reflect, many people are likely to be inaccurately assessed and placed on the wrong benefit, placing additional strain on the already over-stretched Tribunal system.

April 2011

Written evidence submitted by Zechariah Richardson

I had an ATOS medical for my ESA benefit in October last year, it is currently going to tribunal as the way it went was nothing short of disgusting!

I use a wheelchair and suffer chronic pain due to Osteoarthritis and worsened pain after a total knee replacement one year ago that has unfortunately left me in even more pain, I currently am on 35mg Buprenorphine transdermal patch, Dihydrocodeine, paracetamol, Pregabalin, nortryptiline and yet still suffer chronic pain 24/7, I also suffer severe panic attacks after an unsettling incident whilst working as a fire fighter for the MOD 21 years ago.

We waited for our appointment and due to the wait and the pain I had to lay across the seats as I was in a lot of pain, when we saw the doctor he seemed very friendly and after a while he said he thought it best to end the medical due to the amount of pain I was in, he recommended that in future we ask for a home visit for medicals, as we left he rubbed my wife's back and said, don't worry I will fill out the rest and say he needs to be left alone from the hassle of medicals for some time!

We were horrified when we received the outcome that placed me on the work focused group as I hadn't satisfied all the criteria, he had just answered Non applicable to the rest of the questions!

I am unable to attend the tribunal hearing due to my panic attacks, the hearing would mean having to travel and once there use a lift and due to my panic attacks I would not be able to handle that and due to the period of time involved I would be in too much pain.

This doctor has caused us a lot of stress, he lied to us and falsely filled out the rest of the form, we do not need the extra stress that this has place on us, if this is the way ATOS and its staff carry on then it is my belief that they should be stopped from running this service.

April 2011
1. I am responding to your invitation for individuals to submit evidence to your inquiry into Employment and Support Allowance and the Work Capability Assessment.

2. The migration of Incapacity Benefit claimants to Employment and Support Allowance is a matter of serious concern, given the disastrous consequences the Work Capability Assessment has already had. Due to the nature of the assessment, thousands upon thousands of sick and disabled people have been passed as fit for work when they quite clearly are not. Even the terminally ill have been deemed fit for work. In my view, the reasons for this are clear: the design of the assessment itself, and ATOS, the private corporation which administers it.

3. Firstly, the WCA itself is a farcical tick-box exercise in the literal sense of that phrase. On the one hand it is incredibly crude and superficial, on the other hand it is outrageously harsh and unfair. I know from experience that any attempt to explain to the ATOS assessor the effects of how one’s illness or disability impacts on daily life is met with impatience, the assessor instead asking such vital questions as “do you watch films on TV?” and “when did you last go to a shop to buy a CD?”. The test is literally a series of questions on a computer monitor, and the assessor is simply there to tick the boxes. The idea that this pre-determined, one-size-fits-all list of questions is enough to cope with the many and varied illnesses and disabilities that an assessor will encounter, let alone give a detailed picture of how illness or disability affects someone, is intellectually risible, yet that is the system currently in place.

4. Secondly, there is mounting and widespread concern about the role of ATOS in this process. ATOS has a highly lucrative contract with the DWP to carry out the WCA. Since ATOS assumed this role, a distinct trend has become apparent. Many seriously sick and disabled people are deemed fit for work; they then ask for a copy of the ATOS assessor’s report; and when they receive it they find it bears little or no relation to what they actually told the assessor. Organisations such as the Citizens Advice Bureau will tell you that this is not just happening in a handful of isolated cases – on the contrary, it is very common indeed. It is widely suspected that ATOS is incentivized to produce reports which it knows will result in denial of benefit. Unfortunately, all attempts thus far to obtain details of ATOS’ contract with the DWP have been unsuccessful, with even Freedom of Information requests turned down. For sick and disabled people subjected to ATOS’ “assessments” this is an almost impossible situation. A private corporation being offered financial incentives to produce reports which it knows will result in denial of benefit is the sort of thing which would never be permitted in a court of law: it is like finding yourself on trial before a jury which has already been offered money to find you guilty. In other words, whereas even those accused of the most serious and heinous crimes, such as murder, rape and child abuse, have the right to be considered innocent until proven guilty, and the right to a trial by an impartial judge and jury – and rightly so - the WCA assessments carried out by ATOS deny those rights to the sick and disabled, who are considered guilty until proven innocent. Such is the Kafkaesque nightmare to which the sick and disabled are subjected.
5. If ATOS were providing an impartial, objective and high quality service, one would expect the level of appeal success to be very low. However, around 40% of appeals succeed even when the claimant has no-one to represent them at their tribunal. When they do have representation (for example, someone from the CAB), that figure rises to around 70%. The fact that such a high proportion of appeals are successful – and, therefore, that such a high proportion of ATOS assessors’ reports are found to be wrong – is surely proof that something is going very badly wrong; especially as the appeals tribunals consist of independent people, in contrast to those who conduct the WCA, i.e. ATOS staff, who are working for a company motivated by the profit motive. It is certainly amazing how often the verdict changes when that profit motive is removed from the equation.

6. Bearing in mind all of the above, one may well wonder how on earth we have ended up with a situation in which so many sick and vulnerable people are being put through such suffering and misery at the behest of a private corporation. I would strongly urge you to read the following article, which answers this question in some detail. It only takes a few minutes to read and is most illuminating: http://www.lwbooks.co.uk/journals/articles/rutherford07.html

7. The information in this article will come as no surprise to anyone who has been on the receiving end of ATOS’ tender mercies, but it is deeply disturbing nonetheless. What it makes clear is this: the WCA now being run by ATOS in the UK is essentially the same as an assessment system which was tried in an American court and found to be both corrupt and illegal. In particular, the article mentions the four areas of concern identified by the multi-state review following the 2003 court case: “excessive reliance on in-house professionals; unfair construction of doctors’ reports; a failure to properly evaluate the totality of the claimant’s medical condition; and an inappropriate burden on the claimant to justify eligibility for benefit”. All of this will sound all too familiar to those with experience of the way in which ATOS operates. The fact that such a system has been introduced here in spite of the scathing verdict of the American authorities is profoundly shocking. In my view, the respective roles played in this sorry and depressing saga by UNUM, ATOS and Mansel Aylward, as outlined in the article, ought to be a matter of serious concern. This information deserves to be far more widely exposed. As the article shows, the reason the WCA seems to be skewed against the claimant is simple: it seems to be so skewed because it actually is; and furthermore, it is meant to be. What we have here is an ideologically driven assessment system whose sole purpose is to make it as hard as possible for the sick and disabled to qualify for the benefits they desperately need just to keep their heads above water. As if that were not bad enough, ATOS is being paid huge sums of taxpayers’ money to carry out this morally bankrupt agenda. (It is also worth noting that there appears to be no evidence that the ESA / WCA regime has resulted in any increase in the numbers of sick and disabled people moving into employment (let alone sustainable employment) – and yet that was supposed to be the justification for the existence of this regime in the first place.)

8. It can therefore come as no surprise that so many people are being wrongly assessed as fit for work. The WCA is deliberately skewed against the claimant, and the company implementing it has a vested commercial interest in producing as many reports as possible that it knows will result in denial of benefit. ATOS typically uses two arguments to defend its conduct, neither remotely credible. The first is that
decisions on who is eligible for benefit are not taken by ATOS staff, but by DWP decision makers. This is true, but is, to put it charitably, very economical with the truth. One of the most common complaints about the WCA is that medical evidence from a claimant’s GP and even hospital consultant is simply ignored (by both the ATOS assessor and the DWP decision maker). It does not matter if one has medical evidence from an eminent hospital consultant going back many years – this is dismissed out of hand in favour of the crude 30 minute tick-box snapshot gleaned from the WCA. In other words, the DWP decision makers simply rubber stamp the ATOS assessors’ reports, even though evidence from a hospital consultant will inevitably be vastly superior and more authoritative in its level of expertise. It is indeed extraordinary that the opinion of ATOS assessors – who are frequently not fully qualified doctors – is given greater weight than the views of GPs and hospital consultants. (It is worth noting in passing the irony of the government’s policy of allowing GPs to control their own budgets, on the grounds that “GPs know their patients best” - except, it seems, when it comes to the WCA, in which case it is the often dubiously qualified ATOS assessor ticking boxes on a monitor who knows the patient best!)

9. To counter this objection, ATOS then deploys its second argument: the WCA is not a diagnostic test, but a functional test, and hence not a “medical assessment” in the sense in which one would normally understand that phrase. The intellectual vacuity of this argument is obvious: if the assessor does not have a proper medical understanding of the claimant’s illness or disability, it is highly unlikely that they will have a proper understanding of how the symptoms of that illness or disability impact on daily life. (To give just one anecdotal example of an ATOS assessor’s level of understanding: I read of one person who was asked by the ATOS assessor, “are you still diabetic?”, to which the bemused claimant responded, “I wasn’t aware a cure had been found”.)

10. As if all this were not enough, even Professor Paul Gregg, who designed a key element of Employment and Support Allowance, has warned against extending the WCA to Incapacity Benefit claimants until the serious problems with the WCA have been rectified. He has stated that the assessment system “is badly malfunctioning”, and indeed is “a complete mess”. To quote him more fully: “We need to trial the new, proposed, reformed system to check and prove that it works and avoids the serious stress and misclassification of people that we have already seen, before we start implementing it on a large and vulnerable population……..The test so far has caused a huge amount of anguish to the people who have gone through it. We need to have something that is working accurately before we apply it nationally. We shouldn’t roll this out until we have something that is working.” The Citizens Advice Bureau’s verdict is equally damning: the WCA is “not fit for purpose”. Unfortunately we now know that the government has decided to go ahead with the migration of Incapacity Benefit claimants to ESA anyway. In fact, it is even worse than that: as of March 28th, a new version of the WCA has come into force which is even more ludicrously harsh and unfair than the version which has already caused so much suffering (and one must wonder how much good the recommendations of the Harrington report will do, given that Professor Harrington was examining the pre-March 28th version of the WCA, not the even harsher new version).
11. The consequences of this are easy to predict. Even greater numbers of people will be deemed fit for work even though they are not (at which point they may have no option but to try claiming Job Seekers Allowance, even though that benefit is simply not designed for the sick and disabled); the level of appeals will rise even further; GPs and hospital consultants will have to try to pick up the pieces of their patients’ physical and mental health deteriorating even further as a result of having to go through the extremely daunting and lengthy appeals process (and indeed the financial hardship resulting from having their benefit cut) – and meanwhile, ATOS will continue to pocket vast sums of taxpayers’ money, safe in the knowledge that it doesn’t matter how often their assessors’ reports are found to be wrong by independent tribunals, or how much misery they cause to the sick and vulnerable; they still pocket the cash anyway, and they are of course utterly unaccountable. (Incidentally, one result of even more people appealing will be an increase in the length of time it takes for an appeal to be heard – and it already takes so long that, by the time an appeal is heard, even if the appeal succeeds, the successful claimant sometimes finds themselves called in for another WCA by ATOS within a matter of weeks of winning their appeal, thus setting the whole extremely stressful process off again. ATOS should not be allowed to subject someone to another WCA so soon after their own assessor’s decision on the previous WCA has been found to be wrong).

12. I do not think it is unreasonable to suggest that when an independent tribunal finds an ATOS assessor’s report to be wrong, and the claimant’s appeal is successful, it is ATOS themselves who should be made to foot the bill for the cost of that tribunal. The taxpayer should not have to pay for ATOS’ failings; and since the profit motive appears to be the only thing to which ATOS pays any attention (few would suggest that a philanthropic concern for the sick and vulnerable forms any part of their motivation for conducting the WCA), being made to foot the bill for successful appeals might just force them to get their act together.

13. This, however, would be simply an attempt to make the best of a very bad job. It seems to me that the ideal solution to this whole sorry business is to return to the assessment system used for Incapacity Benefit. Those assessments were carried out by properly qualified doctors, and, as they were not working for a private corporation, there was no question mark over the integrity of the system due to the presence of the profit motive (thus, returning to the Incapacity Benefit system would have the enormous advantage of getting rid of the likes of ATOS – if they were sent packing, there would be precious few tears shed by the sick and disabled people of this country). That assessment was also far more medically rigorous than the superficial nonsense of the WCA, and it also took medical evidence from GPs and consultants into account. Nor can this system be said to have been lax: the article to which I have provided a link mentions that in 2003 the OECD described Britain’s benefits gateway as “one of the toughest in the world”, and indeed audits conducted by successive governments, including those actively trying to remove as many people from Incapacity Benefit as possible, regularly found the level of fraud to be remarkably low.

14. Bearing in mind all the points I have raised in this e-mail, I hope you will do whatever is in your power to try to improve the current appalling situation for the sick and disabled. Chris Grayling has attempted to defend going ahead with the migration
of Incapacity Benefit claimants to ESA as a process of continuous “refinement” (despite the fact that this national migration is starting virtually immediately following the end of trials in two areas of the country – quite how those trials can be properly evaluated when no time is being allowed for that evaluation is, to put it mildly, not immediately apparent). However, the whole point of refinement is, at least in theory, to improve the system, not make it even worse. The new version of the WCA is certain to achieve the seemingly impossible feat of inflicting even more widespread suffering and misery on the sick and disabled than the pre-March 28th version, especially with Incapacity Benefit claimants forced to go through this new version along with new claimants. There have already been anecdotal reports of people being denied benefit, driven into poverty and despair as a result, and tragically, in some cases, even suicide. The new version of the WCA can only cause an increase of such cases. This is surely not morally tolerable: if a society is judged by how it treats its’ most vulnerable members, we are in a poor state indeed.

April 2011
Written evidence submitted by David Gillon

Summary:
1) This submission to the inquiry into the migration from Incapacity Benefit to ESA is based on my personal experience of the ESA and WCA processes having been asked by Job Centre Plus to migrate my claim from JSA. The submission takes the form of a narrative account of my direct experiences, an analysis of failures within the system and a brief conclusion.

Narrative Account
2) As an ESA claimant I ‘passed’ the Work Capability Assessment and was placed into the Work Related Activity Group, which I believe to be completely appropriate. However the process I experienced fell so far short of an acceptable level of competence that I think it is essential I pass on my experience of the system and how it is failing those who are exposed to it.

3) After 22 years working as a software engineer on prominent projects in the aerospace industry, the last four fighting to preserve my career against my employer’s attempts to force me out, I was made redundant at the end of 2008. With an Employment Tribunal claim against a multinational to manage I did not have the energy available to fight for ESA, JSA was simpler to claim. However Job Centre Plus proved to be utterly incapable of working with someone who was not only disabled, but highly qualified, and tried to deal with me by ignoring both. That ultimately escalated into a complaint to ministerial level, a written apology from JCP, and a request from them, in early 2010, that I transfer onto ESA.

4) As an ESA claimant I was first expected to fill in the 28 page ESA50 form. The unavailability of an electronic version of this form over a period of years speaks to an utter institutional contempt for disabled people and their needs, similarly so for the requirements of the DDA and now the Equality Act. The paper form is not simply inaccessible to people with visual impairments, but also to anyone, like me, who is unable to write comfortably or legibly as a result of their disability. Equally the space provided in the form is utterly inadequate for anyone, again like me, who needs to discuss several decades of experience of a complex disability. The sheer size and nature of the form render it inaccessible across a wide range of disabilities.

5) My first WCA assessment was scheduled for early May, 2010 at the Chatham Assessment Centre of ATOS. The building is located in the centre of Chatham and has no on-site disabled parking, so is utterly unfit for purpose before you even get to the door. There is a public disabled car park some 150m away, but it regularly requires a wait of over 30 minutes to find a space and like many disabled people I cannot walk even 50m without experiencing significant pain. The next nearest disabled parking is 350m away. Access at the door is via intercom, so how someone deaf and/or without speech is supposed to manage is a mystery. The DDA and the Equality Act both require service providers to make provisions based on the likely needs of their clientele, so a building whose entire clientele is disabled should make a significantly greater degree of access provision than most, yet ATOS continue to
operate centres, and even open new ones, that fail to meet even the most basic standards of accessibility.

6) I had informed ATOS in advance via the ESA50 form that I would require adjustable seating because of the difficulty in sitting which results from my disability, which is in fact the core of my problems regarding working and therefore fundamental to the whole assessment process. None had been provided. The tattily-dressed individual who checked my ID led me into a waiting room filled with cheap, non-adjustable seating completely inappropriate to the needs of a client population containing a high proportion of people with musculo-skeletal and pain and fatigue based disorders. Within seconds of trying the seating I had realised that I was completely unable to sit on it in any comfort, only by rolling sideways onto my hip was I able to tolerate it at all. When I was called through, something over 10 minutes later (despite apparently being the only client in the building), I was in considerable distress, which only deepened when I reached the examination room and found that the seating there was actually worse. It was at this point that I discovered the tattily-dressed individual was actually the doctor who was supposed to assess me, not the caretaker as I had assumed. I pointed out that I had told ATOS I needed an adjustable seat and his reaction was ‘Oh, you’ll just have to book another appointment’. He then admitted that this was not the first time this problem had occurred, that they had asked for adjustable seating to be supplied and that they had been told by their regional management to ‘make do with what you have’. In my opinion this is a clear indication of an active contempt by ATOS management for both their client population and for the reasonable adjustment provisions of the DDA and now the Equality Act.

7) I returned home having wasted my time and experienced major amounts of pain as a direct result. This pain then served to trigger a massive flare-up in my condition and I spent the following week on the floor of my bathroom as I was wracked by one muscle-spasm after another, not knowing even what day it was. I eventually managed to get to my GP, who doubled the strength of my opiate painkillers, which brought the flare-up under control, but at the cost of my wandering around in a daze for several months with no energy or volition. The loss of control in this kind of flare-up is extremely distressing both physically and mentally and I was completely unable to deal with mail during this period, simply the thought of a letter from ATOS or DWP being sufficient to send my pain levels sky-rocketing. Ultimately it took me six months to completely catch up with my mail, at which point I discovered a letter from ATOS dated a week after my initial WCA date and calling me for another WCA a few days later, which needless to say I had not attended, being barely functional at the time.

8) So, knowing that I had a major problem with their centre environment, having failed to provide a requested reasonable adjustment, and having visibly caused me considerable distress, ATOS did not even think it was worth ringing me to ensure that my appointment was rearranged for a convenient time and to assure me that the needed reasonable adjustment would be there this time. Their response was actually worse than this, but it would be several months before I realised how bad.

9) In late-August I received a letter from DWP stating that my ESA payments had been stopped, from the week before my initial appointment, owing to my failure to attend the WCA. I called the office the letter had originated with and the person I
spoke to immediately accepted my inability to attend a WCA I was not aware of and noted that ATOS had made no mention of their failure to provide a required reasonable adjustment, but had simply stated that I had not completed the initial WCA. When ATOS set out to deliberately portray their own error as a failing by the victim of that error, and a failing with fiscal consequences, then there is no way to interpret their actions as anything less than actively and deliberately dishonest.

10) My claim was eventually reinstated in late-September and a further WCA was arranged for mid-October, again at Chatham. This time I was met at the door with an adjustable chair. Unfortunately I could not raise the seat of the chair to an appropriate height and at five feet eight I am not exactly tall. Again I was reduced to rolling sideways onto my hip. This time the delay was not 10 minutes, it was something over 45 minutes. By the time I was called into the assessment room (with the receptionist bringing the useless seat through after me) I was physically shaking. It was a different doctor to my first appointment, but again he was scruffily dressed in a tatty anorak. It is impossible to conclude that this attitude towards dress reflects anything other than a profound lack of respect for their clientele on the part of ATOS medical staff.

11) My pain management consultant has told me that is almost impossible to get doctors who are not specialists in pain management to comprehend just how disabling pain is, and I was therefore extremely concerned about how much of a background the assessor had in chronic-pain based disabilities, unfortunately his manner instantly convinced me that any such question would be interpreted negatively. As the session started I rapidly became aware that I was in so much pain that I was not answering effectively and was making a case for myself that was significantly weaker than it should have been. It also became rapidly apparent that the doctor was profoundly irritated by my refusal to give yes or no answers. He may have found it irritating, but the questions were not ones that could be adequately answered with yes or no and, for him to gain any meaningful understanding of my disability, required that he listen to the details. Despite his disapproval I would not be swayed on the need to answer the questions fully, though undoubtedly many people who are less able to express themselves will have been browbeaten into less than complete answers by his manner. It was also extremely apparent that he was reading from a computer-based script, his eyes fixed on the screen, and that his annoyance correlated with answers that did not fit the format his script mandated. As a result of this there was an almost complete refusal to make eye contact, destroying any sense that he was truly listening to me.

12) More disturbingly, he chose to take umbrage at certain of my points. I do not expect automatic complete agreement, but I do not expect to be told that I am wrong to have tried to search out information on the assessment process, particularly when his subsequent conduct proved the correctness of that information, nor do I expect to be criticised for the way I have described the effects of my disability on my walking, particularly when later events demonstrated that I was being absolutely accurate.

13) Some 20-odd minutes into the assessment I reached my limits on my pain tolerance, either I had to stand, or vomit. I spent the rest of the assessment balanced on one leg and crutches and it was only at this point, a cynic would say at the point he started to fear being found negligent in my treatment, that the doctor finally broke script and started to interact with me. He asked whether I was able to continue, but by that point I just wanted the WCA over with, I certainly wasn’t about to put myself
through the process for a third time. We proceeded into the physical part of the assessment, but even then he criticised me for being unable to bend my leg so he could tap my knee with his hammer. My leg locks when my pain levels are high, it is a feature of my disability I have no conscious control of, and I do not expect anyone, certainly not a doctor acting in a medical capacity, to criticise me for it.

14) WCA thankfully over, I barely managed to drive myself home, pain levels so high that I spent the rest of the day in bed, the first hour physically shaking.

15) In late-November I finally received the notification that I had been placed into the WRAG, together with back-payment of all the ESA payments I had been due since May, but the process had taken 10 months and caused me a considerable amount of pain and physical distress, actually significantly worsening my situation. The treatment I received has convinced me that ATOS have a complete and utter contempt for the needs of their clients that amounts to institutional disability discrimination and that their medical assessors are happily compliant in this. Sadly DWP is little better, my experience has been that the system only works when you complain.

16) So my experience of WCA and ATOS is one of contempt for disabled people that amounts to deliberate abuse. Despite the fact that I have been assessed as belonging in the WRAG, the system nearly managed to turned me into one of those statistics for withdrawn or failed claims that the tabloids love to claim are evidence of fraudulent intent, rather than what they really are, evidence of a system that is failing those who need it most. I got through the system because I am too bloody-minded to give in when people erect barriers in front of me and because I am too articulate and persistent to easily dismiss; but many people are not as bloody-minded, are not as articulate, are not as persistent and the system will be far more of a nightmare for them than it was for me. The system should assess everyone fairly, whoever they are, whatever their disability, at the moment it isn’t even doing that for the people it passes and I believe that those who are less articulate, or whose disability renders them less able to challenge authority figures, will be significantly disadvantaged.

Analysis

17) My own experiences, and those of other disabled people discussed within the disability community, point to the following failings in the ESA WCA system:

18) A complete breakdown in trust between the client population and DWP. Even the most articulate disabled people live in fear of being summoned for WCA, not because of any weakness in their case, but because they do not believe the system is capable of assessing them fairly.

19) The conspicuous failure of the DWP to take the lead in dispelling the campaign of demonization of disabled benefit claimants being conducted in the tabloid press, as is mandated by their Public Sector Equality Duty, leading to the widespread perception that DWP are actually orchestrating the campaign and worsening the breakdown in trust.

20) Dreadful communications practices within DWP, with letters to clients almost universally opening with a threat, further alienating the client population.
21) The ESA50 form is over-long, over-complex, and physically too constrained to allow the questions to be easily answered for any but the most straightforward of disabilities. No consideration has been given to the physical and mental costs to filling out a form of this size and nature. Disabled claimants regularly report taking anything up to a month to complete the form, and that is assuming they do not have a disability that renders it impossible. The documentation accompanying the form signal fails to mention that supporting medical reports may be attached.

22) The failure to meet basic standards of access at Assessment Centres in the form of on-site disabled parking, acceptable seating, in some cases even to have a wheelchair accessible building, tells disabled clients that their access needs are being treated with contempt. If access is treated with contempt, then the presumption must be that their disabilities, and ultimately they themselves, are viewed with the same contempt.

23) The 40-odd minutes allowed per assessment is clearly inadequate to conduct an assessment on a patient the assessor has never met, potentially with a disability they have never encountered before, and to then write a considered report for the DWP decision maker. This is particularly so where the disability is complex, or where supporting medical evidence has been provided.

24) A client with complex mental health issues faced with being assessed by a physiotherapist with less than two weeks of training in assessing all areas of disability has every right to be concerned as to whether they will be assessed competently. Similar concerns exist for every client with a less well known, or widely misunderstood, disability.

25) Clients are entitled to be treated with due respect by ATOS assessors, reports suggest that utter contempt is rather more likely. No assessment should be conducted with the assessor staring at a computer screen, no client should be criticised for their choice of words, certainly no client should find themselves being criticised for the reality of their disability.

26) The 12% error rate represented by the rate of successful appeals of WCA decisions at tribunal would be considered disastrous in any other industry. The question arises as to whether the WCA contract contains required levels of performance and penalty clauses to enforce them. And if not, why not?

Conclusion
27) The idea of a Work-Related Activity Group and a Support Group is a reasonably sound one, but the WCA system as currently implemented fails to meet any reasonable standard of performance. Even if WCA can be fixed, my personal experience of being a disabled employee leads me to believe that the hopes of massively reducing unemployment amongst disabled people will only be met when the government turns its attention away from disabled benefit claimants and towards pro-active enforcement of the Equality Act in the area of private sector recruitment.

April 2011
Written evidence submitted by Law Centre Northern Ireland

1. About Law Centre (NI)

1.1 Law Centre (NI) is a public interest law non-governmental organisation. We work to promote social justice and provide specialist legal services to advice organisations and disadvantaged individuals through our advice line and our casework services from our two regional offices in Northern Ireland. It provides a specialist legal service (advice, representation, training, information and policy comment) in five areas of law: social security, mental health, immigration, community care and employment. Law Centre services are provided to over 450 member agencies in Northern Ireland.

1.2 In this evidence we outline the significant issues likely to be presented by the migration from incapacity benefit (IB) to employment and support allowance (ESA), drawing attention to the Northern Ireland specific issues.

2. The Northern Ireland Context

2.1 With a higher proportion of claimants on IB than other regions in England or the devolved administrations, the impact of the migration of claimants to ESA will have a particularly greater impact in Northern Ireland. In Northern Ireland 8.6 per cent of the working age population are receiving Incapacity Benefit (IB) compared to 5.2 per cent in Britain. In Northern Ireland around 76,000 claimants will be subject to migration (i.e. approximately 500 claimants every week for three years). The migration of IB claimants to ESA has set an ambitious and arguably unrealistic timetable. We are not convinced the Social Security Agency has the capacity to manage this effectively within this timescale.

2.2 The DWP has estimated around 23 per cent of claimants will fail the Work Capability Assessment (WCA) test governing migration. In practice, the early results from the Aberdeen pilot suggest a failure rate of 30 per cent. In addition, with the tightening of the WCA test the expectation is that over 40 per cent of new claimants to ESA will also fail the test. This suggests that up to 17,500 claimants will join the unemployment register over the next three years simply through the migration though some claimants who have partners in work may drop out of the benefit system altogether. Northern Ireland’s employment rate of 66 per cent is below the UK average of 70.7 per cent and is the lowest of the UK regions. The claimant count rose in Northern Ireland in the last quarter of 2010
to 6.5 per cent of the workforce compared with 4.5 per cent in GB.\textsuperscript{1} It is generally accepted by a number of economic forecasters that Northern Ireland will come out of recession at a slower pace than Great Britain.

3. Work Capabilities Assessment

3.1 Where someone is found to have a limited capability for work in this assessment, they will be moved (migrated) onto ESA but of those found fit for work the Government expects that:

- 50\% will move onto jobseeker’s allowance.
- 20\% will move on to another benefit (e.g. income support, carers allowance or re-claim ESA)
- 30\% will move off benefits altogether

3.2 The first review of the work capability assessment (WCA) carried out by Professor Malcolm Harrington was published in November 2010. The review made 25 recommendations with the Government accepting 21 of the recommendations (at least in part). The DWP has published the ‘high-level timeline’ for work to be carried out over 2011 but only a quarter of the recommendations seem to have been planned to be implemented before people on Incapacity Benefits undergo a WCA from Spring 2011 at the rate of 10,000 per week. This will leave a flawed test operational at substantial social and material cost through disabled people not receiving appropriate support, high rates of appeal and an increased role for support staff.

3.3 Law Centre (NI) has also been concerned about the limited understanding of mental health problems in the assessment process and the limited weight given to supplementary evidence such as GP and carer’s testimonies. Almost 46.6 per cent of individuals in receipt of Incapacity Benefit have mental or behavioural disorders in Northern Ireland.\textsuperscript{2} We think that mental health issues need to be more specifically focused on and addressed in the migration process.

4. Decision-making process

4.1 We support the enhanced training of frontline staff conducting the assessments. We are concerned about the capacity of Health Care Professionals (HCP) carrying out the WCA. The Citizen’s Advice Report ‘Not working’ has provided quantitative research whereby claimants have reported ‘hurried medicals in which the HCP does not look at them but at the computer screen’\textsuperscript{3}. Similarly, Citizens Advice (NI) has highlighted delays in processing claims which

\textsuperscript{1} Northern Bank, Quarterly Economic Outlook, November 2010
\textsuperscript{2} Incapacity Benefit and Severe Living Allowance: Statistics DSDNI November 2009
\textsuperscript{3} Citizen Advice Bureau Briefing, ‘Not working’, March 2010 pg 18
cause financial hardship for clients. Delays are often caused by the loss of
documentation supporting a claim or a lack of communication or follow up from
the Social Security Agency. In addition, it is vital that Personal Advisers working
with people with disabilities and mental health issues have a good understanding
of the particular difficulties they may face and the impact this may have on their
health in returning to work. We welcome the intention to develop personalised
support delivered through JSA. However, given the numbers likely to be
transferred to Jobseeker’s Allowance we are doubtful whether this policy
intention can be carried through in practice. Moreover, we are particularly keen
to ensure that decision-makers employ an active role in making decisions rather
than rubber-stamping recommendations made by Atos Healthcare.

5. Outcome of migration

5.1 Claimants who do not satisfy the terms of entitlement to ESA at the point
of transfer will not receive ESA and their award of incapacity will also cease.
Many of these people will have been receiving incapacity benefits for a number of
years and will need to adjust to new criteria and assessment. We remain
unconvinced that ESA and jobseeker’s allowance alone will be able to offer the
flexibility required of claimants in more complex situations, for example when a
claimant qualifies for support under more than one category, such as a lone
parent with caring responsibilities.

5.2 Those found capable of work may be eligible for jobseeker’s allowance if
they meet the criteria for entitlement. We are concerned that there are not
enough safeguards for these people who have been found fit for work. We note
that those who become ill while on jobseekers allowance will have access to
additional support and flexibilities to help them return to work and through
agreement with a personal adviser those with more limited availability to work
and ability can restrict their search.

5.3 Our concern centres on those who are found fit for work, but unable to find
work, and who are ineligible or unable to cope with JSA. A study carried out by
the National Autistic Society surveyed 500 people on the autism spectrum
identified that a third were neither in employment nor on benefits. We believe
that more protection measures should be introduced to ensure that ill and
disabled people do not fall into benefit deprivation and therefore poverty. In
addition, those claimants who come off incapacity benefit with, for example, a

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4 Problems with ESA administration continue in Northern Ireland, Citizens Advice comment on
5 National Autistic Society (October 2009), Don’t write me off: make the system fair for people
with Autism

partner working will fall out of the benefit system altogether. There is a need to devise a strategy to ensure such claimants also have access to support to find work and that what happens to such claimants is monitored. Without such arrangements a considerable number of claimants may be inadvertently written off, precisely the opposite outcome intended by the reforms.

5.4 It also remains unclear whether the equivalent of the Work Programme will be rolled out in Northern Ireland. In practice, we understand from the Department of Employment and Learning that it will be at least April 2012 before any new arrangements are put in place. In effect, we doubt that the challenge that significant additional numbers moving to JSA who need considerable support to get ready for work will be met in reality. The Work Programme is seen as a crucial underpinning of the strategy of welfare to work in Britain yet it will clearly not happen in Northern Ireland for at least another 12 months at the earliest. We would ask the Committee to highlight this situation in their report.

6. Roll out of the scheme

6.1 We are not convinced that the timescale is realistic to manage the roll out effectively within the timescale.

7. Aberdeen and Burnley Trials

7.1 The IB migration trials in Aberdeen and Burnley used a sample of 1,700 claimants. DWP has published statistics which reveal that, in the Burnley and Aberdeen pilots, where people are moved off incapacity benefits using the Work Capability Assessment:

- 30% of former IB claimants entered the new Employment and Support Allowance (ESA) benefit’s support component (i.e. not required to undertake any work);
- 40% were found partially fit for work (ie have some significant underlying health condition/impairment) and enter the ESA work-related activity group; and
- 30% were ‘fully fit for work’ and go on Jobseeker’s Allowance (higher than the previous Government’s 23% fully fit estimate).

7.2 However in examining the actual figures released by the DWP in February 2011, the statistics relate to only 1347 decisions when 1,700 claimants were assessed in the course of the pilot. This means decisions have not been made (or released) in over 350 cases. Also it is of note that 123 claimants from the trials have already appealed the decision. Based on current appeal success rates around 50 of these appeals will be upheld – but this number may prove to be higher as these are all claimants who were previously accepted as incapacitated.
7.3 It is of note that, in our understanding, these claims were handled clerically, which means that DWP computer software was not used for the trial and therefore will not be tested until full migration starts. This is a further concern. In Northern Ireland there are already significant delays in getting cases to appeal tribunal hearings. This is likely to be exacerbated.

8. Conclusion

8.1 Welfare reform needs to take account of specific Northern Ireland circumstances. The Law Centre encourages the Committee to consider what is different about the circumstances in Northern Ireland and the objective ramifications of the migration from incapacity benefits to employment and support allowance for claimants here.

8.2 Law Centre welcomes the opportunity to provide evidence to the Committee. We trust you will find our comments helpful. If there is any further way in which we could contribute to this process we would welcome the opportunity to do so.

April 2011
Key points and recommendations

- Around half of current Incapacity Benefit (IB) and Severe Disablement Allowance claimants are aged 50 and over, so the migration will have a hugely significant impact on this age group.

- Our evidence draws on the experience of our partner, Age Concern Blackburn with Darwen. This partner has been involved with the Incapacity Benefit – Employment and Support Allowance migration pilot scheme, helping individuals aged 50+ who have been affected. Its clients fall within the Burnley Jobcentre Plus pilot area.

- Many older benefit ex-Incapacity Benefit claimants have been unaware of what to expect, both from the migration process and of the post-assessment implications.

- The latest version of the ESA 50 form is not suitable for the needs of many of our clients, in particular those with multiple conditions. We recommend the Government reviews this form and ensures that it accurately and fairly reflects the conditions of all ESA claimants.

- We are concerned that those found ‘fit for work’ will not receive adequate support. Jobcentre Plus advisers must be aware of and able to manage the needs of ex-IB claimants, and the waiting period before referral to the Work Programme – once it is in place – should be abolished.

Experience of the pilot

1. 49.5 per cent of current Incapacity Benefit and Severe Disablement Allowance claimants are aged 50+. Therefore the migration process is likely to have a considerable impact on older benefit recipients, although it is hard to predict a figure with certainty because some will retire (or die) before their re-assessment takes place. There will, of course, be knock-on implications for reliance on state benefits throughout the life course.

2. Age Concern Blackburn with Darwen has been supporting Incapacity Benefit (IB) recipients during and after their reassessment and subsequent migration to Employment and Support Allowance or Jobseekers Allowance. It has been involved with claimants from the Burnley Jobcentre Plus district, which was one of the two areas piloting the process of migrating IB claimants to Employment and Support Allowance (ESA) from October 2010 to April 2011. The evidence in this paper draws on their experience.
3. Clients often lack understanding of the rationale behind the migration and the process through which it takes place. Having typically been claiming IB for many years with minimal work-related support, it is then often a shock to find that their new benefit makes requirements of them to look for work. It appears that there has been a lack of communication about what people can expect as they are migrated.

4. Comments on the severity of the test are widely reported by other organisations, so we will not reiterate those here, although they are echoed by Age Concern Blackburn with Darwen. However, one point of note which we have found to be common is that the ESA 50 form is rarely taken into consideration by the medical assessor. Clients felt aggrieved that they had taken the trouble to fill this out and provide evidence of their condition only for it to be ignored in the medical assessment.

5. There is a demonstrable inconsistency between medical assessors. This needs to be ironed out to ensure the test is fair for all claimants.

6. Many claimants who are found fit for work simply drop out of the benefits system. There needs to be greater support for people who are either ineligible for benefits or who choose not to claim, in particular providing back to work support for individuals who volunteer and ensuring everyone is aware of the Next Step guidance service.

7. The appeals process has been found to be too lengthy. Many clients are told they will have to wait six to nine months, which leads some to drop out of the system. The Government should investigate how this could be speeded up.

8. The second version of ESA 50 form which was launched recently has had a negative impact on many claims. The reduced length means it is harder for people to convey the impact of experiencing multiple conditions. Also, the nature of problems has been simplified – for example it no longer distinguishes between sitting and standing, it simply asks whether the claimant can remain static for an hour. We do not believe this gives a sufficient overview of the nature of an individual’s disabilities.

9. We are concerned that those who are migrated on to Jobseekers Allowance will in particular require significant support. The pilot statistics show that 32 per cent of claimants are found ‘fit for work’ and instructed to claim Jobseekers Allowance, should they wish to. A further 38 per cent are moved into the Work Related Activity Group of ESA. These people will require varying degrees of support in order to successfully find work. We are concerned that the necessary levels of help will not be in place, in particular for those found ‘fit for work’. For example, Jobcentre Plus advisers may require special training to better manage the typical needs of these claimants (who have usually been out of the labour market for many years).

10. While the introduction of the Work Programme may provide additional support for the ex-IB claimant group, they will have to wait three months to be eligible for referral. We believe that more intensive support that is tailored to the needs of the individual should be available immediately on receipt of Jobseekers Allowance.

April 2011
i DWP, Incapacity Benefit/Severe Disablement Allowance statistics, August 2010
ii DWP, Interim results of Work Capability Assessments for IB reassessment trial areas, 1 April 2011
Written evidence submitted by A4e

Introduction

1.1 This formal response is submitted on behalf of A4e in relation to the Work and Pensions Select Committee inquiry into “Migration from Incapacity Benefits to Employment Support Allowance”. We would be happy to provide further clarification on any aspects of our response, and willing to give oral evidence to the committee if required.

1.2 A4e currently delivers a range of contracts across the UK on behalf of the Department for Work and Pensions (DWP), including Flexible New Deal, Pathways to Work and New Deal for Disabled People. These contracts will be rolled into the Work Programme, which is due to commence in summer.

1.3 A4e has been confirmed by DWP as preferred bidders for five of the Work Programme contracts.

Executive Summary

2.1 Customers have been critical of DWP’s communication around their assessment and possible migration. Though there is an inevitable bias in that those customers who have felt well informed by the process may be less motivated to express their opinion. A4e recommends that a more flexible strategy is required in relation to communication [See Paras 4.1 - 4.4].

2.2 The Work Capability Assessment (WCA) is more focussed on physical capability, it is less directed towards mental health issues [See Paras 5.1 – 5.7].

2.3 Practitioners sampled have suggested moving to two or more assessments when an individual’s health conditions are unclear. This would negate the necessity for appeals and periods of inactivity. [See Paras 6.1 – 6.6].

2.4 The speed of rollout, from the Aberdeen/Burnley pilots to mainstream IB migration seems ambitious. A4e believes that DWP needs to balance the pace of reforms against the risk of a high level of customer appeals. A more pragmatic migration could reduce errors and the consequent rate of appeals [See Paras 9.1 – 9.2].
Evidence Base

3.1 The comments, observations and recommendations within this response are based on a number of sources:

- Experience of national delivery of the New Deal for Disabled People;
- Experience of Pathways to Work prime contractor provision in 5 contract areas;
- Direct feedback from 30 Pathways Advisors and Occupational Support Practitioners across a wide geographical spread (England and Wales), including case studies;
- Feedback and insight gained from the A4e National User Group (Disability Services) – which consists of 20 customers who are all in receipt of incapacity-related benefits;
- Feedback from 8 Information and Advice providers in Merseyside and Derbyshire;
- Discussions with five GPs in South Yorkshire and the West Midlands;
The effectiveness of the Department’s communications to customers and the information, guidance and advice provided by DWP and JCP

4.1 There have been a number of common themes in the feedback A4e received across England and Wales.

4.2 The majority of customers that we contacted have expressed confusion due to a lack of awareness and understanding of the necessity for change and the structure of the assessment. Despite clear information to the contrary being available online, many customers perceive the Work Capability Assessment and the Medical Assessment as the same process. This can often cause unnecessary distress and can affect the way the customer perceives the assessment’s rigour. Some customers have stated that any information given to them has been too complex and has fallen short of describing the possible impact on them as individuals.

4.3 This lack of understanding has resulted in a number of customers resigning from working age benefits – some of which were in the process of work-related activity through the voluntary element of Pathways and New Deal for Disabled People.

An A4e customer in the Surrey and Sussex area resigned from benefits due to a significant increase in her levels of stress and anxiety. This resulted in the customer losing the opportunity to accept a job under the Permitted Work Rules. Although she took up the part-time job, the loss of support through the condition management element of Pathways contributed to an escalation of her mental health condition and she left the job after a few weeks. She is now back to square one, but without any benefit support.

4.4 **A4e Recommendation:**

Communication and explanation should be simplified and made available in a variety of formats, including easy-speak. Customers should have access to Advisors who emphasise the positive aspects of welfare reform and who work to change the mindset of customers are assessed by Work Capability Assessment as being fit for work. This should be framed as a positive event. DWP needs to ensure strong reinforcement of the message that work is generally good for people; contributing to longevity and increasing life opportunities.
The Work Capability Assessment: assessment criteria; service provided; suitability of assessment centres; and customer experience.

5.1 Customers’ experiences of the Work Capability Assessment seem to be inconsistent. In Surrey and Sussex, many customers have claimed that although they attended the assessment centre, the assessment was not conducted as the Assessor was not present. Some claim that they had waited for up to two hours and were then told that the centre had no record of their appointment. When assessments have taken place, customers have claimed that they are rushed, sometimes taking ten minutes or less, with some elements completed in their absence.

5.2 In Wales, Pathways Advisors have reported that they have to spend considerable time dealing with negative “fall-out” from the assessments, rather than being able to concentrate on effective work-related activity. Customers are feeding back answers are limited to “yes” or “no”, but their conditions are not so binary. They claim that the health professionals conducting the assessments are generally unwilling to listen to a more detailed explanation of the impact of their fluctuating condition. General customer feeling is that assessments are rushed and they often see mistakes and anomalies in their written feedback.

5.3 Feedback has not been wholly negative. Advisors in West Cornwall have noticed that recently more customers are scoring enough points to “pass” their Work Capability Assessment and that there has been a significant reduction in customers contacting the office for advice after being notified that they had “failed”. Additionally, the number of customers wishing to complain about the process has significantly reduced in recent months.

5.4 However, some customers have commented on a lack of flexibility in agreeing a location that is more suitable for them.

5.5 The Work Capability Assessment remains overly focussed on physical capability. The accuracy of the assessment is contingent on the customer
accurately expressing their condition and readiness to undertake work or work-focussed activity. The assessment format is not transparent and assumptions are made on performance based on broad questions such as “how did you get here today”; and simple tests such as can the customer lift their arms. The assessment contains only a small number of questions focussed on mental health.

A customer in Wales has a severe anxiety condition. When asked if she was comfortable in crowds she reported that she found it very stressful and would avoid it whenever possible. The Assessor went on to ask if she had been in a social situation in the last 6 months. The customer answered honestly and said that she had been to a family celebration. The next question was ‘had she collapsed or urgently needed to leave the event?’ The answer was no, but that she was very uncomfortable and was relieved when it was time to go home. As a result of these answers, the Assessor entered in his report that the customer was fine with crowds, therefore, not accurately reflecting her condition.

5.6 Little attention appears to be paid to GP or Health Consultants notes and work or condition history.

Customer S.T. has a degenerative eye condition, which means that he has gradually lost his sight and is now registered as blind. He has reports from specialists confirming that his sight will not be restored. He recently attended his Work Capability Assessment and was amazed to receive a report of his assessment claiming that he had stated that he would ‘recover’ from this health condition in the next three months and he would need to attend another WCA. The customer has written a strong letter of complaint about his assessment.

Feedback on the assessment centres themselves has been broadly positive.

5.7 **A4e Recommendation:**

De-generalise the Work Capability Assessment by including open questions and introduce more flexibility in timescales and the location of the Assessor.
How can the decision-making process be improved so that customers are more confident in the result of their assessment?

6.1 Customer confidence appears to be primarily affected by the perception that the whole process is rushed, much too reliant on generalisations and significantly lacking in focus on mental health and learning disabilities/difficulties. Customers also expressed concerns around the level of errors/inaccuracies in their report.

Many customers in all areas consulted reported that when they received their copy of their assessment report, they genuinely believed that they had received another person’s report in error.

6.2 The decision-making process is based on a report generated from a single assessment visit. Much concern centres around this single assessment and all areas and practitioners sampled have suggested moving to two or more assessments when the situation is unclear. This may sound timely and expensive, but could negate the necessity for so many appeals and periods of inactivity and uncertainty during those lengthy periods of upheaval caused by the appeal process.

6.3 Frequently, the decision-making process does not allow for varied recovery/acclimatisation times from operations, new or worsening conditions, bereavement and fluctuating conditions. It depends too much on generalisations round a snapshot in time.

6.4 Additionally, feedback has highlighted many cases of customers who are terminally ill, or who are awaiting serious operations but are being placed into the Work Related Activity Group.

6.5 GPs questioned suggested that very little attention is paid to their input regarding the customer’s readiness for work or work-related activity. They believe that they are best placed to comment on a customer’s health condition as they have usually been involved with the customer over a longer period of time.

6.6 **A4e Recommendation:-**

Widen the decision-making process to allow additional evidence to be submitted and taken into consideration – especially evidence provided by health professionals who are aware of the customer’s condition history.
The Appeal process

7.1 The opinion of most people and agencies questioned in A4e’s survey is that customers deemed to have “failed” a Work Capability Assessment generally either lodge an appeal or drop out of the working age benefit system. This, of course, does not include the high percentage of claimants who drop out of the system before the process has reached completion.

7.2 Of people who made a claim for ESA between October 2008 and November 2009 and who were found Fit for Work at assessment, 33% to date had an appeal heard by Tribunals Service. The customer’s appeal has been upheld in 40% of cases. These results are generally considered by the customer group as an indicator of a fair and consistent appeal process, but an ineffective Work Capability Assessment and initial decision-making process. This, of course, is based on the first full year of ESA. Little evidence is available to allow comment directly related to the IB migration period so far.

7.3 The only negative comments regarding the appeal process is the time taken for an appeal to be ratified – a period that is often very prolonged.

7.4 **A4e Recommendation:**

The appeal process should be reviewed periodically to ensure it is kept as efficient as possible.
The outcome of the migration process: different paths taken and reaction to contribution-based ESA being time bound for 12 months.

8.1 Although evidence and feedback is limited due to relatively low numbers going through the migration process so far, a clear picture is emerging that many decisions regarding the question of “fit for work” or fit for “work-related activity/support” are inaccurate.

8.2 As of 22 March 2011, 1,626 decisions had been made on whether a customer’s claim qualifies for conversion to ESA. 32% were found fit for work and so not entitled to ESA; 30% were placed in the support group and 38% were placed in the Work Related Activity Group.

Customer JK was diagnosed with Multiple Sclerosis and been informed by health professionals that this is a chronic illness from which she will not recover. She failed her Work Capability Assessment and this decision was upheld at her tribunal. She was informed she should contact Jobcentre Plus to apply for JSA. Upon doing this, JK was told that she was not eligible for JSA as she was too ill to do job search and could not accept any work due to her current health condition.

8.3 A4e Recommendation:-

Maximise the opportunities that will be available through the Work Programme – i.e., eligibility to services being dependant on need rather than benefit status. The Work Programme is an excellent vehicle to ease the journey from an expectation to be involved in work-related activity to an expectation to actively seek work in exchange for benefit.
Timescale and capacity for national roll-out of the migration process.

9.1 Until very recently, the pilots were based on manual systems and, as shown above, had only migrated 1,626 claimants. With an expectation of around 10,000 customers a week going through a relatively untried software system, the timescale seems ambitious and could lead to errors, which will in turn further hamper the system due to a resulting high rate of appeal.

9.2 A4e Recommendation:

We recommend DWP consider whether a more accurate and controlled migration which may mitigate against high levels of customers appealing against the outcomes of their assessment.

April 2011
Written evidence submitted by Patricia Williams

1. I first claimed ESA in 2009, when the sick benefit part of my pay was stopped by my employer – HM Revenue & Customs. I was subsequently dismissed for inefficiency (ie long-term sick absence due to workplace stress and bullying) in June 2010.

2. In late November 2009 I had a medical to determine if I was fit to return to work. The outcome was that I was not fit to resume my job. Less than two weeks later I had an interview with ATOS for ESA.

3. I received very little support or advice at this stage, but did not anticipate any problems in ‘proving’ I was ill given the result of my other assessment.

4. However, the interview was very difficult for me and the doctor completing the forms misrepresented some of my answers, although this might have been partly due to his command of English. He refused to let me describe my symptoms, insisting on sticking to his checklist. He rarely made eye contact and rushed me through his list.

5. When the result came out, he had scored me at zero. And the letter told me to go back to my job. I was extremely distressed by this, although my GP and Therapist assured me I would not have to return to the situation that had caused my mental health problems.

6. I appealed to DWP, but this was dismissed immediately even though I pointed out that there were mistakes in the report. ATOS also dismissed my complaint about his behaviour and the errors. This was very unsatisfactory – surely if I could prove there were errors in the report they should have investigated?

7. I decided to appeal again, although I knew that the process would delay any recovery, or even make me worse. I waited about ten months for a date. The day before the Tribunal hearing was very difficult and I nearly cancelled. The only reason I was determined to try to go was because some Ministers, MPs and media were representing those of us who did not appeal as scroungers and liars. I did manage to attend, with support from my Therapist and family. Going over the traumatic experiences again was very hard, but the Tribunal judge stopped at the point where I had already scored 24 points. This was without considering my physical health problems (asthma and arthritis).

8. Apart from the personal experience of a doctor who didn't appear to care about me as a human being, the checklist is totally unsuitable for anyone with mental health problems or with diseases where the symptoms fluctuate, as with my asthma.

9. Also I have 'hidden disabilities', for which there is medical evidence, but that this system ignores. I didn't have ten operations for fun! This limits the type of work I can do even when my depression and anxiety resolve. Why doesn't the ESA system take into account evidence from our doctors and other health specialists?

10. I am also very concerned about the proposal to time-limit awards. I no longer receive ESA, but
if I were younger would still be too sick to resume work after two years. The extra stress for people with my conditions is more likely to delay any healing rather than get us back to work.

April 2011
Introduction

The Citizens Advice service consists of the national charity, Citizens Advice, and a network of local bureaux – all of which are independent charities. Together we help people resolve their money, benefits, employment and other problems. We provide free, impartial and confidential advice, and we use our evidence to influence policy makers, to improve the lives of our clients.

In 2009/10, Citizens Advice Bureaux in England and Wales advised 2.1 million clients on 7.1 million problems – an 18 per cent increase from the previous year. We advised on 209,641 enquiries about incapacity benefits, including 147,286 on ESA. Bureaux in Burnley have monitored enquiries from clients being reassessed on the pilot process, and we have designed an ‘ESA diary’ for clients to describe their experiences. We are therefore well-placed to comment on the subject of this inquiry.

The Department’s communications to customers

DWP consulted stakeholders at each stage of the process, and the resulting customer journey shows evidence of this. Citizens Advice Bureaux in the trial area handled relatively few enquiries from anxious clients, suggesting that the telephoning of claimants at key stages in the journey was helpful and reassuring.

We do have concerns, however, about claimants who don’t have telephones. Vulnerable people, such as those with mental health problems or learning difficulties, are disproportionately unlikely to have telephones.

*We understand from one claimant who doesn’t have a telephone that the letter from DWP gives an 0845 number for customers without a telephone. When the claimant rang it, the person who answered knew nothing about the arrangements of the trial, and offered no further help.*

It is important that procedures are put in place to ensure that people who are hard to reach do not miss out on help and support that they are likely to need with the assessment process.

We also have concerns about the communication of the decision, and information on appeals, which we develop below.

The Work Capability Assessment

The process

A full assessment is made up of several stages:

- Collection of evidence from the claimant about how their condition/disability affects their ability to function. Face to face assessments by HCPs are an inefficient and expensive way to do this.
- Verification of the claimant’s condition/impairment and its level of severity. We believe that there should be greater reference to the client’s medical records, especially when there have been investigations by a consultant.
- A decision as to whether what the claimant says about their level of functioning fits with what is known about that condition/impairment. The DWP Disability and Carers Service has built up a detailed database which describes the likely effects on functioning of a given level of condition/impairment.

**The assessment and its descriptors**

We consider that any assessment tool based purely on a functional assessment cannot fairly assess whether someone should be awarded sickness benefit. With a functional assessment, wherever the threshold is set, there will be people who meet the criteria for benefit but who could work – such as Professor Stephen Hawkins. Conversely, there will be people who don’t meet the functional criteria, but who cannot work.

A man in his late fifties who has done manual work all his life, has a physiological age of 80 years, struggles to walk more than 60 metres because of heart problems and emphysema, and is unlikely to live to draw a state pension, will be found fit for work.

*A CAB in the South East saw a client who had to stop work as a cleaner because of severe breathlessness caused by emphysema. After his statutory sick pay ran out, he applied for ESA but was found fit for work. The bureau helped him to appeal this decision, and noted that the worry of appealing was exacerbating his breathlessness. Five months later - while the appeal was still pending - his son rang to tell the bureau that his father had died: the cause of death was a heart attack and emphysema.*

The new regulations which came into force in April will restrict still further the number of descriptors under which people in this situation can qualify. They are likely to score points only under the walking descriptor, whereas at present they would probably score points under the walking, standing and bending descriptors.

* A client of a Yorkshire bureau had cancer. He had had his oesophagus and part of his stomach removed, and was initially placed in the support group under the special rules. After six months, he was sent for an assessment and placed in the work related activity group. He was awarded 9 points because he was unable to walk more than 100 metres and 6 points for not being able to stand for more than 30 minutes without needing to sit down. The bureau helped him to appeal, as his doctors still considered him terminally ill, but the decision maker refused to change the decision. The client died shortly afterwards, leaving his family feeling very angry that he was put through this stress in the last few weeks of his life.

Under the new regulations this man would have been found fit for work, as he would have scored no points for his limited ability to stand, and so would not have attained the necessary 15 points to be allocated to the support group.

As a result of the first year review, led by Professor Harrington, work has started on refining the mental, intellectual and cognitive descriptors for the WCA. The Professor has also asked Citizens Advice to report on whether the assessment could and should incorporate more “real world” elements, following our arguments for a “real world” test (see our report *Not Working*). Citizens Advice believes that the new regulations should be suspended until Professor Harrington reports back at the end of the second review year, and DWP have acted on his findings.

**Customers’ experiences of the process**

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1 http://www.citizensadvice.org.uk/not_working
CAB clients report varied experiences of the manner and politeness of healthcare professionals (HCPs), but we consistently hear descriptions of the poor delivery of the assessment, including concentration on the computer rather than eye contact with the claimant; closed questions; lack of time given to answer fully; and repetition of ‘just answer yes or no.’ In these conditions, it is impossible to take an accurate history that reflects variability, or general pain.

A CAB in the South West saw a client who was a barrister, but was unable to practise because of cancer and lymphoma. She described the assessment as like an “interrogation” led by a computer, held in a bleak assessment centre, by unprofessional HCPs. The HCP moved the client’s legs which caused her great pain, even though she had forewarned the assessor that this would happen. The client said she was shocked by the way claimants were treated and sent a complaint to ATOS.

This does not encourage clients to talk about sensitive topics:

One bureau described a client with learning difficulties who went for an assessment. He was awarded some points for physical limitations, but none for his learning difficulties and was found fit for work. One of the key reasons given was that he had found his way to the assessment centre on his own. When the CAB adviser asked him about this, he explained that he had got up very early, taken the bus to the town centre and then kept asking passers-by. He couldn’t follow instructions, so he would show the letter, walk in the direction they pointed, then ask again until he arrived at his destination. This man was very sensitive about his learning difficulties and had developed strategies for hiding them. The closed question “Did you come on your own?” clearly failed to elucidate this information. (CAB evidence enabled the decision to be overturned).

The accuracy of medical reports
Citizens Advice has had long-standing concerns about the lack of accuracy in ATOS reports. We have several years of evidence, including some extraordinarily inaccurate assessments. It is alleged that our evidence is selective and not representative, but CAB welfare rights workers consider this is a systemic problem.

To assess the extent to which these problems are systemic, Citizens Advice is surveying clients identified in advance of their assessments. Before the assessment, they agree to ask for their report afterwards. Once they have received their report, they check the accuracy of the record and the basis on which they were, or were not, found fit for work. Initial results confirm that there are significant mistakes in a majority of the reports, and serious errors in some.

Recommendation: We would like to see the reliability of the WCA tests independently measured, using the standard measures of the accuracy of any diagnostic or classificatory test (its false positives and false negatives), and research into the most accurate methods of assessment.

The role of UNUM
We are concerned about the apparent conflict of interest between UNUM’s role in the internal review governing entitlement to ESA, and their commercial interests as a leading provider of health insurance. There is clear potential for a financial motivation in undermining the benefit payable by the state, when someone is too ill to work.

The decision-making process
In our report *Not working*, one of our key recommendations was the need for a thorough consideration – and re-consideration - by the DWP decision maker (DM), not simply a rubber stamping of the ATOS recommendation. We are very pleased that this concern was taken seriously by both Jobcentre Plus and Professor Harrington, and there is now some movement on the issue. We hear from welfare rights workers that when strong evidence is presented, decisions are sometimes – though far from always - reconsidered in the client's favour, without going to a tribunal.

In the recent trial of the process for the reassessment of incapacity benefit (IB) claimants, claimants were encouraged to send medical evidence with their ESA50 forms. DMs were also encouraged to take account of other evidence than that provided by ATOS. We welcome these steps, which we see as significant improvements. Ideally, we would like to see medical evidence - or evidence from other relevant professionals - sought in all cases.

We are concerned, however, that it is the claimant's responsibility to produce such evidence. Some clients are unable to get such evidence because GPs frequently charge for the information. Someone receiving £65 /week for all their living expenses will not be able to pay £30 for a letter. A two tier system will emerge if those who can afford to pay for medical evidence are more likely to be found eligible for ESA.

### The appeals process

In the recent trial, before the DM made the formal decision to find someone fit for work, they rang the claimant to discuss the assessment, to ask if the claimant disagreed with the conclusions about their level of functioning, and if so, whether they were likely to provide further supporting evidence. This call - named “touchpoint 13” - has the potential to be very positive, and to save claimants the stress of an appeal and tribunal hearing. However, we believe that safeguards are necessary to ensure that these calls do not become a mechanism to persuade someone that it isn’t worth appealing when they have a strong case.

If someone does have a good case for appeal, they stand a much better chance if they are represented. A client, or even a health professional, can often find it difficult to know what will be relevant:

> An adviser from a CAB in Yorkshire saw a client who came to the bureau, astounded after losing her appeal at tribunal. She was too ill to attend the hearing, but had sent very strong letters from her GP, her consultant and her physiotherapist, all of whom had said very clearly that in their opinion, she could not work. The reason she had lost was that neither she nor the health professionals had realised that the tribunal did not need their opinion on whether she could work. The legal issue was whether she had been awarded the right number of points on the various descriptors, which the letters did not address.

The DWP has had to provide additional funding to the Tribunals Service to manage extra demand since the introduction of ESA in 2008, and the number of appeals is likely to increase again in the next few years because of:

- the IB reassessment process
- the time limit of one year for ESA(CB) for those in the WRAG
- the introduction of a large financial difference between the support group and WRAG, when the welfare reform bill is enacted
- the introduction of face to face assessments for PIP
We are very concerned that support through legal aid will no longer be available, so there will be a huge cutback in welfare rights workers. We believe that many more people will face the wrong decision, as a result of these cuts. There is likely to be more strain on the appeals service, and judges and doctors will be asked to spend more time helping unadvised and unrepresented clients.

Evidence of different outcomes for various client groups

Research shows that claimants who move off benefits and re-enter work generally experience improvements in income, health and well being. However, it is vital that someone is not forced into taking a job that makes their condition worse.

A client had his ESA stopped after being assessed and found fit for work. He had a congenital hip problem but had worked all his life as a plasterer. After a serious fall, he was in a great deal of pain and could not do his old job. His wife worked, but they struggled to manage financially since he had stopped work, and they couldn’t manage with the loss of his ESA as well. He felt he had no option but to take a job working in a supermarket, despite this work causing him severe pain and a resulting change in personality that nearly broke his marriage of over 30 years. He won his tribunal, but was very angry that the benefits system failed to support him when he most needed it, after having paid contributions all his life.

Others who have their benefits stopped may be faced with having no job at all. Research not only demonstrates the benefits of good work, it also demonstrates that:

“those who move off benefits but do not enter work are more likely to report a deterioration in health and well being”

Limiting of ESA(CB) for those in the WRAG to one year

A number of people will not be eligible for income-based ESA after one year on contribution-based ESA, either because of savings, or because of other income in the household. This could typically be a drop in household income from, say, £500/week when the main earner was in work, to £150/week if a partner is in low-paid or part-time work. We are concerned that many more people will find themselves in the position of choosing between a totally unsuitable job which aggravates their condition, or having no income of their own and struggling financially. Many of these will be people who have worked and paid contributions all their working lives, but whose life expectancy means that they will not live long enough to draw a retirement pension.

We are currently conducting a survey on our website, of people who are claiming ESA(CB), are placed in the WRAG group, and have a partner who works, or have savings over £16,000. One very clear message already coming through, is that people feel betrayed because, after working for many years and paying their contributions, the system will not help them when they need it. Some respondents with mental health problems express their feelings of hopelessness if their benefit stops, and some say that they will end their lives. Most respondents are very worried about how they will cope:

One woman dictated her response to her daughter to send in: she and her husband both worked until she lost her sight. She is now unable to cope with all the everyday tasks unaided, and she is unable to leave the house safely on her own. Since she had to give up her job, they have struggled to manage financially, as her husband’s wages pay the mortgage and all the household bills, while her ESA pays for their family’s food and other expenses. Since she

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2 Waddell and Burton (2006) Is work good for your health and wellbeing?
heard that her ESA is likely to be stopped, she says she has not stopped crying, as she thinks there is no way they can manage financially and they will lose their home.

Many of those found fit for work will not be able to look for work
We are also concerned for those who are found fit for work. The new descriptors for the WCA have been brought in with reference to a modern office environment, but with no reference to how someone could actually look for work. A person who can walk only 50 to 100 meters, has difficulty standing for long, and receives just £65 /week to live on, will have considerable difficulty getting to the jobcentre to sign on, getting to the library to do a job search, and getting to interviews – especially as they are likely to be reliant on public transport. While, in principle, reasonable adjustments have to be made, we fear that, in practice, many such claimants will find themselves sanctioned.

We think it is vital, as Professor Harrington has recommended, that research is rapidly undertaken to find out what happens to people who are found fit for work, or have their benefit stopped at the end of a year in the WRAG. We also think this research should examine whether people actually move further away from support and help – especially those who are not entitled to JSA - and are therefore less likely to move into work.

Implications for the national roll-out of the reassessment

We strongly recommend that the new WCA descriptors are not applied, at least until Professor Harrington has reported back at the end of his second year review.

We are already seeing some signs that shortcuts will be taken with the process, as the system struggles to manage the high volume of reassessments: the telephone call to new ESA claimants who are going to be found fit for work, is not being made by a decision maker. This means that the caller therefore simply explains the decision, without offering an informed discussion about whether the client may have other evidence. As outlined above, this is much more likely to result in pressure to drop an appeal and claim JSA, even if the client has a good case to take to appeal.

April 2011
Written evidence submitted by Penny Meade

Summary – The following account is my experience of an ATOS Work Capability Assessment and how it was totally unfit for purpose.

1) My Condition - I have progressive disease that affects my skin and my joints (palmer planter pustulosis, pustular psoriasis & psoriatic arthritis)

2) I worked until 2009 when it became impossible to continue and on the advice of GP & 2 consultants I stopped working and made a claim for ESA.

3) The first I knew of an ATOS medical was when I got a letter through demanding I attend for one. The place they wanted me to go was an hour away by car and as I have mobility problems I arranged for my husband to take me.

4) I got a phone call 2 hours before my appointment time on the day to inform me they were over booked so would have to cancel my appointment, I explained that I had made special arrangements to attend but was told 'sorry but that's the way it is. I got really stressed and upset and my husband phoned them in disgust and he was told to bring me up and they would 'fit me in'

5) Centres are inaccessible - There was no parking near the building but I can't walk so we parked illegally.

6) The actual assessment went quite well, I saw a GP who seemed aware of my condition although she still managed to get a couple of points wrong i.e she wrote I could put my own shoes on and off even though it was summer and I had slip on sandals on and explained that I couldn't bend to fasten shoes.

7) She didn't do the WCA as she felt there was no point, she wrote on my assessment 'this condition will continue to deteriorate and this woman will NOT be able to return to work at ANY time in the future.

8) Mis-Categorised - So imagine my surprise when I received my notification that I had been placed in the 'work activities group' and expected to attend the job centre for 6 interviews!

9) As it stated not to recall me for 2 years and no one mentioned the appeal process as a possibility I accepted it.

10) I made it to 2 interviews at the jobcentre, as the meds I was on caused me to get infections the girl at the jobcentre didn't insist on me attending the other 4. She said it was ludicrous as she couldn't possibly do anything with me, she only had 3 options to offer me:

1) a year's subscription to the gym (I am disabled with mobility issues)
2) a college course in basic skills i.e reading and writing (I am a doctor of Psychology!)
3) a jobcentre workshop on CV writing etc (no use to me at all)

11) Her opinion - many of the people she was seeing should not be in this category but she knew the only way to get in the support group was if you had less than 6 months to live.

12) Conclusion - My overall impression of ESA- hugely stressful, unnecessary, demeaning, inhumane waste of time and money.

April 2011
Written evidence submitted by Papworth Trust

About Papworth Trust

1. Papworth Trust is a disability charity and registered social landlord, whose aim is for disabled people to have equality, choice and independence. Papworth Trust helps over 20,000 people every year through a wide range of services including employment, vocational rehabilitation, housing and personal support.

2. Papworth Trust is a sub-contractor to the Department of Work and Pensions in the delivery of employment programmes. In 2010/11, we helped nearly 8,000 disabled and disadvantaged people through our employment services.

3. Papworth Trust welcomes the opportunity to submit evidence to the House of Commons Work and Pensions Select Committee Inquiry into the migration from Incapacity Benefits (IB) to Employment and Support Allowance (ESA) and share with you our thoughts and concerns on the Work Capacity Assessment (WCA).

4. In July 2010 and January 2011, Papworth Trust chaired two roundtable seminars of like-minded disability charities, voluntary organisations and employment service providers to discuss the failings of the WCA and the measures that should be taken to improve its accuracy. These seminars culminated in open letters to Professor Harrington in September 2010, as part of his independent inquiry, and Chris Grayling MP in January 2011 calling for the Government to focus on implementing the Harrington Review recommendations. The letters were signed by over 36 organisations and copies of both are attached to this submission.

Overview

5. Papworth Trust fundamentally believes that a job is the best form of welfare and route out of poverty. Where individuals can work, they should be supported to do so. For some individuals work is not always a viable solution, this may be due to their condition or circumstance, and there must be a system in place that supports them as well.

6. In the past, the Government has recognised¹ some of the issues which prevent people returning to employment such as disability, health problems and in some circumstances the complex nature of our benefits system. Papworth Trusts also believe that discrimination, language barriers, criminal records, lack of experience and transportation needs further restrict the opportunities and ability to gain work. A major barrier for our clients is that employers often seek ‘ready-made’ employees who are proficient in their role.

¹ DWP, 21st Century Welfare, July 2010
with minimum training, support, cost or perceived risk to the employer. Extra support or training is viewed as inconvenient, time consuming and costly. Access to Work goes someway to solving this barrier, although the future of this funding is currently being looked at as part of the Sayce Review.

The Work Capability Assessment (WCA)

7. For a long time, Papworth Trust has been concerned about the outcomes of the WCA which suggest it is a flawed assessment. When the WCA was first applied to existing IB claimants, the Government estimated that:\[2:\]
   - 65% would be assessed to be in the work-related activity group of ESA,
   - 20% would be assessed to be in the support group of ESA, and
   - 15% would be passed as fit for work.

8. In reality we see the breakdown for all completed assessments carried out by the end of May 2010\[3\], as follows:
   - 25% were assessed to be in the work-related activity group of ESA,
   - 10% were assessed to be in the support group of ESA, and
   - 65% were passed as fit for work.
   This means that the Government’s original estimate of those being found fit for work by the WCA was inaccurate by a factor of over 330% compared to reality.

9. The Government has so far welcomed that more people are being found fit for work than it originally estimated\[4\]. Papworth Trust is concerned at how vastly different the predictions made are from reality. We are concerned that vulnerable people are being wrongly assessed as fit for work, and what the legacy holds for those people subsequently placed onto Job Seekers Allowance (JSA) on reduced incomes and with less support to find employment. In our experience, simply reducing benefits does not help the hardest to reach to find work; instead tailored support is required to help them into employment.

10. We are increasingly puzzled at the significant proportion (37%) of people who close their claim before the assessment process has ended. Whilst many of these people will have found jobs or may have stopped their assessments for personal reasons, we are concerned about those who may have become frustrated by the system and simply given up, excluding themselves from appropriate support. This is in part due to our welfare to work system where eligibility for support is based on which benefits a person is claiming. We believe greater understanding of this group is needed, and as part of second year independent review the Government has promised to start tracking

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\[2\] Answer provided by Jonathan Shaw MP to a Written Parliamentary Question, Hansard Column 1347W, 20 Oct 2009


\[4\] Department for Work and Pensions press release, Majority of people found fit for work as Government presses ahead with reforms, 25 Jan 2011
people who do not complete their WCA. As part of this inquiry, we urge the Committee to ensure that the DWP has started tracking the final destinations of this group and that this data is made publicly available.

The Assessment criteria

11. Papworth Trust was extremely disappointed with the Government’s decision to implement the recent regulations6 to amend the WCA descriptors. In a joint letter to Chris Grayling MP (see attached) in January 2011, we expressed our concern that these amendments were developed prior to Harrington’s review and were not subjected to the same level of external scrutiny. Unlike the Harrington Review, which has received strong support from the sector, the internal review was widely criticised, including by 10 of the 12 organisations involved in the internal review.

12. As a result of these regulations, the number of descriptors under the new assessment will fall from 21 to 17. Whilst Papworth Trust supports the move to a more employment outcome based approach, we are concerned that the reduction in the number of descriptors will further worsen the WCA, rendering it even less effective for vulnerable people.

13. Papworth Trust has a long standing concern that the assessment is too focused on a person’s physical capability, and needs to better recognise the barriers faced by people with learning disabilities, mental health issues and fluctuating conditions. The reduction in the mental health descriptors from three to one under these regulations is particularly concerning, considering the assessment is already poor at recognising these conditions.

14. There appears to be an underlying assumption that because someone has physically managed to arrive for an appointment, that they must be fit to work. The assessment illustrates what people can do in a test, but it fails to do so in a way which reflects work. Taking claimants through a system which is not fit for purpose and does not accurately determine a person’s capability for work has caused stress and anxiety to claimants and represented significant costs to the public purse. We know the system needs a complete overhaul and believe Professor Harrington’s review is the most effective way of delivering this, including through the work he has already instigated by establishing four expert working groups to recommend changes to the descriptors.

15. The Government has indicated it will make further, necessary amendments to the assessment if identified. As part of this inquiry, we urge the Committee to ensure this commitment happens and without delay. We are concerned that even a six month delay between identification and implementation of a solution could now result in over 250,000 people having an assessment that is not fit for purpose.

Customer communications

16. Papworth Trust believes that past communications with claimants going through this process has been extremely poor. During Professor Harrington’s independent review last year, we expressed our concern that the current support was insufficient with notifications of assessments sent without warning and no further support offered to help individuals to prepare for the process. Under circumstances where a claim for ESA was rejected, individuals were given no indication of the support they could receive or the actions they needed to take to ensure their benefits were reinstated. Claimant’s letters did not explain how they could claim JSA, nor inform them that they had the right to appeal and any explanation of the appeal process.

17. Papworth Trust felt these communications were causing unnecessary anxiety to vulnerable people and were pleased when Professor Harrington shared these concerns: “the communications lack empathy and clarity, they are at best bland and technical and at worst confusing and threatening.”

18. Since Professor Harrington’s review, we understand Jobcentre Plus has taken good steps to try to correct these inadequacies. Telephone calls are now made to claimants before they receive their initial letter calling them for their assessment to provide further information and advice, and to establish whether any help or support is needed. In cases where the claim for ESA has been rejected, an adviser telephones the claimant to inform them of the entitlement decision and advises them of their options and how they can make a claim for JSA, if they wish. Whilst these changes have only recently come into practise, Papworth Trust welcomes the move to a more personalised service from Jobcentre Plus with clearer, and less-threatening, communications. As part of this inquiry, we urge the Committee to ensure these measures are rolled out and are closely monitored.

The decision making process

19. In the past, decision makers have tended to act as little more than a rubber stamp to the Atos assessment. In future, Papworth Trust understands that decision makers will undergo better training to empower them to use the assessment as guidance whilst they make the final decision. We welcome this change.

20. Papworth Trust understands that better use will be made of the reconsideration process. At present, if a claimant disagrees with their decision, they tend to pursue an appeal rather than seek a reconsideration of that decision. We welcome this and the subsequent saving it should make to the public purse given that it will not be subject to the same costly, judicial process. However, at present the Government does not track the reconsideration process and the subsequent outcomes. As part of this inquiry, we urge the Committee to ensure that reconsiderations and their outcomes are tracked in future. Without this tracking, we are unable to draw any conclusions as to whether a fall in the appeal rate is as a result of more

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6 Professor Harrington, An Independent Review of the Work Capability Assessment, p.34, Nov 2010
correct decisions in the first place, or that the reconsideration process is simply a shortened version of the appeal process.

The timescale for national rollout

21. Papworth Trust recognises the expectation to assess 1.6 million existing Incapacity Benefit claimants over the next three years, equating to 11,000 per week, is an ambitious target, especially when added to the routine flow of new claimants, estimated at a further 11,000 per week. In addition, DWP statistics show that of the 273,900 who were found fit for work under the current assessment (by November 2009), a third of those people went on to appeal, causing further strain on the assessment flow. As part of this inquiry, we urge the Committee to probe how the system will cope with this strain.

Impact on the Work Programme

22. Papworth Trust supports the principles behind a single Work Programme. We believe the Work Programme will provide a real opportunity to help those who are furthest away from the labour market. With the right support, those people who are fit and able to work should have the necessary requirements placed on them to actively engage in work. However, for those people found wrongly fit for work under the WCA, they will receive a third to two-thirds less support to find and retain work under the Work Programme payment structure, which is extremely concerning.

23. Furthermore, the failings of the WCA in the past has meant that employment adviser’s spend more time providing advice and guidance on how to appeal their outcomes than supporting them into work. Papworth Trust’s experience has shown that clients simply will not engage in employment programmes whilst they believe they have been placed on the wrong benefit.

24. As part of this inquiry, we urge the Committee to explore what impact this has on the success of the Work Programme, and how the Government might review this in future.

April 2011
Dear Professor Harrington

Independent Review of the Work Capability Assessment
As charities, voluntary organisations and employment service providers from across the country, we work with some of the most disadvantaged and vulnerable individuals and communities in the UK. For a while, we have been concerned about the accuracy of the outcomes from the Work Capability Assessment (WCA). This concern was compounded by the announcement of changes to Housing Benefit in the Emergency Budget statement in June 2010, where payment will now be tied to the period of the JSA claim. It is concerning that an assessment which we do not believe has demonstrated its ability to place people correctly onto Employment and Support Allowance (ESA) may become the basis of eligibility for a far wider range of benefits.

We welcome your appointment to independently review the WCA, and would like to share with you our firsthand experience in working with people who are being let down by this assessment.

The role of WCA providers
Amongst all the uncertainties, what is clear is that the medical assessors will have a heavy workload over the next three years. The expectation to assess 1.6 million existing Incapacity Benefit claimants over that time period, equating to 41,000 per month, is an ambitious target. It is particularly ambitious considering that DWP statistics show that of the 166,300 who were found fit for work under the current assessment (by June 2009), a third of those people went on to appeal. Your review of the situation is timely, particularly with the current backlog of 50,000 assessments in mind.
Assessment principles
The assessment should be founded on a realistic model of what ‘work’ is and what is meant by ‘limited capability for work’ as per the Work-Related Activity Component assessment under ESA. Rather than simply assessing whether someone can work, the WCA should be amended to evaluate the full range of employability factors including an individual’s barriers to work, which could then inform the appropriate segmentation for the Work Programme. These barriers can include, but are not limited to literacy, numeracy, confidence, self-esteem.

Recognising conditions
The current WCA is too heavily focussed on physical capability, and needs to better recognise the barriers faced by people with learning disabilities, mental health issues and fluctuating conditions. Given the stigma attached to mental health, our experience indicates that people are more likely to answer questions in the way that they want to be viewed. It is therefore imperative that a trusting relationship can be established to allow the claimant to feel comfortable in sharing such personal information. We recommend assessors are provided with better training on working with people with learning disabilities, fluctuating conditions and mental health issues.

Supporting claimants through the process
Better upfront support needs to be provided before claimants undergo their assessments, as the current support is insufficient. Notifications of assessments are sent out without warning and no further support is offered to help individuals to prepare for the process. Under circumstances where a claim is rejected, individuals are not signposted to any person or organisation who can help them understand why their claim was rejected or who can provide assistance with reinstating their benefits. This causes unnecessary anxiety to vulnerable people.

Post assessments
We are increasingly puzzled at the significant proportion (37%) of people who close their claim before the assessment process has ended. Whilst many of these people will have found jobs or may have stopped their assessments for personal reasons, we are concerned about those who may have become frustrated by the system and simply given up. Greater understanding of this group is needed and we urge you to recommend that the DWP begins to track the final destinations of this group in the future.

In addition, we believe a further recommendation should be for DWP to track people post-assessment by their disability type. This will enable the sector to better understand what happens to people with particular barriers who are passed fit for work, and will demonstrate whether the system is capable of supporting them.
Taking these factors into account, we believe the current WCA interview time needs to be lengthened in order to form a realistic impression of a person’s employability and to build up the trust required.

We see your review as a real opportunity to make the necessary changes to the assessment before the wider migration from Incapacity Benefits begins next year. We wish you all the best of luck and look forward to working with you on this important issue.

Yours Sincerely

Matthew Lester
Director of Operations

Steve Swann
Director

Dr. Mark Baker
Head of Social Research and Policy

Leslie Morphy
Chief Executive

Emma Mamo
Policy & Campaigns

Anthea Cox
Director

Page 3 of 6
Dear Minister

Work Capability Assessment

As charities, voluntary organisations, associations and employment service providers from across the country, we work with some of the most disadvantaged and vulnerable individuals and communities in the UK. We share a common interest in the Work Capability Assessment (WCA) and have worked hard to support the Government with its review and reform.

We welcomed your appointment of Professor Harrington to lead an independent review of the assessment. We also support his recommendations for change. We have been encouraged by your public support for Professor Harrington and the swift and positive Government response which followed. We are keen that his recommendations are implemented quickly to ensure the flaws in the WCA are addressed in a structured and effective way.

However we are increasingly concerned about the implementation of the internal Departmental review of the assessment, which was developed prior to the Harrington review and was not subjected to the same level of external scrutiny. Unlike the Harrington Review, which has received strong support from our organisations, the internal review was widely criticised. We think implementation of this internal review will:

- further worsen the WCA, rendering it even less effective for vulnerable people;
- increase the level of WCA appeals being experienced;
- diminish the positive impact of Harrington’s recommendations; and,
- divert limited resources from addressing the Harrington reforms.

Taking claimants through a system which is not fit for purpose and does not accurately determine a person’s capability for work has caused stress and anxiety to claimants and represented significant costs to the public purse. We know the system needs a complete overhaul and believe Professor Harrington’s review is the most effective way of delivering this, including through the work he has instigated around reviewing certain groups of descriptors based on the expertise within the voluntary sector.
We urge you to implement Professor Harrington’s recommendations as a matter of urgency, and not divert resources and risk further problems for vulnerable people by implementing the internal review.

We would be happy to meet you and look forward to working with you on this important issue.

Yours Sincerely

Matthew Lester  
Director of Operations

Emma Mamo  
Policy and Campaigns  
Mind  
For better mental health

Dr. Mark Baker  
Head of Social Research and Policy

Mark Lever  
Chief Executive

Neil Betteridge  
Chief Executive

Philip J Connolly  
Employment Campaigns Officer

RNIB  
Supporting blind and partially sighted people
Written evidence submitted jointly by Centre for Mental Health, Hafal, Mind, Rethink, the Royal College of Psychiatrists and SAMH (the Scottish Association for Mental Health)

About Us

Centre for Mental Health
Centre for Mental Health is an independent, national charity that aims to help to create a society in which people with mental health problems enjoy equal chances in life to those without. We aim to find practical and effective ways of overcoming barriers to a fulfilling life so that people with mental health problems can make their own lives better with good quality support from the services they need to achieve their aspirations. Through focused research, development and analysis, we identify the barriers to equality for people with mental health problems, we explore ways to overcome those and we advocate for change across the UK.

Hafal
Hafal is run by its 1,000 members - people with a serious mental illness and their families and carers. Every day our 160 staff and 150 volunteers provide help to over 1,000 people affected by serious mental illness across all the 22 counties of Wales. The charity is founded on the belief that people who have direct experience of mental illness know best how services can be delivered. In practice this means that at every project our clients meet to make decisions about how the service will move forward and the charity itself is led by a board of elected Trustees, most of whom either have serious mental illness themselves or are carers of a person with a mental illness. 'Hafal' means equal. Our mission is to empower people with serious mental illness and their families to enjoy equal access to health and social care, housing, income, education, and employment, and to achieve a better quality of life, fulfil their ambitions for recovery, and fight discrimination.

Mind
Mind is the leading mental health charity in England and Wales. We work to create a better life for everyone with experience of mental distress by:

- Campaigning for people’s rights
- Challenging poor practice in mental health
- Informing and supporting thousands of people on a daily basis

A fundamental part of Mind’s work is provided though our network of over 180 local Mind associations who last year worked with over 220,000 people running around 1,600 services locally. Services on offer include supported housing, crisis help lines, drop-in centres, counselling, befriending, advocacy, and employment and training schemes. Over 30,000 people are supported by our national telephone help lines. Welfare reform is a key issue for many of the people Mind has contact with. We also work extensively with the Disability Benefits Consortium (DBC) on issues of welfare and benefits.
**Rethink**
Rethink Mental Illness, the leading national mental health membership charity, works to help everyone affected by severe mental illness recover a better quality of life. We help over 52,000 people each year through our services and support groups and by providing information on mental health problems. Our website receives over 600,000 visitors every year. Rethink's Advice and Information Service helps almost 8,000 people each year and advises people daily with benefit claims.

**Royal College of Psychiatrists**
The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

**SAMH (Scottish Association for Mental Health)**
SAMH is the biggest mental health charity in Scotland, providing an independent voice on all matters of relevance to people with mental health and related problems and delivering direct support to around 3000 people through over 80 services across Scotland. SAMH provides direct line-management to respectme (Scotland’s anti-bullying service) and ‘see me’ (Scotland’s anti-stigma campaign).
1 Summary

1.1 Our organisations understand the motivation for moving claimants off existing incapacity benefits (IB), which is seen as a ‘passive’ benefit, onto Employment and Support Allowance (ESA), which is seen as more ‘active benefit’. Around 43 per cent of those people due to be migrated are claiming primarily due to a mental health problem,¹ and many more will have experienced mental distress. We welcome efforts to help people with mental health problems back to work, where appropriate and if done in a supportive and understanding manner. However, we are concerned that the process will not be fair; will cause substantial distress; and will lead to many people receiving inadequate support and being subject to inappropriate and potentially harmful requirements.

1.2 All of our organisations have received substantial feedback, from people with mental health problems who have experienced the WCA and from professionals who work with them, that the assessment is unsuitable for gauging the impact of mental health problems on an individual’s ability to work. Some of our organisations have also been involved in various stages of creating and reviewing the assessment, but have often felt that our perspectives and objections have been largely disregarded. We do not believe the assessment is working fairly and effectively and we do not think migration should go ahead until these issues are resolved.

1.3 We are also concerned about the way in which the process will be communicated to IB claimants; the timescale of the migration; and the outcome of the process for those claimants reassessed.

2 The Department’s communications to customers going through the assessment and whether the information, guidance and advice provided by the Department and Jobcentre Plus is effective in supporting customers through the process

2.1 It is clear that, in response to Professor Harrington’s Independent Review, the Department and Jobcentre Plus in particular is paying considerable attention to how the process of migration is communicated. We welcome recent innovations in the customer journey, such as additional phone calls during the process to ensure that the customer is kept informed and up-to-date.

2.2 However, we are keen that, throughout the process, customers are regularly reminded of their rights at each stage of the process around submitting additional evidence; being accompanied during the assessment; accessing their report from the assessment questioning the Decision Makers verdict; and appealing the final decision. We would be very concerned if any of the additional contact established with the customer.

¹ DWP Incapacity Benefits Migration: Customer Segmentation Programme Summary of Key Findings and Final Customer Segments, April 2010, Government and Public Sector Consulting
customer resulted in a sense that it wasn’t worth questioning or appealing a decision that they were not happy with.

2.3 We are not confident that people feel well informed about the process of migration and we are concerned that uncertainty and anxiety about the process is having a detrimental effect on people’s health. In a recent survey on the Mind website of over 300 current IB claimants:

- 78 per cent did not feel well informed about the process
- Only 20 per cent had received their information from the Department (62 per cent had picked up their information from the media)
- 75 per cent said concern about the WCA had made their mental health worse and 51 per cent reported it had made them have suicidal thoughts
- 95 per cent do not think that they will be believed at their assessment and 89 per cent believe that they will be forced back to work before they are ready or able.

2.4 Although we understand that a huge number of people are due to be reassessed over a significant period of time, we do feel that it would be helpful if the Department could indicate to people when they are likely to be reassessed. The knowledge that you are due to go through a process that could have a profound impact on your life, along with the uncertainty of when this will occur in the next three years, is an unpleasant combination for those concerned. The ongoing anxiety this situation is causing may well worsen people’s mental health and could place them even further from the job market.

“I was due to be re-assessed for IB last September, nothing has happened yet except for a daily dread of brown envelopes”

“I dread the post coming each morning just in case there is a brown envelope with DWP printed on it and can no longer listen to news reports on the radio about anything to do with benefit changes.”

2.5 Informing people would not need to involve sending letters out to all those due to be reassessed, or even identifying specific dates. It could simply consist of a webpage where people can check the month or quarter when they are likely to be called in for reassessment. This webpage could be promoted to third sector organisations who could assist those without direct access to the internet. We feel that this would prove beneficial to a huge number of people.

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2 Quotes taken from claimants who have contacted our organisations
3 The Work Capability Assessment including: the assessment criteria; the service provided by Atos staff; the suitability of assessment centres; and customers' overall experience of the process

3.1 Our organisations have, between us, worked extensively on the WCA: from involvement in the meetings that led to the creation of the assessment and two reviews of its functioning, to listening to the concerns of people with mental health problems going through the process and feeding these concerns back to government. However, we do not feel that the DWP or successive governments have been particularly responsive. We believe that the assessment is not fit for the purpose of gauging the impact of mental health problems on an individual’s ability to work.

3.2 Professor Harrington’s Independent Review in 2010 vindicated the vast majority of the criticisms of the WCA that we had been expressing. We do not go into detail here about all of these criticisms, as the majority are well known. However, we have summarised our concerns below and have also enclosed our joint submission to the Harrington Review, which explains these concerns in more detail:

- Many people with mental health problems that pose a serious barrier to them finding employment are being found ‘fit for work’ and that many of these people are scoring zero points
- A huge number ‘fit for work’ verdicts are being successfully overturned at appeal, suggesting that these cases are not initially being assessed fairly or effectively
- The process is impersonal and mechanistic and does not allow the applicant to express the extent of their impairments and the details of their circumstances
- Applicants often feel that they have been treated unfairly and that this can cause distress that can both worsen their mental health and put them further away from the job market
- The assessment does not take sufficient account of fluctuations in conditions, which is vital to understanding the impact of mental health conditions
- The assessors do not have adequate expertise or training to understand mental health problems and the impact they have on an individual’s ability to work
- Too much weight is given to the verdict of the assessment and not enough to the perspective of clinicians who have a more complex and nuanced understanding of the applicant’s condition
3.3 We are pleased that the Department has now taken some of these criticisms on board and is looking to implement Professor Harrington’s recommendations. We support these recommendations and believe that they should help to significantly improve the WCA for people with mental health problems. We are also pleased that Professor Harrington has been kept on to perform a subsequent review which will include monitoring the implementation and effectiveness of his initial recommendations.

3.4 However, we do have some remaining concerns about the assessment that were not fully addressed by Professor Harrington’s Review:

3.4.1 We do not feel that there has ever been a rigorous evaluation of whether the WCA is both valid (i.e. it correctly measures what it is intended to measure) and reliable (i.e. it provides consistent and reproducible results). The high rate of successful appeals suggests that there is poor reliability and validity. We recommend that a thorough and scientifically rigorous evaluation of the WCA is undertaken, with a view to a more scientific approach to redesign if necessary.

3.4.2 We are concerned that the format and content of the current descriptors drives the behaviour of assessors in terms of only requiring them to seek a minimal amount of information from an applicant before assigning them to a particular category. The descriptors tend to try and measure complex impairments with multiple dimensions on a linear scale and we believe this fundamentally undermines their capacity to assess mental health problems. An example of this would be the descriptor on ‘coping with social situations’ which primarily measures the frequency of this impairment but doesn’t treat severity or duration as a variable. Professor Harrington has asked Mind to make proposals on improving the descriptors along with Mencap and the National Autistic Society. These proposals have been submitted to Professor Harrington and should go before Ministers around June 2011. We believe that these proposals would help to alleviate the limitations of the current descriptors but nonetheless call for fundamental review of assessment format.

3.4.3 The Government recently began implementing the recommendations of a previous, internal review of the WCA. Our organisations have significant concerns about both the process of this review and the outcomes. We are particularly concerned about the reduction in descriptors around mental, intellectual and cognitive function from ten to seven and we believe that this will render the assessment even less fair and effective for gauging the impact of mental health on an individual’s ability to work.

3.4.4 We believe that the guidance given to assessors compounds the problems with the descriptors by suggesting that they should look for sufficient cause to disqualify the applicant rather than rigorously assessing for reasons to qualify them. For example, there are a number of descriptors where simply turning up alone for the assessment is seen as cause for scoring zero points for the area impairment. This is particularly problematic for mental health where the impairments may not be obvious from appearance or even behaviour and where people’s
condition as presented on the day of assessment may not be representative of their usual or worst states of fluctuation. The guidance often cites the most extreme example of impairment, rather than providing suggestions around more borderline cases which may allow assessors to make more balanced decisions. For example, descriptor 15 (execution of tasks) has the following guidance:

“The pattern of typical day activity should really reflect a person who should struggle to get through the basics of a day due to their mental disablement as a result of tasks taking so long to complete that they would be unable to cope with work due to the length of time required for basic tasks. For example those who have severe and continuous disabling anxiety where they struggle to even get out of their bedroom may come into this category”.

By citing such an extreme case, it can overshadow less extreme, but still serious, cases and may lead to people being ‘under-assessed’.

4 The decision-making process and how it could be improved to ensure that customers are confident that the outcome of their assessment is a fair and transparent reflection of their capacity for work.

4.1 As stated in our joint submission to Professor Harrington (see attached) we believe more weighting should be given to the professional opinion of those clinicians in contact with the individual making the claim. This would help not only to reduce the number of people erroneously judged to be 'fit for work' but would assist in dealing with some of the problems of fluctuating conditions and symptoms and of combined mental and physical disorders. These clinicians would also have a greater understanding of how the condition affects the individual and how it might impact on their ability to work. The process would be more transparent if DWP Decision Makers were obliged to explain to the applicant why they had contradicted the opinion of the clinician, where relevant.

4.2 We are pleased that Professor Harrington recognised the problems in this area and we hope that his recommendations on this issue are fully implemented. Since this will involve retraining Decision Makers and a culture-shift in their approach to balancing different sources of information it is likely to be a lengthy process.

4.3 We would also like to see applicants regularly reminded during the process that they can submit additional evidence; that they can request a copy of their report from the WCA to check for accuracy; and that they can ask for reconsideration of their decision or go to appeal.

4.4 To support this it would be helpful to have a named person from the DWP system to be responsible for each claimant’s benefits claim who could be contacted by the claimant or clinicians when queries are required and who can assist in guiding the claimant through the benefits system.
5 The appeals process, including the time taken for the appeals process to be completed; and whether customers who decide to appeal the outcome of their assessment have all the necessary guidance, information and advice to support them through the process

5.1 A number of Community Mental Health Teams (CMHTs) have reported that many of their service users have been winning their appeals. Under the old Incapacity Benefit system, the fact that they were using a CMHT would be an indicator of a severe mental health condition and so the benefit would be awarded. The fact that the WCA no longer has this feature increases the likelihood of people being assessed and placed in the wrong groups as well as the cost/trauma of subsequent successful appeals.

5.2 We are also concerned that clients who have won their appeals are being reassessed through the WCA within a very short time frame. We have been in touch with a claimant who was initially declared ‘fit for work’, but overturned this verdict at appeal. He was sent an ESA50 form within months of the appeal being settled, and has now been called for a further medical assessment. This is causing him great distress and could potentially impact on his health, causing unnecessary expense for the NHS; particularly as he was assured it would be at least a year before he is reassessed.

5.3 Success rates for appeals are much higher when appellants are accompanied by an advocate or companion, suggesting that people appealing alone may not be able to adequately represent their case. People need to be encouraged to bring support to appeals.

5.4 We would like to see evidence from appeals being fed into the WCA system to ensure that those whom a tribunal has found to be eligible for ESA do not have to suffer the distress of presenting the same information to a different part of the system shortly afterwards, and that the DWP learns from these cases for future reference. This would also allow Decision Makers to understand why their decision was overturned, which should lead in time to a reduction in the need for appeals. At present, there is no systematic method for Decision Makers to learn from the decisions of Appeals Tribunals.

6 The outcome of the migration process and the different paths taken by the various client groups

6.1 1.6 million IB claimants will be migrated onto ESA by March 2014. We are concerned that many of these people may drop out of the benefits system due to the stress of the process or because they are not eligible for other benefits. Even if people are found to be legitimately ‘fit for work’, they will have been on benefits for many years, often without the right support to find paid work, and thus will take time to adjust to the demands being made of them and will in the interim face distress and hardship. As the current system of assessment is presently not sufficiently efficient they will
be doubly disadvantaged. Policy will need adjusting to allow the long-term IB claimants who are found to be ‘fit for work’ to have a period of time on ESA before being moved to JSA.

7 The time-scale for the national roll-out for the migration process, including the Department’s capacity to introduce changes identified as necessary in the Aberdeen and Burnley trials.

7.1 We have been aware for several years that the WCA is a flawed process and often denies people with mental health problems the benefits and support that they are entitled to. The Harrington Review has highlighted many of the problems in the process of assessment that contribute to this. The number and extent of the recommendations from this review demonstrate that the assessment is not functioning fairly and effectively. These recommendations need to be implemented in full, and their impact assessed to ensure they have had the desired effect, before the migration of existing IB claimants goes ahead.

7.2 We understand that it would be extremely complicated to halt new assessments of ESA applicants while reforming the assessment. However, there is no such imperative to begin migration at this precise moment. The average duration of claim for those due to be reassessed is nine years. We agree that it is hugely regrettable that so many people have been left for so long without active support, but it is absurd to claim that starting migration now should take priority over ensuring that the assessment process is fair and effective. A delay of a few months to ensure that the recommendations are implemented and have taken effect is clearly preferable to a more immediate migration with a flawed assessment.

APRIL 2011
The Work Capability Assessment – a call for evidence. 
Department for Work and Pensions, July 2010

Joint response from Centre for Mental Health, Mind, Rethink and the Royal 
College of Psychiatrists.

Who are we?

Centre for Mental Health
Centre for Mental Health is an independent, national charity that aims to help to 
create a society in which people with mental health problems enjoy equal 
chances in life to those without. We aim to find practical and effective ways of 
overcoming barriers to a fulfilling life so that people with mental health problems 
can make their own lives better with good quality support from the services they 
need to achieve their aspirations. Through focused research, development and 
analysis, we identify the barriers to equality for people with mental health 
problems, we explore ways to overcome those and we advocate for change 
across the UK.

Mind
Mind is the leading mental health charity in England and Wales. We work to 
create a better life for everyone with experience of mental distress by:
• Campaigning for people’s rights
• Challenging poor practice in mental health
• Informing and supporting thousands of people on a daily basis

A fundamental part of Mind’s work is provided though our network of over 180 
local Mind associations who last year worked with over 220,000 people running 
around 1,600 services locally. Services on offer include supported housing, crisis 
help lines, drop-in centres, counselling, befriending, advocacy, and employment 
and training schemes. Over 30,000 people are supported by our national 
telephone help lines. Welfare reform is a key issue for many of the people Mind 
has contact with.

Rethink
Rethink, the leading national mental health membership charity, works to help 
everyone affected by severe mental illness recover a better quality of life. We 
help over 48,000 people each year through our services and support groups and 
by providing information on mental health problems. Rethink’s National 
Information and Advice Service help almost 8000 people each year, including 
many who ask for help with the WCA.
Royal College of Psychiatrists
The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

Introduction

We welcome the opportunity to respond to this consultation.

As leading organisations in the mental health field we know that the great majority of people who experience mental ill health, even those with serious conditions, see some paid employment as a contribution to and a marker of their recovery.

We also know that there is good evidence that given the right conditions and the right support, for most people work is a realistic ambition. In our response we will focus on the ways in which the WCA as it is presently constituted and delivered creates the wrong conditions for people with mental health conditions to (re)launch themselves into the world of work by creating uncertainty, anxiety and unfairness. This is a matter of great concern to us and the people we represent because it not only impacts on quality of life and hope for a better future, but can also lead to worsening mental health for which mental health services will have to pick up the tab.

“We know that people with mental health conditions can and do pursue successful careers. We know that the majority would dearly love to be gainfully employed – in fact, people with a mental health problem have the highest ‘want to work’ rate of all disabled groups. We know that appropriate employment improves mental health and can protect against relapse. There is a wealth of research evidence showing how we can help many people with a mental health condition to realise their ambitions, yet, in most areas, we have failed to provide this support. And the number of people with a mental health condition who are workless continues to rise”. (Perkins et al, 2009)

Recommendations

In our evidence we are aware that in many ways the problems that existed for the PCA are still being replicated in the WCA process, particularly the problems with the Atos clinicians and the accuracy of the WCA medical assessment.
Centre for Mental Health, Mind, Rethink, and The Royal College of Psychiatrists recommend the following:

- Greater use of treating clinician’s opinions should be made throughout the WCA process.

- A claimant’s exemption should be based on the recommendation of the medical professionals who work with them that the assessment process would cause harm to health, rather than being prescribed for any particular health conditions.

- The overall assessment of claimants requires a more realistic approach to functionality, reflecting more accurately how a disability affects someone’s entire life, rather than identifying which tasks they can perform in isolation.

- Policy will need adjusting to allow the long-term IB claimants who are found to be fit for work to have a period of time on ESA before being moved to JSA.

- We recommend that regular thorough and scientifically rigorous evaluations of the WCA medical assessment are undertaken to ensure that it reflects new health conditions and evidence

- The current WCA interview and associated assessments should be reconsidered and the views of clinical, service user and third sector experts used to reconsider the current interview process, the descriptors and additional ratings.

- The current descriptors should be supplemented by an additional rating that assesses the overall impact on functionality caused by claimants’ conditions. These subjective aspects of distress could be used to determine an overall score of the claimant’s current functioning in addition to the current descriptors. We recommend that serious consideration is given to this proposal.

- The assessment should take account of how the illness or impairment affects an individual’s chances of finding work in the context of the workplace environment. We recommend that the WCA takes them into account for those people who may have reasonable functioning and may not automatically qualify for benefit, but have reduced chances of being able to work. This includes issues such as employer stigma.

- We recommend that improvements are made to the clarity of the WCA medical assessment. The WCA interview could be made into a semi-structured interview which would aid the systematic collection of data and may also help improve the interaction of the assessing doctor and claimant.
• We recommend that a thorough evaluation of the ability of the medical assessors is undertaken.

• The guidance given to WCA assessors should be improved, giving more and less extreme examples.

• For fluctuating conditions we recommend that the assessment differentiates between variable conditions and variable symptoms. Assessors should be asked to evaluate the variability in several ways and use these methods to develop a judgement as to the combined effects of these fluctuations.

• The contribution of multiple conditions may be managed by improving the assessment by the Atos clinicians, making it more reliable and valid. The process should assume at least an additive model such that the scores on the individual mental and physical descriptors are summated to provide the final score.

• Evidence from the appeal should be fed into the WCA systems to ensure that those whom a tribunal has found should be on ESA do not have to present the same information to a different part of the system shortly afterwards. This would save time and reduce stress for claimants, which can cause relapse.

Response to questions

In our response, we will concentrate on the effects of the Work Capability Assessment (WCA) on people with mental health problems. We are aware that this group of people form a significant proportion of those on welfare benefits. We believe that the process that assesses the eligibility of people for welfare benefits should be fair, accurate and just. It should not discriminate against any particular group and the benefits should offer protection to people when vulnerable and should offer a means of support to improve their opportunities when they are able to do so.

1a) How effectively does the WCA correctly identify those claimants whose condition is such that they are unable to undertake any form of work related activity (the support group)

Current DWP figures for ESA claims to November 2009 show that 6.8% of those with mental health problems assessed through the WCA were placed in the support group.
Support Group and 24% in the Work-Related Activity Group, whilst 69.2% were found to be ‘fit for work’. The equivalent figures for those with physical problems are 11.6%, 23.7% and 64.7% (Department for Work and Pensions, 2010a). It is not known how appropriate this figure is as we know of no evaluations that assess the accuracy for the assessments of people entering the Support group, but the figure for those being found ‘fit for work’ is much higher than that of 49% originally estimated by the DWP (Citizens Advice Bureau, 2010).

However Mind, Rethink and The Royal College of Psychiatrists are aware through their support work that many with mental health conditions who should be placed in the Support Group are inaccurately placed in other groups. Due to limitations of the current WCA, it is likely in our experience that people who are too disabled by their condition to work, and should be in the Support Group, are assessed as ready to engage with work-related activity.

The assessment for ESA does include “special circumstances” in which claimants can automatically be considered as having limited capability, and therefore eligible for the benefit. However, these “special circumstances” cover far fewer situations than for the Personal Capability Assessment (PCA), which was used to determine eligibility for Incapacity Benefit (IB). One exemption from the PCA that is not now included in the “special circumstances” for ESA is medical evidence to show: “A severe mental illness which severely and adversely affects mood or behaviour and which severely restricts social functioning or awareness of the immediate environment”. We will return to this point in our response to question 2.

It is now very common to employ Benefits Advisors in Community Mental Health Teams to advise and assist service users in making claims. These advisors, along with clinicians working in these teams, report an increase in problems with those people with severe mental illness who should be placed in the Support Group being called for assessment and being refused ESA (Citizens Advice Bureau, 2010). They also report that it is less common now for clinicians to be sent the form ESA 113 than it was to be sent IB50 forms under the previous system. These errors are damaging to the patients’ mental health and costly in terms of money and resources. This means that the system ignores the expertise of mental health practitioners to accurately assess the capabilities and any support needs of their patients. The CAB report also finds that seriously sick and disabled people are being found ineligible for ESA. It is generally recognised that people who move off benefits but do not enter work show deterioration in their health (Waddell and Burton, 2006). One example from the CAB illustrates this:

An adviser from a community mental health team reported that almost all their new clients applying for ESA are being refused benefit. In the last few months, she has helped 10 clients appeal ESA decisions: three have been resolved, and the other seven are all waiting to go to tribunal. None of these clients would be

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1 Table 5, page 12, Department for Work and Pensions, 2010a
getting the very significant resources of the community mental health team if they were not seriously mentally ill. Under the IB rules, this would be used as an indicator that there was a severe mental health problem and the benefit would be awarded. The stress and worry of the ESA process is damaging the clients’ mental health and delaying recovery and the possibility of an eventual return to work.

1b) How effectively does the WCA correctly identify those claimants whose condition is such that they are currently unable to work due to illness or disability (the limited capability for work group?)

Without further evaluation of the accuracy of the WCA to place people in the correct eligibility groups it is not possible to give a firm answer to this. However, from the official statistics we are aware that of the overall appeals against the decision of fitness to work, 40% of the decisions are overturned.² Up until November 2009, 66% of those assessed were found to be ‘fit for work’³ so if the 40% error rate were applied across all those people then a further 131,400 would be found to be eligible giving a total rate of eligibility of 60%, and would account for some of the overall rates of eligibility being 20% less than the government originally expected (Citizens Advice Bureau, 2010).

A potential error rate of up to 40% in the WCA process implies some serious inaccuracies in the assessment system. If there was a more accurate assessment of people’s eligibility for benefit, this would result in a reduction in the number of appeals to the decision, and ultimate cost savings to the DWP, and a reduction in distress for those making the appeal (Department for Work and Pensions, 2008). Where decisions are not appealed, inaccurate assessment has a detrimental effect on the wellbeing of the person with mental illness, as they are put through a programme which is not suited to their needs or denied support tailored to their situation, further damaging their confidence and ability to work.

“I have had to appeal a decision for my benefits that said, after a medical assessment, that I did not qualify due to the points system on certain issues they use. I did win my appeal though went through a lot of stress which was hard to deal with, particularly with a mental health condition. Now, only months after winning the appeal, I have been called to another medical assessment” – Rethink Supporter with severe mental illness

This not only results in worsened health but also denies appropriately tailored support to those who most need it. Within a competitive job market and where employers still hold stigmatising attitudes towards those with mental illnesses, this can increase rather than reduce an individual’s distance from the job market.

Our responses to questions 1a and 1b indicate that there is overall evidence that the WCA is not sufficiently accurate in identifying people with ill-health who are

² Table 1, page 7, Department for Work and Pensions, 2010b
³ Tables 3 and 4, pages 9, 10, Department for Work and Pensions, 2010b
eligible for ESA. This suggests that the WCA process is not efficient in providing a structure in which information is processed and it is likely that the medical assessment is not being carried out adequately and is not able to identify people who are unable to work due to ill health or disability. However we know of no published data that allows us to examine differences in outcome (correct identification of eligibility for ESA) between people who have mental health problems and those with physical impairments or disabilities. Such data would be essential to examine any bias or inaccuracy in the WCA process.

1c) What are the main characteristics that should identify claimants for each group, where these may differ from the current assessment?

Identification of all claimants needs a more realistic and evidence-based approach to functionality. The test needs to more accurately reflect how a disability affects someone’s entire life, rather than identifying which tasks they can perform in isolation. This should take into account how their quality of life, and health would be impacted, both in the short and long term, by any work that they are performing. Clinical practitioners who know an individual well, such as their GP or psychiatrist, could play a vital role in providing this contextual information and in reducing the risk of inaccurate assessments and subsequent appeals or loss of income.

The assessment also needs to take into account the quality of the support that will be available to individuals in the different groups and the external barriers they may face in finding work. Particularly for existing IB claimants, many of whom will not have worked for a long time, a ‘fit for work’ decision based on a purely functional assessment does not address the fact that they will inevitably face difficulties in actually returning to the workplace after such a long time away from it. These claimants in reality may not be able to access the support that would be necessary to overcome these realities – it is unfair for the system to work as though this support is available when in many localities it is not and claimants should not be penalised for this lack of provision.

2) What evidence is there to suggest that any issues with the operation of the WCA are as a result of the policy design and what evidence is there to suggest that they are a result of delivery?

Policy design
Current policy affects the operation of the WCA in several ways:

1. Migration from Incapacity Benefit
Policy suggests that 1.6 million IB claimants will be migrated onto ESA by March 2014. None of this group are likely to be eligible for contribution-based JSA if they are found fit for work and the majority who are not eligible for a top-up on their current sickness benefit are not likely to qualify for income-related JSA. Thus, many of those migrating who are then found ineligible for ESA will have no benefit to replace the income they have lost as a result of their illness or disability. Many of these people, even if they are found to be legitimately fit for work, will have been on benefits for many years, often without the right support to find paid work, and thus will take time to adjust to the demands being made of them and will in the interim face distress and hardship. As the current system of assessment is presently not sufficiently efficient they will be doubly disadvantaged. Policy will need adjusting to allow the long-term IB claimants who are found to be fit for work to have a period of time on ESA before being moved to JSA.

In addition there are concerns that there may not be the capacity to process the migration from IB to ESA. The House of Lords Merits of Statutory Instruments Committee (2010) notes that the DWP has revised its estimates of those likely to be found to be fit for work during phase 2 from 15% to 23% but they comment that there is no indication of how robust is this assumption. They also have concerns about the lack of evidence to support the methods of migration:

“.... the Committee’s view that, from the limited evidence we have seen, a major project with a potential impact on the lives of some of the most vulnerable in the community is being conducted in a rather ad hoc fashion. The second phase is being rolled out before the first has been evaluated and although better information will be sought on the outcomes, the Department’s intended course of action, and evidence to support it, all seem rather vague.” House of Lords Merits of Statutory Instruments Committee (2010).

The Social Security Advisory Committee report (2010) echoes this concern: “It is of particular concern to the Committee that the Department is moving ahead with the migration of existing claimants of incapacity benefits without a solid evidence base for either the decision to migrate or the proposed migration arrangements. The Committee notes that the evaluation of ESA for new claimant is not planned to be complete until 2011 by which time the proposed migration arrangements will have commenced.”

2. Greater areas for exemption

Some people with mental health conditions, particularly those being seen by Community Mental Health teams may be too unwell to work. In addition, participating in the process of the WCA itself is further detrimental to their mental health. Under the previous IB system those with severe mental illnesses were exempt from having to undertake the PCA (see: our response to Q1.a). There are also specific problems for the group of people with mental health conditions
who have limited awareness into the nature of their illness and who may complete the self-assessment ESA50 form on the basis of this and thus not be found eligible for ESA despite being unable to work.

Rethink have collected many examples of cases of people attending Community Mental Health Teams (CMHTs) for whom the WCA process does not work well. These have been highlighted in the CAB Not Working report (Citizens Advice Bureau, 2010), for example:

“A client with a diagnosis of schizophrenia who lacked insight into his mental health and was non-compliant with treatment. He had paranoid thoughts, had hallucinations and heard voices, and had suicidal thoughts, having previously attempted suicide. He claimed DLA and was awarded higher rate care and lower rate mobility. He was detained under Section 3 of the Mental Health Act 1983 (MHA83). Regulations state that a claimant should be treated as having limited capability for work on any day that they are receiving hospital treatment – thus he should have been automatically placed in the support group. He received the ESA50 in hospital and returned it while he was still detained. The ESA50 was not completed accurately as he was acutely unwell, but he attended a WCA a few months later and was found fit for work.”

“An adviser with a community mental health team recorded grave concerns about a client diagnosed with bipolar disorder but who had no insight into his condition. He had a WCA and was found fit for work. The client signed on and was delighted because he believed that is showed he was right all along and was not ill. The psychiatrist wanted this decision to be challenged but it was not possible because the client did not want to appeal.”

Considerable amounts of money and resources are invested in treating and supporting the patients of CMHTs, who are mainly diagnosed as being seriously ill. CMHTs have expert and often long-term knowledge of the people they see and it is this expertise and knowledge that should be sought, rather than decisions made on the basis of an assessment by a generalist health care professional. Greater weight should be given to supplementary evidence provided by the claimants’ own physicians and carers. Incorrect decisions are damaging the work done by the CMHTs, thus costing further resources to the public purse.

We believe that this aspect of current regulations should be changed to protect those using secondary mental health services from being subject to unnecessarily entering the WCA process and being allowed to enter the Support Group at an early stage. We suggest that this group are exempt from the process as they were for the PCA under the IB system. We recommend that their exemption should be based on the recommendation of the medical professionals who work with them, rather than being prescribed to any particular conditions.

3. The WCA process re-starts too soon after settlement of an appeal
We are also concerned that clients who have won their appeals are being reassessed through the WCA within a very short time frame. Rethink has been in touch with a supporter who was initially put onto JSA, but who appealed and had won his appeal. He was sent an ESA50 form within months of the appeal being settled, and has now been called for a further medical assessment. This is causing him great distress and could potentially impact on his health, causing unnecessary expense for the NHS; particularly as he was assured it would be at least a year before he is reassessed.

We would like to see evidence from appeals being fed into the WCA system to ensure that those whom a tribunal has found to be eligible for ESA do not have to suffer the distress of presenting the same information to a different part of the system shortly afterwards.

**Delivery**

There are several problems with the current delivery of the WCA process:

1. **The medical assessment interview of the WCA has never been subjected to scientific scrutiny**

For any test to be able to correctly identify individuals as experiencing any problem (in this case having reduced functioning that impairs their ability to work) it must be both valid (correctly measuring what it is intended to measure) and reliable (provides consistent and reproducible results). It should also be comprehensive and easy to administer. The WCA was a revision of the PCA and claimed to be a more robust, accurate and fair assessment than its predecessor (Department for Work and Pensions, 2006). The WCA has been re-assessed (Department for Work and Pensions, 2009; 2010c) but it has never been exposed to any rigorous evaluation and its validity and reliability is not known (Verbeek and van Dijk, 2008).

The evidence given above (Questions 1a and 1b) shows that the current WCA is subject to a high rate of errors suggesting poor reliability and validity. There is much at stake for the WCA. Not only does it dominate the provision of sickness benefits, it also determines the financial survival of many people with incapacities owing to illness. As it stands, the WCA does not yet pass the test of a fair and just process. We recommend that a thorough and scientifically rigorous evaluation of the WCA is undertaken, with a view to a more scientific approach to redesign if necessary.

2. **Current content of the medical assessment**

The medical assessment interview component of the WCA currently contains ten descriptors relating to mental health but the DWP’s internal review proposes to reduce the descriptors to seven (Department for Work and Pensions, 2010c).
These represent a much revised version of the original WCA (Department for Work and Pensions, 2006) and have not yet been evaluated.

In addition to the lack of evaluation, these specific descriptors are limited as they do not assess the overall impact of performing the tasks mentioned in the descriptors. This could be addressed by the overall assessment process by paying greater attention to the ‘subjective’ experience of the claimant, which the current score of ability to perform tasks or present well does not capture. These subjective experiences potentially include: overall distress experienced; chaotic thinking; difficulty organizing self or routine; feeling overwhelmed; tolerance for frustration; self confidence; fear of others’ expectations; debilitating side effects of medication; and difficulty coping with stress. We need assurance that these things are considered when assessing people’s ability against the descriptors. We are told by our beneficiaries that these aspects of their condition are not taken into account. Data on these issues is currently being collated through a major survey being conducted by Rethink on behalf of the Disability Benefits Consortium and we will be able to report results in October this year. We recommend that serious consideration is given to this proposal.

In addition, the WCA has further problems that need to be addressed:

a. Evaluation of variability

The WCA is not sufficiently robust to deal with either the variation of the conditions, or the variability of symptoms. For example, a person with a mental health problem may find that 30% of the time their mood is low and at other times they cannot concentrate or at other times they are irritable or have to withdraw to deal with their auditory hallucinations. Perhaps none of these factors, on their own, may affect the items on the WCA sufficiently to achieve the desired points, but together they are sufficient to affect their overall functioning. The same may apply to the variation of these individual symptoms.

The present guidance states that “For conditions which vary from day to day a reasonable approach would be to choose the functional descriptors which apply for the majority of the days.” However, for those with variable conditions this is not sufficient or reasonable as they may be fit for work on their better days, but on their bad days they may not be able to work. Symptoms may be so severe on the minority of days that they need to be given greater weighting.

b. Combining physical and mental descriptors

For people with more than one condition, the evidence suggests that the combined effect may be more than the sum of the two conditions (Scott et al, 2009). Many people with mental health problems also have physical problems and their combination is not taken into account in the WCA. These combined problems often make adaptation to work difficult.
This is a particular concern for those with mental health conditions where some elements of the condition can impact on others. For example, if a person is unable to cope well with change and is also unable to deal well with other people, they are likely to become worse at dealing with other people in times of change. This will then compound the anxiety about the change and create a problem which is greater than the WCA would reflect.

Citizens Advice (2010) found that when there are physical problems as well as mental health problems, the mental health problem is more likely to be ignored in the WCA. They cite this example in their report:

“A Midlands bureau saw a client with a long history of depression, as well as many other problems including back problems and diabetes, and who was also having investigations for possible epilepsy following a series of blackouts. The assessment only seemed to have considered the physical problems and the client was awarded no points. Yet at that point, the client’s mental health was causing more concern than the serious physical problems. The client had made three suicide attempts that year, still had suicidal thoughts and was unable to go out the house on their own. The bureau noted that the client had a social worker who confirmed all the details.”

This point will be returned to in our response to question 4.

c. Relating the assessment to the ‘real world’

The current assessment takes no account of how the illness or impairment affects an individual’s chances of finding work in the context of the workplace environment, such as the impact of long-term unemployment, adapting to the workplace and the barriers to getting into work. People with mental health problems face particular prejudice and discrimination from employers. The WCA does not take these factors into account. We recommend that the WCA is expanded to take these factors into account for those people who may have reasonable functioning and may not automatically qualify for benefit.

3. The competence of the WCA medical assessors to undertake effective assessments for people with mental health problems

One possible reason for a lack of reliability in the WCA system may be the ability of the medical assessors to accurately assess the level of functioning in this group of people.
There is no published data on the quality of the assessments carried out by the WCA medical assessors, but the reports of people who have been assessed suggest that this is poor. In 2006, Citizens Advice questioned the quality of the medical assessments for the PCA, reporting that these did not give sufficient consideration to mental health problems, were often hurried, that many clients reported encountering rude or insensitive examining doctors, and that reports were inaccurate and took answers out of context. (Citizens Advice, 2006). In their latest report Citizens Advice paint a similar picture for people with mental health problems (Citizens Advice, 2010). They found repeated evidence of people with severe mental health problems being found fit for work, that the impact of mental health problems was being underestimated in the presence of coexisting physical problems, and that people's mental health difficulties were downplayed.

There seems little doubt that the medical assessors still have a poor awareness of mental health problems. People attending consultation events facilitated by Mind and Rethink, during the development of the original WCA in 2007, highlighted that assessors tend to make judgements on a person's capability based on their appearance or ability to articulate their problems rather than on their capability to work as measured by the WCA.

There are reports of claimants who are assessed being frequently confused about the purpose of the medical assessment and not understanding why the doctors performing the assessment reach a different conclusion to their own doctor. Communication about the assessment needs to be more accessible and provide a clear explanation of the purpose of the assessment should be provided.

Further to this, the ability of the medical assessors to carry out high-quality assessment for all claimants has been questioned by the findings of the CAB report (Citizens Advice, 2010). The report highlights several important factors including: the accuracy of the medical history in the clinician’s report; distortions of what they were told in the interview; poor questioning by the clinician; inadequate recording of claimants’ responses; a failure to observe accurately; a lack of understanding of the criteria; poor recording of variable conditions; the downplaying of the severity of conditions; and overuse of referral for repeated medicas.

The evidence gathered by Citizens Advice and others over the years points to the need to evaluate formally the ability of the medical assessors to accurately assess the functioning of the claimants. It also suggests that there may be systematic problems in relation to those with mental health problems. At present the process run by Atos is opaque and has not been subject to external scrutiny. Some of this may be improved by improvements in the clarity of the WCA medical assessment. The WCA interview could be made into a semi-structured interview which would aid the systematic collection of data (as with many research interviews) and may also help improve the interaction of the assessing doctor and claimant. Such an interview design would also allow for improved
training of the assessors and a ready means of evaluating the quality of their interviews and rating. We recommend that a thorough evaluation of the competence of the medical assessors is undertaken.

4. Problems with the guidance

There are some areas where the guidance to the assessing clinicians may contribute to underestimating the degree of incapacity. The guidance often cites the most extreme example of impairment, rather than providing suggestions around more borderline cases which may allow assessors to make more balanced decisions. For example, descriptor 15 (execution of tasks) has the following guidance:

“The pattern of typical day activity should really reflect a person who should struggle to get through the basics of a day due to their mental disablement as a result of tasks taking so long to complete that they would be unable to cope with work due to the length of time required for basic tasks. For example those who have severe and continuous disabling anxiety where they struggle to even get out of their bedroom may come into this category”

By citing such an extreme case, it can overshadow less extreme, but still serious, cases and may lead to them being under assessed.

3) What is the best way to ensure that the effect of fluctuating conditions is reflected in the recommendation of the WCA?

We have covered the problems with fluctuating conditions and symptoms above.

While there seems no single reliable way of assessing this, we recommend that the assessment distinguishes more clearly between variable conditions and variable symptoms.

Assessors should be asked to evaluate variability in several ways and use these methods to develop a judgement as to the combined effects of these fluctuations. These multiple ways could include not only the assessment of a ‘typical day’, but also a ‘typical week’. A judgement should also be made of the claimant’s functioning at its worst. Each of the functional descriptors rated could be assessed as to how often they apply, and the worst case scenario could be used to provide a reliable rating. The subjective components that we outlined above could be assessed in a similar way. The use of a semi-structured format to the interview as outlined above would also facilitate this process.

We would like to see the WCA reflect the nature and severity of variations in mental health conditions. At the very least, we would like individuals to be provided with a greater explanation of how the effect of fluctuating conditions is assessed in the WCA. This would allow individuals to be clear in explaining how their condition does vary.
4) What is the best way to ensure that the effect of multiple conditions is reflected in the recommendation of the WCA? Are there specific conditions that should be regarded as contributing to or adding additional weight to others, where both are present?

We know from past research that mental health problems are at least as disabling as common physical conditions (Moussavi et al, 2007) and that mental and physical disorders are known to co-occur at greater than chance levels (Scott et al, 2009; Buist-Bouwman et al, 2005). There are two main ways of considering the effects of co-existing mental and physical disorders: first that their effects are additive i.e. that the individual components of these coexisting disorders have independent effects on functioning and thus the total effects are equivalent to the sum of the parts. The second view is that this co-existence is interactive and is associated with significantly greater levels of dysfunction than predicted by a simple sum of the main disorders i.e. the total dysfunction is greater than the sum of the parts. By contrast there is no evidence that mental health and physical health problems add up to less than the sum of their parts, yet in the operation of the WCA this is often how they are interpreted.

There is evidence for both additive and interactive effects when mental and physical disorders co-exist. A recent large international survey (Scott et al, 2009) found that people with depression and anxiety are more likely to be severely disabled than those with physical disorders and that those with combined physical and mental disorders are more likely to be severely disabled than those with one condition alone. Those with combined disorders also had higher levels of disability than predicted by the sum of the disability attributable to the individual disorders.

The evidence suggests there may be an alternative method of managing the contribution of multiple conditions. We recommend making the assessment more reliable and valid by the means suggested above and by ensuring that equal weight is given to the assessment of mental and physical conditions.

5) What is the best way to give adequate weighting to additional (or initial) evidence outside of that through the WCA? How can any changes be achieved without placing a burden on GPs and health care professionals, and without compromising their relationships with their patients?

We believe more weighting should be given to the professional opinion of those clinicians in contact with the individual making the claim. This would help not only to reduce the number of people erroneously judged to be fit for work but would assist in dealing with some of the problems of fluctuating conditions and
symptoms and of combined mental and physical disorders. These clinicians would also have a greater understanding of how the condition affects the individual and how it might impact on their ability to work.

We would suggest that clinicians are routinely sent ESA 113 forms at the early stages of the process and that these should be sent to CMHT clinicians if appropriate. The clinicians who carry out the WCA assessments should also have sight of these medical assessments when they see the claimants and should be obliged to fully account for a decision which contradicts the advice of the relevant clinicians in terms of the claimant’s ability to work.

While it could be argued that this may place an additional burden on clinicians, we believe that supporting service users in their employment aspirations should be a core function of NHS workers. Many clinical teams already offer benefits advice and where a service user is subject to an inaccurate WCA, this can increase the burden on clinical teams. Therefore, involving professionals up-front in getting the assessment right would be a more cost-effective option than leaving them to pick up the pieces of a poorly administered WCA.

To support this it would be helpful to have a named person from the DWP system to be responsible for each claimant’s benefits claim who could be contacted by the claimant or clinicians when queries are required and who can assist in guiding the claimant through the benefits system.

6) Is there any evidence to show that there has been particular problems with the WCA for any specific groups? These groups may include, but are not limited to, men and women, people from black and minority ethnic backgrounds, or people from differing age groups.

The information outlined above provides evidence for the specific problems with the WCA faced by those with mental health conditions.

7) Do you have any suggestions for how the WCA process could be improved to better assign people with health conditions to the most appropriate part of the benefits system?

In our evidence we are aware that in many ways the problems that existed for the PCA are still being replicated in the WCA process, particularly the problems with the Atos clinicians and the accuracy of the WCA medical assessment.

Our recommendations are outlined at the beginning of this document.
References


Written evidence submitted by Catherine Burns

Summary: I fear that Work Capability Assessments are unfit for purpose and do not treat younger claimants fairly. Time limiting ESA to one year will cause unnecessary stress and suffering. It is unfair and unrealistic.

1) My initial fear is the assessment process. I have heard several stories about people being treated unfairly, the reports being false and not representative of the claimant’s needs or disabilities. I was born with my disability, and being only 37, I now have mobility issues, and also pain and tiredness. Having been through the process of an appeal for DLA, I know how the system can react to a younger person asking for support. So the idea of having to go through even harsher tests for ESA really frightens me.

2) Time limiting ESA - I understand the ‘idea’ behind this is to try and help to get people back to work, but you can’t put a time limit on how people recover. In the past 5 years I have had 5 operations on my legs, just to keep me walking and to try and slow down the rate at which my joints are falling apart. The first operation took me 9 months to recover from. I face many more surgeries just to keep me active and then eventually 4 joint replacements, which all have a limited life, mainly because of my age.

3) Time limiting ESA to 12 months, will do nothing for my health, it won’t help to find me a job, it won’t help to make me better off, it will do the opposite. It will financially burden me and my family, it will add stress, worry and sleepless nights (which I already have) because of the thought of what will happen when the money runs out.

4) This is putting unreasonable pressure on my family - To be completely honest I am really worried about what the future holds for me, on top of the surgery and recovery, then no finance to help support me and my family, to give me the time to recover from the operations, I am sure it will eventually cost me my family. At some point the strain will take its toll.

5) Working families like mine are being unfairly punished by time limiting ESA - I have two children, my daughter helps me with a lot of my care needs, she is only 11. My husband works every hour he can to provide us with enough money to get by on, but because he does that we are being punished, not only because he can work, but because I was born with a disability.

6) Don’t get me wrong I would love to return to work, but it needs to be at a point when I am strong and healthy enough to cope with that. It needs to be with an employer who will understand that I need further surgery and who accepts that I will need the time off to recover. I know myself that those types of employer are few and far between, but what makes it worse, is restricting disabled people to 12 months at a time when unemployment is rising. The chance of finding work with an employer who understands your needs is virtually impossible.

7) ESA shouldn’t just be about getting people fit for work, it should be about providing the support to get people back to work, but at a point that is sustainable to them. A 12 month limit is unfair, unrealistic and virtually barbaric. The government promised nobody will get left behind. I will and so will my family. I will face the biggest cuts of any group under the coalition government. Even people in the highest earning bracket loosing child benefit will not lose as much as me and my family.
8) I sincerely hope the government reconsiders time limiting ESA. It’s punishing the most vulnerable in society who face the harshest conditions to return to a non-existent jobs market.

April 2011
Written evidence submitted by M Turner

Summary: I am a disabled person with a degenerative condition, among other problems, that is never going to improve and will only ever get worse. Over the last few years my support and care needs have increased greatly to the point that I can no longer look after myself. I can only walk a few steps and have to use a wheelchair pushed by my carer. I am currently receiving Incapacity Benefit and am one of those that are about to face the WCA and its possible repercussions to my life and to be perfectly honest I am terrified.

1) To start with I have great concerns about the private company that will be carrying out the WCA. I have had a Medical Assessment with Atos in the past and the whole experience left me feeling degraded and miserable and in severe pain for three days due to spending so much time in my wheelchair and being bounced around trying to get to and access Atos’s offices.

2) The staff were polite enough, apart from the fact that they were surprised I was in a wheelchair, but the building itself was completely inappropriate and unsuitable for the purpose it was being used for.

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

4) I fully accept that there are some sick and disabled people who are capable of and would benefit from work but I feel that the WCA is not capable of giving a clear picture of a person’s actual ability to work and/or sustain work. It is far too simplified and does not appear to take in to consideration basic facts such as the effect of pain on someone’s day to day life, fatigue, whether working would make a person’s health or disability worse, variations within a condition or even if a condition is permanent or degenerative. It appears to be nothing more than a snapshot of how a person is at that particular moment conducted by someone who does not know the medical
history of the person before them and who has never met them before. It is even possible that the Healthcare Professional conducting the WCA may not have even heard of some or all of the conditions they are meant to be assessing.

5) Considering this is designed to be a Work Capability Assessment it doesn’t even consider a person’s ability to get to an interview or job or the amount of help they would need to sustain a job if they managed to get one in the first place. Simply ticking a few boxes in isolation of an overall picture and telling someone they are fit for work based on their ability to pick a pen up, even if they are unable to use that pen for more than a few minutes, is totally out of touch with reality. Simply telling someone you are fit for work does not make it so.

6) I can see many of those told they are fit for work and told to claim JSA will find themselves ineligible simple because one of the criteria for JSA is you must be, “capable of work”. How many will end up unable to work but totally unable to claim any kind of out of work benefit?

7) The whole WCA seems set up to ensure as many people as possible will not pass and is just an exercise to push as many as possible on to cheaper benefits or off benefits altogether. I feel it has all been rushed through far too fast and no consideration has been given to what will actually happen to those told to find work via JSA or the Work Related Activity Group, especially since research has shown that, despite legislation, the percentage of disabled people in employment has not changed in over twenty years and in some areas has actually decreased.

8) Employers are not keen to take on people who could need a high level of support just to carry out their job and who could be absent on a regular, and possibly long term, basis due to an illness or disability whether that is due to a conditions variability or for regular medical tests and treatments. A far as most employers are concerned sick and disabled people cost them money to employ. When there are so many able bodied people looking for work the sick and disabled do not stand a chance.

9) Put in simple terms, when it comes to employers taking on more sick and disabled people employers will always go for the most cost effective option for their business and that is an able bodied person.

10) My biggest concern is the time limiting of ESA. Presently I receive IB and as I have a working partner who works full time, who is also my carer, we receive nothing else. No free prescriptions, no housing or council tax benefit and no free dental care. It may surprise you that we are just fine about that. We have enough to take care of ourselves and we get by. My benefit pays for my medication, the small bits of equipment I need to keep me in my own home, the extra heating I need and, since I can no longer use public transport, the petrol to get me to medical appointments and to allow me to just have a life outside the four walls of my home. Because of my IB we don’t ask for help from any outside agencies.

11) Because I have a hard working and caring partner I face the real prospect of completely losing my benefit and hence a third of the household income. If this happens the effects would be nothing less than catastrophic. I would struggle to pay even for basic pain relief let alone any other medication, would be unable to access
health care, would become totally housebound and would struggle to pay my rent and face possible homelessness. My partner and I would end up in the ridiculous position of being better off if my partner stopped working and we relied totally on benefits which would end up costing the government about three to four times more a week than the IB that I currently receive.

12) My partner and I want to take care of ourselves using my partner’s income and the support I already get. We do not want to ask for any more help but we could be forced to and I believe there would be many, many other people in the same position.

13) At the moment the whole section of the benefit reform aimed at the sick and disabled feels like a massive social engineering programme designed to dump the most vulnerable, and least able to stand up for themselves in society, off benefits and to force them back behind closed doors where they will not show on any government figures and where they can be ignored and neglected.

April 2011
Written evidence submitted by Steve Turner

Summary:
Circumstances and events to date into the loss of my employment through mental illness, my claim for ESA and subsequent WCA medical and outcome.

The Facts:

1. I have been in full employment for 35 years until March of last year (2010) when I was forced to leave my job due to severe depression. I claimed ESA towards the end of that year and filled in an ESA50 claim form in quite some detail and at considerable expense to the current state of my health, the form taking me 6 weeks to complete, sometimes at just one sentence a day. In December I was requested to attend a Work Capability Assessment which I did.

2. The medical examination was undertaken by a registered nurse. She asked me no more than 12 questions, including “do you have a dog?” and “do you watch television?” No questions were asked pertaining to my condition and how it affects me daily.

3. The interview lasted just over 20 minutes during which time the nurse was mostly typing on the computer and entering the details of my medication into the computer.

4. I left the medical quite ill, taking 2 days to recover some semblance of health, and feeling inconsequential and dismissed.

5. Some weeks later I received notification from Jobcentre+ that my application for ESA had been turned down and that I must now apply for Job Seekers Allowance. The shock of this decision intensified my illness and, suicidal, I was referred by my GP to a psychiatric team. I was advised to request a copy of my ESA85 medical report which I did.

6. The trauma of the above decision was nothing compared to the despair I felt on reading my medical report and my first impression of it (which I have come to understand is a common response) was that I had received someone else’s medical report in error.

7. I have struggled with words such as mistaken and misleading to describe the contents of the report, not wishing to ascribe serious accusations to a government department or private company in its service (ATOS) however I am reluctantly forced to describe the contents of the report as deliberately fraudulent.

8. It is littered with inaccuracies, statements ascribed to me which I did not make and incorrect observations.

9. I am now appealing this decision, with representation, and cannot help but feel bewildered, disappointed and utterly dismayed that a person (I am 51 years of age) in the UK in 2011 should be failed so totally by the welfare state in which he believes, and has contributed to, for over 30 years.
10. My illness has now intensified and my required treatment increased. My return to work has been delayed by many months and my faith in the system is totally shattered.

April 2011
I'd like to submit my concerns about the proposed changes to ESA in relation to my brother and other adults with autism. My brother is a pretty typical adult with Asperger's syndrome; he's suffered with it all his life (it is a lifelong condition with no cure other than understanding & awareness) but was only diagnosed aged 30. He is intelligent, hardworking and honest, but cannot communicate in social contexts and situations, and becomes stressed, anxious and unable to function when it's demanded that he do so.

1. The Department’s communications to customers going through the assessment and whether the information, guidance and advice provided by the Department and Jobcentre Plus is effective in supporting customers through the process.

My brother was unemployed when he was diagnosed with AS, but desperate to find paid work to start to regain his independence and sense of self. He applied for ESA, hopeful that he would be offered aspergers-friendly advice and assistance on getting back into the job market and not be forced into doing jobs that would make him stressed, anxious and depressed - as promised by the ESA “blurb”. The national Aspergers specialist who diagnosed him provided a detailed 15 page report on what types of work he would be able to do easily, and also what types of work would cause him distress. Sounds simple.

Unfortunately, it does not appear that DWP assessment processes, information, or staff have any training or understanding of autistic conditions or the difficulties in communication and social understanding that the sufferer has to deal with. He was not offered any communication advocate, so I helped him complete the assessment form (which he needed a lot of interpretation for - he took each question at purely face value and answered simply yes and no even where that did not reflect the true intent of the question - because he did not see the true intent of the questions and because the questions were directed towards people who have normal social understanding of lateral, metaphorical and social language). My mum accompanied him to the face to face assessment, but she was shushed up by the doctor when she tried to explain my brother's yes and no answers more accurately, before the doctor told my brother that she didn't see that there was anything wrong with him because he played computer games like any other lad. We were also told that the nationally recognised specialist's report his aspersers’ specialist had provided us with had been intentionally ignored because "the DWP like to focus on what a person can do, not what they can't" - even though that's exactly what the report contained!

This is not the only story I have heard in relation to people with autism spectrum conditions applying for benefits. It is clear that there is completely inadequate training and understanding within the DWP in relation to people with Autism Spectrum Disorders (ASDs) applying for ESA as a route to support get them back into work.

2. The Work Capability Assessment including: the assessment criteria; the service provided by Atos staff; the suitability of assessment centres; and customers’ overall experience of the process.

My brother left the WCA feeling marginalised, patronised, overwhelmed, stressed and unfairly treated, with no source of income or appropriate help getting a job. The criteria are clearly geared towards people with a physical or IQ-related learning disability and there is no scope for inclusion for people who understand things differently from neurotypical people. This paucity of social communication affects the type of work ASD sufferers can do so it makes no sense that the assessment process does not reflect this.

3. The decision-making process and how it could be improved to ensure that customers are confident that the outcome of their assessment is a fair and transparent reflection of their capacity for work.

There needs to be provision of an independent, ASD trained advocate throughout the whole process of assessment and any reassessment, and training of DWP staff in ASDs. As such the assessment is completely unfair on ASD sufferers. Assessors need to listen to advocates and not poo poo information
from people who know the applicant best.

4. **The appeals process, including the time taken for the appeals process to be completed; and whether customers who decide to appeal the outcome of their assessment have all the necessary guidance, information and advice to support them through the process.**

My brother’s appeal is still ongoing, nearly 2 years on. He is still trying to find work. He has had no support rom the DWP in this and when we have asked for transcripts of the appeal ruling to contest this, we have been given illegible handwritten extracts, and refused typed ones. We have been offered verbal interpretation but only if we can tell them what it is we can’t read - clearly if we could tell them that we wouldn’t need the explanation. This is entirely insulting and unsatisfactory.

5. **The outcome of the migration process and the different paths taken by the various client groups: those moved to Jobseeker’s Allowance, including the support provided to find work and the impact of the labour market on employment prospects; those found fit for work who may be entitled to no further benefits; those placed in the Work Related Activity Group of the ESA, including the likely impact of the Department’s decision to time-limit contribution-based ESA to a year; and those placed in the Support Group.**

My brother was refused ESA and offered JSA instead. He has been on JSA before and found it stressful and degrading being offered jobs completely inappropriate to his capabilities. You would not suggest someone with the use of only one leg get a job as a door to door salesperson, so why suggest that someone who cannot communicate in the same way as most people get a job in a telesales centre, and then penalise them for being honest and telling you they would not be capable of doing such a job. In the end he found the demands of JSA too stressful and in fact he felt it was dishonest to keep attending the interviews they demanded he attend, as he knew he couldn’t do the jobs. He refused JSA and started to live off his credit card. Inevitably this led to financial disaster and he is now living with my mum who is a pensioner and struggling herself. I help out when I can.

Limiting ESA to 1 year for anyone with a lifelong condition, whether aspergers, other forms of autism, or any other issue, seems completely pointless, costly in terms of reassessment time and money, and certainly for ASD sufferers, incredibly stressful and counter productive in terms of their ongoing well-being and confidence within society.

**In summary:**

The ESA application process marginalises people with Autism spectrum disorders (ASDs), has no understanding whatsoever of their needs, to the extent of causing severe stress to sufferers which exacerbates their condition and can even reduce their capacity for work. ESA applicants with ASDs are unfairly treated in the assessment process, are ignored during the appeals process and attempts by family members or other advocates to explain more accurately the exact problems facing sufferers are specifically ignored.

This is a biased, unfair, degrading process for ASD sufferers, which often leads to refusal of ESA thus throwing the financial burden of care onto already struggling and stressed family members - and deprives the job market of hardworking, honest but misunderstood employers who just happen to need understanding and patience in the workplace.

April 2011
Written evidence submitted by Advice Network on behalf of Advice Centres for Avon (ACFA)

1 Introduction & Summary

1.1 We are extremely concerned about the hardship and destitution that is highly likely to be the outcome of the migration from IB to ESA for many thousands of severely sick and disabled people. Our member agencies are already dealing with the fallout for new claimants who go through the WCA, which is not fit for purpose, has been largely disowned by the academics involved in its design, and has been the subject of numerous damning reports.

1.2 We agreed with our members to focus on the Work Capability Assessment, as the most urgent aspect of ESA that we hope will be addressed, and to provide narrative evidence providing examples of individual client’s experiences. Examples of poor practice were supplied by advice workers who specialise in Welfare Benefits law from a range of agencies.

1.3 Our member agencies see clients’ everyday who are clearly not fit for work being assessed as such due to poor quality WCA reports. Common causes of this include (but are not limited to):

- Insufficient medical knowledge of specific conditions on the part of examining medical professionals
- Inappropriate interviewing techniques by examining medical professionals
- Failure to accurately record statements made by claimants
- Leading questions, and suggested answers, by the examining medical professionals
- Failure to deal appropriately with clients with mental health issues

1.4 We would therefore call for a complete overhaul of the WCA and the examination procedure prior to the roll-out to existing IB claimants, as this inappropriate test and its unprofessional application are leading to destitution and severe hardship for thousands of extremely vulnerable people with long-term health problems and people with disabilities, as well as costing the state huge amounts of money in appeal and tribunal processes.

2 The assessment criteria

2.1 The problems with the basic assessment criteria are well reported and include, but are not limited to, a failure to fairly assess variable conditions; a complete failure to adequately explore the needs and
problems of people with mental health issues; a failure to recognise the cumulative effect of having several functioning problems; and the failure to consider recovery times, ability to repeat functions, or the pain and discomfort experienced while carrying out a function.

2.2 Our members reported significant and specific problems with the way the assessment is carried out for claimant who have mental health issues.

2.3 One adviser, who states she has several cases every week of claimants being awarded zero points based on an ATOS medical report who subsequently are awarded fifteen-plus points at Tribunal, reports:

“There seems to be a general tendency for the questioning to lead clients into positive responses, so that they agree they are able to do things that are in fact extremely difficult or impossible for them to achieve.

A client with addiction and severe anxiety issues was awarded 0 points under the WCA based on the medical professionals report. This was increased to 15 points by the Tribunal who heard her case, who placed her in the Support group without even asking her to go into the Tribunal hearing room.

When I asked her about her medical she told me that when she came out of the medical examination she believed she could do anything ‘as the man had told her she could’.

2.4 The same adviser expressed her fears about the new descriptors for mental health issues:

“I fear that the new descriptors will make it even more difficult [for vulnerable claimants] and require an even greater level of competence from ATOS examiners, who appear to have little training or insight into mental health or addiction.”

2.5 Advisers have also reported clients with severe mental health problems being told that their Support Worker would not be allowed into the examination. In this case the client was unable to articulate themselves, the medical examiner seemed to take no notice of the condition the client was in, and 0 points were awarded based on the examination report. This was subsequently overturned at appeal, but at great cost – both in terms of money for the process, and extreme mental distress experienced by the claimant who was suddenly destitute. As the adviser states all of this could have been avoided by allowing the Support Worker to stay with the client to help them express their difficulties to the examiner.

2.5 We have multiple reports of poor medical assessments leading to an incorrect refusal of benefit, including cases where the debilitating effect of HIV-medication was ignored by the examiner, cases where clients
have received the notification that they are fit for work on the very same day they undergo emergency heart-surgery for the heart defect that prompted the claim, and cases where a 0-point score based on the medical examination becomes a 24-point score based on a brief yet meaningful examination of the clients severe mental health problems by the Tribunal.

3 Assessment centres

3.1 When asked about the suitability of assessment centres one agency reported having advised on cases where the accessible route into the building was unavailable, yet the claimant was told they would be deemed to have not attended if they failed to make it into the building and to the second floor.

3.2 The agency reported that:

“The client struggled to the examination room up several flights of stairs, with large amounts of help from their partner. The medical examiner reported that the claimant had been able to climb stairs and gave no points for restricted mobility. This decision was unsurprisingly overturned at appeal, but caused huge amounts of problems for the family.”

3.3 One agency reported several cases where interpreters had been requested for the examinations of clients who had limited English, yet interpreters had not been provided. These examinations unsurprisingly resulted in claimants being incorrectly deemed to be fit to work, due to their difficulties in expressing themselves fully to the examining Healthcare Professional.

4 Service provided by ATOS staff

4.1 Our members reported several extremely concerning client experiences, particularly around the assessments of the most vulnerable clients.

4.2 One welfare benefits specialist stated that ATOS staff seem to have little recognition of the possibility that aggressive and insensitive questioning of claimants suffering from Post-Traumatic Stress Disorder can ‘trigger’ debilitating episodes for those claimants. She states:

“I have had two clients where PTSD, depression and substance dependency arising from past sexual abuse and assault are key factors. Both experienced insensitive interviews where the assessor had little or no understanding or awareness of the relevant issues and no concern as to how the questioning would affect the clients after the interview ended”

4.3 The same adviser also reports repeated use by ATOS of male assessors for female clients who are victims of sexual abuse/assault.
4.4 Other agencies report difficulties for clients caused by a superficial approach to questioning, with no reference to pre-existing medical notes to guide questioning. For example one agency reported a client with severe and debilitating Carpal Tunnel Syndrome, who also has great difficulties expressing themselves, being assessed as having no problems with their hands or arms. The assessment report stated that the client had no problems washing, bathing, dressing, cooking, or carrying out many other functions, despite, in reality, being unable to do any of these things. When asked by the adviser why they hadn’t told the examiner about these problems the client replied that the examiner had rushed through the assessment and that the client didn’t feel confident enough to ask them to slow down, repeat questions, or to correct answers suggested by the examiner that were then recorded as fact.

5 Conclusion

The WCA is clearly failing in its primary function: to identify claimant’s who are unable to work. Reform of the test is therefore urgently needed to halt the ongoing damage that is being done to some of the most vulnerable people in society through its failure to provide a means by which those people unable to work can still have sufficient income to feed themselves, clothe themselves and secure a roof over their head.

April 2011
Written evidence submitted by Rhydian Fon James

Summary

1. ESA is not fit for purpose. The system is badly designed, in terms of eligibility testing and the process of claiming the benefit
2. WCA is not fit for purpose. The test for eligibility does not work correctly, with many wrongly found fit for work and a high percentage of appeals
3. the appeals procedure is not fit for purpose. People are automatically assigned to the lower rate of ESA while appealing. This loss of income makes it harder to appeal
4. WRAG is not fit for purpose. Unfair conditions imposed so that many claimants must work for their benefits when unfit to do so
5. The Government is planning to time-limit ESA to one year, meaning that claimants will be means-tested after a year. If the claimant’s partner or spouse works more the 24 hours a week, they will lose the benefit. This punishes working families.
6. This response has been informed by evidence from members of The Broken of Britain.
7. The submission is made on behalf of all the disabled people in Britain who were unable to respond personally to the consultation.

The work capability assessment and work-focused health-related assessment

8. claimants must undergo the work capability assessment1 (WCA) and work-focused health-related assessment (WFHRA) to determine whether they are eligible for a replacement benefit, employment support allowance (ESA).
9. over the next three years 1.5 million people currently claiming Incapacity Benefit will undergo the work capability assessment, carried out by a medical and IT company, Atos
10. a complex computer program will help a team of "disability analysts" to rule on who is sufficiently fit for work
11. a computer-led assessment leads to the situation where DWP decision-makers are sidelined when deciding on the eligibility of claimants, merely approving decisions that are made by what is a blunt and unsophisticated tool2
12. the drive to reform IB has led to implicit targets for caseload reduction, with expected savings of £1bn over five years, even though the Government denies that there are targets

1 Library Standard Note, The Work Capability Assessment for Employment and Support Allowance, SN/SP/5850
2 Gentleman, Amelia, 2011. ‘The medical was an absolute joke’, The Guardian, 23rd February
13. the estimated fraud rate for Incapacity Benefit is 0.5% - the joint-lowest\textsuperscript{3} fraud rate in the benefits system according to the latest available data - so why is this benefit seen as being so problematic?
14. media focus on 859,000 people claiming sickness and disability benefits for over 10 years, ignoring the fact that sickness and disability is often a long-term problem
15. the system has been in place for new claimants since 2008, but will be expanded to retest all existing IB claimants from the start of this month
16. 11,000 existing claimants will be retested every week
17. the new test is much harsher than the old version, and the government expects to save £1bn over five years by bullying people into work, or failing that on to a lower-paid benefit
18. the combination of this hurried roll-out and implicit targets is pernicious, as those reassessed earlier on will face harsher tests from officials under pressure
19. speakers at a meeting\textsuperscript{4} between MPs on the Work and Pensions Select Committee and claimants who were part of the pilot\textsuperscript{5} of ESA gave negative accounts of their experience of being tested
20. the test has been vigorously criticised by charities such as Citizens Advice and by a government-commissioned independent review, saying that the process is impersonal, and ill-equipped to gauge the seriousness of mental health conditions, or the nuances of complex medical problems.
21. many undergoing the WCA felt it was assumed that they are lying or exaggerating
22. the WCA is physically-oriented, and uses a list of limited and disjointed ‘descriptors’ – such as the distance the claimant can walk and for how long they can stand – to assign points
23. 15 points are required for a claimant to be declared unfit for work, with points ‘awarded’ on the basis of ability to do things like picking up a one pound coin
24. written evidence including specialist medical advice is all but ignored and the face-to-face assessment means that only a ‘snapshot’ consideration is made, disadvantaging those with mental health problems or hidden conditions
25. the WCA test is not fit for purpose, frequently declaring people with serious health conditions fit for work on the basis of how many points are scored
26. during the preliminary roll-out of the test, people with terminal cancer, multiple sclerosis and serious mental illnesses have been found fit to work
27. the health care professionals (HCP) who run the WCA are not necessarily doctors, and may well have no knowledge about the medical condition of the claimant they are assessing
28. the majority of people find the experience impersonal and find that the HCP does not listen to them.\textsuperscript{6,7} They also feel that the WFHRA duplicates many of the steps in the WCA

\textsuperscript{3} Information Directorate, Fraud and Error in the Benefit System:: April 2009 to March 2010, Department of Work and Pensions, 2010
\textsuperscript{4} Gentleman, Amelia, 2011. Work Capability Assessment is assessed, and found lacking, The Guardian, 7\textsuperscript{th} March
\textsuperscript{5} Interim results of the Work Capability Assessments for IB reassessment trial areas, Department for Work and Pensions
\textsuperscript{6} Employment and Support Allowance: Findings from a face-to-face survey of customers, 2010, DWP Research Report No. 717
29. people with mental health problems have complained their condition is not taken seriously
30. people with complex illnesses report that the tick-box system is not able to cope with the nuances of their problems
31. one claimant has originally been given zero points in the assessment, despite having multiple sclerosis, and providing a letter from a surgeon stating they were too ill to work
32. in pilots 30% fewer people have been found unfit for work and 70% fewer people have been found eligible for the full-rate, unconditional support benefit
33. the second figure is particularly interesting, as it suggests that the vast majority of those who had previously qualified for full-rate support are likely to regain the ability to work in the foreseeable future. These people will include those with serious mental health conditions and learning disabilities who are highly unlikely to be able to work.
34. a report\textsuperscript{8} commissioned by the Department for Work and Pensions found that health care professionals (HCP) wanted more supplementary medical evidence to help them make decisions, and more discretion over individual cases
35. Prof. Paul Gregg, a prominent welfare reform expert, recently told \textit{The Guardian} that: "The test is badly malfunctioning. The current assessment is a complete mess,"\textsuperscript{9}
36. Gregg, who helped design the new ESA, recommends a further trial before it is introduced nationally
37. since early 2009, more than 240,000 cases contesting the result of the health tests have been accepted for tribunal hearings
38. in total, 40% of claimants whose claims are disallowed appeal the decision
39. 40% of appeals are successful, with decisions overturned at tribunal – this figure rises to 70-80% when the claimant has representation
40. when appealing a decision claimants are automatically assigned the lower rate of ESA
41. the loss of income for those on the higher rate of IB made it more difficult to appeal
42. a DWP-led review\textsuperscript{10} of the WCA led to The Employment and Support Allowance (Limited Capability for Work and Limited Capability for Work-Related Activity (Amendment) Regulations 2011
43. this review, and an addendum\textsuperscript{11} by the DWP’s Chief Medical Adviser, recommended a number of changes which will increase the number of claimants placed in the Support Group by 0.5%, but increase the number found fit for work by 5%

\textsuperscript{7} Employment and Support Allowance: Customer and staff experiences of the face-to-face Work Capability Assessment and Work-Focused Health-Related Assessment, 2010, DWP Research Report No. 719
\textsuperscript{8} Ibid.
\textsuperscript{9} Gentleman, Amelia, 2011. New disability test ‘is a complete mess’, says expert, The Guardian, 22\textsuperscript{nd} February
\textsuperscript{10} Work Capability Assessment Internal Review, Department of Work and Pensions, October 2009
\textsuperscript{11} Addendum: Work Capability Assessment Internal Review, Department of Work and Pensions, March 2010
44. the resulting changes will mean that: “For example, an individual may no longer be entitled to ESA if they cannot walk but can successfully use a manual wheelchair to mobilise. This is expected to increase the numbers of customers assessed as capable of work.”

45. These changes\(^\text{12}\) are intended to increase the number of claimants found fit for work by 5%, creating a new implicit target.

46. an independent\(^\text{13}\) review of the WCA by Malcolm Harrington, published in November 2010, found serious flaws in the way it was functioning and called for major improvements.

47. the review highlighted the lack of empathy built into the WCA, the fact that decision-makers were reduced to rubber-stamping the output produced by the Atos-run computerized test, that there was a lack of transparency about the test, and that the test was failing to properly assess some conditions; proposed a set of recommendations to remedy these flaws.

48. the Government has promised to implement these recommendations, some politicians, charity workers and academics think the roll-out is going ahead too fast.

49. the process of re-testing IB claimants has already begun at the rate of 11,000 people a week, with no sign that the Harrington recommendations will be implemented.

The work-related activity group, limited capability for work and conditionality

50. beyond the immediate issue of the WCA, the work-related activity group is symptomatic of the deeper problem in ESA.

51. the Work Capability Assessment (WCA), and the Work-Focused Health-Related Assessment (WFHRA), can assign people to the WRAG, where ESA is conditional on work-related activity, and the Support Group, where the benefit is paid at a higher rate and without conditions.

52. the decision on where claimants are assigned is, ostensibly, made by a DWP decision-maker.

53. the Welfare Reform Act 2007 carries the message that all ESA claimants must have a limited capability for work. Work-related activity is, by definition, activity that is related to work. If claimants are judged unable to work, it is not reasonable to expect work-by-proxy.

54. People assessed to have limited capability for work are placed in the work-related activity group, and those assessed to have limited capability for work-related activity are assigned to the Support Group.

55. limited capability for work is assessed solely by their ability to perform narrowly defined activities, which is both unfair and unrealistic. The level of each activity is measured by points which must reach a set total for entitlement to benefit.


Chapter 42 of the DWP Decision Makers’ Guide\textsuperscript{14} states, when discussing limited capability for work, that: “It does not provide that a claimant with a variable condition that incapacitates them for part of each day has LCW throughout the whole of every day.”

57. the WRAG is not clearly defined in terms of purpose as a ‘rehabilitation’ group and many claimants placed in the group are unlikely to be ‘rehabilitated’

58. the WRAG is often thought of as the ‘group for those who will eventually be fit for work’ and the Support Group for those who ‘will never be fit for work’

59. Chris Grayling, Minister of Employment, noted during the 9\textsuperscript{th} sitting of the Welfare Reform Bill Committee that: “People in the work-related activity group are judged to have some potential to return to work, either now or in future, and they have an obligation to take part in work preparation activities.”\textsuperscript{15}

60. an obligation to take part in work-preparation activities is illogical and insidious when imposed on those who are unable to cope with them

61. Given the documented problems with the WCA, assuming that claimants have been correctly distributed across groups seems tenuous

62. The ESA system itself seems confused on this point, as claimants who are distributed to the Support Group have been sent ATOS forms following this decision, beginning the process anew.

63. There are documented cases of a Support Group claimants being automatically re-assessed, and being wrongly moved to the WRAG as a result. This would seem to be a hidden conditionality in what is ostensibly an unconditional benefit.

64. Reviewing claimants in the Support Group is unhelpful to the claimant due to the stress caused, but is also a waste of resources and time for the claimant and the taxpayer.

65. Most people distributed to the Support Group will have clearly defined medical conditions that will not improve and, in many cases, are likely to progress. As such, reviews are unnecessary bureaucratic procedures.

66. The Department of Work and Pensions Impact Assessment\textsuperscript{16} on Time-Limiting ESA tells us that: ”It was never intended that ESA for those in the Work Related Activity Group (WRAG) should be paid for an unlimited period to people who, by definition, are expected to move towards the workplace with help and support. Government intervention is required to help ensure that ESA is paid for a temporary period for those placed in the WRAG, thereby encouraging a return to work and stopping people being trapped on benefits for a lifetime.”

67. People who have been assigned to the WRAG include those who are too mentally ill, learning disabled, chronically sick or physically impaired to be realistically assessed as being able to work in the foreseeable future.


\textsuperscript{15} PBC (Bill 154) 2010 – 2011, c384-385

\textsuperscript{16} Time-limiting Contributory Employment and Support Allowance to one year for those in the Work-Related Activity Group Impact Assessment, Department for Work and Pensions, February 2011
very many severely disabled people who will never be fit for work wrongly assigned to WRAG.

The work-related activity group seems spectacularly unfit for purpose, as the group is dependent on work-related activity being available for its members. Given that these claimants will have limited capability for work, it seems unlikely that potential employers will be convinced by their capability, especially given the continuing structural weakness in the labour market.

a DWP working paper found that: “some aspects of the design of the system and the support available were initially designed for conditions of labour market growth.”¹⁷ This means that the system will struggle to support people into work in the current economic climate.

Thus the conditionality imposed in this case is not suitable, especially for those with variable conditions. That is, the misapplication of financial penalties is a likely but very unfair outcome for those whose symptoms change markedly in severity over a period of weeks and months.

This combination of problems seems to raise objections to the very concept of conditionality in this benefit.

The work-related activity group also covers too narrow a criteria, with many former IB claimants being found fit to work and thus denied the support that they need. Most IB claimants will have a real illness or disability, even if the WCA “proves” that they are capable of work.

Shifting such people onto JSA, alongside healthy JSA claimants, is deeply unfair, given that employers will choose the healthy worker over the ill or disabled. In this case, a person deemed fit to work by the WCA will become trapped by the conditionality of the JSA, and at the same time be denied access to the employment support promised by the ESA.

a report¹⁸ commissioned by the Department of Work and Pensions found that staff involved with ESA were concerned about process issues, such as delays and IT problems, and more substantive issues such as the allocation of customers to particular claim outcome group (WRAG or Support Group)

a report¹⁹ commissioned by the Department for Work and Pensions found that advisers felt that the scope for helping many claimants in WRAG back to work was limited

the same report concluded that providers were targeting adviser resources explicitly on those closer to the labour market, so that even those in WRAG are given limited support unless they are very close to being fit for work

a report²⁰ commissioned by the Department for Work and Pensions found that there are risks attached to the significant involvement of for-profit organisations.

They are likely to follow profit maximisation strategies shaped by contract incentives and this may not necessarily deliver what is best for clients, especially for those with greater barriers

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¹⁸ Employment and Support Allowance: Early implementation experiences of customers and staff, 2010, DWP Research Report No. 631
¹⁹ Ibid.
82. A report commissioned by the Department for Work and Pensions found that several US interventions on “back-to-work” schemes for disability benefit claimants have shown no impacts on caseload size.

83. The Department for Work and Pensions knew about all the potential problems with ESA before it was implemented. They also knew what worked in terms of supporting people facing disability barriers into employment where possible and caseload reduction. Why did they proceed with disregard for the evidence?

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22 The profile of exits from incapacity-related benefits over time, 2004, DWP Working Paper No. 17
24 Pathways to Work: the experiences of existing customers Findings from a survey of existing incapacity benefits customers in the first seven pilot areas, 2008, DWP Research Report No. 527
26 The impact of Pathways on benefit receipt in the expansion areas, 2009, DWP Research Report No. 552
1 SUMMARY

1.1 This document sets out evidence provided by participants on the Mindfulness Programme of their experience in the current benefits system, and how this relates to the migration from incapacity benefits (IB) to employment and support allowance (ESA).

1.2 The Mindfulness Programme is supported by the Department for Health and NHS North West, and delivered a programme of work to help individuals with mental health issues and in recovery from addiction to be more mindful. The programme was attended by several individuals recovering from addiction and with mental health issues, some of whom also had physical health issues. Many were either claiming incapacity benefits or had previously claimed some form of inactive benefit.

1.3 The evidence presented is a reflection of the experiences of participants on the programme, and a summary of the main barriers faced.

1.4 The document covers the main aspects of the call for evidence, in particular:

- The Department’s communications to customers going through the assessment and whether the information, guidance and advice provided by the Department and Jobcentre Plus is effective in supporting customers through the process;
- The Work Capability Assessment (WCA) including the assessment criteria; and
- The appeals process, including the time taken for the appeals process to be completed; and whether customers who decide to appeal the outcome of their assessment have all the necessary guidance, information and advice to support them through the process.

1.5 None of those providing evidence have undergone a Work Capability Assessment yet. Whilst they are aware of the process, they are not aware of when their assessment will be. For confidentiality reasons, individual names have been left out of this submission.

1.6 The evidence gathered identified three main issues that individuals feel that they will face as part of the migration to ESA:

- Communication
- Support; and
Flexibility.

1.7 Communication is a key issue for those already on IB. Many feel that they have not formally received enough information about either the Work Capability Assessment (WCA), or the migration to ESA and JSA. This has resulted in some emotional distress for individuals who have been out of work for a long period of time, and who feel that they may be considered fit for work or pushed towards work at a pace that they are uncomfortable or unfamiliar with.

1.8 As a result, the continuation of support is essential to claimants. During the WCA process, individuals may find themselves on a lower rate of pay, which may be further extended beyond the initial 13 week period of assessment if they decide to appeal the decision. Again, this adds unnecessary stress and emotional discomfort to individuals who may be in a process of recovery.

1.9 Lastly, participants on the programme identified the need for flexibility in the approach. Having received no formal information about the assessment or how this would affect them, individuals were keen to stress that the WCA and ESA approaches need to be flexible to individuals’ circumstances, previous mental and physical health and expected future health.

2 COMMUNICATION

2.1 Individuals who are currently claiming incapacity benefits are aware that there will be changes to their benefits in the near future. However, this information has not been provided formally, and has often only been received from an informal source. Whilst the information is available online, individuals feel that they have not been formally provided with guidance or understanding about the process.

2.2 This has placed undue stress on individuals who may have mental health issues, or be in recovery from addiction. For many individuals, receiving information that they will be expected to attend a Work Capability Assessment will be the first formal communication that their benefits will change. The lack of communication in this respect can place unnecessary strain on individuals and does not help to support their mental or physical health. In particular, it was felt that this could lead to misconceptions about the changes, and lead to potential further emotional distress.

2.3 Many have been claiming an out-of-work benefit for a long period of time. This has meant that they are assured of continued support, and as a result have the ability to develop at an appropriate pace that does not rush them or place unnecessary expectations or strains on them. The lack of communication around the future of their benefits does not contribute to the mental wellbeing individuals, who may fall ill due to unnecessary pressure.
2.4 The communication issue is perhaps hindered by the fact that some individuals have only heard of the future changes to their benefits through informal sources – their friends, fellow claimants or through the media. A lack of official clarity and communication heightens the likelihood for potential misconceptions about the migration.

CASE STUDY: IMPORTANCE OF COMMUNICATION

2.5 The lack of communication has also added undue pressure in terms of expectation of income. One individual who is in recovery highlighted that their previous experience of a change in benefits coloured their perceptions about what may occur with the migration from IB to ESA. In particular, their previous experience has included several instances of lack of clarity and communication prior to changes to their benefits. As a result of this, they expect a significant change in benefits as part of the migration from IB to ESA. This has led to additional and unnecessary pressures on this person. This is particularly distressing, as the individual suffers from both a mental health condition and a life-threatening illness. Further to this, when the individual suffers mental ill health, her condition also manifests itself physically.

2.6 In one instance, the individual in question was claiming the high rate of Disability Living Allowance, alongside housing benefit, as well as working with a health professional on their care plan. In deciding to attend university to study towards a career in support work, the individual also moved into new accommodation with a friend. The expectation of responsibility fell to her new housemate, leading to an overall reduction in benefits. However, this was not fully explained or communicated beforehand – despite the individual’s obvious desire to move towards employment, they felt they were not supported in doing so.

2.7 As this person’s benefits changed, they did not feel they were given the same level of support towards employment as they would have received had they stayed in their original accommodation. Their belief is that when they are expected to move towards ESA the change will again alter the support they receive – to the detriment of this person’s physical and mental health, as well as this person’s road to recovery and their road to sustained employment.

2.8 Better communication in this respect could reduce the fears and negative expectations of individuals about the forthcoming change to their benefits. Some individuals felt that the expected change could benefit their road to recovery and employment. However, others felt that the lack of formal communication did not assure them of continued financial, and subsequently emotional, support towards employment and recovery.
3 SUPPORT

3.1 As identified above, support, especially the continuation of financial support, is an important issue for existing claimants. The latest DWP figures (January 2011) show that 33% of those who were found fit for work between October 2008 and November 2009 have had appeals heard by September 2010. Furthermore, two-fifths of these appeals had a decision in favour of the appellant. Whilst these figures are not final, it is estimated by DWP that the number of decisions in favour of the appellant will rise.

3.2 The appeals process resulted in a 9% reduction in the number of individuals in the ‘fit for work’ group – indicating that the process may be pushing individuals who are not yet ready for employment towards work. After the appeals process, the number of individuals experiencing enhanced support towards work (in the ‘work related activity (WRA) group’) increased by 21% - indicating that over one in six currently in the WRA group were assessed as being fit for work when they actually required more tailored support towards employment.

3.3 In addition, a further one in twenty claimants in the support group was initially assessed as either ‘fit for work’, or suitable for additional support to return to work in the longer term.

3.4 As a result, individuals expecting to be assessed want to ensure that the WCA process does not result in a reduced level of support – either financially, if individuals feel they should be in the higher level support group; or towards employment, training and education, if they feel they are in the WRA group.

3.5 Individuals have identified a variety of expectations: some indicated that the expectation of getting a full-time job at present would benefit them, but that they would need continued support towards employment; others felt that if they were assessed as ‘fit for work’, this could cause significant mental health issues and emotional distress. Being incorrectly categorised within the ‘fit for work’ group for those who feel they would need more enhanced support towards work could potentially have an adverse effect on individuals suffering from mental ill health, or in recovery, and therefore push them further from employment.

3.6 Many individuals have expressed a desire to move into employment, training or education. This corroborates findings from previous research, which has found that 90% of psychiatric service users wanted to go back to or into work¹. Individuals have identified the desire to attend university; to start a new career in a variety of sectors; to learn basic literacy, numeracy and IT skills to support their personal growth and recovery; and generally to work towards a rewarding job.

¹ Grove, B. (1999); Mental health and employment: Shaping a new agenda; Journal of Mental Health, Vol. 8, No. 2, p131—140
3.7 However, for many, this also involves a period of recovery. Whilst many individuals are aware of the positive benefits of employment – especially in aiding recovery – the need for support throughout this is important. If individuals find themselves without a required level of support – either towards work, or generally if the individual is unable to work – it may take several months for individuals who feel they have been allocated to the wrong group to have their appeal heard. In the meantime, individuals are worried that the support received will not be suitable.

3.8 The limited weekly rate during the assessment phase can also promote mental discomfort and emotional distress. Individuals moving from the long-term basic rate of IB to the assessment phase of ESA see a drop of over two fifths (43%) in their income – up to £40.80 a week – if they are under 25; those aged over 25 see a smaller fall of £26.75 a week, but this still accounts for a fall of over one quarter (28%) in their weekly income.

3.9 Similarly, if individuals are found ‘fit for work’, they would continue to receive the same amount as in the ESA assessment phase – a significant reduction in the income of individuals who would have to adapt, for at least a short period of time, to a much lower level of financial support.

3.10 Seeing such a dramatic fall in financial support throughout the assessment phase is likely to impact on the emotional wellbeing of claimants. If individuals feel they want to appeal this decision, the level of financial support they receive could continue to be lower than expected until the appeal is heard – further prolonging difficulties for individuals who feel they have been assigned to the wrong group.

3.11 Further to this, and linked to the overall issue of communication, is that the effects on other associated benefits are not fully understood by many claimants. After a WCA, individuals are unsure as to how their assignment to each group would affect other benefits, such as housing benefit. Again, this provides a needless cause of worry for claimants who have not yet been assessed and may heighten misconceptions about the process.

4 FLEXIBILITY

4.1 One key factor reflected on by individuals was the need for flexibility in the Work Capability Assessment to take account of differences in mental and physical ill health. An internal report has already identified the need for widening the support relating to people’s mental functions². A further review by Professor Malcolm

² DWP (October 2009); Work Capability Assessment Internal Review;
Harrington noted the need to involve mental health charities and organisations to help refine mental, intellectual and cognitive descriptors for the WCA\(^3\).

4.2 Individuals feel that this is especially important, as different people suffer different mental health issues. Mental wellbeing is not consistent and, especially for those in recovery from addiction, the path to recovery and employment is not always a straightforward and easy one. Continued support throughout recovery and towards employment should be something an individual in recovery can rely on.

4.3 Individuals have noted a concern for the WCA to take account not only of current mental and physical health, but also of previous health and wellbeing. One individual noted that, with a life-threatening illness, the medications they take often vary. As a result, they would seem a confident and healthy individual one day, but may not feel consistently well throughout the week. As such, they may be fit for a part-time job, but not a full-time job. The differences and sensitivities within the WCA, without any formal communication on the issue, is a worry for some individuals.

4.4 Therefore, the WCA should take note of previous changes (especially regular changes) in medication as well as in physical and mental health.

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\(^3\) Harrington, Prof. M. (2010); Harrington WCA Review: Year 2 Recommendations – Timeline
1. SUMMARY

1.1 We understand that though the committee’s focus is on the migration the committee is interested in examining all aspects of the Limited Capability for Work (LCW) assessment process.

Stockton-on-Tees and District Advice and Information Service (Stockton CAB) has seen a substantial increase in the numbers of claimants who have experienced problems with entitlement to benefit in respect of incapacity. We are concerned that these problems will worsen with migration.

1.2 This report concentrates on the following areas of concern:
  o Claimants who do not attend medicals are refused entitlement to benefit, subject to just cause provisions
  o We have seen a increasing number of clients who are refused benefit on these grounds
  o The claimants that we deal with who are refused benefit following non-attendance are often those with severe mental health problems.
  o It is possible that part of the problem might lie with a more inflexible approach which may, in turn, be due to the nature of the decreased level administrative decision making undertaken in house.
  o It is considered disproportionate that benefit is stopped completely in these instances

1.3 The following conclusions are drawn:
  o The process of assessment should be retained in house
  o Consideration should be given to sourcing information from other places such as GPs, CPNs.
  o Consideration should be given to a fast track to a medical for vulnerable claimants who have failed to attend a previous medical
  o Consideration should be given to not simply stopping benefit.
  o Consideration be given to clarifying guidance that claimants can re-qualify for the assessment rate of ESA
  o That measures are put in place to assist claimants who have greater difficulty managing to get to medicals to attend (e.g. text messaging, phone calls, e-mails etc.)
  o That the assessment of the time by which claimants are expected to be work ready be put on a statutory footing and communicated to claimants.
2. DETAILS

2.1 In connection with this investigation we wish to ask the committee to consider the matter of disallowance due to non attendance at medicals. This may prove to be a particular problem with many claimants who have traditionally been exempt (e.g. severe mental illness/disability) who may have to attend their first medical in many years. We are concerned that there is already an estimated threefold increase in the numbers of clients we have seen who are seeking our assistance in connection with problems associated with being disallowed benefit following non attendance at medicals.

A client of our youth advice service, had a broken leg at the time of completing his ESA50 questionnaire. Since then he had started to suffer from depression had failed to attend a medical. He had slept in after having been up all night following the birth of his first child. He was told that he did not have good cause for not attending

One client who had been refused benefit following non attendance at a medical, was told she had to sign on. She indicated that she had missed two appointments through her poor memory as a consequence of her mental health problems. She was told that if she failed to turn up on time again she would be sanctioned

Employment and Support Allowance pending the determination of their appeal (see appendix 3).

2.2 Though the Current legislation (Appendix2) does not appear to differ greatly from its predecessor under Incapacity for Work legislation (appendix 1) it is our experience that the number of clients seeking help in connection with refusal has increased.

2.3 We are unclear whether this arises due to an increased reliance on Atos medical services increased evaluation role, which does not allow for the level of nuanced decision that might be made where the process is internal. It is noted that, with the introduction of ESA, Atos appear to have assumed a far greater role in determining the procedure to follow in assessing a claimant’s LCW and in the process administrative decision making associated with this. It is suggested that it is the nature of a contractual relationship that this arrangement makes it harder to approach individual cases innovatively (in comparison to such decisions made in house).

2.4 All the clients we have seen who have suspended for not attending medicals have had some degree of mental health problems. In many cases the degree of mental health problems are severe and are often a significant contributory factor in the non-attendance.

2.5 In these circumstances, the difficulties faced by claimants with mental health problems are exacerbated by the fact that the benefit options for claimants are limited. We have seen a worrying number of clients who have not claimed benefit at all or who are having considerable difficulties coping with claiming alternative benefits.

2.6 It is currently the case that most claimants who appeal a decision refusing benefit are entitled to claim

2.7 Unfortunately, this is not an option in the case of claimants who are treated as not having limited capability for work because of non attendance. In these circumstances, unless claimants can show that their condition has significantly worsened or they have a new condition they can only, initially, claim Job Seekers Allowance.

2.8 Vulnerable claimants often have difficulty expressing themselves and may have “fallen out” of the system through non- engagement with mental health services, due to motivational problems associated with their condition.

2.9 It is recommended that more use of alternative sources of evidence are used there being no requirement in law that a formal medical assessment is undertaken. At the moment a medical assessment by Atos Medical Services appears to be seen as the default position and it is suggested that medical assessment is frequently seen as an accurate assessment of entitlement. Unfortunately (in our experience), this is often not the case. It is found that medical assessments are often inaccurate, based on

Another client, with learning difficulties, was terrified at the thought of having to use the new touch screen on being told she had to sign on due to her illiteracy

A client with such severe agoraphobia such that she could not even leave the house when her house was on fire. She is lacking is self confidence and unable to articulate her difficulties. She failed to take action for 5 months therefore had been without any income for 6 months until a late appeal from CAB was successful on revision.
misconceptions due to erroneous assumptions and especially poor at assessing the circumstances with claimants with mental health problems / mental disability. The approach taken in reports has been criticised by the Upper Tribunal\(^1\) for not properly assessing the claimant’s condition in terms of the statutory test.

2.10 Though an appeal can be made against a decision that a claimant has good cause and the vast majority of cases we appeal are overturned, tribunals can currently take 5-9 months to be heard due to the demand on HM Courts and Tribunal Service\(^2\). To give the credit to the local decision making and appeals team many cases are revised before cases get to appeal but many cases still go ahead to appeal and, again, the vast majority of these are overturned. It is noted that, though most of the cases are overturned on the basis that Medical Services have provided inadequate details that letters have been sent, there are often underlying additional problems that have complicated the situation for the claimant.

A client who comes under a different Benefit Delivery Centre failed to attend a medical due in the most part to considerable mental health problems. He had made a new claim and was in danger of losing his house when he called in to see us as mortgage interest had ceased. The new claim was refused following a medical, probably because the claimant was in denial about his mental health problems. Benefit was paid but subsequently withdrawn following a review, which the claimant was not advised of. The BDC maintain that benefit should not have been paid as their guidance states otherwise. The decision is being challenged.

2.11 We note that new claims can be made but this will inevitably lead to a long wait for the claimant which experience would suggest is at least 2 months. It remains our view and that of the local office that if a decision is, subsequently, made that a claimant does not have LCW that this can be appealed and that the claimant can qualify for the assessment rate of ESA pending a decision under regulation 30 (Appendix 3). It is of concern that this does not appear to be the guidance universally, as a different BDC has told us that their internal guidance is that such a claim cannot be made. It is suggested that this is a disproportionate response and appears to discriminate against this group of claimants compared with their counterparts who have not failed to attend a previous medical.

2.12 We also note that, under new rules, there is a mandatory referral to work programme activities where the claimant is expected to return to work in three months. The length of time until a claimant might be work ready is currently determined by decision makers in local offices and does not have any implications on the claimant (other than when they may be called for a new medical, which admittedly does cause distress in many of our clients) – nor are claimants advised of the date as a matter of course. We suggest that, it would be appropriate to put, what is in effect a period of award, on a statutory footing and communicate this to the claimant so that the claimant is able to challenge the decision.

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\(^1\) 2010 UKUT 50 AAC
\(^2\) In spite of the fact that the throughput by tribunals in our area has increased substantially
3. CONCLUSIONS

3.1 The process of assessment should be retained in house except in the case of medical assessment which should not be used as the default source of information.

3.2 Consideration should be given to sourcing information from other places such as GPs, CPNs, etc. This approach works well in Disability Living Allowance cases and can lead to an approach which better takes account of the claimants normal circumstances and variation in conditions. Alternatively the Examination is often reduced to yes/no answers to questions which do not, in the eyes of claimants, have yes/no answers.

3.3 Consideration should be given to a fast track to a medical for vulnerable claimants who have failed to attend a previous medical.

3.4 Consideration should be given to undertaking sanctions of ESA rather than completely ending benefit or, preferably, extending provisions that allow receipt of benefit pending appeal to be extended to claimants appealing a good cause decisions.

3.5 Consideration be given to clarifying guidance that claimants can re-qualify for the assessment rate of ESA.

3.6 That measures are put in place to help claimants who have greater difficulty managing to get to medicals to attend (e.g. text messaging, phone calls, e-mails etc.)

3.7 That assessment of the time by which claimants are expected to be work ready be put on a statutory footing and communicated to claimants.

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Person may be called for a medical examination

8.–(1) Where it falls to be determined whether a person is capable of work, he may be called by or on behalf of a health care professional approved by the Secretary of State to attend for a medical examination.

(2) Subject to paragraph (3) where a person fails without good cause to attend for or submit himself to such an examination, he shall be treated as capable of work.

(3) A person shall not be treated as capable of work under paragraph (2) unless written notice of the time and place for the examination was sent to him at least 7 days beforehand, or unless he agreed to accept a shorter period of notice.

Matters to be taken into account in determining good cause

9. The matters which are to be taken into account in determining whether a person has good cause under regulation 7 or 8 (failure to provide information or attend a medical examination) shall include—

(a) whether he was outside Great Britain at the relevant time;
(b) his state of health at the relevant time; and
(c) the nature of any disability from which he suffers.
Claimant may be called for a medical examination to determine whether the claimant has limited capability for work

23. (1) Where it falls to be determined whether a claimant has limited capability for work, that claimant may be called by or on behalf of a health care professional approved by the Secretary of State to attend for a medical examination.

(2) Subject to paragraph (3), where a claimant fails without good cause to attend for or to submit to an examination listed in paragraph (1), the claimant is to be treated as not having limited capability for work.

(3) Paragraph (2) does not apply unless written notice of the time and place for the examination was sent to the claimant at least 7 days in advance, or unless that claimant agreed to accept a shorter period of notice whether given in writing or otherwise.

24. The matters to be taken into account in determining whether a claimant has good cause under regulations 22 (failure to provide information in relation to limited capability for work) or 23 (failure to attend a medical examination to determine limited capability for work) include

(a) whether the claimant was outside Great Britain at the relevant time;
(b) the claimant’s state of health at the relevant time; and
(c) the nature of any disability the claimant has.
Provisions regarding attendance at medicals in the Employment and Support Allowance Regulations 2008

30. (1) A claimant is, if the conditions set out in paragraph (2) are met, to be treated as having limited capability for work until such time as it is determined

(a) whether or not the claimant has limited capability for work;
(b) whether or not the claimant is to be treated as having limited capability for work otherwise than in accordance with this regulation; or
(c) whether the claimant falls to be treated as not having limited capability for work in accordance with regulation 22 (failure to provide information in relation to limited capability for work) or 23 (failure to attend a medical examination to determine limited capability for work).

(2) The conditions are

(a) that the claimant provides evidence of limited capability for work in accordance with the Medical Evidence Regulations; and
(b) that it has not, within the 6 months preceding the date of claim, been determined, in relation to the claimant’s entitlement to any benefit, allowance or advantage which is dependent on the claimant having limited capability for work, that the claimant does not have limited capability for work or is to be treated as not having limited capability for work under regulation 22 or 23 unless

(i) the claimant is suffering from some specific disease or bodily or mental disablement from which the claimant was not suffering at the time of that determination;
(ii) a disease or bodily or mental disablement from which the claimant was suffering at the time of that determination has significantly worsened; or
(iii) in the case of a claimant who was treated as not having limited capability for work under regulation 22 (failure to provide information), the claimant has since provided the information requested under that regulation; or
(c) that it has not, within the 6 months preceding the date of claim, been determined, in relation to the claimant’s entitlement to any benefit, allowance or advantage, which is dependent upon the claimant being incapable of work, that the claimant is capable of work, or is to be treated as capable of work under regulation 7 or 8 of the Social Security (Incapacity for Work) (General) Regulations 1995 (the 1995 Regulations), unless

(i) the claimant is suffering from some specific disease or bodily or mental disablement from which the claimant was not suffering at the time of that determination,
(ii) a disease or bodily or mental disablement from which the claimant was suffering at the time of that determination has significantly worsened, or
(iii) in the case of a claimant who was treated as capable of work under regulation 7 of the 1995 Regulations (failure to provide information), the claimant has since provided the information requested by the Secretary of State under that regulation.

(3) Paragraph (2)(b) does not apply where a claimant has made and is pursuing an appeal against a decision that embodies a determination that the claimant does not have limited capability for work and that appeal has not yet been determined by an appeal tribunal constituted under Chapter 1 of Part 1 of the Social Security Act 1998.
Written evidence submitted by Action for M.E.

About M.E.

M.E. (Myalgic Encephalomyelitis/Encephalopathy) is a chronic, fluctuating illness, also known as Chronic Fatigue Syndrome (CFS) and sometimes diagnosed as Post Viral Fatigue Syndrome (PVFS). It affects over 250,000 people in the UK. Common symptoms include persistent exhaustion, un-refreshing sleep, poor concentration and memory, headache, muscle pain and digestive problems. It is of crucial relevance to this submission to understand that this illness fluctuates over time, and that its profoundly disabling characteristic symptoms are not routinely understood by the Department of Work and Pensions (DWP) and their agents Atos assessing applications for support from people with M.E.

Patient surveys and epidemiological estimates indicate that up to 25% of people with the illness are so severely affected that they are unable to leave their homes or beds, some for many years. M.E. can affect anyone, at any age and from any ethnic group.

About Action for M.E.

Action for M.E. is the UK’s leading charity dedicated to improving the lives of people with M.E. We have been at the forefront of the campaign for more research, better treatments and services since 1987, and we provide information and support to people affected by M.E.
Introduction

The purpose of this document is to respond to the Work & Pensions Select Committee Inquiry on Migration from Incapacity Benefits (IB) to Employment Support Allowance (ESA) drawing on feedback we have received from people with M.E. and other evidence.

Action for M.E. welcomes the opportunity to comment on Migration at this stage so that improvements can be made in a timely fashion before more people are rushed through a process which has shortcomings acknowledged by the Government and which is damaging to the health of a number of patient groups including those who suffer from M.E. We are also hopeful that this inquiry will not be the end of the Committee’s scrutiny of the migration. At this stage it is not possible to determine how representative the experience of claimants in the pilot transition exercise have been and we hope there will be further opportunities to feedback problems that emerge.

The Work Capability Assessment (WCA)

The procedure for transition from IB to ESA centres upon the same Work Capability Assessment that is made for new Applicants for ESA. Action for M.E. gave a comprehensive response to the Government call for evidence for the independent review of the Work Capability assessment in 2010. Our five key areas of concern were:-

1. Inadequate opportunity/scope to reflect the impact of symptoms typically experienced by people with M.E. including fluctuating symptoms over time, the post-exertional pattern of malaise and inability to sustain a given activity, and “invisible” factors such as mental fatigue and cognitive difficulties. This is exacerbated by a reluctance to accept evidence provided by those who have an ongoing relationship with the person with M.E. including General practitioners, hospital consultants and other healthcare professionals, and carers and family members.

2. Unfounded scepticism towards the diagnosis of M.E. set within a broader cultural perception within the benefits system that applicants are fraudsters until proven otherwise, and a lack of recognition of barriers to work which are not patently visible, including cognitive problems and fatigue, particularly when the applicant “looks well.”

3. Insufficient understanding of and training in up-to-date data on M.E. by assessors and decision-makers including medical staff.

4. Unrealistic expectations on claimants with M.E. to find and sustain work over time.

5. The system is overly complex and demanding, confusing those who experience “brain fog.” It is also excessively stressful, with inadequate support to navigate it.

Our evidence included input from a leading M.E. Clinical Consultant to demonstrate the adverse impact that the WCA is having on the health of his patients. An example of one of his anonymised letters is attached to this submission for ease of reference.

On 23 November 2010, Professor Malcolm Harrington published the first independent review of the WCA. The report highlights a number of problems which have been experienced by new applicants for Employment & Support Allowance, in particular those who suffer from fluctuating conditions such as M.E.

The Government responded to the independent review by saying that they supported all of Professor Harrington’s recommendations. We hope that the Select Committee will hold the Government to account in any areas where this commitment is not being upheld.

Meanwhile increasing numbers of people with M.E. are contacting us in despair to tell us that they have been assessed as ‘fit for work,’ yet the practicalities of seeking and sustaining even part-time work would be unmanageable for them. We expect these cries for help to increase dramatically because:

1. The recently introduced changes to the descriptors which are used to “score” applications for ESA have been changed in a manner that makes it even harder for people with M.E. to achieve the points required to substantiate a claim for this allowance

2. As ESA is rolled out to current Incapacity Benefits claimants a very much larger number of people with M.E. will have to undergo assessment

**Migration from IB to ESA**

Action for M.E. has objected strongly to the WCA being conducted on people with health problems for which it is not fit for purpose. The Government has acknowledged that further work needs to be done and this is part of Professor Harrington’s ongoing remit. We believe that there is a strong case for suspending the assessment of people with M.E. and similar neurological conditions such as Parkinsons Disease and MS until an appropriate way of

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2 http://www.dwp.gov.uk/docs/wca-review-2010.pdf
conducting assessments has been established. When pressed the best answer we can
obtain from the DWP amounts to administrative inconvenience.

It is therefore doubly disappointing that the rate of assessments will now increase rapidly
with the initiation of transition from IB before Harrington has reported his year two findings
and made recommendations concerning the assessment of claimants with chronic
fluctuating conditions.

Another major concern is that the limitation to 12 months for people who are granted ESA at
the contribution rate will greatly exacerbate the disability poverty already endured by those
on IB.

At the time of writing, Action for M.E. has been contacted by one person with M.E. who had
personal experience of the migration that was not unfavourable. Some administrative
problems and delays were experienced but the Health Care Professional involved took time
over the face to face assessment and had an understanding of M.E. This made a huge
difference and is an example of good practice shows that the Department for Work and
Pensions (DWP) and Atos can do better if they so decide.

**Recommendation**

Our main recommendations to the Select Committee are to press the DWP to:-

- expedite its work to develop a more accurate and appropriate assessment process
  for people with M.E. and similar neurological conditions.

- justify why it has gone ahead with transition from Incapacity Benefit to Employment
  and Support Alliance using an assessment process that it knows to be flawed for
  people with fluctuating chronic conditions

- Give an undertaking that genuinely disabled people such as those with M.E. will in
  future be assessed properly and treated fairly by a system which will provide them
  with the financial support to which they are entitled and desperately need.

April 2011
In responding to the Call for Evidence for Professor Harrington’s Review\textsuperscript{4}, Action for M.E. was able to submit just under 30 sample letters from specialist doctors written in support of a person with M.E. who applied for ESA. This letter is given as just one example of the consequences which can occur when the system fails:

To Whom It May Concern:

Dear Sir or Madam

Re  ESA

I am writing in very strong support of this patient’s appeal against refusal of ESA, as informed in a letter to her of 18 June, 2010.

This patient is under my clinical specialist care for Chronic Fatigue Syndrome (CFS/ME) and has been so since January 2008, with her last assessment in February of this year. She has in fact had periods of illness for very many years, but has had episodes when she has functioned better and other episodes when she had significant deterioration and greatly reduced function and disability. From time to time she has also had co-morbid depression.

My diagnosis in January 2008 not only related to her present situation, but also as an interpretation of her illness phases in previous time. She is somebody who has high expectations of herself and has tried to overcome her illness and her reduced functioning by maintaining as high a level of activity as she can over a long period of time. Regrettably her illness has reached a point where she has had to acknowledge that in order to maintain sustainable functioning and to give herself the prospect of improving her health in the long term, she needs to set a lower level of activity that does not cause detriment. Her previous trajectory of illness was one of repeated bouts of illness and indeed a progressive tendency to deterioration by attempting to function within the work place at a level that she could not sustain. Recommendations in her treatment have been geared to aligning her sustainable functional capacity to match more closely her illness, not only in terms of the short-term effects, but also in terms of the longer term impact on potential recovery and rehabilitation.

Over the period that I have been seeing her this has meant that she has had to stop working for a prolonged period and has still not been able to regain the level of functioning that would be compatible with actual return to work, despite her best intentions and best efforts.

Against that background we now have an ESA assessment, which gives her zero points
across physical and cognitive domain of functioning. It is hard to credit that somebody has been assessing the patient that I know in making such a judgement. Sadly this type of misjudgement is all too frequent and represents a failure to represent in the scoring system and the considerations that lead to that scoring, the effect of multiple functions and repeated function in any domain of activity, in a holistic sense. Moreover, it fails to take account of the impact of functioning above a sustainable baseline. In the case of Chronic Fatigue Syndrome (CFS/ME) this leads to a typical pattern of increased symptoms and increased disability in the day or days following the increased activity, further undermining the person’s health at the time, but also through the biological impact of that, having a detrimental effect on her health and functioning in the longer term. Wide experience with this clinical condition has shown me that patients who regularly exceed their sustainable capacity, do undoubtedly undermine their longer term prospects for recovery. I am well aware that assessments for benefits are supposed to take account of the longer term impact of activities on health and functioning, as well as their more immediate impact. It is evident that this has not been taken into account in this case, otherwise the scoring system would be totally different.

At a very straightforward level this patient is clearly incapable of work at any level, of any sort, at the present time, as a result of her disabling illness. She is undergoing a treatment programme that is geared to stabilising her function and enabling her to improve, so that in due course she will be able to return to suitable and appropriate work. In my very wide experience and professional judgement, she is not capable of work and indeed, that she would be eligible for ESA on any normal interpretation of personal capability assessment if done correctly. Only by a formulaic and narrow interpretation of the process of personal capability assessment and without referencing one domain to another, or looking at repeated affected functioning, could such an absurd score have been arrived at. Sadly this is a very frequent occurrence and seems to represent a substantial systems failure, or a failure of training and application.

From my wide experience of these sorts of problems and of this clinical condition, I could clearly identify ways in which she would score more than sufficient points on physical and cognitive domains to be shown to be eligible for ESA and I would strongly urge that her ESA application is accepted. At the moment the failure to grant this coincides with a deterioration due to other factors and undoubtedly is likely to trigger further deterioration due to the upset and distress caused by a manifest misjudgement.

I hope the matter can be rectified soon and I would be happy to answer any specific questions that may arise, that would assist in that process.
Written evidence submitted by Disability Alliance

Disability Alliance and this response

Disability Alliance is a UK charity which aims to break the link between poverty and disability. We have over 250 members and 36 years of benefits and welfare experience. Our Board of Trustees contains a majority of disabled people. For further information please visit: www.disabilityalliance.org

We welcome the Work and Pensions Committee inquiry into the migration of people from Incapacity Benefits to Employment Support Allowance, including using the Work Capability Assessment. We are unable to respond in full due to the significant level and pace of change to the range of welfare services disabled people require which results in increased demand for our services at a time of reduced DWP funding and urgent need to work constructively with Government to ensure the negative effects of some proposals for disabled people and their families are mitigated as far as possible.

However, we have chosen to submit this short briefing as disabled people are disproportionately reliant on the welfare state – including out of work support such as unemployment benefits and are likely to be affected by ‘migration’ from incapacity benefits using the Work Capability Assessment (WCA).

We believe there are fundamental problems with the current migration plans, processes and likely outcomes for disabled people which will significantly increase disability poverty for thousands of families across the UK.

Summary

Disability Alliance supports welfare reform which genuinely delivers opportunities for disabled people to contribute in work. However, we believe the current migration plans, using the evidenced problems of the Work Capability Assessment will:

- fail to ascertain disabled people’s needs effectively;
- generate costs to Government through avoidably high appeal rates (40% of which are successful costing £8 million in 2010);
- not deliver ‘welfare to work’ but will shift many disabled people from one source of support to an alternative, lower value benefit or even cut people off from out of work support altogether; and
- increase hardship for some disabled people and their families (with a third of all disabled people already living in poverty).

We believe the WCA process, timeframe and individual descriptors also require significant improvement to ensure it is more effective at identifying needs and allocating appropriate resources.

Sadly, the independent review of the WCA was not fully implemented before national migration began. Only a quarter of the recommendations appear to have been fully accepted prior to national transfer of roughly 10,000 people per week from incapacity benefits. This is despite the conclusion of the independent review that: “the WCA is not working as well as it should” and represents a significant missed opportunity.
Several further independent reports\(^1\) have demonstrated the failings of the WCA in particular and its negative impact for many disabled people and their families. Given the evidence failings of the testing system, the known barriers to work for disabled people and the current economic climate, it is even harder to comprehend the failure of Government to act on an area known to cause such significant disadvantage for disabled people and their families.

**Background**

In planning for the introduction of the Employment and Support Allowance (ESA; accessed through the WCA) in 2008 the former Government estimated that 49% of people undergoing the WCA would be found ‘fit for work’ – ie allocated Jobseekers’ Allowance (JSA).

However since the introduction of ESA:

- around 69% of new claimants have been signposted to JSA after being found fully fit for work;
- only 9% of new claimants have been placed in the ESA support group (not required to undertake any work-related activity); and
- 22% have been placed in the ESA work-related activity group.

We do not believe that any Government has deliberately intended to use an assessment which routinely failed to accurately identify disabled people’s potential support needs. But the WCA statistics demonstrate:

- a disparity with the original Government estimates for how many people would access ESA;
- a difference between disabled people, their personal healthcare provider and the broader public’s expectation of the WCA compared with the outcome from DWP decision-makers; and
- a systemic failure requiring regular appeals at considerable (but avoidable) public expense.

In August 2010 the Government laid new regulations which DWP estimate will increase the number of people found fully fit for work by a further 5%. This means an even greater number of disabled people likely to be found fully fit for work – including people with visual and/or mobility impairments.

**Welfare reform as a barrier to work for disabled people**

The inefficacy of the WCA in ensuring an accurate assessment is made for disabled people also:

- delays the provision of work-related support to people who have a limited capability for work and require additional help to get or keep a job; and
- places considerable and avoidable stress and anxiety on disabled people, their families, Jobcentre Plus and Tribunals staff. For disabled people, this can exacerbate mental or physical health problems and have further knock-on costs to

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\(^1\) Including Citizens Advice, Macmillan, the National AIDS Trust and the Centre for Economic and Social Inclusion.
individuals as well as public services (if people require GP/NHS treatment for example).

This undermines the aspirations of welfare reform and increases the accusations that reform is motivated not by genuinely seeking greater numbers of disabled people in work, but by more simplistic reductions in overall welfare expenditure without accounting for the consequences for disabled people and their families.

We believe that disabled people’s pathways post-WCA should be monitored closely and reviewed to ensure that groups of people experiencing greater difficulty in accessing work be either reclassified into the ESA work-related activity group to help overcome barriers to employment, or receive additional help from an alternative part of the Work Programme for example.

If, for instance, people with learning difficulties are routinely being found fully fit for work but monitoring reveals that they remain out of work after a year (or again after two years) it would seem prudent to better support this group into work to tackle benefit dependency and ensure everyone is able to contribute – including through National Insurance and income tax.

**Time-limiting ESA support and overall timeframe concerns**

Current Government plans include time-limiting ESA payments to just one year for disabled people in the work-related activity group who have previously made National Insurance contributions. This not only penalises people who have worked and contributed, but will directly cause an increase in disability poverty.

The aim of the Universal Credit is to tackle poverty but this policy directly contradicts that objective. The means-testing which will prevent some disabled people losing all support will result in a disabled person with a partner earning £135 per week after tax (ie under the National Minimum Wage for a full-time position) not receiving alternative support (from income-based ESA). This also puts huge pressure on partners of people losing support and could result in family breakdown, carers leaving work and further costs to government at both local and national level.

The Government estimates roughly 400,000 disabled people will lose all out of work benefits as a result. Disability Alliance does not accept that:

- a year is long enough for newly disabled people to adapt to a health condition/impairment and (re-)enter work;
- one year is enough for someone with a significant impairment to find suitable employment – especially in areas of lower work availability;
- evidence has been provided to suggest one year is a suitable timeframe for people to find work; or
- disability poverty is an acceptable direct outcome of Government policy.

For disabled people being moved onto contributory-ESA in the work-related activity group from April 2011 there are further challenges due to the full Work Programme not being operational until June. This may mean someone losing benefit after less than twelve months support has been provided – especially when the initial assessment phase has been taken into account and any subsequent time spent appealing an initial DWP decision.
For disabled people in areas where there are backlogs in the Tribunals system, the effect could be a twelve week assessment period, six month appeal and only accessing ESA work-related activity support for under three months before the time limiting takes effect and ends out of work help.

The next review

Professor Harrington’s first review of the WCA made recommendations which are being considered for the second independent review. Recommendations 19-25 all relate to the next review of the WCA for instance.

We are very concerned that disabled people who have not had needs identified including people with fluctuating conditions and mental health problems are likely to be disproportionately over-represented in incapacity benefits recipients. Many disabled people will be amongst the 10,000 people expected to undergo assessments under national migration and will be very surprised that no action has been undertaken as a result of the initial review despite evidenced failings to appropriately assess needs.

April 2011
1. About The Mental Health Resistance Network.
This is a new organisation which was founded this year 2011 - set up by and for mental health service users to discuss the Coalition's Welfare to Work strategy and changes to Mental Health and other Health Services. It is not yet formally constituted but reaches a membership (including members of local groups of mental health system survivors) of about a few hundred. It is supported by Mad Pride UK which has a membership of about 800 people in Britain and branches in the US, Ireland, Ghana and many other countries.

2. Summary
We deplore the lack of communication about the changes to benefits brought about through the migration of IB claimants to ESA. We are very worried that the process is going ahead without adequate attention given to mental health related impairments - through the descriptors and that the Harrington review recommendations have not been implemented, as promised, before the migration is rolled out. Some are so worried they are discussing suicide. The Work Capability Assessments do not address the impairments which fluctuate, nor do they take into account support structures (such as day care) already in place. Mental Health Service Users are consistently saying they want to work, but the support they need is very often lacking. And most of all we are horrified by the prospect that huge numbers of people - labelled up to now - with "severe and enduring" mental health problems will just be cast adrift and lose benefits and services, to languish on the lowest possible benefit – jobseekers’ allowance.

3. Lack of Communication
We have been told nothing, hearing only through the grapevine, without knowing what information is correct and what is not – rumours and Chinese whispers. We have been living with this worry and financial insecurity for three years without any communication from the DWP.

We should be informed that there has been a change in criteria for what constitutes ‘being unfit for work’, what these changes are, i.e., ‘focusing on what we can do and not what we can’t do’, what this means (if anyone can explain that!) and why these changes have been made.

4. Fluctuating Impairments not recognised by the test
Fluctuation in mental health conditions should be specifically assessed according to the manner and the extent to which they fluctuate; how frequently would we be able or unable to function and what are the levels of severity of the more difficult periods.

5. Process is stressful, worrying and may cause suicides
The WCA makes no assessment of the cumulative effects of stress which could result in mental health breakdowns at great cost to the individual, the NHS and the employer.

We have seen this before, with cuts to services after WW1, the Great Depression, etc., with distressed individuals wandering the streets.
We are finding that current cuts in services are unable to cope with the distress this process is causing including high levels of suicidal thinking and ideology. (51% reported it had made them have suicidal thoughts (i) MIND ESA Survey April 2011)

Mental health is a hidden disability whereas the Atos assessment is based on superficial observation that places significance on appearances.

Mental Health Champions do not know us on an ongoing basis and our disabilities need to be viewed over a longer term; this ties in with their awareness of how our condition fluctuates and how we respond to different situations. We do not believe that they are sufficiently qualified to assess the specific idiosyncrasies of such variable conditions as mental health problems.

6. No account taken of people who are sometimes sectioned

People who have a history of being sectioned as an inpatient, on a section 117 or on a CTO may be subject to additional discrimination by employers.

We have concerns that services are being designed around government policy rather than directed by clinical needs.

7. Back to Work – but with what support?

The Recovery Model was conceived of by mental health service users but is now being misrepresented by the government in order to get us off disability benefits. The Recovery Model speaks of meaningful work and activities as defined by the individual, not paid work at all costs. Also, one of the original prerequisites of recovery under this model is that we start from a position of financial security, precisely what we have not had since these changes were mooted.

Previous administrations have abolished sheltered factories and other projects. Assistance for service users to set up collective businesses and other projects would be good.

We don’t believe that all mental health claimants can reliably present or give an adequate account of their condition and the problems these cause them at an interview with a stranger who is not medically qualified.

The stress for someone with a mental health problem that involves anxiety or mood disorder having to attend these interviews cannot be overstated.

If someone has to go to work, all of the support systems that have been put in place to maintain them at their current level of functioning will be lost, such as day care services.

People will disengage with services which will result in loss of continuity.

8. Side effects of medication not taken into account

Side effects from anti-psychotic medication require further drugs treatment which adds yet more side effects. These side effects can be debilitating.

Claimants in the WRAG will be subject to harassment when it is already established that they are not yet fit for work.
The speed with which you are recalled for subsequent assessments, in some cases just a few months, means that people will be in a constant state of anxiety and insecurity.

The whole process involves attrition and is adversarial, designed to trip you up rather than help you back to work. 95% expect not to be believed. (ii) MIND ESA Survey April 2011

9. Benefit Fraud is not an issue with people with “severe and enduring” mental health problems.

Nobody with extended contact with community mental health teams and with severe mental health problems are doing so fraudulently.

We want the vast majority of cases to get back to work but we need sensible and realistic support structures in place and we don’t want to languish on JSA with minimal help in the competitive job market place. This would be a move to poverty.

10. We want to work, but with the right support, so it is sustainable

This is happening when there is no likelihood of jobs and when mental health services are being slashed.

11. Lack of accurate mental health descriptors should mean the process should be paused.

Harrington’s review of mental health descriptors won’t be happening till this year and published around November, after many people have been assessed.

The high number of appeals that are launched tells us that huge numbers of claimants feel they have been misunderstood.

We are concerned by the length of time people have to wait for appeal tribunals which causes undue stress.

The high number of successful appeals reflects the inaccuracy of the tests.

Despite Harrington’s recommendation that Tribunal judges be given evidence supporting the idea that work is always beneficial, a recent Australian Study published in Online First found that poor psychosocial work causes deterioration in mental health.

12. People with communication difficulties who may also lack capacity may not understand the process.

The descriptors are worded in a way that is almost cryptic so that it is difficult to recognise what kind of experience that they might refer to, i.e. hearing voices may affect concentration or make someone feel suspicious or pressurised to do something they would not choose to do. The questions are so open that many people with mental health problems may be unable to make the connection between what they are experiencing and the fact that it is this that affects their functioning in a particular area.
References

(i) The MIND Survey April 2011 (not yet published) summary is appended as a web
document 4811_welfare_reform_anxiety_making_people_ill.htm.

April 2011
Written evidence submitted by Valerie Crane

Summary: My experience of a Work Capability Assessment and concerns over time limiting ESA

1) I worked for the DWP for almost 25 years until August 2009 when I was retired on Ill Health grounds.

2) My employer uses ATOS for occupational health advice and I was advised by a consultant in Occupational Medicine to accept that I was unable to continue working despite having many adjustments made over a number of years, and after reducing my hours of work.

3) I have a form of Muscular Dystrophy which was only diagnosed in 2009 after my son was found to have the condition. This diagnosis came as a huge shock, especially as my daughter and grandchildren are at risk of developing the same disease.

4) One of my concerns is related to the assessment process in claiming ESA. I believed that with rare and complicated conditions that some communication would be made with the medical specialists that were looking after me, but this did not happen. The ESA50 stated that no medical evidence could be sent in.

5) The assessment itself was an unpleasant experience. The assessor was not happy that my husband wanted to come into the examination room and made him sit at the back and raised her hand to stop him speaking.

6) I was unable to get up from the chair in the waiting room without support from my husband but the assessor in her report claimed that this was a 'show' and stated I had no problem with rising.
7) My medical report incorrectly stated that I could do things I could not, and some things I have little problem with were awarded points.

8) There was no empathy or kindness from the assessor and I was made to feel worthless and guilty of scrounging.

9) I had taken reports from my neurologist which confirmed I had severe weakness in my legs, arms and neck muscles and he had witnessed my difficulty in standing from sitting and also the confirmation of my diagnosis of Myotonic Dystrophy from the Clinical Geneticist. These were accepted but not read.

10) I was placed in the WRAG with a prognosis that I would be unlikely to return to work in the longer term as my condition is progressive and there is currently no treatment for MD.

11) My other concern is that contributory based ESA will be time limited to 1 year for people in the WRAG. I am never going to get better unless a cure or treatment for MD is found. My life expectancy is probably limited.

12) I have paid NI contributions for more than 35 years in the belief that it was a form of insurance.

April 2011
Written evidence submitted by Heather Price

Summary – My experience of a Work Capability Assessment and how it failed me completely.

1) I attended an assessment funded by my employer after suffering chronic depression. At that assessment Atos reported that my depression significantly affected my life, and should be treated as a disability. Although my employer made all the right noises, there was in fact no extra support and I was given no choice other than leaving my job.

2) At that point the Job Centre Plus advised me to apply for ESA, and gave me support to fill in the forms. They could see no reason why I would not be entitled to it. I was told by letter shortly after applying that I had to attend a medical assessment.

3) I was extremely distressed the morning of the assessment, but a friend helped me get dressed, and helped me get there. It took well over an hour on public transport to get there, and cost a significant amount of money, considering at this point I had no income.

4) After waiting nearly an hour in the waiting room with no advice how delayed my appointment would be (the receptionist was rather rude), I was called into a room for my assessment. The doctor (I’m assuming he was one) did not introduce himself, and as I sat down said “You look macho, there can’t be much wrong with you”, at which point I got more distressed, and started to cry. After that he proceeded to ask me to bend over and touch the floor, walk across the room, sit up on the bed etc. At no point did he ask me anything about my mental health. The doctor made very little eye contact, and seemed more interested in his computer screen than listening to what I was trying to tell him. I also found him extremely difficult to understand as his English was very poor.

5) I became hysterical in the waiting room after the assessment and the receptionist phoned a taxi to take my friend and me home. I was also not able to claim my train fare there back as my tickets were lost by the company.

6) I scored no points.

7) At that point I was too ill to appeal thanks to my treatment at the assessment. I am still too ill to work, and have to attend interviews at the job centre. They believe I should be on ESA, but I’m too frightened to go through it again.

April 2011
Written evidence submitted by Susan Marsh

Summary - ESA is unfit for purpose. A policy bought in by Labour based on flawed evidence has been continued under this coalition and made infinitely worse by time limiting those in the WRAG to one year. Every independent study, including the Harrington report, have found it unfit, yet the government presses ahead with a policy which is causing real hardship and suffering.

1) I have little confidence that any of the points I raise will be addressed. The enquiry into DLA was a total whitewash with not one single point raised taken on or accepted. Nonetheless, I will make this submission in the hope that when everything I campaign so hard to highlight turns out to be true, it will be shown that this government had all the evidence before them yet chose repeatedly to ignore it.

2) ESA is based on suppositions made by Mr Purnell that because the Incapacity Benefit figures rose so markedly under the Conservative government of the 80s, there must still be, 30 years later, some 1.7 million people languishing on benefits who could work. This totally ignores the advances made by medicine in that time. Thousands of people now survive conditions that would have killed them in the 80s. Surgery and medicine have improved beyond all recognition and long term variable conditions such as cancer, bowel disease, parkinsons, alzheimers, mental illness, kidney, heart and liver disease are now conditions that people can learn to live with. Nonetheless, treatments are often unsuccessful or carry their own side effects and as a society we simply have to accept that we will need to support many more people through long term illness than we did in the 80s. In fact, the figures for Incapacity Benefit have remained static for 14 years. There is no great surge of claimants, no mythical millions living a life of ease on sickness benefits.

3) The Harrington report found serious flaws with ESA. DWP Ministers claimed to accept all the findings of the report, yet there is little evidence that any significant changes have been made at all. On the contrary, as many people are being found "fit for work" now as they were pre-Harrington. The body of evidence grows daily as the Citizens Advice Bureau, Compass, the government's own advisory committee, the Statutory Social Security Advisory Committee and even the professor who designed ESA, Professor Paul Gregg have all declared ESA unfit for purpose - variously "a shambles" "chaotic" or "unfit for purpose", appealing to the government to halt the process until it has been significantly modified, yet every study has been ignored. The decision to time limit ESA.

4) The decision to time limit contributory ESA to one year is possibly the most ill thought through policy I've ever encountered. In my opinion it shows the total lack of understanding of long term variable or chronic conditions shown by this government and previous administrations. To suggest that only those with cancer might be unduly affected is laughable. Very high percentages of those with long term conditions are being found capable of some work and therefore placed in the WRAG group, yet their conditions are often degenerative, painful, distressing and limiting. Often, these people need considerable support and care from their working partners. Taking away nearly £5000 from them will simply force these partners who want to work to support their families to give up their jobs and become full time carers. This will cost up to 5 times more in 100% state dependency than ESA currently costs the taxpayer. I understand WHY ministers think this will work. Evidence
shows that those who are off work for more than a year are less likely to return to work at all. What no-one seems to consider is that those who stay off work for more than a year are likely to be those very people with the most severe long term conditions. As a policy, it's like sticking your fingers in your ears and shouting "We can't Hear you" These people will not miraculously become well just because the year is up - on the contrary, the stress and fear of destitution will often simply make these conditions worse. If the government presses ahead with time limiting ESA to one year, I believe it will cause utter chaos as those abandoned by the state find they can no longer cope. Families will be broken apart, fraud will increase and hundreds of thousands of people will find that the covenant they thought they were promised by the state no longer exists. It is a step too far and must be withdrawn.

5) ATOS assessments are possibly the most counter-productive way of measuring a person's ability to work that it was possible to devise. Of course, if any government really wanted to help sick or disabled people find fulfilling careers, it would take money, innovation and commitment. A 15 question tick box questionnaire is so clearly going to fail those with complex or multiple needs, that I find it hard to believe any minister would need me to point it out. Assessment centres are inaccessible with no parking, they are often not modified to accommodate wheelchairs and reports show that staff vary from "cold" to "rude" and even "fraudulent." Appeals are made in 40% of cases with up to 80% of those being upheld - why would we carry on spending money on tribunals for a system that clearly isn't working? Those with mental health issues often simply cannot face the assessments at all leading to many "falling through the net" and disappearing from statistics altogether. There are countless reports of people being found fit for work simply because they were able to make it to the assessment centre with their clothes on! It's farcical. The 15 questions do not even ask about pain. Pain is one of the most significant factors in an individual's ability to work, ignoring it is a cruelty.

6) It almost goes without saying that at a time of high unemployment, it is unlikely employers will want to take on those with long term illnesses or disabilities if there are able-bodied applying for the same job. Of course, that's not to say we shouldn't try, but it needs incentives and resources - cutting schemes like Access to Work and the Independent Living Fund show the lack of consistency in this government's approach to illness and disability. Between 1.2 and 2 million people are estimated to be taken off ESA and DLA in the next 4 years. Unemployment figures will surely rise exponentially through this, simply shifting the burden of those who are truly vulnerable elsewhere.

7) Claims that "Virtually everyone should be on an active pathway into work" totally fail to take into account the many, many people who suffer from autoimmune or degenerative conditions that can in fact, be made worse by "overdoing it". Forcing those who are unable into work will simply increase the burden on the NHS and make people more likely to need state assistance, not less. The answer given by ministers that "those who are in genuine need will be protected" or "there is nothing to fear" is simply not true. Every scrap of evidence shows that that is simply not happening and that seriously unwell people are being found "fit for work" every day. No-one objects to a genuine policy of helping those who wish to work to do so, or even encouraging those who are unsure or nervous, but an assumption that work will make everyone better is so ignorant, I believe it is negligent.

8) If ministers were to sit down and read the submissions people have taken great trouble to write and send in to this enquiry, I believe they would learn more in an afternoon than they would from years of Westminister statistics and forums. I read stories every day that should
shame us. Stories that are so shocking they are almost unbelievable. Stories so painful to read that it makes me want to weep, yet if I were to read them from an ideological viewpoint, certain that work was always the answer, I would probably ignore them. The longer we ignore evidence that Labour got ESA totally wrong, the more people will suffer. Any policy that starts with targets for reducing a benefit is not based on compassion or a desire to help, but on an attempt to save money. You won't save money, you will simply cause untold suffering and the longer you ignore the overwhelming evidence, the more disastrous ESA will become.

9) I urge ministers to halt the migration of IB to ESA immediately and engage with sickness and disability campaigners who are trying to make reasonable changes. We have decades and decades of experience of long term illness and it's nuances and we are best placed to devise a policy that would actually achieve the aims you say you want to achieve. I can only warn the enquiry in the strongest terms that continuing to roll out ESA and time limiting it to one year will be a disaster. It will leave some of the most vulnerable people in our society destitute and traumatised and bring awful problems to our welfare system that will only need to be dealt with further down the line.

April 2011
1. The Department’s communications to customers going through the assessment and whether the information, guidance and advice provided by the Department and Jobcentre Plus is effective in supporting customers through the process.

1.1 The reliance of telephone communication throughout the process can cause considerable inconvenience. The use of the telephone is not compatible to many sick and disabled people. Mobile phones cannot be relied upon to always have power, credit or network coverage. Disabled people may not actually have a conventional phone, or always be able to access one. The use of a non free-phone number also is a concern, as these numbers, and the length of calls involved often raise an additional expense to the disabled person.

1.1. The lead time for appointments is often not sufficient for the claimant. There appears to be no acknowledgement or adjustment for disability when the disability means that the claimant cannot respond in time, or organise their lives, transport, care to meet the demands of form filling and assessment appointments.

1.2. The complaints procedure is complex, as the claimant may be complaining about associated actions. The separation of the DWP and Atos results in complaints being referred between the two organisations with neither willing to state they are responsible, and refusing to be accountable. This adds to the stress for claimants who are already ill or disabled, and struggle with everyday life.

2. The Work Capability Assessment including:

2.1. the assessment criteria;

2.2. Having read the entire ESA Handbook for 2011 I am concerned that the criteria for being “fit for work” or “fit for work related activity” do not correlate with criteria of “fit to be employed”. The criteria only demonstrate that the claimant has an absolute minimum amount of functionality, and this bare minimum will not be acceptable to employers. Some of those found “fit for work” will have a very limited window of employment, much reduced by their illness, condition or disability, compared to a person who has good, very good, or excellent health.

2.3. The Handbook refers to jobs that involve working at a work station. Out of the whole spectrum of career opportunities available in the UK, the constant referral to one single occupation suggests that those who are found “fit for work” or “fit for work related activity” are actually only being assessed to be working at a work station. Hence they are actually only being assessed as “fit for work, or work related activity that occurs at a work station”. Until the assessment criteria tests for ALL work types it is actually not a test for work, or employment.

2.4. the service provided by Atos staff;

2.5. From the information I have received, and from Atos’s own literature, the recommended amount of time is not being taken to complete the assessments. The situation of “pay-by-assessment” should be stopped to discourage shortened assessments. The ESA Handbook has some
181 pages of explanation, including constant references to observation and criteria, which, if completed as dictated by the Handbook would mean at least an hour of assessment. Claimants have reported that the interview was rushed, that few questions were asked, and the questions asked were irrelevant. The Handbook instructs examiners to avoid this, but it appears that a proportion of examiners are failing to remain within the guidelines laid out in the handbook.

2.6. A large proportion of the Examining Medical Professionals (EMP) do not have English as their first language. Many did not qualify at British training and educational establishments. Many are newly qualified. When confronted by an EMP who demonstrates an inability to understand the claimant, or cannot be understood by the claimant, or does not recognise the claimants’ condition, then the claimant should be able to halt the assessment and request a different EMP.

2.7. The Handbook is not a simple list of instructions on how to perform the assessment. It includes statements about the history and reasons for the ESA that will cause bias. The assessment must be unbiased, and the handbook clearly introduces a bias, including, amongst other aspects, the bias of where the claimant would be expected to work, what type of work they would be expected to do after assessment etc with the constant referral to a “work station”. An EMP may look at a female as someone who would traditionally fill a work station based job, and hence be more inclined to judge accordingly. I request that the references to the reasons for the WCA are not disclosed to the EMP, and that references to certain work environments are either removed, or expanded to cover all working types.

2.8. The Handbook makes far too many assumptions about the client group. It suggests that claimants will mobilise by public transport, will be walking, will be able to be examined physically and will improve or learn to accommodate their disabilities or illness.

2.9. The handbook does not recognise that there are incurable genetic conditions that will not improve, or that some of these conditions cause illnesses that are uncontrollable. Hence the time intervals for re-assessment are far too short. The data gathered by the DWP and Atos should indicate if a person has an illness or condition that currently has no known cure or effective analgesic. When, and if, a cure, advance or analgesic becomes available then the Chief Medical Officer for the DWP could ask that these people are then re-assessed.

2.10. the suitability of assessment centres;

2.11. All assessment centres should be checked for suitable access, lighting, parking, toilets, and have seating suitable for people with disabilities. Also the EMP should have individual and sufficient medical equipment and experience for testing sensory disabilities. The Handbook suggests using waving the hands and counting fingers to test for sight, and reduces a standard hearing test from 9 metres to 3 metres, whilst stating that this is sufficient. A test is not a test if the rules are not the same, it is invalid.

2.12. and customers’ overall experience of the process.

2.13. Customer’s experiences vary. There should be a “Customer Satisfaction Survey” given to each claimant, and an independent company that collates this evidence. This evidence should be included in any reconsideration or appeal, and any complaints procedures that may occur. This simple survey would improve customer confidence, which is currently very low.
3. The decision-making process and how it could be improved to ensure that customers are confident that the outcome of their assessment is a fair and transparent reflection of their capacity for work.

3.1. At present Atos claim that they ONLY provide guidance to the Decision Makers (DM), however the DWP claim that they only “rubber-stamp” the decision of the EMP. The Handbook states that both the DM and the EMP read the claimants’ provided medical evidence, and use it together with the assessment. However this does not seem to be happening.

3.2. A customer cannot be confident that the assessment is a fair and transparent reflection of their capacity for work when;
   a) They cannot see the EMP’s report
   b) They have been judged to have capacity to work ONLY at a work station
   c) They have been tested to establish minimal functionality, when the capacity to work and employability requires much greater levels of functionality than those tested for.

4. The appeals process, including the time taken for the appeals process to be completed;

4.1. The appeals process can exceed the interval of ESA granted to the claimants. An example of this would be a claimant placed in the Work Related Activity Group (WRAG) after assessment for a period of 6 months, who then appeals to be moved into the Support Group. The time delay for appeals (currently in excess of 6 months) could mean that the appeal takes place AFTER the period of WRAG has finished. The claimant then has a re-assessment for the upcoming period of time based on their current health condition, and then has an appeal based on their condition some 6 months plus earlier. If their condition is the same, then the second award must match the first, which may result in a second appeal if they are different. And during this six or seven month period the claimant has had two assessments, one appeal, filled out another two or three sets of forms, had to comply to the WRAG activities (possibly to the detriment of their health). Can this level of activity, stress and reduction in benefits be considered to be humane to a person who might well be entitled to the support group? It should be noted that 6 months wait for an appeal is the shortest time available at present for the majority of the UK, and that awards are often for 3, 6 or 9 months meaning that the claimant could enter into a constant cycle of appeals and re-assessments, where the re-assessments occur before the previous award has been appealed. Disabled and chronically sick people cannot sustain this level of stress, and will result in many claimants simply abandoning the benefits they are entitled to because they are simply not well enough to continue in a cycle that is destroying their health.

These people will encounter real poverty as a result.

5. and whether customers who decide to appeal the outcome of their assessment have all the necessary guidance, information and advice to support them through the process.

5.1. The reduction of funding for CAB and other welfare organisations means that many claimants are unable to access adequate support. Atos refuse to assist beyond their minimal obligations, the DWP provide only the bare minimum of instructions. Many claimants complain that they are too ill to attend an appeal, and have no method of having a representative at the appeal.

6. The outcome of the migration process and the different paths taken by the various client groups:

6.1. those moved to Jobseeker’s Allowance, including the support provided to find work and the impact of the labour market on employment prospects;

6.1.1.1. Many of those moved to JSA are not employable because
of the limitations of their functionality. This is caused by setting the levels of functionality too low. These people are then moved onto a subsistence level benefit, that is set up to allow for the minimum expenditure for an average of 6 weeks. These people are still too disabled to be employed, and will be in poverty through no fault of their own, and will be unable to change this situation. There are NO workplace adaptations that will negate the effects of illnesses that cause pain, confusion, exhaustion or absences for medical appointments. These people are NOT employable because they will consistently fail the basic requirements of employability, which are performance, reliability, attendance and punctuality.

6.1.1.1.2. These claimants are more likely to be sanctioned on JSA as they cannot fulfil the basic requirements of attendance and reliability and punctuality. They may not be able to afford the transport to the Job Centre. They may be too ill to attend the Job Centre. They may not be able to access that assistance they need to attend.

6.1.2. those found fit for work who may be entitled to no further benefits;
6.1.2.1. These people will be entirely reliant on the charity of others. They will have no money that actually belongs to them (unless they have substantial savings). They will be the only group who have NO CONTROL over their circumstances, and have no ability to change their situation. Unlike those of good health, who can find work doing “something somewhere” the sick and disabled have a very small “employment window” of choices, and still have to compete with those who have excellent health.

6.1.2.1.2. It cannot be stressed enough that denying disabled people money of their own is not right. These people have NOT made a choice to be disabled and thus limit their employability. The decision to remove any income will lead to family breakdown, abuse and neglect, and be seen as a further burden. Partners will resent having to work and care and pay for a second person when the option of walking away is available. More disabled people will be on their own becoming a greater burden on state benefits and the NHS.

6.1.2.1.3. This group of people will be the only people who are without money. Non-working Mothers receive Child Benefit, and can always try to find work without handicap. Pensioners receive pensions in their own right. Teenagers get EMA and also can find work without handicap. Those who are sick and ill and disabled will get nothing at all, and yet they did NOT enter into this situation voluntarily. Most of the population are responsible for their life decisions, sick and disabled people DO NOT decide to become sick and disabled, and yet are the one group that is denied money because of circumstances beyond their control.

6.1.3. those placed in the Work Related Activity Group of the ESA, including the likely impact of the Department’s decision to time-limit contribution-based ESA to a year;

6.1.3.1.1. Whilst in the WRAG claimants will be expected to attend WR activities, which may contribute to a deterioration of their condition.
6.1.3.1.2. These people have already proved that they were employable, that they had skills and often careers. It is therefore unlikely that they will benefit from WRA.

6.1.3.1.3. These people paid into a system that assured them that should they ever be unable to work then they would be supported. This promise has been broken; the assurance has been reneged upon. People DO NOT want to become sick, ill or disabled.

6.1.3.1.4. These people will be entirely reliant on the charity of others. They will have no money that actually belongs to them (unless they have substantial savings). They will be the only group who have no control
over their circumstances, and have no ability to change their situation. Unlike those of good health, who can find work doing “something somewhere” the sick and disabled have a very small “employment window” of choices, and still have to compete with those who have excellent health.

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6.1.4. and those placed in the Support Group.

6.1.4.1.1. People in the Support Group will be constantly re-assessed, as the Handbook suggests that very few conditions should not be. It is a cruel system that states a person is severely disabled and yet needs to check this every 3, 6, 9, or 12 months, up to 2 years. The obvious examples that should be re-assessed are those in the support group because they are pregnant or have a highly contagious disease. The support group means very little regarding financial security. For those who are re-assessed and move into the WRAG, they then have to appeal. I think it is beyond the comprehension of many MP’s and policy writers that those in the Support Group are usually massively disabled or very, very ill, and forcing them to appeal will cause actual mental and physical harm. 7. The time-scale for the national roll-out for the migration process, including the Department’s capacity to introduce changes identified as necessary in the Aberdeen and Burnley trials.

7.1. Implementing change to criteria before implementing the Harrington report is wrong, and not the intention of the Harrington report. 7.2. Implementing change to contributions based benefits before the Universal Credit (UC) is introduced will cause hardship, poverty and relationship breakdown. Under UC Mr Ian Duncan Smith assured that no couple will be worse off if they live together. The time limited contributions based benefit cuts will mean that couples WILL be significantly financially penalised because they have been unfortunate enough to become sick, ill or disabled.

Summary;
It appears that the ESA WCA is too either being applied too strictly, or that the criteria are set for very low levels of functioning. The levels of functioning are too low for employment. Any level of impairment, illness or disability puts the claimant at a disadvantage in the employment market as there will almost always be a fit and well person with the same skill sets available who will be more reliable, have better attendance and require less adjustments. There is little recognition of incurable illnesses and conditions.
There is an assumption that illnesses or conditions will all be cured in a given time span (to be decided by an EMP who may not be familiar with the illness or condition), or that the claimant will be able to “adjust” given time. There is no adjustment that can be made for pain when analgesia either fails to work or has side effects that then in themselves restrict the claimant.

The WCA stereotypes sick and disabled people by only giving a “work station” as a work place, and working in a call centre as an example. The “work station” work place example is biased towards those traditionally seen as employees in these work places. EMP’s are not Employment Specialists, nor are they Occupational Therapists, nor are they Employment advisors. They may have no knowledge of employment beyond what they have experienced. They are not specialists in disability despite having completed a five day “in-house” course. The disability training should be carried out by an independent body and no EMP should examine a claimant if they are not experts in the conditions and the implications of the condition.

Repeated assessments at short intervals are not necessary for most conditions. Contributions based benefits should not be time limited until all IB claimants have been assessed and the UC is established.

People should not be denied personal finances because of a situation beyond their control, i.e. sickness and disability.

People should not be sanctioned when they cannot comply with regulations because of a situation beyond their control, i.e. sickness and disability.

Couples should not be financially penalised because of a situation beyond their control, i.e. sickness and disability.

April 2011
Written evidence submitted by DWP

SUMMARY

1. Starting in October 2010 and ending in spring 2014, customers who receive Incapacity Benefit, Severe Disablement Allowance and Income Support paid on the grounds of illness or disability will be assessed to see if they qualify for Employment and Support Allowance (ESA).

2. Approximately 1.5 million people will be reassessed. Reassessment commenced in October 2010 with a trial in the Aberdeen and Burnley areas. At the end of February, the Department began a limited introductory phase reassessing 1,000 cases a week. Full national reassessment began in April 2010. Jobcentre Plus has redeployed around 1,200 extra staff to handle the reassessment of these cases. Around 16,700 personal advisers will also be trained to deal with reassessment customers.

3. The Government will ensure that the transition runs smoothly for all customers. For those who transfer to ESA the Department will ensure that benefit payments are not disrupted. No one moving from their existing benefits to ESA will see a reduction in the level of their benefit entitlement at the point of change.

4. Other important changes are being introduced alongside the reassessment exercise that will ensure the necessary support is available to incapacity benefits customers both during and after the reassessment process: delivery of changes from Professor Harrington’s independent review of the WCA and the introduction of the new Work Programme arrangements are being dovetailed with reassessment, to optimise the experience for customers, the quality of decision making and therefore delivery of the overall policy objectives.

INTRODUCTION

Background to the reassessment

5. The Department introduced ESA for new customers with a health condition or disability from 27 October 2008.

6. ‘The Coalition: our programme for government’ published on 20 May 2010 committed to reassessing people on incapacity benefits for potential entitlement to ESA between 2010 and 2014. Further detail was provided in Written Ministerial Statements on 29 June 2010 and 25 January 2011. A summary of key facts about the reassessment is included at Annex A.
7. The Employment and Support Allowance (Transitional Provisions, Housing Benefit and Council Tax Benefit) (Existing Awards) (No.2) Regulations 2010 (SI 2010/ 1907), were laid before Parliament on 29 March 2010. They came into force on 1 October 2010 and provide the legal basis for reassessment.

The case for change

8. There are over 2.5 million people on incapacity benefits\(^1\) and Employment and Support Allowance. This is some 7 per cent of the working age population at a cost to the taxpayer of around £13 billion a year. The Government recognises that many of these people, with the right support, could and indeed do want to work, but the current system does not give them that opportunity.

9. For someone on incapacity benefits it may have been some considerable time since they last spoke to anyone at the Department about their condition or their work options. People have been left on their own with no support or sense of when and how they might get back to work. The Government believes this is not right and that radical reform is needed.

10. The Government will bring people into the Work Programme which will offer targeted, personalised help for those who need it most, when they need it. Supporting families back to work is the only way to break the cycle of inter-generational poverty.

Implementing the change

11. Approximately 1.5 million people will be reassessed by April 2014. This represents a significant challenge for Jobcentre Plus and its partners. Around 1,200 Jobcentre Plus staff have been redeployed to handle the reassessment. Atos Healthcare, the Department's medical services contractor, is recruiting over 100 additional healthcare professionals to support reassessment.

12. The Government recognises that the timescale for delivery of this change is challenging, but it is important that customers are provided with employment support as quickly as possible.

13. To support staff in delivering this change the Department has produced extensive guidance. A comprehensive programme of learning has also been developed. Overall, the following approximate numbers of staff will be trained:

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\(^1\) ‘incapacity benefits’ is a collective term for Incapacity Benefit (IB), Severe Disablement Allowance (SDA) and Income Support (IS) paid on the grounds of illness or disability.
• 900 staff engaged in processing activities in Benefit Processing Centres;
• 260 staff engaged in telephony activities in contact centres; and
• 16,700 staff in Jobcentres – including advisers involved in back to work activities.

14. The implementation of reassessment is being carefully managed. Rigorous project disciplines, including comprehensive and integrated planning and the management of risk have been adopted. External assurance has been applied throughout the lifetime of the project, including two independent Gateway reviews by the Office of Government Commerce.

Continuous improvement and evaluating the change

15. The reassessment has been informed by learning from the current ESA experience, best practice within the Department and research with customers.

16. Before reassessment commenced the Department commissioned insight research, including a survey of 2,000 current incapacity benefits customers. This research examined customers’ attitudes towards work, their levels of skills and their preferred methods of communication. The results were used to inform customer communication strategies and Jobcentre Plus staff training.

17. The Department also trialled the reassessment process. This began in October 2010 and involved 1,700 customers in the Jobcentre Plus–led Pathways Districts supported by Burnley and Aberdeen Benefit Centres. 850 customers were selected from each Benefit Centre. The trial was designed to provide early indicators about customer and staff reactions to the reassessment process, evaluate whether the communications were effective and to provide recommendations on how the process could be improved.

THE CUSTOMER JOURNEY

Designing the customer journey

18. The reassessment process, or ‘customer journey’, was designed based on learning from the implementation of Employment and Support Allowance. Feedback from ESA revealed that some customers found it difficult to understand the end-to-end claim process because they were unsure of where they were in the journey and what to expect next.

19. In response Jobcentre Plus have added additional points of contact with the customer. Specifically a telephone call is made to the
customer after they have been notified that they are having their benefit reassessed and an additional call is made to discuss the decision about their benefit entitlement. Simplifying the journey for customers in this way allows Jobcentre Plus to:

- identify any additional needs a customer may have, such as the need for an interpreter or other reasonable adjustments;
- provide further information to the customer at each step;
- provide the customer with more opportunities to ask questions;
- explain what will happen next so that the customer knows exactly where they are in the journey; and
- improve the decision making process by providing an opportunity for customers, who may be disallowed, to provide additional evidence in support of their claim.

20. Reassessment also builds in many of the recommendations of the recent review of the Work Capability Assessment (WCA) undertaken by Professor Malcolm Harrington\(^2\), including additional telephone contact with customers, and giving customers a chance to discuss the decision in their claim with a decision maker.

The reassessment customer journey

21. A diagram of the customer journey is included at Annex B.

22. Customers are first informed that their benefit is being reassessed when Jobcentre Plus sends them a written notification. Within two weeks of sending this notification, Jobcentre Plus telephones the customer. The member of staff will check that the customer has received the letter, that they understand the action they need to take, and find out if they need any extra help.

The medical questionnaire and WCA

23. Customers will then be sent a limited capability for work questionnaire (ESA50) by Atos Healthcare to complete and return. The customer is asked to provide as much detail as possible on this form about their medical condition and how it affects them. In order to improve this part of the process, the Department has amended the ESA50 to encourage customers to send any relevant, additional, medical evidence when they return the form.

24. Upon receipt of the ESA50 at Atos, a healthcare professional will review the questionnaire and any other medical evidence supplied to decide if the customer needs to attend a face-to-face assessment. If

necessary, the healthcare professional can request further medical evidence from a customer’s GP or other professionals.

25. If Atos are able to conclude that a customer satisfies the conditions for the Support Group or Work Related Activity Group (WRAG) on the basis of paper evidence, for example if the customer is terminally ill or is very seriously disabled, they can return the case to Jobcentre Plus with a recommendation without inviting the customer to a face-to-face assessment.

26. If a customer is asked to attend a face-to-face WCA, Atos Healthcare will telephone them to arrange an appointment. A healthcare professional, employed by Atos, will produce an independent medical assessment based on how the customer’s condition affects them. The assessment is a functional assessment which focuses not on diagnosing an individual’s condition but on the effects the condition has on that individual. This report is sent to Jobcentre Plus.

27. Using the information from the questionnaire, the face-to-face assessment and any other evidence provided, a Jobcentre Plus decision maker will decide if the person’s existing award qualifies for conversion to ESA and, if so, whether they qualify for the Support Group or the WRAG.

If a customer qualifies for ESA

28. If a customer’s qualifies for ESA, Jobcentre Plus will telephone them to inform them of the decision, whether they are in the Support Group or WRAG, and what they need to do next, before putting the customer’s benefit into payment. They will be sent a letter to confirm the decision.

29. Customers placed in the WRAG will be told during this call that they will be invited to a work-focused interview at a Jobcentre. At this interview they will be able to discuss any support they will need to return to work.

If a customer does not qualify for ESA

30. If, on reviewing the evidence, the Jobcentre Plus decision maker believes the customer is likely to be disallowed, they will telephone the customer and explain why they believe the customer may not be entitled to ESA and the evidence they have used to reach this conclusion.
If the customer queries the decision and has additional evidence which may alter the decision, this call provides an opportunity for the customer to bring further evidence forward. They will then be given 14 days to send in this evidence before a final decision is made.

If the decision maker decides the award does not qualify for conversion to ESA they will then discuss with the customer their benefit options. If a disallowed customer wishes to claim Jobseeker’s Allowance (JSA), they will be transferred straight to someone who will take their claim details. This will help to ensure that customers who claim another benefit do not have a break in their payments.

Following a disallowance, benefit will not stop immediately. The date a customer’s payment stops will be at least two weeks after the decision has made. This will provide time for a new benefit claim to be processed and put into payment.

Disallowed customers will be sent a letter to confirm the decision.

If a customer thinks the decision is wrong

When telephoning or writing about a decision, Jobcentre Plus will also advise people what to do if they think the decision is wrong. If a customer decides to appeal against a decision their case will be automatically reconsidered, before the case is sent to Her Majesty’s Court and Tribunals Service. A decision maker will call the customer to see if they have any additional information to inform this reconsideration.

Support for vulnerable customers

Customers with health conditions that may affect their ability to comply will not be disadvantaged. If someone who is known to have a mental health condition or a learning disability fails to return the ESA50 or attend a face-to-face WCA their case will not be closed immediately. The Department will make every effort to gather the information necessary to process it, including undertaking safeguarding visits to the customer’s home if necessary.

During the initial telephone call to the customer, Jobcentre Plus will ask if the customer has any additional needs and will endeavour to meet any reasonable adjustment request.

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3 Her Majesty’s Courts and Tribunals Service was created on 1 April 2011. It brings together Her Majesty’s Courts Service and the Tribunals Service into one integrated agency providing support for the administration of justice in courts and tribunals.
38. Not receiving the telephone calls from Jobcentre Plus does not stop the journey moving forwards. Where a customer is unable to use the telephone they can request contact is delivered face-to-face. Customers can also contact Jobcentre Plus via a textphone/texbox and the Royal National Institute for the Deaf (RNID) typetalk service. Large print forms are available for people with visual impairments. Jobcentre Plus also supports customers’ right to be accompanied by a representative.

COMMUNICATIONS WITH CUSTOMERS

39. The primary channels of communication with customers are the telephone calls and written notifications delivered by Jobcentre Plus and Atos Healthcare. Comprehensive information has also been made available for customers on the DirectGov website.

Involvement and best practice

40. Reassessment notifications and forms were developed with involvement from the Social Security Advisory Committee, Customer Representative Groups and the Department’s psychologists. For example, at the request of Citizen’s Advice, the initial notification and disallowance notifications highlight to customers that they can seek additional support from welfare rights organisations.

41. Jobcentre Plus has worked with the Department’s Transforming Letters Project, in conjunction with Reading University, to ensure that the letters are in plain English.

42. Members of the Jobcentre Plus Customer Representative Group Forum were given the opportunity to comment on the customer information published on the Government’s DirectGov website. As part of focus groups in the Aberdeen and Burnley trial areas, customer representative groups were also asked to evaluate this content.

Results and learning from the reassessment trial

43. The trial demonstrated that the customer journey and customer communications are working well. The customer journey has been shown to be viable, with staff and customers reacting positively to the additional customer interventions. There was little adverse customer reaction and low levels of active non-compliance. Enquiries by telephone and in person have been much lower than expected, suggesting that the communications provided to customers have effectively provided for their needs.

44. Management information gathered during the trial suggests that the additional customer contact has improved compliance with the
reassessment process. 13% of customers contacted the Department after receiving their initial notification to correct their contact details. 68% of initial outbound phone calls were successful. Finally, only 14% of customers failed to return their ESA50 medical questionnaire and 9% failed to attend their WCA. This compares favourably with the experience of new claims to ESA.

Improvements from the trial

45. The trial evaluation identified some specific recommendations to improve the customer journey and communications, which are being implemented. These improvements include:

- The language used when customers are informed they have been placed in the WRAG has been clarified as some customers were unsure about what was expected of them.
- Decision makers have been given the flexibility to arrange a break of up to 72 hours in the outbound call to disallowed customers, if necessary. This was introduced because the research showed that customers were sometimes unable to engage with this phone call because they needed time to take in the fact they were being disallowed ESA.
- Atos Healthcare is addressing feedback by some customers that the face-to-face WCA felt impersonal through its soft skills training which is already taking account of feedback from the customer satisfaction survey, analysis of complaints trends and the Harrington Review.

Further testing and assurance

46. Staff guidance, learning and development and supporting IT have been evaluated through model office testing, which replicated the conditions in a real, live office environment. Jobcentre Plus operational staff have also been involved throughout the development and testing of supporting IT and business processes. This has taken many forms, including the embedding of operational staff within the project development teams to add technical expertise and assurance at source. These arrangements have identified improvements and confirmed that all products are fit for purpose for national reassessment.

Communications with external stakeholders

47. As well as communicating directly with customers the Department also recognised that customers currently in receipt of incapacity benefits may be vulnerable, may not have had contact with the Department for a considerable period of time and may look to third sector organisations for support. A comprehensive communications strategy for external stakeholders was therefore developed. This involved:
• meetings with representatives of national external stakeholders in July 2010 and again in March 2011, alongside regular updates to stakeholders at the quarterly Jobcentre Plus Customer Representative Group Forum;

• local liaison between Jobcentre Plus District External Relations teams and third sector organisations. As part of this activity External Relations Teams were asked to liaise with Primary Care Trusts, local authorities and relevant disability charities; and

• a series of communications products for external stakeholders, developed with input from key stakeholder groups, hosted on the Department’s Adviser website. ⁴

WORK CAPABILITY ASSESSMENT

48. The Work Capability Assessment (WCA) was introduced in October 2008 to assess entitlement to Employment and Support Allowance.

49. The WCA is based on the principle that a health condition or disability should not automatically be regarded as a barrier to work, that there is a large body of evidence which shows that work is good for physical and mental well-being and can be beneficial for individuals with health conditions and disabilities, and that being out of work can contribute to poorer health and other negative outcomes.

50. The WCA is an independent functional assessment which focuses on the overall effects of a condition or impairment on the individual. This is different from assessments by GPs or other healthcare professionals where the emphasis is on specific diagnosis and condition management, and the healthcare professional takes an advocate role for their patient. Thus as an independent assessment the WCA can help better determine an individual's readiness for work. Other supporting evidence is considered alongside the WCA, where appropriate, to get the fullest picture.

51. To determine how an individual is affected by their condition or impairment, the WCA looks at a range of different activities related to physical, mental, cognitive and intellectual functions. It also assesses certain additional criteria that do not directly measure function (such as terminal illness) to determine capability for work.

52. The WCA also takes account of conditions that fluctuate. If a customer is unable to complete an activity repeatedly, reliably and safely, then they are considered unable to complete it at all.

⁴ http://www.dwp.gov.uk/adviser/updates/ib-reassessing-claims
Development of the WCA

53. The WCA was developed by technical experts and medical specialists, in consultation with specialist disability groups. It sought to take account of the demands of the modern workplace, developments in medicine and our understanding of disability.

54. The Welfare Reform Act 2007 legislated for the introduction of the WCA. Chapter 5, Part I, sections 8 and 9 outline the structure of the assessment, establishing that individuals will be assessed for benefit entitlement on the basis of their Limited Capability for Work (LCW), and for membership of the Support Group on the basis of Limited Capability for Work Related Activity (LCWRA).

55. Enshrined in this legislation was the need to monitor and update the assessment in the light of new experience. A number of reviews have examined the WCA and made recommendations for improvements, which are now being implemented.

The Department-led review of the WCA

56. In March 2010 the Department published an internal review of the WCA. This was undertaken with significant input from technical experts and specialist disability groups. It focused on the technical descriptors and made recommendations for improvements. These changes came into force through regulations on 28 March 2011.

57. Recognising ongoing concerns of specialist disability groups, further detailed work was undertaken. The outcome of this was published as an addendum to the report. These changes are fully reflected in the final legislation.

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

59. The Department modelled the impact of these changes using data from almost 60,000 assessments. From this analysis the number of new claimants put in the Support Group, specifically those who are awaiting or between courses of chemotherapy, and some whose limited capability relates to certain mental function and communication difficulties, is expected to increase.

60. By accounting for adaptation, the number of new claimants being found fit for work is also expected to increase by around 5%. This will affect individuals who are well-adapted to their condition and will benefit from the support available on Jobseeker’s Allowance. For
individuals with mental health and cognitive conditions a slight increase in the number in the Support Group and broadly no change to the numbers in the Work Related Activity Group are expected.

**The Harrington Review**

61. In November 2010, Professor Malcolm Harrington published his Independent Review of the Work Capability Assessment, the first of five annual Independent Reviews. The review examined the end-to-end process for the assessment, including the Atos assessment, the decision making process and the appeals process. It found the WCA is the right assessment but it is not working as well as it should. As a result he made a series of practical recommendations for improving the WCA, which the Government has committed to implementing as quickly as possible.

62. As a result, the Department is:

- empowering Jobcentre Plus decision makers to make the right decision. They are being given clear responsibility for the decisions they make and the support they need to ensure those decisions are independent and considered;
- ensuring individuals are treated with compassion by clearly explaining everything to them, helping them fully understand the process they will go through, and ensuring they know they can provide additional evidence for consideration at any time;
- improving the transparency of the face-to-face assessment by running a pilot to look at audio recording assessments; and
- accounting for the particular difficulties in assessing mental health conditions by supporting Atos to create and use mental health champions.

63. Many of the recommendations are already in place and the remainder of those that the Department is responsible for will be in place by this summer. A high level timeline for the remainder includes the following milestones:

- a review of the ESA customer journey, to include additional interventions supporting customers throughout their benefit journey. This will be tested from June 2011, prior to national rollout from October 2011; and
- the introduction of a plain English Personalised Summary Statement of a customer’s medical assessment from June 2011, copied to disallowed customers from the end of September 2011.

64. Professor Harrington has been reappointed to take forward the second annual review of the WCA, continuing the process of improvement. As part of this, he will look in more detail at the
assessment of mental health and other fluctuating conditions and provide any recommendations as appropriate.

The role of Atos Healthcare

65. Atos Healthcare provides independent medical assessments on behalf of the Department for Work and Pensions. The Departmental decision maker makes a decision on benefits entitlement using this advice as well as other equally important sources of information. The result of the assessment has no bearing on Atos Healthcare targets or remuneration.

66. Atos Healthcare is responsible for:

- recruitment and training of healthcare professionals - doctors, nurses and physiotherapists;
- managing the assessment centres;
- scheduling appointments via its contact centre;
- conducting medical assessments developed by the Department that are designed to see what people can do; they are not the same as an examination carried out by a doctor or consultant which is designed to diagnose a medical condition; and
- providing an independent medical report to decision makers in the Department.

67. An overview of the Atos Healthcare process for ESA is included at Annex C.

68. Each assessment looks at how the customer’s health condition affects their ability to do everyday tasks, so is not the same for everyone. The average time taken for an assessment is around forty five minutes, calculated from over five hundred thousand assessments completed each year.

69. The assessment is largely ‘non touch’. The physical aspects of the assessment are different from that used for diagnostic/treatment purposes and rely largely on ‘active movements’ (that is, movements carried out under the direction of, but without the physical intervention of, the assessing healthcare professional. This is as opposed to the ‘passive movement’ examination often carried out in the diagnostic setting (where the examiner will move the joints without the customer having to do anything). The level of the physical assessment is determined by the claimed medical conditions i.e. asthma (a peak flow would be taken), hypertension (blood pressure would be taken).

70. During the assessment, the healthcare professional refers to a computer programme to complete the assessment and captures information given by the customer in real time. The programme, called LiMA (Logic-integrated Medical Assessment), was developed
to improve and ensure consistency and quality of the reports. It is an evidence-based computer programme that includes medical protocols and incorporates the latest clinical research on mental health, musculo-skeletal and cardio-respiratory conditions. It serves as a guide only and the healthcare professionals are required to use their own clinical judgement to justify the medical opinion contained on the medical report.

71. Atos Healthcare professionals are expected to be mindful of the fact that many illnesses produce symptoms that vary in intensity over time and are instructed not to base their opinion solely on the situation as observed at the medical assessment. Part of the training for healthcare professionals involves the effects of variable conditions on daily life. The aim is to make sure that the assessing healthcare professional provides sufficient information on the pattern of variability for the decision maker.

Training for Atos Healthcare staff

72. All doctors working for Atos Healthcare must be registered with the General Medical Council, all nurses with the Nursing and Midwifery Council and all physiotherapists with the Health Professions Council. There are about 1,400 doctors, nurses and physiotherapists working to deliver the contract.

73. All healthcare professionals must have three years broad-based clinical post-registration experience and achieve approval (post training) from the Department for Work and Pensions Chief Medical Adviser in the appropriate benefit. All doctors, nurses and physiotherapists are provided with comprehensive training in disability analysis. For the WCA this includes an eight day course for all doctors and a seventeen day course for nurses and physiotherapists, which is accredited by the University of Derby.

74. To provide consistent, high quality, independent medical assessments to the Department, Atos Healthcare has put in place:

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

- generic training - includes principles of disability analysis, professional standards (including manner & behaviour) and multi-cultural awareness;
- training to undertake benefit-specific assessments - includes learning path approach for ESA and other benefits, assessments, modular training with competency testing at each stage and approval process; and
- scrutiny / file work training - includes provision of advice to the decision maker when appropriate on the basis of available documentation within a customer’s file, theory and casework exercises followed by supported individual casework.

Following the WCA training course, healthcare professionals will complete assessments under the supervision of an experienced trainer. Only when they are deemed to have achieved competency will they progress to unsupervised assessments. Every assessment is audited until they produce four consecutive A grade reports. Once this has happened they will be referred to the Chief Medical Adviser for approval on behalf of the Secretary of State.

Atos Healthcare has a strong Continuing Medical Education programme. Healthcare professionals receive training in response to changes in legislation, changes resulting from decisions made by the Upper Tribunal, and alterations in procedure. Atos Healthcare regularly updates healthcare professionals on current best practice, often in response to issues that have been identified as causing difficulty to the decision maker or customer. The data derived from Atos Healthcare’s auditing processes is used extensively as a source of information to assist it to determine the content and priorities for the Continuing Medical Education programme.

Training in medical topics is based on up to date, critically evaluated published research and, wherever possible, is evidence-based. Different training media are employed according to circumstances. These range from formal trainer-led sessions to the issue of bulletins and guidance notes or the use of video. The trainer-led sessions are designed to promote participation by trainees by including inter-active elements and case examples. In 2010 a National Training Event was held for all employed healthcare professionals in preparation for reassessment. Expert independent speakers presented on a range of topics such as Cognitive Impairment, Chronic Pain, Fatigue and Post Traumatic Stress Disorder. All training that takes place is recorded in the individual healthcare professional’s record.

Quality monitoring

Quality monitoring is carried out by both Atos Healthcare and the Department. This includes regular audit of reports by accredited
auditors and the monitoring of complaints. Atos Healthcare aims to audit every healthcare professional every six months.

80. Management information is provided to the Department on a regular basis. If the Department has any concerns in relation to an individual healthcare professional, Atos will investigate further and subsequent action will be taken in consultation with the Department.

81. Doctors working for the Department and experienced auditors from within Atos Healthcare carry out a regular programme of joint audit in order to ensure the quality of audit at individual units is maintained.

82. If any individual healthcare professional's work is found to be deficient, he or she is contacted by a mentor. The mentor will arrange for retraining if necessary, or feedback face-to-face, by letter or telephone call depending upon the issue raised.

83. Targeted audit is used when a problem has been identified with a particular healthcare professional, as a result of random audit, a complaint, rework, or as a chance finding. It involves consideration of a number of reports by the healthcare professional to gauge the overall standard of their work. Persistent failure, despite remedial action by Atos Healthcare, to meet a satisfactory standard may result in revocation of approval to carry out medical assessments by the Department's Chief Medical Adviser.

84. Medical reports that are audited are rated with an A, B or C grade to enable appropriate feedback, mentoring and retraining as necessary. Up to 20,000 national audits were randomly undertaken in the last twelve month period. Atos Healthcare has a target to achieve 95% reports rated A or B. In the past twelve months its achievement has been consistently above 95%. Medical and Clinical Directors participate in the Atos Healthcare Clinical Governance Forum where all aspects of their clinical practice and standards are reviewed regularly.

85. The Department’s Commercial Management Team undertakes continuous monitoring of Atos Healthcare’s performance. Information is gathered from various sources including customer surveys, mystery shopping activity, and information from complaints. Other sources of information include reports which Atos Healthcare is mandated to supply to the Commercial Management Team, and various checks are undertaken to ensure that the reports are accurate. The Team also has access to staff working at the Department for Work and Pensions local offices who report issues when they arise.

**Contract and buildings**
The services are delivered from 123 permanent assessment locations and 25 casual hire sites. Of the permanent sites, 20 are directly leased by Atos Healthcare to deliver the contract and 103 are located within government buildings. The majority of these are Jobcentre Plus offices.

The majority of assessment centres are located on the ground floor. There are 31 locations that are not located on the ground floor. For these locations, prior to a customer being called to an assessment, efforts are made to identify customers who may have problems in evacuating via the stairs during an emergency. These customers are either offered an assessment at the nearest ground floor centre or a home visit. Inevitably however, some customers in this category are not identified and still attend the centre.

In four of the sites, that difficulty has been overcome by acquiring the use of a ground floor room in the building that can be used on an ad hoc basis for customers who arrive at the locations and who would not be able to safely exit the building in the event of an emergency evacuation.

Atos Healthcare is exploring a range of measures to improve service to these customers including:

- improving communications when scheduling of the appointment over the telephone;
- improving appointment documentation; and
- the use of Personal Emergency Evacuation Plans with increased on site support with a ‘buddy system’.

Customer satisfaction

Atos Healthcare uses an independent market research company to survey over 31,000 customers each year. Customers are selected at random and include those who failed to attend an assessment. Customers are informed their replies are anonymous and their identity will not be shared with Atos Healthcare. Questions asked of the customer focus on six key areas:

- scheduling of the appointment over the telephone;
- appointment letter information;
- queries made by the customer;
- how polite, helpful and knowledgeable the receptionist at the assessment centre is;
- the facilities in the assessment centre; and
- how courteous, professional, gentle and unhurried the healthcare professional is.
91. For 2010, Atos Healthcare’s overall satisfaction rating was 88.6%. The professionalism and approach of Atos’ healthcare professionals is often in excess of 90%.

92. Atos Healthcare analyses the results and comments on the surveys at an individual Assessment Centre level. It ensures that appropriate action is taken to rectify problems with accommodation, administration or staff.

93. Nationally, Atos Healthcare has instigated a number of activities to ensure levels of customer satisfaction are improved. These include additional enhanced customer service training for staff at the Virtual Contact Centre, for assessment centre receptionists and healthcare professionals.

94. As part of the implementation of the recommendations of the Harrington review, Atos Healthcare has recently launched a Customer Charter which explains to customers what to expect during an assessment and what their responsibilities are.

**Atos Healthcare complaints**

95. Atos Healthcare has a three-tier complaints process agreed with the Department. All customers are informed about how to make a complaint. All issues of dissatisfaction are investigated and following the investigation, the appropriate remedial action is always taken.

96. Complaints about the manner or approach of healthcare professionals are very low at approximately 0.14% of all assessments.

**DECISION MAKING**

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

98. The decision maker assesses this information and, following any discussion with the customer, decides whether or not the customer is entitled to ESA. The decision maker issues a decision notice informing the customer of the outcome and whether or not they are entitled to ESA. If benefit is awarded, the notice specifies the amount of benefit and the date from which it is paid, and informs customers whether they will be placed in the Work Related Activity Group or the Support Group.
The decision notice advises the customer on what they can do if they are not satisfied with the decision, and informs them of their right to appeal to an independent tribunal. The decision notice informs customers that they can ask for leaflet GL24, *If you think our decision is wrong*, which provides a detailed explanation of the decision-making and appeals process.

The decision notice invites customers to get in touch with Jobcentre Plus by telephone or in writing, within one month of the date of the letter. The customer can do any or all of the following:

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

**Improvements to decision making**

Jobcentre Plus has recently made improvements to the decision making process. Since 13 December 2010 arrangements have been made for Atos Healthcare practitioner advice to be provided to ESA decision makers. 33 Benefit Centres now benefit from a weekly on site visit by a healthcare practitioner. This enables decision makers to discuss complex cases and to raise questions relating to the WCA report before deciding a case, or if an appeal has been received, to seek advice on the issues raised by the customer as part of their appeal. The healthcare practitioners can provide advice to decision makers at other Benefit Centres that do not have someone from Atos on site.

Since September 2010 the Jobcentre Plus Director of Benefit Centres has regularly hosted a conference telephone call with decision makers to share information and views on issues relating to decision making and appeals. The call allows decision makers to hear directly about initiatives to improve quality and effectiveness. It also provides an opportunity for decision makers to ask questions and offer their thoughts and comments on decision making and appeals related topics. A recording is made available after the call to ensure all decision makers have had the opportunity to hear it. All questions and answers are published internally for future reference, to extend knowledge and spread best practice.

Jobcentre Plus has developed a new learning and development package for all decision makers. The learning focuses on equipping decision makers with the skills and knowledge required to make good quality decisions on a consistent basis.
The training emphasises the role of the decision maker in the process and, in so doing, implements one of the key findings from Professor Harrington’s review of the WCA. It builds on the lessons learnt from the Aberdeen and Burnley trials. The content centres on: understanding the Limited Capability for Work Assessment, raising awareness of the WCA descriptors, facilitated by Atos Healthcare practitioners, and gathering and using evidence effectively. It also equips decision makers with the skills for communicating their decisions by phone with customers.

The reconsideration process

If a customer is not satisfied with a decision, they can ask for an explanation and for the decision to be reconsidered. If a customer appeals this will also trigger the reconsideration process, as the Department aims to put decisions right at the earliest opportunity. A decision maker will telephone the customer to see if there is any additional evidence the customer wishes to be taken into account, re-examine the original decision in the light of the customer’s representations or additional evidence, and decide if the decision should be changed; legally this is known as a revision. If the decision is changed, the customer has the right of appeal against the new decision. If an appealed decision is revised in favour of the customer, the appeal will lapse and action is discontinued.

Improvements to the reconsideration process for ESA

Her Majesty’s Courts and Tribunals Service is an executive agency of the Ministry of Justice and its responsibilities include administration of the First-tier Tribunal. The Department and the Ministry of Justice have been working together to improve the appeals handling process, including the reconsideration stage. During 2009-2010 there were three joint Lean exercises to review the end-to-end appeals process, including one between Jobcentre Plus and the former Tribunals Service that focussed on ESA appeals.

Jobcentre Plus conducted a pilot at Wrexham following the joint Lean exercises with the Tribunals Service on the appeals process for ESA and Income Support. Following this, Jobcentre Plus implemented a new approach to have one person conducting both the reconsideration and preparation of the appeal response on an individual case, which has reduced the need for two people to look at a case in detail. This was fully rolled out nationally for all benefits by 1 Lean is the application of a set of behaviours and techniques to improve the Department’s benefit administration. By using Lean ways of working and a set of techniques to make the most of staff knowledge and experience, Lean reduces waste, engages staff and improves efficiency.
November 2010. The new approach also involves direct telephone contact with ESA customers, to explain how the decision has been arrived at and to identify any other information that may be relevant to the decision. This telephone contact has been built into the incapacity benefits reassessment process.

An exercise was also carried out to apply this more robust reconsideration process to over 55,000 appeals that had already been sent to the Tribunals Service, but not yet heard. This took the form of seven teams of decision makers deployed on Tribunals Service premises carrying out a systematic review of live appeals and revising decisions if appropriate. Ultimately the objective of the exercise was to prevent appellants needlessly attending Tribunal hearings. The work was completed at the end of March 2011 and saw approximately 7,000 decisions revised, removing the associated appeals from the Tribunals Service workload.

APPEALS

Customers are informed of their appeal rights by the decision notice, which explains what needs to be done and within what time. However, the Department encourages customers to seek explanations for decisions before appealing. Where a customer feels that the decision is wrong, the Department will look at it again, so that any favourable change can be made as soon as possible. Where the Department does not change the decision, the customer has the right of appeal.

The Department produces an appeal response that gives a full explanation of how the decision was reached, including copies of all the evidence used to reach the decision. The response sets out the relevant law, case law, evidence and argument in support of the decision under appeal and stands alone as the Department’s case. The appeal response is copied to the customer at the same time as the case is referred to the Her Majesty’s Courts and Tribunals Service, well in advance of the hearing.

The First-tier Tribunals are administered by the Ministry of Justice’s Her Majesty’s Courts and Tribunals Service, and are independent of the Department. An appeal can be decided at an oral hearing or the customer can ask the Tribunal to make a decision on the papers only. The Tribunal will consider the appeal and the evidence submitted by the customer and the Secretary of State, as well as taking oral evidence at a hearing. The Tribunal will then consider the evidence and issue its decision. Both the customer and the Secretary of State

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6 For reassessment, the reassessment site will do the reconsideration, whilst the appeals work will be prepared in the benefit centre that will maintain the case after it has been reassessed.
have the right of appeal, with permission, on a point of law only, to
the Upper Tribunal. Further rights of appeal lie with the higher
appellate courts.

Support for customers during the appeal process

113. The Department publishes leaflet GL24 If you think our decision is
wrong which contains the form that can be used to make an appeal.
The leaflet explains how the appeals process works and provides
advice on the type of organisations who may provide free assistance
in preparing for a tribunal hearing. This information is also available
on the Directgov website, together with links to the website for Her
Majesty’s Courts and Tribunals Service.

114. On receipt of the appeal response, Her Majesty’s Courts and
Tribunals Service assumes responsibility for handling the appeal and
providing support for the appellant. They will contact the appellant
and provide further information about the hearing.

115. The Department sends a Presenting Officer to a hearing if the appeal
is complex or where directed to attend by the Tribunal. If the
Presenting Officer attends, he or she will make points in favour of the
customer where appropriate, as part of their role.

Time taken for the appeal process

116. There is currently no single system that records the average length of
time taken for appeals to be processed from initial lodgement at the
Department until receipt at Her Majesty’s Courts and Tribunals
Service and final clearance of the appeal. Information is only held on
those cases which proceed to the Tribunal. Therefore, customers
who abandon their appeal, fail to provide evidence or withdraw their
original appeal, are not recorded. Her Majesty’s Courts and Tribunals
Service data indicates that for ESA, on average, it takes 9.2 weeks
between an appeal being notified to the Department and submission
of papers to the Tribunal.

117. Her Majesty’s Courts and Tribunals Service records all appeals
received within the Social Security and Child Support (SSCS)
jurisdiction of the First-tier Tribunal and has a published performance
indicator which measures the percentage of appeals where the final
outcome is promulgated within sixteen weeks of receipt at SSCS.\footnote{The latest statistical information on SSCS appeals can be found at:
SSCS Statistical notice for April 2010 to February 2011 -
Quarterly Tribunals Statistics (latest quarter is for October to December of
the period between April 2010 and the end of February 2011 the SSCS performance stood at 47%, against a target of 75%. SSCS also records the average time taken to clear or dispose of a case and as at February 2011, this average stood at 21.8 weeks.

118. In the financial year to February 2011 the combined total of Employment Support Allowance and Incapacity Benefit (ESA/IB) cases accounted for 55% of the SSCS intake of appeals. Sizeable monthly increases have been evident since June 2009 when the monthly intake stood at 10,200 appeals. Since that time the number of appeals has generally continued to increase until August 2010, reaching a peak of 23,600 appeals for that month. Since then receipts have gone down each month until December 2010. There was a slight increase in the following two months and in February there were 18,500 ESA/IB appeals received.

119. Both the Department and the Ministry of Justice recognise the importance of reducing the time taken to process appeals which has been mainly caused by the introduction of ESA which resulted in a large number of appeals being received above original forecasts. As a result, tribunals capacity was not then in place. In 2009-2010 receipts exceeded the original autumn 2008 forecast by 82,000. For the period 1 April 2010 to 28 February 2011 receipts exceeded the original 2008 forecast by 107,000.

120. The Ministry of Justice and the Department are working together to manage the increase as part of a Task Force with Her Majesty’s Courts and Tribunals Service, Jobcentre Plus and the Pensions, Disability and Carers Service. The Task Force is working on two broad fronts. The first is to reduce the high level of appeals arising from initial decision making. The second is to increase capacity within Her Majesty’s Courts and Tribunals Service.

121. As discussed above, Jobcentre Plus is focussing its efforts on improving the quality of decision making and the reconsideration process so that cases do not unnecessarily proceed to a hearing. Her Majesty’s Courts and Tribunals Service has been concentrating on increasing its capacity through the recruitment of additional staff, judiciary and medical Tribunal Members, as well as a range of judicial and business process improvements. As a consequence Her Majesty’s Courts and Tribunals Service will, by the end of the 2010-2011 business year, have cleared a third more social security cases than in 2009-2010, and 50% more than it did in 2008-2009. It is also significant that ESA/IB disposals have generally increased month on month since June 2009, reaching the highest level of 20,100 appeals in the month of February 2011 and at three times in the last four months: November 2010, January 2011 and February 2011, the
number of disposals has outstripped receipts. In December 2010 receipts outstripped disposals by 8 appeals.

THE OUTCOME OF THE REASSESSMENT PROCESS

122. The Department published interim results from the reassessment trial on 1 April 2011. These show that, as of the 22 March, 1,626 decisions on whether a customer’s claim qualifies for conversion to Employment and Support Allowance had been made. Of these:

- 526 individuals (32%) were not entitled to Employment and Support Allowance;
- 484 individuals (30%) were placed in the Support Group; and
- 616 individuals (38%) were placed in the Work Related Activity Group.

123. Further results from the trial are being received and the Department will update the findings in due course. The Department commissioned the independent research company, IFF Research Ltd, to carry out research into the trial reassessment and the results from this research will be published in mid-May. This should provide insights into the impact of the process and the final decision on claimants.

124. The trial has run from October 2010 and the results are still coming through. Information on claimants destinations is particularly thin because it is presently too early in the process. For ESA claims the Department does not get reliable information about destinations until a few months after the decision.

The impact of the decision to time limit contribution based ESA

125. On the 20th October, the Chancellor set out the intention to introduce a time limit of one year for those claiming contributory ESA who are placed in the WRAG. This proposal will not apply to people in the support group and income-related ESA will continue to be available for the poorest. The change requires primary legislation and is included in the Welfare Reform Bill which is currently being considered in Parliament.

126. As with other contributory ESA claims, those people who have undergone the reassessment process will be affected by the time limiting proposals if they have been allocated to the WRAG. Subject to Parliamentary approval, the proposals are:

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

• those who are in receipt of incapacity benefits and are reassessed and qualify for contributory ESA after April 2012 will also receive 12 months benefit from the point of conversion.

127. No one will receive less than 12 months contributory ESA, and those who were reassessed early in the process will receive more than a years benefit entitlement by the time the change comes into effect. Introducing a time limit of a year from the individual date of conversion will ensure that reassessment cases are treated in the same way as new ESA claims.

Back to work Support for customers moving onto ESA

128. The vast majority of ESA customers who want the more intensive support offered by the Work Programme will be able to access it as soon as they are placed in the WRAG or Support Group. Additionally, where a healthcare professional assesses that a return to work in 6 months or less is likely, the customer will be required to access the Work Programme if they receive income-related ESA. This will place these customers in the best possible position to return to work once they are well enough to do so.

129. Contributory ESA customers will be able to volunteer for the Work Programme, and if they wish, remain on the Programme after their benefit has come to an end.

130. Most ESA customers in the WRAG who do not access the Work Programme will be expected to prepare for a return to work with support from Jobcentre Plus. Those with greater disability related barriers to work may be referred to Work Choice, if mainstream support is not appropriate for them. Work Choice helps people with more severe disabilities or complex needs to prepare for work and to undertake supported employment, with the aim of progressing into unsupported employment where possible.

131. Disabled people will also have access to Residential Training College provision, which can provide intensive support and training, in particular for people with sensory impairments or very complex barriers to work. Where a disabled person moves into work, Access to Work can provide funds for support over and above that which an employer could reasonably be expected to provide.

132. Subject to the passage of secondary legislation, from June 2011 advisers will be able to require customers in the ESA WRAG, with some exceptions, to undertake work related activity to prepare for a return to work.
**Back to work support for customers claiming JSA**

133. Most people who make a claim for Jobseeker’s Allowance are able to move off benefit relatively quickly. This reflects in part that the labour market is dynamic, with thousands of new job opportunities coming up every day, so that people who are actively looking for a job have a good chance of finding one. However, the Department recognises that former incapacity benefits claimants who choose to claim JSA may need extra support to find work compared to a typical claimant, particularly at a time when unemployment remains high following the recession.

134. Therefore, customers who move from incapacity benefits on to JSA will be able to access the Work Programme from 3 months into their claim, recognising the additional challenges that may be faced by jobseekers that have been away from the labour market for a long time. They will receive personalised support from Jobcentre Plus before their Work Programme referral.

135. Customers on JSA must actively seek work and be available for work. However, the requirement may be tailored to individual circumstances. For example, an adviser may agree with a customer that he or she can limit his or her availability for work to a certain number of hours, in light of a health condition or caring responsibilities.

**The Work Programme offer**

136. For customers entering the Work Programme, the Government is clear that providers are best placed to know what works for customers and as such the Government will not specify what providers should deliver. This means that the exact nature of the support provided will vary from provider to provider, and from customer to customer.

137. However, all bidders for Work Programme contracts have been asked to provide a summary in their tender of the minimum service they will offer to all customer groups. These promised service levels will be made public so that customers and their representatives will be able to judge whether providers are delivering what they have promised.

138. All customers will be attached to the Work Programme for two years, or until the provider has received all the sustainment payments that they are able to, as a result of the customer spending a sustained period in work. During this period the customer will remain attached to the programme whether they are in work or not, incentivising providers to help customers stay in, as well as find, work.
The Jobcentre Plus offer

139. Jobcentre Plus managers and advisers will have more flexibility to judge which interventions will help individual customers. Advisers will be able to refer customers to a flexible menu of activities for additional support, to complement one-to-one support from an adviser. The specific options will depend on local circumstances but are likely to include services such as job brokering, Next Steps skills training, Work Clubs, support for those seeking to move into self employment, and Service Academies. They will also be able to refer customers to external services such as those provided by the voluntary sector or health service, supported by resources from a Flexible Fund where appropriate.

TIMETABLE AND SEQUENCING OF NATIONAL REASSESSMENT

140. The reassessment exercise is scheduled to be completed by April 2014. Customers receiving Incapacity Benefit and Income Support paid on the grounds of illness or disability, previously attended Personal Capability Assessments (PCA) to determine and review their entitlement for benefit. The order in which customers will be selected for reassessment will be based upon the date on which they would otherwise have been called for their next PCA. Customers currently claiming Severe Disablement Allowance will be reassessed at the end of the reassessment process.

141. The national rollout of reassessment is being undertaken in three stages:

- On the 28 February 2011, a limited introductory phase was implemented. This involved the extension of the controlled trial conditions nationwide, with around 1,000 customers commencing their reassessment journeys every week, for five weeks.
- On the 4 April 2011 national reassessment was implemented. From this date around 7,000 customers a week are being reassessed.
- On 9 May 2011 this number will be increased to around 11,000 cases per week.

142. This steady increase in activity has been designed to ensure that Jobcentre Plus and its partners are ready for and could deal with customers effectively as the volumes built. The approach also meant that the lessons learned from the trial in Aberdeen and Burnley could be shared across all centres and progress carefully monitored. Importantly, the timetable also enabled many of the findings in the recent Professor Harrington review of the Work Capability Assessment to be put into practice.
143. The Department is committed to continually monitoring and reviewing the reassessment process. Management information is reviewed at a senior level, supported by regular and close liaison between the project and operational working teams. Plans are currently on track. Further improvements will be incorporated into the reassessment process going forward as they are identified. The Department is confident that it has the capacity to deliver the reassessment exercise to the agreed timetable.

April 2011
Annex A: Summary of key facts

- No new claim will be required for reassessment of incapacity benefits, the process will be triggered by a notice to the customer.
- The date of a customer’s reassessment will be based on the review date of their Personal Capability Assessment. Customers exempt from undertaking a Personal Capability Assessment will have a review date set.
- People already over State Pension age or who reach State Pension age before April 2014 will not be reassessed.
- Where possible, the Department will use existing data held for incapacity benefits claims to determine entitlement to Employment and Support Allowance.
- The Department will help customers adapt to their new circumstances and ensure continuity of payment is maintained.
- Existing awards of incapacity benefits will continue to be paid to the day before the conversion decision takes effect, whether or not those awards qualify for conversion to Employment and Support Allowance.
- Where people who are eligible for Employment and Support Allowance receive more on existing incapacity benefits than the appropriate Employment and Support Allowance rate, their existing rate of benefit will be protected at the point of conversion.
- Where people who are eligible for Employment and Support Allowance receive less on incapacity benefits than the appropriate Employment and Support Allowance rate, their benefit will immediately be increased to the Employment and Support Allowance rate on conversion.
- On conversion to contribution-based Employment and Support Allowance, all customers are liable to income tax on the rates payable, regardless of whether their previous benefit was exempt from tax.
- Contribution-based Employment and Support Allowance is a taxable income for Tax Credits purposes, so the rate of Tax Credits may be affected if the customer previously received Severe Disablement Allowance or non-taxable Incapacity Benefit.
- All claims to incapacity benefits on or after 31 January 2011 will be treated as new Employment and Support Allowance claims – there will be no link to earlier claims for incapacity benefits.
- Where a person is appealing against a decision that their award does not qualify for conversion to Employment and Support Allowance, and this decision was made on the basis that the person failed to meet the Work Capability Assessment threshold, Employment and Support Allowance will be paid, pending the outcome of the appeal, at a rate equivalent to the rate that new Employment and Support Allowance customers receive in the thirteen week assessment phase at the beginning of their claim.
- The Housing Benefit / Council Tax Benefit Regulations have been amended to ensure that the majority of customers moving onto
Employment and Support Allowance will see no reduction in their overall benefits income solely because of this change (however, some Child Dependency Allowance customers may be affected by the change).
Annex B: The Customer Journey

Reassessment of Incapacity Benefits Customer journey

1. I receive a letter informing me that changes are about to commence and advising me on the next steps
2. Someone calls me to give further information and advice, find out if I need extra help with the process
3. I receive a letter informing me of the entitlement decision and advises me of my options. If I wish to claim JSA I am transferred to someone who takes my claim details
4. Someone calls me to arrange a WCA
5. I attend the WCA with Atos
6. I receive a letter informing me of benefit disallowance and the WCA outcome
7. Someone calls to advise on ESA entitlement and next steps in the ESA regime
8. I receive a letter with my ESA award notification
9. I attend the WFI
10. Someone calls to confirm information for reconsideration
11. I receive a letter with my JSA award notification
12. The Jobcentre contacts me to arrange a WFI
13. Someone calls to arrange a WCA
14. I attend the WCA with Atos
15. I receive a letter informing me of benefit disallowance and the WCA outcome
16. Someone calls to confirm information for reconsideration
17. I receive a letter informing me of the entitlement decision and advises me of my options. If I wish to claim JSA I am transferred to someone who takes my claim details

*if customer calls they will be told appeal needs to be in writing
Annex C: Overview of the Atos Healthcare Process

- Customer referrals for ESA are either electronically registered by Jobcentre Plus staff and sent to Atos Healthcare or sent via an electronic interface (IB Reassessment customers only). A central print facility then sends a medical questionnaire to the customer along with an information leaflet.
- When Atos Healthcare receives the questionnaire, a healthcare professional will assess whether the customer is to be called for assessment or qualifies for the Support Group or WRAG based on the paper evidence alone.
- Details of customers who are to be assessed are then entered onto the workflow system, MSRS (Medical Services Referrals System). Separately dedicated Resource Management Teams will manage healthcare professional capacity to meet the volumes of customers requiring assessments.
- The customer is then contacted by staff operating out of two dedicated “Virtual” Contact Centres, situated in Cardiff and Newcastle, to agree an appointment date. A letter is sent to confirm the appointment along with an information leaflet confirming the date, providing directions to the assessment centre and additional information about the assessment.
- If the Contact Centre agent is not able to contact the customer by telephone, an appointment letter is issued to them by post.
- The requirement laid down by the Department is that under normal circumstances, customers are not asked to travel more than ninety minutes by public transport.
- A customer can request a home visit. They may need to provide medical evidence from their GP to confirm they are not able to travel to an assessment centre.
- When the customer arrives at the assessment centre, the receptionist takes their details and the healthcare professional carries out the assessment.
- The report which is produced following the assessment advises the DWP decision maker if the customer has Limited Capability for Work or Limited Capability for Work Related Activity. The decision maker uses the report to help them make the decision on benefit.
Written evidence submitted by the Careers Development Group

Executive summary

1. Welfare to work charity Careers Development Group (CDG) supports the overarching principles of the Work Capability Assessment (WCA). It welcomes the coalition government’s commitment to reassess the capability of Incapacity Benefit (IB) claimants to participate in work-related activity leading to employment.

2. CDG also welcomes the recommendations to improve the WCA made by the Independent Review of the WCA by Professor Malcolm Harrington\(^1\) and welcomes the government’s commitment to implementing its recommendations in full. In particular, we support the coalition government’s commitment to refine the WCA’s mental, cognitive and intellectual descriptors. In CDG’s experience it has been those customers with primary or secondary health conditions who have fallen under this category who have occasionally felt that the WCA has not effectively and accurately assessed their capability to work.

3. This is of particular importance to the Work Programme, as former IB claimants will be a key customer group for CDG to work with throughout contract delivery. Currently, 46\(^{\%}\) \(^{ii}\) of IB claimants in London claim IB due to mental health conditions. CDG therefore welcomes continued improvement of the WCA to ensure migrating IB customers receive effective back to work support through the Work Programme.

4. CDG is pleased the coalition government recognise the more complex employability support needs of former IB customers through the Work Programme. This enables providers to more effectively meet these needs by encouraging the use of a flexible and personalised ‘black box delivery methodology’. The more intensive and bespoke service required by former IB customers during the Work Programme has also been reflected in the payment and performance targets for this customer group.

5. However, CDG is raising the importance of ensuring there is a high level of accuracy on every individual’s WCA. This will mitigate any adverse impact on customers’ wellbeing through the ongoing WCAs that occur throughout the duration of the Work Programme for former IB claimants and Employment Support Allowance (ESA) claimants.

6. The importance of accurate and consistent results from an individual’s WCA throughout their time on the Work Programme is vital, due to the
potential impact on prime providers if individuals move between Work Programme customer groups as a result of ongoing WCAs. This also applies to the proposed changes claimant conditionality for the ESA Work Related Activity Group outlined in the Welfare Reform Bill.

7. CDG welcomes the opportunity to submit evidence to the Work and Pensions Committee in relation to the migration process and the different paths taken by the various customers.

**Overview of Careers Development Group**

8. CDG is a welfare to work charity with nearly 30 years’ experience in helping those who are unemployed find and sustain employment. Many of the people CDG supports have multiple barriers to employment including a lack of recent work experience and disabilities. CDG’s customers include those claiming IB, ESA, JSA (Jobseekers’ allowance) and individuals with health conditions. The charity provides its customers with training, work experience and the support necessary to move into and sustain employment and to achieve a better quality of life.

9. With over 350 employees, CDG currently operates from 27 centres across London, the South East and the East Midlands. In 2009/10, CDG supported 33,000 people on their journey back into work.

10. The charity provides employment programmes as both a prime contractor and subcontractor including New Deal, Flexible New Deal, Pathways to Work, Work Choice and European Social Fund contracts.

11. In April 2011, CDG received preferred bidder status as a prime contractor for the Work Programme in London East, and as part of an alliance with MAXIMUS this status was received in London West and the Berkshire, Buckinghamshire, Oxfordshire, Hampshire and the Isle of Wight contract package area. Throughout the life of these Work Programme contracts it is estimated that CDG will support approximately 100,000 customers.

**Introduction**

12. CDG is delighted to respond to this inquiry and CDG has provided evidence based on its knowledge of the Work Capability Assessment through its introduction in 2008 which has impacted on the delivery and its customers’ experience of the Pathways to Work subcontract.
13. Pathways to Work is a national programme to support individuals with mild to moderate health problems claiming IB and ESA back into sustained employment. Jobcentre Plus provides the programme in 40% of the country with the private and voluntary sector providing the programme in 60% of the country. CDG delivers Pathways to Work as a subcontractor in Sussex, and has worked with over 400 customers on the provision since delivery commenced in 2008. The contract is due to end on 27th April 2011.

14. CDG is also responding to the inquiry in its capacity as a charity and a future provider of the Work Programme.

15. Based on its experience CDG believes that it is most appropriate to respond to the following issue in this inquiry:

16. “The outcome of the migration process and the different paths taken by the various client groups: those moved to Jobseeker’s Allowance, including the support provided to find work and the impact of the labour market on employment prospects; those found fit for work who may be entitled to no further benefits; those placed in the Work Related Activity Group of the ESA, including the likely impact of the Department’s decision to time-limit contribution-based ESA to a year; and those placed in the Support Group.”

17. As a charity that seeks to help those who are unemployed to find and sustain employment, many of whom suffer from health related barriers to working, CDG believes that a refined Work Capability Assessment will ensure that it is better able to provide relevant support to progress our customers into sustainable work.

18. CDG’s experience on Pathways to Work demonstrates a number of challenges related to ongoing WCAs at regular intervals in a customer’s ESA claim, which has impacted both on our customers’ ability to secure suitable work and on our ability to provide the most appropriate support level to customers. An improved assessment will lead to customers being allocated to the most appropriate customer group on the Work Programme, consequently improving customers well being and their ability to find and sustain work.

**Impact on customers’ well being of ongoing WCAs**

19. The experiences of the charity’s Pathways to Work customers have been overall positive, with regard to the WCA. However, there are a small number of issues that could be refined, particularly regarding customers with cognitive and mental health problems.
20. Currently, customers access Pathways to Work provision if they have been allocated to the ESA Work Related Activity Group (WRAG) after their first WCA has been completed. Customers in the ESA Support Group and IB customers can volunteer to access Pathways to Work at any time.

21. Once allocated to the ESA WRAG group customers will be expected to participate in additional limited capability to work assessments - the medical evaluation part of the WCA. This includes customers participating in back to work provision such as Pathways to Work.

22. On CDG’s Pathways to Work provision, customers have sometimes experienced a lack of consistent decision making within the WCA process. ESA WRAG customers undertaking subsequent WCAs, particularly those with mental health related problems, have been deemed fit for work as a result of the follow up WCAs, despite a lack of perceived change in their health condition. In addition, some customers who have been moved into the ESA WRAG group as a result of a successful appeal have also experienced being deemed fit for work in a follow up WCA shortly after the appeal’s outcome. It is therefore imperative that the WCA process is consistent and accurate for future customers.

23. Where customers believe they have been assigned the wrong benefit this can particularly lead to significant distress and anxiety and in some circumstances can accentuate existing mental health conditions.

24. Some customers who believe an inappropriate decision has been made following WCA have decided to make an appeal. Of the charity’s Pathways to Work customers expressing concern with the outcome of their WCA, CDG has offered support to prepare for and navigate the appeals process. This has been on the basis of facilitating the achievement of an accurate and decisive outcome.

25. The appeals process places a lot of emotional strain on customers and they can spend a significant amount of time contesting the decision. The uncertainty and time consuming nature of the appeals process can be counter-productive if it reduces the amount of time and effort they spend on preparing for and looking for employment.

26. This occasional lack of consistency with the WCA combined with the stress and anxiety of undertaking an appeal can create an additional barrier to work for some of the most vulnerable customers with health problems. The implementation of the recommendations of the Harrington Report will in the long term lead to the refinement of the WCA. This in turn will lead to a more accurate assessment of an individual’s capability to
work, fewer appeals and an increased capability for customers to find and enter work.

Impact on Work Programme prime providers of ongoing WCAs

27. The Work Programme enables providers to deliver a personalised journey for each customer dependent on individual needs and CDG wholeheartedly supports this approach. Alongside employability training and back to work support, providers are able to work in partnership with a range of specialist organisations to tackle customer’s barriers to work. This can include through condition management programmes, drug and alcohol support and rehabilitation, specialist support for people with learning disabilities and mental health issues.

28. Work Programme customers will be divided into eight different customer groups dependent on benefit claimed and the level of support they require to help them return to work. There are two customer groups specifically for former IB claimants: ESA ex-IB and JSA (Jobseekers Allowance) ex-IB.

29. The payment structure for the Work Programme is dependent on the type of benefit that customers are claiming and their previous benefit status. It allows more money to be paid for customers with a greater level of need. For example, providers will be paid more to support former IB customers claiming JSA into work than JSA customers aged 18-24 due to the more complex, often health related, support needs former IB customers experience on their journey into work. The level of need is defined by their current and previous benefit type. Therefore it is of paramount importance that the WCA leads to the customer being transferred to the correct benefit at the earliest opportunity. A full overview of the levels of payment for each Work Programme customer group can be found on page 10 of the Work Programme specification document.

30. If WCA does not lead to the correct decision being made regarding a customer’s readiness for employment, prime providers may not be in the best position to provide the required level of support because of financial restrictions in the Work Programme payment structure. Customers could potentially be initially allocated to the JSA ex-IB Work Programme customer group and could then be moved into the ESA ex-IB customer group after an appeal or subsequent WCA. This could lead to providers receiving initially a lower amount of funding to support more disadvantaged customers thereby limiting the amount of support they are able to buy in from specialist support agencies across their partnership network. This could have an effect on each customer’s ability to move towards and enter employment. This is why it is vital that WCAs are accurate and consistent
throughout delivery, to ensure that customers can fully receive the right level of individualised support to enable them to move into work.

31. On CDG’s Pathways to Work contract, where customers believe they have not been allocated to the correct benefit, the charity has been required to provide considerable additional support to overcome the resultant emotional issues encountered by our customers. This is particularly the case for those with cognitive and mental health problems. This is in addition to delivering the employability and motivational support required by the Pathways to Work contract.

32. The charity envisages that a similar level of support would need to be provided in such circumstances in the Work Programme contract. In London, 46% of IB claimants receive this benefit due to mental health problems. Refinement of the WCA will lead to a more effective assessment of a IB customers’ long term work capability, however, this may not happen until Professor Harrington’s working group reports back on how to further improve the WCA for customers with mental, intellectual and cognitive problems.

33. The importance of consistency and accuracy can also be seen in the implications of the proposed changes to the claim period for contributions-based ESA customers allocated to the ESA WRAG group. Under the government’s welfare reform proposals, these customers would lose eligibility to claim the benefit after one year of unemployment. As per the previous example, this could lead to customers moving from the ESA Flow Work Programme customer group and into one of the JSA customer groups. This changes the payment received by the provider for the customer, which could potentially affect the level of support providers could offer the customer. In addition, many of the Pathways to Work customers the charity works with who have more complex health needs, for example those with Multiple Sclerosis, potentially need longer than one year to move into employment.

34. Ongoing WCAs and changes to the ESA claim period could mean that a customer’s status changes a number of times during their engagement on the Work Programme. This could cause confusion amongst providers around the payment structure and the level of support they are thus able to provide to customers. It is therefore vital that WCAs are accurate and consistent to support both providers and more importantly, customers.

35. Where customers decide to appeal a decision, previous experience through CDG’s Pathways to Work contract demonstrates further support is required to help customers manage the appeals process. In some instances, support from CDG’s team of advisors has been very extensive
and has included help to complete the appeal form, continual emotional support and advice throughout the process, ongoing liaison with Atos Healthcare, liaison with GPs and contacting tribunal telephone lines on behalf of customers. This is to facilitate the achievement of an accurate and decisive outcome. Based on our previous experience CDG envisages that a similar level of support will need to be provided to customers throughout the appeals process whilst on the Work Programme. The consistency and accuracy of WCAs are imperative to the success of the Work Programme.

Conclusion

36. CDG welcomes the government's improvements to the Work Capability Assessment as recommended in the Harrington Report. The charity anticipates that the impact of these changes, particularly for customers with mental health problems, will be positive and that the changes will go someway to address the issues faced previously by our customers particularly those who have appealed a WCA decision.

37. In addition, CDG has raised the importance of clarity regarding how the movements between Work Programme customer groups as a result of WCA decisions will impact on our customers’ abilities to find work and on the payments to prime providers. The charity is confident the coalition government will address this.

April 2011

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1 Harrington, M (2010), An Independent Review of the Work Capability Assessment
2 Office of National Statistics, IB/SDA statistics for small areas, November 2010
Written evidence submitted by RSI Action

Summary

RSI Action has a number of concerns relating to ESA, and submitted evidence to the Work and Pensions Select Committee in September 2009. Since then we have been further concerned at the WCA changes proposed by DWP, and by further experiences of working with disabled benefit claimants.

The evidence and recommendations below relate to the specific issues which the committee are investigating, and include recommendations to improve both processes within DWP and their sub-contractors, and also within the Tribunal system.

RSI Action

RSI Action is a national charity (Registered Charity No. 1114977) focused on Repetitive Strain Injury conditions (RSI), which are frequently caused by work activities, and can result in a significant degradation in the capacity for work. RSI Action is a member of the Disability Benefit Consortium.

Evidence

The Department’s communications to customers going through the assessment and whether the information, guidance and advice provided by the Department and Jobcentre Plus is effective in supporting customers through the process.

1. No specific comment on this issue, although some of the points raised in other sections may have an impact on the Department’s communication and guidance (e.g. with respect to reliability, repeatability and safety, and the details of WCA descriptors).

The Work Capability Assessment (WCA) including: the assessment criteria; the service provided by Atos staff; the suitability of assessment centres; and customers’ overall experience of the process.

2. RSI Action and other disability charities have repeatedly asked ministers and officials to include the consideration of reliability, repeatability and safety within the wording of the WCA Regulations, and within the wording of the WCA application form (ESA50). DWP Minister Lord Freud stated in the House of Lords debate to annul the WCA Regs (SI 228 2011) on 16th March 2011: “It must be possible for all the descriptors to be completed reliably, repeatedly and safely, otherwise the individual is considered unable to complete the activity.” Although similar statements have been made by both ministers and officials from both the present government and the previous government, claimants and their advisers find that in reality this is often not the case.

3. Since the wording of most descriptors is for a single action or activity, and there is no guidance to the claimant that their ability to undertake the descriptor "reliably, repeatedly and safely" should be taken into account, claimants feel obliged to complete the WCA application form (ESA50) just considering a single action, without the consequences of pain or further disability.

4. We recommend that both the WCA Regulations and the WCA application form (ESA50) should specifically include the requirement to consider reliability, repeatability and safety when considering if the descriptors can be undertaken.
Some of the descriptors are completely absent from the WCA application form (ESA50), and others are missing important parts of the descriptor criteria. For example in the 2008 WCA regulations, scheduled 2 part 1, manual dexterity descriptor 6(a) “cannot turn a star-headed sink tap with either hand” is not included in the ESA 50. There are over 40 descriptors which are either missing completely from the ESA50, or where key aspects of the criteria are missing.

We recommend that all ESA applicants are provided with complete information on the WCA descriptors.

The decision-making process and how it could be improved to ensure that customers are confident that the outcome of their assessment is a fair and transparent reflection of their capacity for work.

DWP have no mechanism for capturing the claimants view of his/her capacity to undertake the WCA descriptors. In fact as mentioned above many of the descriptors are not included in the questions within the ESA 50 (WCA application form). DWP does record the ATOS HCP recommendation on each descriptor, and also the decision-makers (DM) view on each descriptor. Consequently lacks the ability to check for descriptors where the HCP and DM decisions are frequently at variance with the applicant, and consequently investigate if there is a systematic problem or misunderstanding caused the variance.

We recommend that DWP should record the ESA applicant’s view on capacity to undertake WCA descriptors, and to identify any systematic differences between the Atos and the applicant’s assessment.

The appeals process, including the time taken for the appeals process to be completed; and whether customers who decide to appeal the outcome of their assessment have all the necessary guidance, information and advice to support them through the process.

We have encountered tribunals where the tribunal member has assessed the ability to walk 100m by asking the applicant if he could walk to a building visible from the tribunal room. However the tribunal room was 5 floors up, there was no ground, roads, or trees visible, just parts of large high rise buildings. The applicant had no means of assessing how far away the building was, or the scale of the landscape.

We recommend that tribunal’s should only ask questions where it is reasonable to expect the applicant to have the information or knowledge to provide an accurate response.

We have found significant delays involved in ESA tribunals which appear to result from some of the procedures adopted by tribunals. In one case, the first tier tribunal heard and disallowed the ESA case in mid September 2010, but over 30 weeks later we are still awaiting the necessary paperwork from the first tier tribunal to appeal to the upper tribunal. Two-days after the hearing we received the decision notice, advising that the first step for permission to appeal was to apply to the first tier tribunal for a statement of reasons (no mention in the tribunal bundle of a record of proceedings). We immediately applied, and received statement of reasons in mid-January 2011. However it referred to 20 pages of the case bundle which neither the applicant or the representative had been provided with, which we now know to be the record of proceedings. We immediately applied for the record of proceedings, which arrived at the end of February, however it was 20 pages of handwritten manuscript most of which was illegible. We immediately asked for a typed copy, which has not yet been received. Consequently in this case, more than six months after the first tier tribunal, the applicant is still unable the submit to grounds for appeal to the upper
tribunal, furthermore the Tribunal service have not advised when they will be able to comply with our request for a legible record of proceedings, and the applicant has been denied ESA benefit since November 2009.

12 We recommend that tribunal’s should be required to make the statement of reasons, and the record of proceedings available to the claimant within 1 month of the request, and that the information provided to the claimant with the decision notice, should advise the claimant (and representative) that there are two documents they may wish to request (statement of reasons and record proceedings), so that both can be requested at the same time and both be provided within a single 1 month period. A one-month time limit would be compatible with the time limit which is allowed for the claimant to provide a case for appeal to the tribunal.

13 We understand that medical members of tribunal’s are not required by the Ministry of Justice to hold a GMC licence (although they are required to be registered by the GMC). Licensing for doctors was introduced in 2005 to ensure that doctors are up to date with their practice and knowledge, and are still suitable to continue their work as a doctor. The GMC are required to establish a system for relicensing (known as revalidation), but the responsibility of legislation determining which doctors must be licensed is delegated to primary or secondary legislation applicable to the work that the doctor is undertaking. In the case of medical members of tribunal’s, this is the responsibility of the Ministry of Justice. We understand that the Ministry of Justice has decided that medical members of tribunal’s are not required to be licensed. Whilst they will be registered, in many cases this will be a record of their academic achievements several decades earlier, and provide little if any confidence of their current medical experience and capability. Since medical members of tribunals have significant influence on determining disability benefits, it is reasonable that society and the individual claimants expect medical members to medically competence and up to date with their knowledge.

14 We recommend that medical members of tribunal’s should be required to be licensed by the GMC and therefore subject to medical revalidation.

The outcome of the migration process and the different paths taken by the various client groups: those moved to Jobseeker’s Allowance, including the support provided to find work and the impact of the labour market on employment prospects; those found fit for work who may be entitled to no further benefits; those placed in the Work Related Activity Group of the ESA, including the likely impact of the Department’s decision to time-limit contribution-based ESA to a year; and those placed in the Support Group.

15 We believe that time limiting contribution-based ESA to one year is both unfair and unnecessary. Some disabilities may be overcome, and enable some form of return to work after 12 months, but others may take much longer. Particularly where a worker has had 20 or 30 years contributing to society and the world of work, and then becomes disabled (possibly through illness or a work-related accident), it is unfair to limit his ESA to 12 months, if his incapacity is such that medically qualifies.

16 We recommend that if the provision in the Welfare Reform Bill 2011 to time-limit contribution based ESA becomes legislation, then provision should be made to monitor those cases which are time-limited, to determine the impact of this measure.

17 The DWP have no mechanism of identifying if ESA applicants who have been refused ESA benefit and found fit for work, have indeed been able to find and
Feedback from cases that have been moved from ESA to JSA should help to validate the current ESA criteria or identify corrective action.

18 We recommend that DWP monitor cases that are refused ESA and found fit for work, to either validate current ESA criteria or identify corrective action.

The time-scale for the national roll-out for the migration process, including the Department’s capacity to introduce changes identified as necessary in the Aberdeen and Burnley trials.

19 No specific comment on this issue.

Recommendations

- We recommend that both the WCA Regulations and the WCA application form (ESA50) should specifically include the requirement to consider reliability, repeatability and safety when considering if the descriptors can be undertaken.
- We recommend that all ESA applicants are provided with complete information on the WCA descriptors.
- We recommend that DWP should record the ESA applicant’s view on capacity to undertake WCA descriptors, and to identify any systematic differences between the Atos and the applicant’s assessment.
- We recommend that tribunal’s should only ask questions where it is reasonable to expect the applicant to have the information or knowledge to provide an accurate response.
- We recommend that tribunal’s should be required to make the statement of reasons, and the record of proceedings available to the claimant within 1 month of the request, and that the information provided to the claimant with the decision notice, should advise the claimant (and representative) that there are two documents they may wish to request (statement of reasons and record proceedings), so that both can be requested at the same time and both be provided within a single 1 month period. A one-month time limit would be compatible with the time limit which is allowed for the claimant to provide a case for appeal to the tribunal.
- We recommend that medical members of tribunal’s should be required to be licensed by the GMC and therefore subject to medical revalidation.
- We recommend that if the provision in the Welfare Reform Bill 2011 to time-limit contribution based ESA becomes legislation, then provision should be made to monitor those cases which are time-limited, to determine the impact of this measure.
- We recommend that DWP monitor cases that are refused ESA and found fit for work, to either validate current ESA criteria or identify corrective action.

April 2011
About Advanced Personnel Management (APM) UK

APM is a private company with representation in all Australian states and territories. APM’s UK operations commenced in October 2010. Our core business is to provide assessment, vocational rehabilitation and employment services assistance for clients with an injury, disability or health condition in order to optimise their social and economic participation in the community.

APM is the largest private sector provider of Australian Government funded Job Capacity Assessments (JCAs) and Disability Management Services (DMS). APM has more than 17 years experience working within the Workers’ Compensation, Life/Income Protection and Compulsory Third Party Motor Vehicle Insurance markets, and providing consultancy services for employers.

In 2002, with the introduction of the Australian “Better Assessment Model”, APM was awarded a National contract to provide Australian Government funded Work Capacity Assessments (WCAs.) In the period 2002-2006, APM completed more than 150,000 WCAs and also participated in the Early Intervention & Engagement Pilot (EI&E) in 2005 and the Direct Registration WCA pilot in 2006.

In 2006, APM was awarded the largest non-government provider market share of the Job Capacity Assessment contract (JCA) in all Employment Service Areas throughout Australia. APM has performed more than 450,000 Australian Government funded interview based holistic assessments (in the form of WCAs and JCAs).

APM assists more than 80,000 Australians each year in 478 locations across the country. Our service reach extends from all capital cities to some of the most remote locations in Australia. Our work with the Australian Government and private sectors has provided us with experience working with people with a diverse range of disabilities, health conditions and injury types; together with an understanding of the socioeconomic, personal, psychological and geographic challenges faced by many people in their day to day lives.

APM’s work with employers provides our consultants with a realistic understanding of the requirements of work, employer expectations and the interface between work and an individual’s everyday functioning.

APM UK have been afforded the opportunity to deliver ‘front end assessment’ to both Employment Support Allowance (ESA) and Incapacity Benefit Customers (IB) within the context of the Work Programme. We will be working alongside A4e in 5 contract package areas. These are East London, Thames Valley and Hampshire & Isle of Wight, East Midlands, Merseyside, Lancashire and Cumbria and South Yorkshire. We will be co-located within A4e office sand work with front line advisors to ensure a warm handover of customers from the assessment stage, allowing us to provide further support to A4e advisors should this be required.

Our model will see potential job seekers assessed by a qualified Allied Health Professional who will ascertain the individual barriers to employment and make recommendations on
the interventions required to progress that individual efficiently to a sustainable employment outcome. Following the assessment, a report will be produced which details:

- The recommended level of support that the customer will require to transition to employment

- The type of skills required by the Employment Service Provider (end to end job broker who will support the customer for the remainder of their journey into employment and beyond) to best meet the individual need of the customer

- The interventions that are required to assist the customer into sustainable employment, for example the critical issues that must be incorporated into an Action Plan

- The number of hours that the customer is able to participate in either employment or work related activity at the time of the assessment

- The approximate date when the customer will be ready for full time employment subject to the recommendations that have been given

The use of allied health professionals, with both a knowledge of the workplace and the customers disability, provides an informed guidance regarding how injury, illness and disability can be successfully accommodated by employers. Doctors possess the disability and medical condition knowledge whilst Allied Health Consultants with a Vocational Rehabilitation background also understand the work place requirements. Vocationally trained allied health professionals are able to successfully integrate these two aspects and provide informed guidance on vocational direction, thereby facilitating sustainable employment.
Our Response

“The Department’s communications to customers going through the assessment and whether the information, guidance and advice provided by the Department and Jobcentre Plus is effective in supporting customers through the process.”

• APM believes that the manner of DWP’s initial communication with its customers can have a lasting effect on the likeliness of an individual to move off benefits and into work. To this end, communication must be clear, concise and appropriate to the personal circumstances of the people that it is seeking to serve.

• APM strongly believes that assessors must be skilled in dealing with the multiple and complex barriers faced by people with disabilities and the multitude of medical, psychological and social elements that can form barriers to labour market entry.

“The Work Capability Assessment including: the assessment criteria; the service provided by Atos staff; the suitability of assessment centres; and customers’ overall experience of the process.”

APM considers that:

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

• The assessor could link the client to appropriate medical or prevocational services to address barriers that would have previously seen a customer exempted from participating to their capacity (e.g. poorly managed medical and psychological conditions). This would improve the transition process and reduce systematic delays.

• Allied health professional staff, with a vocational rehabilitation background, would bring both the experience of working within a client focused model of service delivery. This approach would ensure a joined up method of assessment and ultimately deliver better outcomes for the DWP and its customers.

“The decision-making process and how it could be improved to ensure that customers are confident that the outcome of their assessment is a fair and transparent reflection of their capacity for work.”

• In APM’s experience, the assessment model needs to ensure flexibility by not placing limitations on the allied health professional’s ability to exercise professional judgment.

• APM recommends that allied health professionals are provided scope in regards to their professional opinion by reducing the rigidity of prescribed phrasing, allowing allied health professionals (assessors) to exercise professional judgement and make recommendations.
• APM fully supports the need for assessors to have appropriate professional qualifications, skills and training to ensure consistent, valid and reliable assessment outcomes. APM believes this is of critical importance given the responsibility of the assessment in the determination of benefit eligibility and income and their ability to be challenged within the appeals process.

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

• APM recommends a highly functioning system to allow for appropriate access to the relevant information (subject to privacy and social security legislation) for staff across agencies. Furthermore, this system needs to allow access to historical client information to ensure appropriate follow up and referral.

“...The appeals process, including the time taken for the appeals process to be completed; and whether customers who decide to appeal the outcome of their assessment have all the necessary guidance, information and advice to support them through the process.”

• APM believes in an holistic approach to the complex issues arising from long term benefit dependency. We consider that a “one size fits all” philosophy is wholly inappropriate in this context. Furthermore, professionally accredited assessors should be able to complete an accurate assessment of an individuals benefit eligibility against the department’s criteria which is both robust and defensible. Additionally, APM believes the focus of the assessment should also be to engage with the client, and to refer those appropriate clients to an employment service provider at the time of assessment. This approach would diminish the focus on whether the client “passes or fails the assessment” and increase the focus on the assistance that will be provided for the client to participate in the workforce.

A properly functioning system of this type model would lessen the number of appeals against determinations perceived to be negative and diminish confusion amongst all stakeholders.

• The absence of a joined up system that draws assessors, medical professionals and employment experts onto a single platform will inevitably cause delays and appeals. This could be due to systematic failings as much as genuine factors affecting appellants.
In Conclusion

APM understands that a robust, evidence based defensible assessment of a job seeker’s work capacity underpins the success of any government welfare to work initiative. Our nine year partnership with the Australian Government has provided us with extensive experience in assessing the impact of injury, illness, disability and health on a client’s capacity for work in hour bandwidths and determining medical impairment within the legislative framework of Australian Social Security legislation.

As active participants in the Work Programme we are committed to bringing the benefits of our expertise to the United Kingdom market. We believe that Australia’s recent history of policy development will be of much relevance to this inquiry.

April 2011
1. Introduction

1.1. The Employment Related Services Association (ERSA) is the trade body for the welfare to work industry. It has nearly 70 members, drawn from across the private, public and voluntary sectors and represents both primes and subcontractors.

1.2. Please accept this document as ERSA’s submission to the Work and Pension Committee’s inquiry into the Work Capability Assessment (WCA). Please note that ERSA’s response is not concerned with the rights or wrongs of the WCA from an ethical perspective, but concentrates on the impact of the WCA on the ability of Work Programme prime providers and subcontractors to deliver success for those referred to the programme.

2. Summary

2.1. The WCA process needs to ensure that it accurately assesses customers’ ability to work so that people who should be referred to the Support Group are not instead referred to the Work Related Activity Group (WRAG) or moved to Jobseekers Allowance which could then make them eligible for the Work Programme.

2.2. Such a scenario has a range of implications, both in terms of (a) those unable to work being referred to Work Programme providers; and (b) potential damage to individuals caused by their experience of the process and the potential impact of this on their ability to become work ready. Put simply, the Work Programme will be most effective if the right people are referred to it and if the WCA process aids the progress of individuals to work rather than hinders it.

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

3. Inappropriate referrals

2.3 A major concern is the high number of successful appeals against WCA decisions. Providers do not want to see a “revolving door” situation where people are referred to the Work Programme only to appeal and then leave. The emphasis has to be on ensuring that the WCA is right first time. There needs to be an onus on Jobcentre Plus officials using the reconsideration process effectively, thereby minimising the number of decisions going to appeal.

2.6 From a statistical point of view, both the government and Work Programme providers will want to minimise the number of individuals inappropriately referred to the Work Programme. Given that Work Programme performance will be measured in terms of numbers into jobs compared to numbers of customers referred, a high number of people winning appeals or needing to be re-referred will lead to misleading statistics.

4. Minimising harm to customers

4.1. It can be anticipated that ex-IB customers who are referred to the Work Programme will have complex needs, least of all because of their longevity outside of the labour market. For many this will be the first time they have had to look for a job in a very long time. Combined with the impact of benefit changes this could made for a distressing situation for some customers.
4.2. Professor Harrington’s finding that claimants’ interactions with both Jobcentre Plus and Atos are often impersonal, mechanistic and lack clarity is a concern. The WCA must be conducted in a way which minimises harm to customers if Work Programme providers are in a position to realistically help them back into work.

5. Interaction between the WCA processes and The Work Programme

5.1. It is important that the WCA is joined up to the mechanisms of the Work Programme. It is intended that ESA (income related) customers in the Work Related Activity Group (WRAG) will be referred to Work Programme providers, some on a mandatory and others on a voluntary basis. However, further clarity from the government is needed regarding how this referral mechanism will work in practice.

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

2.4 A further concern is that the move from one type of benefit to another (potentially lower level benefit) will not be fully understood by the individual and this will mean that the first few sessions spent by the customer with a personal adviser on the Work Programme will need to concentrate on the implications of this benefit change. Many claimants will also feel aggrieved by the decision which will create additional pressures on advisers. This will take considerable resource which may be better spent elsewhere and it is therefore important that the WCA decision and its implications are fully explained to the customer prior to this stage. Better communication from JCP might help to alleviate those frustrations before they see their Work Programme adviser.

5.3. There needs to be exploration of the merits of a re-referral mechanism from the Work Programme back to Jobcentre Plus by providers if individual assessments are felt to have been clearly faulty. ERSA recognises that this may be seen as creating a loophole allowing Work Programme providers to park difficult customers. However, this needs to be balanced with the harm that may be done to that individual if he or she does not receive an appropriate assessment. Having said that, we believe that DWP should concentrate its efforts on getting the referral right first time.

April 2011
1) My submission will centre on two issues outlined by the Committee as areas for investigation in its Inquiry: first, the service provided by ATOS to those going through the Work Capability Assessment (WCA) process; and second, the appeals process for those who do not agree with the decision by Jobcentre Plus following the WCA.

Service provided by Atos

2) The experience of both my constituents and my own office of the customer service provided by Atos has been entirely negative.

3) I contacted the Atos number provided by the DWP’s own website, to determine how long a constituent would have to wait before being dealt with. I did this after being contacted by a constituent who had waited on hold for 40 minutes before she was able to speak with a human being.

4) It took me 135 phone calls before I was put through to an automated telephone service. This is a ridiculous level of service from an organisation carrying out a public function.

5) Following this experience, I submitted a number of written Parliamentary Questions to the Secretary of State for Work and Pensions on Atos and the service it provides. The responses I received made it quite obvious to me why the service from Atos was so poor.

6) At present, Atos has only 57 full-time equivalents working in its Virtual Contact Centre, dealing with 56,056 phone calls a month. This works out at, on average, 983 cases a month per individual member of staff. If one considers the absence rate on the day I tried to get through as an average, the caseload per individual member of staff increases to 1,121 a month.

7) I brought this matter to the attention of the Secretary of State for Work and Pensions, and was advised by the Minister of State for Employment in a letter of 15 February 2011 that improvements to the service provided by Atos would be made. It is essential that this does actually happen in time for the nationwide rollout of the WCA. With 11,000 per week due to be assessed, the customer service system as present
would quite simply collapse if it carries on as at present.

**Appeals process**

8) The appeals process for the WCA has been an issue of great concern for an increasing number of my constituents.

9) Of the 43,500 people in Scotland who underwent a WCA between October 2008 and May 2010, 74% were deemed fit to work. However, 40% of these people had the decision overturned successfully on appeal. It is reasonable to suggest that this figure would be even higher were it not for the fact that a large number of those deemed fit for work do not appeal as they do not wish to go through the stress the whole process entails. It goes without saying that it is not acceptable to reduce the numbers of those on Employment and Support Allowance, and its predecessor benefits, simply by making the testing process as difficult and strenuous as possible for those involved.

10) Following a written Parliamentary Question to the Secretary of State for Justice, whose department is responsible for overseeing the Tribunal Service for ESA applicants, it was revealed that the cost of WCA appeals between 1 May and 30 September 2010 was estimated to be £22.15m. If this is taken over the whole year, the annual cost to the taxpayer of WCA related appeals is around £50m.

11) Without properly addressing the problem of wrong decisions being made by the DWP first time around, in the majority of cases on the advice of Atos, there is no possibility of this situation being improved. In fact, it will only be compounded when the current pilot project is rolled out nationwide.

12) The Atos assessment must be reformed in line with the Harrington recommendations to take greater account of an individual applicant's needs and condition. Given the wide range of illnesses and conditions that are suffered by those claiming ESA, a one-size fits all test is simply not suitable and will inevitably result in wrong decisions being made first time round and being reversed at a costly appeal stage.

13) Greater account must also be taken of the professional medical opinion of the applicant's own doctor or consultant, rather than allowing untrained DWP staff to
take decisions that they are patently not trained for. Situations can arise whereby an applicant’s condition can change. It is then for the medically untrained Jobcentre Plus Decision-Maker to determine whether this change necessitates a termination of ESA.

14) The Chief Executive of Jobcentre Plus, Darra Singh OBE, advised me in a letter that "Decision makers do not receive formal medical training...Where evidence of a change in the customer's medical condition is received, the decision maker must consider whether this change could lead to a change in the award of ESA. Where the nature of the change means that the effect of the award is not clear, advice can (emphasis added) be sought from Health Care Professionals employed by ATOS Healthcare."

15) It is little wonder, then, that so many decisions are wrongly made and almost £50m a year is spent on the appeals process for WCA.

April 2011
Written evidence submitted by Equality 2025

Thank you so much for agreeing to accept a late written submission from Equality 2025. We are very grateful for the opportunity to make a contribution to your work.

1. The intention to re-assess everyone who has been on IB to establish if they are fit to work or should move to the ESA ‘Work Related Activity’ or ‘Support’ group has, understandably, provoked a great deal of fear. If not handled in a sensitive and considerate manner, the fear engendered by the process itself may well serve to exacerbate some people’s health condition/impairment and thereby have the paradoxical effect of rendering them less fit for work.

2. We would like to raise four issues in relation to the migration process for your consideration.

Issue 1: The duration of receipt of IB and need for a holistic assessment

3. Many people have been receiving IB for many years and some are now approaching retirement age. The condition that led them to IB has therefore been exacerbated by years of inactivity.

4. There was a large influx of people to the IB roll at the time of the demise of traditional industries (e.g. coal mining). Those of us who were working in the field at the time were aware that, at this time, many people were actively encouraged to apply for IB, (at the time there was a commonly held belief that people were encouraged onto IB to reduce the numbers who were classified as ‘unemployed’). Whatever the reasons for their entry to IB, many who have been on IB for decades have received little or no treatment for their condition or vocational assistance and have long ago abandoned any hope of returning to employment. While we would welcome the provision of support to a group who have often received none, for many the accumulated barriers may make re-entry to the labour market extremely difficult, if not impossible.

5. We are concerned that decisions about the fitness for employment of those on IB will be based on the Work Capability Assessment (WCA).
Work Capability Assessment provides only a narrow assessment of their functional capabilities. It does not take into account other facets of a person’s life and circumstances that in any holistic, ‘real world’, evaluation, might significantly impact their possibilities of employment.

6. We would therefore ask that the Select Committee consider the possibility:
   - That everyone on IB be automatically transferred to the ESA ‘Work Related Activity Group’ where they would receive assistance to move towards work. Anyone wishing to be considered for the ESA ‘Support Group’ could then request an assessment for this. This would greatly decrease the enormous costs associated with the re-assessment of everyone on IB, as well as the fear engendered by the process, and ensure that people received the support to return to work that should be their due.
   - That, for the purpose of assessment of those moving from IB to ESA, the WCA be augmented/replaced by a more comprehensive social assessment of the person’s work capability that takes into account the manifold barriers of health, life and circumstances that, in the real world, influence a person’s ability to re-enter employment, what it would take to break down these barriers, and whether the necessary support/adjustments are available.

Issue 2: The quality and appropriateness of the Work Capability Assessment

7. We remain concerned about the quality of the Work Capability Assessment (WCA). Disabled people continue to fear the process and report that it does not provide an accurate evaluation of the barriers that they face in relation to work. These anecdotal reports are substantiated by the large number of decisions that are overturned at appeal (Harrington review: http://www.dwp.gov.uk/docs/wca-review-2010.pdf). If, on the basis of a more thorough review of all the available evidence, the Appeal Tribunal so often reaches a different decision then we consider that this must reflect a failure of the WCA to collect all the relevant information.

8. The review of WCA conducted by Professor Harrington identified many shortcomings in the WCA process. While it may have been possible to
implement some of the recommendations made by Professor Harrington to improve the quality and experience of the WCA, it would seem premature to embark on the large scale assessment of everyone on IB without evidence that the measures he proposed to improve the WCA have had the desired effect.

9. In his review, Professor Harrington acknowledged that there was particular concern over the WCA mental, intellectual and cognitive function descriptors and the extent to which these offer an accurate picture if, as is so often the case, the person has a fluctuating impairment. He commissioned a review of these by three major charities, (Mind, Mencap and the National Autistic Society) in conjunction with an expert scrutiny group of professionals in the area. This report was completed at the end of March 2011, but we are not aware that its recommendations have been implemented. As there are a disproportionate number of people in receipt of IB who have a primary mental health impairment, it would seem premature to use the existing WCA as the basis for migrating recipients from IB to JSA.

10. We would therefore ask that the Select Committee consider the possibility of:
   - Ensuring that all the recommendations of the Harrington review, (including the changes recommended to the mental, intellectual and cognitive descriptors), are fully implemented and their veracity evaluated prior to use of the WCA to establish the ‘fitness to work’ of those receiving IB.
   - Augmenting/replacing the WCA with a specifically designed, more holistic assessment of barriers to work (as indicated in issue 1 above).

**Issue 3: The availability of specialist disability employment support**

11. We are concerned about whether those disabled people who are considered fit for work, or placed in the ESA ‘Work Related Activity Group’ will receive the specialist support they need to help them into employment. The DWP offers a number of specialist disability employment programmes, including Work Choice, Employment Support through Remploy, Access to Work and Residential Colleges. However, the number of places within these is strictly limited. The migration of people from IB is likely to create a situation
where there may not be enough places on specialist disability employment programmes for everyone who needs their help.

12. We would therefore ask the Select Committee to consider the possibility of:
   • Requiring that everyone reassessed be offered the specialist support that they need either through one of the DWP funded disability employment programmes or through one of the numerous voluntary and charitable sector employment support providers that exist.
   • Allowing people to remain on their existing benefit unless, and until, appropriate support is available.

**Issue 4: The availability of appropriate treatment**

13. Sadly, it is too often the case that people receiving IB have not been offered the treatment that is appropriate to their condition, (as recommended by the National Institute for Health and Clinical Excellence – NICE - guidance). While this may be the case for many conditions that impose barriers to work, it is widely acknowledged to be the case for people with mental health conditions, especially the depression and anxiety experienced by the majority of those claiming IB because of mental health problems. The ‘Increasing Access to Psychological Therapies’ programmes in England were specifically introduced in order to rectify this shortfall, however they are not yet available to all and it remains the case that many people with conditions that may benefit from these interventions do not have access to them. Unless a person has been offered the treatment appropriate for their condition, including assistance in managing their condition themselves, it is not possible to accurately determine their fitness for work.

14. We would therefore ask the Select Committee to consider:
   • Requiring that the assessments used in the migration from IB to ESA explicitly consider whether a person has been offered the treatment they require for their condition as determined by NICE (and related) guidance.
   • Allowing people to remain on their existing benefit until they have been offered the appropriate treatment for their condition.

*May 2011*
Written evidence submitted by Independent Resource Centre, Clydebank

Our Organisation:
We provide welfare rights and debt/money advice to all sections of the community. We are currently overwhelmed with appeals against ESA Work Capability Assessment decisions to decline benefit payments.

Our concerns:
We will outline here our three main concerns with the ESA assessment process, each of which will be illustrated by way of a case study. We would like to point out, from the outset, that these case studies are by no means unusual, but actually represent the experiences of a disturbing proportion of our clients. Our concerns are as follows:

1. Clients’ experiences and their GPs’ medical evidence are being ignored at the WCA. Clients have to go through the ordeal of an appeal before this ‘evidence’ is taken into account. WCA’s should begin with this evidence, not ignore it until the final stage of appeal.

2. The WCA itself and the process of appeal is seriously damaging to clients’ health, particularly where the symptoms of their health condition fluctuate and they are wrongly assessed as fit for work. The case we will describe here is not the only one we have dealt with in which a client has died whilst waiting for their appeal to be heard.

3. Many of the lower scoring descriptors have been removed from the ESA WCA criteria as of 28th March 2011. We believe that this will substantially and disproportionately affect those with complex/multiple illnesses, and those with an accumulation of what would individually be considered to be ‘minor’ illnesses but cumulatively have a substantial impact on daily life and ability to work. We are seeing that this particularly affects those with complex mental health needs.

Case 1:
Mr W is a 35 year old with moved discs in his back and neck, nerve damage and inflammation. At the time of the examination he was prescribed an array of strong pain killers and wrist splints and was undergoing a series of tests by a specialist, including MRI scans. After attending his medical and failing to score any points at all, he appealed. He was concerned that the medical examiner had not actually carried out any physical tests on him, using only his brief description of his day to day activities as ‘evidence’ that he was fully mobile and capable of work. Mr W was also confused as to why his current medical treatment, medical tests and the fact that he lost his last job due to his ill health were not taken into account.
The WCA report described disturbed sleep, inability to dress and cripling pain but found that Mr W did not satisfy the criteria for physical disability because he “stands in the shower for a few minutes”, “was able to sit in a chair with a back for 28 minutes”, “stood independently for 1 minute without difficulty” and “walked 20 meters normally”. The examiner found that “although a typical day suggests a high level of limited activity, this was not evident from observations. This indicates that the client does not have a severe disability”.

At his appeal tribunal, Mr W was awarded 54 points, for difficulty with walking (6), standing (6), bending (6), reaching (15), moving objects (9) and manual dexterity (9). The tribunal judge stated in his decision letter: “In light of what this claimant has described, and the findings actually made, this tribunal finds it difficult to understand how the HCP could have awarded no points at all”.

The details of the medical treatment that Mr W was receiving at the time should have been enough for the assessor to find him incapable of work. Mr W’s descriptions of his daily life, both on the application form and in the WCA should have been more than sufficient. Instead, the medical assessment that he underwent at the hands of Atos Healthcare was inappropriate, unnecessary, unprofessional and damaging.

Case 2:
Mr C was a 59 year old who suffered from severe anxiety and depression, as well as an eating disorder, all of which began when he was made redundant some years earlier. He also suffered from nerve damage, which affected his mobility. At his medical examination he described severe mobility problems, including regular falls, problems with washing, housework and eating, severe problems sleeping, poor concentration and visual hallucinations.

The examiner found him to have no physical disability because he “was able to sit on a chair with a back for 31 minutes”, “stood independently for 1 minute” and “walked 15 meters normally”. The examiner considered his nerve damage to be “mild” as he had not seen a specialist for this condition, only his GP, and that his mental health condition was “moderate”, as he was “pleasant and co-operative” at the examination.

In the 5 months between his medical assessment and his appeal hearing, Mr C died. He may have seemed, during the examiner’s brief meeting with him, to be able to cope with social interaction, self maintenance and his difficulties with mobility, but the examiner took no heed of the variability of either his mental health or physical condition. Mr C was far from fit for work and we feel that this stressful process contributed to his declining health and eventual death.
**Case 3:**
Ms M is a 52 year old experiencing poor mental health, including depression, tearfulness, anxiety, poor concentration and severe difficulty with social interaction, all of which stemmed from her childhood experiences of abuse. She had been prescribed pain killers and anti-depressants at the time of her examination but described continuing emotional distress, including an inability to bring herself to wash and dress on some days and a lack of motivation to do housework, as well as substantial panic attacks when leaving the house and suicidal thoughts.

As she did not see a specialist for her mental health problems and she was able to shop for food, alone, on a weekly basis, the examiner found that “whilst the client has some impairment of their mental function, overall they are unlikely to have significant disability” and “despite wishing to avoid people, the client will go out when she has to”. She was awarded no points at her examination, which was overturned at appeal, where she was awarded 18 points, from 3 separate descriptors.

This again raises the issue of the variability of a person’s condition, as covered in Case 2. It also raises the issue of complex and cumulative conditions. Ms M’s depression and tearfulness may have been moderate, her panic attacks and anxiety may also have moderate, but in combination they were severely prohibitive of a normal and enjoyable life and entering employment was not a viable option for her.

Ms M won her appeal under the old ESA descriptors but the amended WCA points system is proving largely unworkable in such cases. Under the new descriptors, which have substantially reduced the number of points available to those with anything less than very severe mental health conditions, Ms M would struggle to attain 12 points. This brings us to the third and final issue with this case: the medical examiner recognised that “the client will go out when she has to”, a comment which was made in reference to her weekly food shopping. Ms M had already described how these outings made her feel: anxious, frightened, panicky, tearful and, at times, suicidal. Yet, the examiner saw fit to declare her fit for work, to create more situations in which she would be confronted by these overwhelmingly unpleasant feelings. We feel that this decision and the system that encourages examiners to make such decisions every day, is thoroughly inhumane.

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