



# Replacing Employment and Support Allowance: Part 2 Consultation on a New System



Funded by  
St Joseph's Province

Stef Benstead and Emma Nock  
July 2016



## Contents

<b>Executive Summary</b>	<b>1</b>
<b>Introduction</b>	<b>3</b>
<b>Chapter One: The Assessment Process</b>	<b>4</b>
<b>Chapter Two: A New System</b>	<b>11</b>
<b>Flow-chart</b>	<b>19</b>
<b>Questions</b>	<b>20</b>
<b>References</b>	<b>22</b>



## Executive Summary

This consultation report is based on data from a survey conducted by Ekklesia from October 2015 to January 2016. It is the second of three reports that use the results from the survey to explore a new system of assessment and support for people with chronic illness and disability. The aim of these reports is to develop a new system, designed by people with chronic illness and disability, which can replace the current Employment and Support Allowance, Work Capability Assessment and Work Programme. This report proposes a new system based on the responses to the survey, and invites comment and critique from anyone with chronic illness or disability, and from individuals or organisations who support those with chronic illness or disability whether through charitable, grass-roots, caring or advisory services.

### A New System

In terms of support needed for finding work, respondents were strongly against conditionality and sanctions (67%). Sanctions can be counter-productive, as they are destabilising and damaging to long-term relationships with caseworkers (Nevile & Lohmann, 2011; Meershoek, 2012). They create barriers to work, due to the financial pressure and instability they cause, and the knock-on effects to mental and physical health (Hale, 2014).

An alternative approach to sanctions is to provide a top-up as a reward or compensation for engaging with a support worker. Some respondents suggested this in the free-text questions. This top-up would compensate claimants for the cost of the time, energy and finance put into engaging with a support worker.

It was felt that the current system was not sufficiently enabling of an attempt to try work again. Respondents said that claimants should not suffer financially should they try to work again but be unable to sustain the role. It was felt that benefits should continue while work was trialled or that the claimant should be able to return to the benefit without reassessment. Respondents considered that benefits should still be awarded when a person was volunteering, working part-time or self-employed. This would provide security and stability to claimants, increasing the likelihood of success and removing the stress associated with current attempts to work.

### A New Process

Based on the results from our respondents, it is proposed that a new assessment process should include the following features:

- Medical evidence should be provided for all individuals; this is a more efficient way to get an accurate medical opinion than having to employ medics who are not involved in the individual's care.
- The assessment should be in the format of a discussion taking place over several meetings.
- Claimants should have the opportunity to comment on the assessor's report before a decision is made.
- The assessor should also be the one who makes the decision on fitness for work.
- Reassessment need only occur for those not in regular contact with a caseworker, and should be light-touch in recognition that these are the people who are least likely to become fit for work.

## **New Criteria**

The criteria of fitness for work should be based on the following:

- The decision of capacity for work should include labour market competitiveness.
- The assessment should consider the overall capacity for work, including the need to work at a slower pace or have breaks from work, rather than focussing on isolated activities.
- The assessment should give direct consideration to the skills that the individual has and whether or not these can be used given the claimant's health condition.
- A decision of fit for work should be based upon the ability to identify jobs that that individual could perform.
- If an individual needs particular forms of support to be able to work, that individual is considered unfit for work unless and until that support is provided.
- The assessment includes consideration of the individual's labour market competitiveness.

## Introduction

This consultation document follows on from our previous report, Replacing Employment and Support Allowance: Part 1. That report focussed on what support people with chronic illness need if they are to be able to work. It recommended that the assessment of capacity for work be centred on the amount and type of support that is needed to make work possible. Where this support cannot be provided, an individual with chronic illness is to be classed as unable to work, unless and until that support is provided.

Our previous report was based on a survey of around 300 people with chronic illness. For many of our respondents, the problems they experience are those common to what are often termed fluctuating, variable or invisible conditions. These include pain, physical and cognitive fatigue, and unpredictable capacity for work. The difficulties that these cause can make standard forms of work impossible; these people need to be able to work in small amounts at random times.

It was felt that the WCA as it stands cannot capture these issues well, either from the point of view of the claimant or that of the employer. The points-based nature of the WCA means that conditions that cause diffuse effects across the majority of activities are poorly treated compared to those that cause very specific effects on particular activities. Yet this accumulation of difficulties is arguably more debilitating than scoring highly on a restricted range of activities, because it is less amenable to improvement through the use of aids and adaptations.

An adequate assessment needs to factor in the impact on the claimant's health of trying to work whilst ill, and the impact on the employer of having someone who needs frequent time off on both a regular (such as for medical appointments) and irregular (such as due to a flare-up) basis. An assessment that focussed on an individual's labour market competitiveness might better serve both chronically sick people and employers (OECD 2010).

We concluded that the government can either provide the support needed for those with chronic illness to work, and then ask such people to undertake that work; or they can reduce expenditure and allow those with chronic illness to live lives that contribute in other ways, without conditions. But the government cannot have it both ways; it cannot refuse to pay the cost of employment support and simultaneously insist that individuals with chronic illness 'prepare for' work that they will never find.

The next stage in this research is to run a consultation on a proposed new system. Using data from our previous survey, we have developed an initial proposal for a new benefit and assessment system. We are now opening this consultation to people of all impairment and illness types. We want to know whether the proposals we have developed are heading in the right direction, what needs changing, removing or fine-tuning, and what else needs to be included that hasn't yet been covered.

Chapter One presents the results from the survey we ran from October 2015-January 2016. Chapter Two presents a suggestion for a new assessment system, based on the results in Chapter One and evidence from other areas including academic literature and other countries.

The method and results of the survey can be found in the appendix to our first report (Benstead & Nock, 2016). The work was commissioned by Ekklesia and funded by St Joseph's Province.

## Chapter One: The Assessment Process

This chapter looks at responses to questions on how to assess capacity for work, including factors that should be included (both health and non-health related), who should carry out the assessment, what procedure should be followed, and what support should be offered after an assessment.

### 1.1 Process

#### 1.1.1 The Assessor

Respondents were overwhelmingly in favour of having their own GP (89% agree or strongly agree) or a medical specialist (85%) carry out the assessment. The current situation, where generalists or those specialised in other conditions carry out assessments, was very unpopular with 84% disagreeing that this was suitable. Failing this, a doctor (not a nurse or physiotherapist) was acceptable to 41% of respondents. In the free text responses, a number of respondents were concerned that the assessment should be fully independent from the DWP.

Assessments need to be carried out by an expert professional. In the WCA, assessors with less relevant qualifications have been found to give fewer points to claimants (Harrington, 2010) and a tribunal ruled that the opinion of an assessing physiotherapist has “no probative value” for a claimant’s mental health condition (Judge Mark, 2012). Neville and Lohmann similarly conclude that, “It is unrealistic to expect a registered nurse or OT to be able to make an informed assessment of a client with mental health issues” (2011).

I would only employ assessors who understand the social model of disability and impairment, who are committed to combating discrimination against disabled people, who understand the law pertaining to reasonable adjustment and who understand why employment is not pragmatically possible for many people who are ill in the current social structures the UK lives under.

However, GPs are opposed to becoming the gatekeeper for long-term sickness benefits (Hussey, et al., 2003; Wynne-Jones, et al., 2010; Engblom, et al., 2011), and DWP contracted companies have struggled to recruit assessors from medical professions including nurses and physiotherapists (Pring, 2015). GPs are concerned about maintaining a good relationship with their patients, including trust and advocacy, which may not always be compatible with acting as a gatekeeper to benefits (Mowlam & Lewis, 2005). GPs also lack the time and experience to discuss occupational health matters with their patients (Mowlam & Lewis, 2005; Waddell, et al., 2013); appointments are typically a matter of minutes, not the near hour-long assessment that sickness or disability benefit assessors carry out.

There is a conflict here between what people with chronic illness want, and what medical professionals (specifically GPs and consultants) can offer. It may be possible to reach a compromise based on using medical evidence for the initial gateway, as currently occurs during Statutory Sick Pay and the initial three months (or longer) on ESA before assessment, and then having vocationally-trained professionals such as Occupational Therapists or a mental health professional assess what support needs to be put in place before an individual can prepare for, look for or take on work.

### 1.1.2 Medical and Other Evidence

There was high support for professional evidence to be included before an assessment with 78% saying one's GP should always give evidence, and 69% wanting the professional most involved in their care to always give evidence. It may prove more efficient to ask the medic most closely involved with an individual's care to give a medical opinion, rather than employ separate medics to form an opinion on the basis of one, lengthy, meeting with the individual.

Other forms of evidence could be included if either the assessor or the claimant thought it appropriate, but it was not largely felt that these should be submitted in every case. It was strongly felt that medical evidence should be collected and read before an assessment is carried out (92%). Responses to the free text questions raised the issue of giving appropriate weight to medical reports, and that the DWP should not be permitted to dismiss any evidence submitted to them.

Some of my impairments are extremely obscure, I am scared by the idea that my neurologist who understands obscure issues can simply be dismissed by the DWP medic who won't have a clue what the impact of some of my invisible impairments are.

#### Proposal:

1. Medical evidence should be provided for all individuals; this is a more efficient way to get an accurate medical opinion than having to employ medics who are not involved in the individual's care.

### 1.1.3 Face-to-Face or Paper-Based

There was an even split between those who felt decisions should always be on paper (45%) and those who accepted a face-to-face element (44%). However, those in the Support Group were more likely to say there should be no face-to-face element (45%) whilst those not on ESA thought that having no face-to-face element would be unhelpful (46%) and a substantial proportion were unsure either way (16% overall). It may be that people in the Support Group are more ill and therefore less likely to feel a need for a face-to-face discussion to explain their difficulties with work. There were no other significant differences by age, gender or ESA status.

The assessment shouldn't be based on trick questions and spurious inferences, but be co-produced with the claimant.

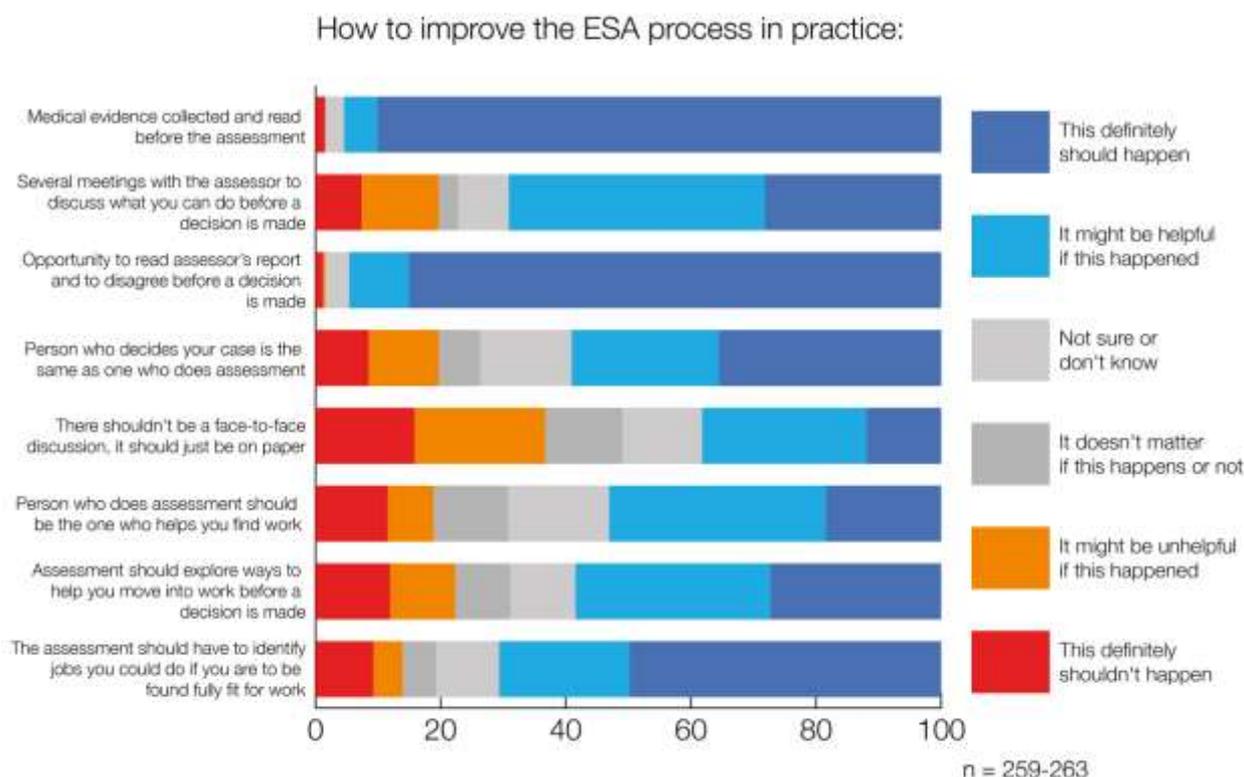
The assessment should be based on a discussion between the assessor and the claimant, in which they explore what the claimant can do, and what support would be needed to do it. A majority (55%) felt that the assessment should have to identify possible jobs before finding someone fit for work, rising to 78% when those saying this might (rather than definitely would) be helpful are included. There was also majority support for having the assessment explore ways to assist a move into work (66%). Assessors would need to have the expertise and professional ability to make these judgments without needing to rely upon a tick-box, points-based system; as with medicine, it is both an art and a science, and depends upon considerable expertise for its success (Panda, 2006).

This discussion may need to take place over several meetings, as claimants can struggle to verbalise what they can and can't do when faced with a stranger for the first time (Nevile & Lohmann, 2011; Meershoek, 2012). The majority of respondents felt that it might or definitely would be helpful if there could be several meetings with an assessor before a decision is made (75%). People in the support group were less likely to say this than were people not on ESA and who had not applied (60.5% vs 80%), perhaps because people in the Support Group are more ill so are less likely to need several meetings in order to discuss their capacity for work fully.

There was strong support for being able to comment on the assessor's report before a decision is made (86% thought this definitely should happen). Allowing claimants to comment on the report before a decision, as in Denmark (AMS, 2010), could improve the accuracy of the initial decision making, reducing the need for reconsiderations and appeals. Currently claimants have to request the report and ask for a mandatory reconsideration if they are to be able to clarify any points of contention. Accuracy may also increase if the decision maker is also the assessor as this would reduce the room for human error. 64.5% of respondents thought this might or would be helpful.

#### Proposals:

2. The assessment should be in the format of a discussion taking place over several meetings.
3. Claimants should have the opportunity to comment on the assessor's report before a decision is made.
4. The assessor should also be the one who makes the decision on fitness for work.



## 1.2 Groups

In terms of a requirement to look for work, there was some approval of having a specific ESA group with tailored requirements for certain groups of people including those who could work full-time with the right support but are limited in the range of jobs they could do (56%), those who could work part-time (48%), and those who could work if they had re-training (46%). However, for each of these over 20% of our respondents thought people who fit these groups should not have any requirement to engage at all.

Women were more likely than men to say that people who can work full-time in the right situation should be in an ESA group with tailored requirements (60% vs 49%) compared to having no requirements (19% vs 34%). Younger people were also more likely than older people to choose the tailored requirements group (59% vs 53%) than the no-requirements group (18% vs 31%) for people with ability to work full-time in the situation.

The majority considered that those with a self-limiting (55%), progressive (90%) or terminal illness (93%) should not have any requirement to engage with moving towards work. No-one thought that people in the latter two groups should either be on JSA or in a general ESA group with requirement to engage (equivalent to WRAG).

Respondents wanted to either retain the current distinction between those permanently incapable of work and those ostensibly expected to recover, or wanted more categories to cover the difference between short-term sick, permanent disabilities and those with a long-term or chronic illness.

It's [job search] a huge waste of employers time and applicants time. It's only there to provide DWP with reasons to sanction people

Job search by people like me cannot be mandatory and conditional - they're just aren't that many, if any, jobs available.

I am pretty much housebound as my depression and anxiety have progressed to agoraphobia. Despite Rehab JobFit being aware of my agoraphobia they changed my phone appointments to office appointments after I made a complaint. They made no secret of the fact that they were using this as a punishment, given that it involves 1 and 1/2 hours of bus travel. After 2 years on the WP I am now much less able to work than when I began!

## 1.3 Sanctions or incentives

In terms of support needed for finding work, respondents were strongly against conditionality and sanctions (67%). At the same time, the proportion of sanctions is increasing (Low, et al., 2015). Sanctions can be counter-productive, as they are destabilising and damaging to long-term relationships with caseworkers (Neville & Lohmann, 2011; Meershoek, 2012). They create barriers to work, due to the financial

pressure and instability they cause, and the knock-on effects to mental and physical health (Hale, 2014). The risk of sanctions puts pressure on claimants to take jobs or take part in activities that are beyond their capabilities (Nevile & Lohmann, 2011). As a consequence, sanctions have negative long-term effects, by pushing people into unsuitable, temporary and low-paid work (Arni, et al., 2009; Griggs & Evans, 2010).

An additional concern at this time is the proposal for in-work conditionality under Universal Credit. What this means is that people who cannot increase their hours, due to their health condition, risk being penalised for not finding and taking on more work. UC as it stands has no adequate safeguard to protect people with chronic illness from being or feeling pressured to take on more hours, and nor does it consider how insisting on engagement with JobCentre Plus detracts from the capacity for work (Welfare Conditionality, 2016; Hale, 2016).

I certainly don't think cutting someone's money is an 'incentive'. People don't need fear as an incentive.

No-one with a health problem should be sanctioned.

An alternative approach to sanctions is to provide a top-up as a reward or compensation for engaging with a support worker. Some respondents suggested this in the free-text questions. This top-up would compensate claimants for the cost of the time, energy and finance put into engaging with a support worker.

Amongst the free text responses, there was also a broad feeling that the benefit paid should be higher, reflecting both the additional difficulties that disabled people experience in finding and retaining employment, and the longer time spent on benefit. Jobseeker's Allowance is deliberately set at a level that is adequate for only short-term living, and is therefore too low for anyone out-of-work for more than two or three months.

It was felt that the current system was not sufficiently enabling of an attempt to try work again. Respondents said that claimants should not suffer financially should they try to work again but be unable to sustain the role. It was felt that benefits should continue while work was trialed or that the claimant should be able to return to the benefit without reassessment. Respondents considered that benefits should still be awarded when a person was volunteering, working part-time or self-employed. This would provide security and stability to claimants, increasing the likelihood of success and removing the stress associated with current attempts to work.

In particular, permitting individuals to engage in voluntary work without penalty may be an efficient and effective way to assist those with chronic illness to contribute to society. Currently, voluntary work may not be permitted, may trigger a re-assessment as fit for work, or may result in a sanction because it clashes with other unpaid activity. However, voluntary work may be a more productive and beneficial use of time than attending workshops on basic skills such as CV writing or interview technique or carrying out unpaid entry-level work for private companies. The government may therefore wish to encourage and support participation in voluntary work as an acceptable return for benefits.

One thing that bugs me is that ESA is supposedly about limited capacity for work but is spoken about as if it's about not being able to work. I think that society should openly and fully recognise that some people are so disabled that it's unreasonable to demand that they should work, only reasonable that they should be encouraged to work.

**Proposals:**

5. Sanctions and conditionality are detrimental to health, well-being and financial security. They should not be used for people with chronic illness. Instead, a system of top-ups (above a liveable base-level benefit) could be acceptable to compensate individuals for engagement in activity.
6. The basic rate of benefit should be set at a level that is adequate for long-term living including social participation in society.
7. Voluntary work should be encouraged as a valuable contribution to society and as an acceptable activity for people with chronic illness who claim sickness benefits.

### 1.4 Reassessment

It was felt that certain conditions should not require an assessment or should lead to a permanent award with no reassessments. Permanent awards were felt to be most appropriate for progressive or terminal conditions, permanent disabilities and those with profound and multiple learning difficulties.

Reassessment should aim “not so much to withdraw benefit payments as to identify people who should (again) be offered training, rehabilitation or re-employment schemes” (OECD, 2003). Instead of having fixed period reassessments, a reassessment could be triggered by significant changes in the claimant’s life, or by the claimant or caseworker considering that health has improved. If a claimant is in regular contact with a caseworker, the two can decide together when a move onto Jobseeker’s Allowance is appropriate. If a claimant is not in regular contact with a caseworker, this should be because the claimant is in a stable position in terms of health and (in)ability to work. In these situations, offers of support should occur periodically, and this may include a light-touch reassessment.

**Proposal:**

8. Reassessment need only occur for those not in regular contact with a caseworker, and should be light-touch in recognition that these are the people who are least likely to become fit for work.

### 1.5 Universal Credit

Universal credit may provide a better framework for increasing hours in work at a gradual rate; however, this assumes that employers are able to take someone on at a small number of hours and provide the opportunity to gradually increase these. Such a scheme may not be possible for many employers. It may be more feasible for voluntary work, if the government would accept this as a route towards work without impacting on benefits. This was suggested by several respondents, with an emphasis on being able to re-train, try part-time work or self-employment, or engage in voluntary work without losing benefits.

Where respondents discussed UC in their free-text responses, they either rejected it completely or wanted sickness and disability benefits to be separate. In particular, as mentioned above, it is vital that people with chronic illness or disability are not pressured to take on extra work that they cannot do, and additionally do not lose out on time they could otherwise put into work or social participation due to being required to attend JobCentre Plus sessions (Welfare Conditionality, 2016; Hale, 2016).

## Chapter 2: A New System

The Work Capability Assessment and Employment Support Allowance have failed to deliver a system that accurately assesses an individual's capacity for work. The consequence of this is that individuals are not assigned to a benefit that provides an adequate level of income, income stability and support for moving towards work.

We welcome the increase in the proportion of new claimants now entering the Support Group, and the increased use of regulations 29 and 35, which provide for situations where work or activity risk making an individual's health worse. However, we are concerned that such regulations are necessary and believe that a suitable assessment system would not depend on such alternative criteria to correct the failings of the main criteria.

Here we present suggestions for a new assessment process, as a point from which to start our consultation. We invite comment on all of these suggestions, including parts that should be taken out and anything that should be added in.

### 2.1 Principles

A good sickness benefit would be based on valid and appropriate principles, as detailed in the previous chapters. We therefore draw attention to the following key points from our first report, numbered according to their position in that report:

1. Individuals contribute to society in a number of ways other than paid work, and the value of these contributions should be recognised.
2. A range of areas not well captured by the WCA are key to the understanding and assessment of capacity for work. These include mental health, varying or unpredictable capacity for work, and the accumulation of incapacity from multiple origins.
3. The social security system needs to protect those whose health and quality of life is at risk of being damaged by requirements to engage in work or work-related activity.
6. Capacity for work is impacted by the provision of support in areas of life outside of the individual workplace. These can include health care, personal assistance, home help, caring responsibilities, commuting and regulation of the labour market to promote more and better quality jobs.
7. People with chronic illness need a wide range of support if they are to be able to work.
8. People with chronic illness may benefit from re-training, particularly where re-training may allow the individual to use remaining health capacity better or compensate for loss of capacity in a previously trained area.
10. Employers may be reluctant to employ people with chronic illness due to founded or unfounded concerns of associated costs. Employers may need practical advice, support and/or financial assistance to make it viable for them to take on an employee where the any associated costs are uncertain.
11. There is a mismatch between what employers mean and can manage when they refer to flexible working, and what people with chronic illness mean and need when they refer to flexible working.

12. There is a difference between an individual being 'capable' of work (which could include working for small units of time at irregular intervals, spread out over a longer period), and an individual being employable or being able to find or sustain work.

And the relevant proposals from this report:

5. Sanctions and conditionality are detrimental to health, well-being and financial security. They should not be used for people with chronic illness. Instead, a system of top-ups (above a liveable base-level benefit) could be acceptable to compensate individuals for engagement in activity.

6. The basic rate of benefit should be set at a level that is adequate for long-term living including social participation in society.

7. Voluntary work should be encouraged as a valuable contribution to society and as an acceptable activity for people with chronic illness who claim sickness benefits.

### Question – underlying principles.

1. What do you think of these principles? Should any be changed or removed? Should there be other principles?

## 2.2 Assessment Process

The assessment process needs to be designed around the needs of sick and disabled people. The system proposed below has been constructed from the responses given in this survey. The relevant recommendations are given first, then the detail of the resulting system.

### 2.2.1 Proposals

1. Medical evidence should be provided for all individuals; this is a more efficient way to get an accurate medical opinion than having to employ medics who are not involved in the individual's care.

2. The assessment should be in the format of a discussion taking place over several meetings.

3. Claimants should have the opportunity to comment on the assessor's report before a decision is made.

4. The assessor should also be the one who makes the decision on fitness for work.

8. Reassessment need only occur for those not in regular contact with a caseworker, and should be light-touch in recognition that these are the people who are least likely to become fit for work.

### 5.2.2 Detail

When a person becomes unwell or disabled to the extent that she cannot carry on with her current job or, if not in employment, cannot meet the requirements of JSA, we recommend the following process:

1. The claimant goes to her GP who provides her with a medical certificate (fit note or sick note) if the GP considers that the person cannot currently work. If the person is in employment at this time and earning over the weekly threshold, she will receive Statutory Sick Pay. If the person is not in employment or earning under the threshold for SSP, she will receive sickness benefit.
2. The GP acts as a triage to further support, depending on the claimant's capacity for work and support needs, as follows:
  - 1) A claimant has a temporary condition that is expected to resolve within a time period that is normal for that condition (e.g. infection or injury). The claimant receives sickness benefits until he or she has recovered. The GP continues to sign medical certificates during the course of the illness or injury.
  - 2) A claimant is in work and has a health condition that may not resolve, or has a permanent impairment/condition\* and the claimant may be able to do some work with the right support. The GP refers the claimant to a professional, such as an occupational therapist, who can assess the support the claimant needs and liaise with the claimant's employer to get the necessary in-work adjustments. The employer is legally obliged to provide the in-work adjustments, and the government must provide necessary outside-of-work support such as health, personal and household care.
  - 3) A claimant is NOT in work and has a health condition that may not resolve, or has a permanent impairment/condition,\* and the claimant may be able to do some work with the right support. The GP refers the claimant to a professional who can assess what capacity for work remains and what support is needed in order to work. E.g. autism spectrum disorders, learning difficulties, sensory impairment, or limb loss/loss of use of limb.
  - 4) A claimant has a permanent, severe disability and is unlikely to be able to do some work, or it would clearly be unreasonable to expect a return to work. This includes people with terminal conditions and progressive conditions. The claimant receives sickness benefits with no further action. The GP periodically confirms that the work-limiting disability is still present. The claimant is offered a referral to an advocate who can assist the claimant to get necessary support for all areas of life, including healthcare, personal assistance, home help and support for social participation.

\* E.g. autism spectrum disorders, learning difficulties, sensory impairments, or limb loss/loss of use of limbs.

### Question – a triage system

2. What do you think of the GP-and-triage system proposed here?
  - a) Who should have an initial role in signing someone off as too sick or disabled for work?
  - b) Should there be a triage system for further assessment as proposed here, or should the initial assessment be the only assessment? How would this fit with concerns from GPs that they are not the right people to be carrying out long-term assessments?
  - c) If there is a triage system, how should it work? Would the four suggestions work?

The remaining section applies to claimants who are referred for an assessment of work capability and support needs.

3. The professional to whom the claimant is referred has the responsibility of assessing what the claimant can and can't do, and what might be possible with support. The professional (here called a claimant advocate, to better fit the job title to its role) gathers information on the claimant's capacity for work and support needs, and arranges for any necessary support to be put in place.

The claimant advocate receives medical evidence from the claimant's GP as part of the referral process. The claimant may also submit evidence from any other healthcare or social care professional identified by the claimant as able to provide useful information on the claimant's capacity for work.

The claimant advocate meets with the claimant three times in the three months after the referral from the GP. The claimant advocate will discuss with the claimant why and how she currently struggles to work, what job roles might be possible, and what support would be needed to undertake any possible job roles.

4. At the end of three months, the claimant is assigned to a benefit group depending upon her circumstances and capacity for work. The claimant advocate discusses her findings and preliminary decision with the claimant before a final decision is made.
5. Claimants may move fluidly between sickness benefit groups depending on circumstances. The government may also wish to consider how to make it smoother for claimants on JSA who develop temporary or chronic illness to move onto sickness benefit. It might be that the claimant instigates this by obtaining a medical certificate from their GP, whilst a claimant advocate can also at his own discretion move a claimant onto sickness benefit.

### Questions – the assessment process (based on survey responses)

What do you think of the following suggestions for an assessment process:

3. What do you think of the proposals for what evidence is included?

- a) Should evidence be automatically collected from some professionals, and if so who?
- b) Who should be responsible for collecting evidence – the claimant, claimant advocate or DWP?

4. What do you think of the suggestion that there should be more than one meeting to discuss support needs?

- a) Would this be helpful? How many should there be?

5. What do you think of the suggestions for the decision making process?

- a) Should the decision maker be the person who made the assessment (the claimant advocate)?
- b) Should the claimant advocate discuss the preliminary decision with the claimant before the final decision is made?

## 2.3 Assessment Criteria and Outcomes

### 2.3.1 Assessment criteria

4. The decision of capacity for work should include labour market competitiveness.
5. The assessment should consider the overall capacity for work, including the need to work at a slower pace or have breaks from work, rather than focussing on isolated activities.
9. The assessment should give direct consideration to the skills that the individual has and whether or not these can be used given the claimant's health condition.
13. A decision of fit for work should be based upon the ability to identify jobs that that individual could perform.
14. If an individual needs particular forms of support to be able to work, that individual is considered unfit for work unless and until that support is provided.

#### Question – criteria

6. What do you think of these criteria?
- a) How easily could these criteria be used to make consistent, fair and accurate decisions?
  - b) Would these criteria be both sensitive (correctly identifies people who can't work or who struggle to work) and specific (doesn't identify people who can work as unable to work)?

### 2.3.2 Assessment outcomes

There are five possible outcomes for the claimant, depending on the assessed capacity for work and support needs. Apart from the distinction between Jobseeker's Allowance and sickness benefit, the outcome has little significance for the claimant. Instead it serves as an indicator of what the claimant can be expected to be able to achieve and what level of support is needed to achieve it. Claimants can move fluidly between sickness benefit groups, depending on circumstances.

- 1) If the claimant advocate can identify at least three different job roles/types that the claimant could do full-time (or part-time if the claimant is also a lone parent) and without any additional support, then the claimant is transferred to Jobseeker's Allowance. The claimant can appeal this decision. A claimant may move to JSA at any time from sickness benefit, for example if a temporary illness or disability has resolved, upon evidence from the claimant advocate that the claimant can now undertake any one of at least three different job roles, full-time (or part-time if the claimant is also a lone parent) and without support.
- 2) If the claimant advocate can identify at least three different job roles that the claimant could do full-time (37.5 hours a week) if given appropriate support then the claimant enters the 'work capacity – full-time' group. The government must provide all necessary support up-front before the claimant can apply for or accept any job offers. The support could include, but is not limited to:

- i. personal care assistance (as provided through social care)
- ii. household assistance (e.g. cooking, cleaning, laundry, shopping. This is similar to, but extends beyond the current scope of, PIP)
- iii. assistance to travel to work (as provided through Access to Work, but with less stringent requirements – for example, not expecting claimants to travel as far on public transport)
- iv. assistance in the work-place (including physical adaptations, technological support and support workers. Again this is similar to, but more generous in scope than, Access to Work).

The claimant advocate is additionally responsible for job-brokering. Even with appropriate support, people with chronic illness and disability may find they are not offered work because employers have concerns regarding productivity and the costs of managing a person with illness or disability. The claimant advocate must be able to liaise with employers to alleviate unfounded fears, and to assure the employer of the support (funded by the government) that the claimant will bring with them. The government is responsible for providing protection for the employer against relevant costs, such as paid disability leave during flare-ups or for medical appointments. Without this support, the claimant is not competing for jobs on an equal footing with healthy and able-bodied job applicants, and consequently it is unreasonable to expect these claimants to receive job offers without support from the claimant advocate and the government.

- 3) If the claimant advocate can identify at least three different job roles that the claimant could do part-time if given appropriate support then the claimant enters the 'work capacity – part-time' group. Part-time refers to people capable of between 16 and 37.5 hours of work a week.

The government must provide all necessary support up-front before the claimant can apply for or accept any job offers, as detailed above. The case-worker is also responsible for directly seeking and negotiating jobs for the claimant with local employers. Additionally, upon the receipt of a part-time job the government must pay a top-up wage or benefit to the claimant to compensate for the reduced hours that the claimant can work.

- 4) If the claimant cannot work now but is likely to be able to work in the future, she enters the 'work capacity – recovery and rehabilitation' group. This would include people who have a temporary condition (e.g., a broken limb; non-terminal cancer; short-term infections), those who would benefit from medical rehabilitation (e.g. to learn to manage a recent limb loss or paralysis; or to learn to manage a chronic illness), and those who would significantly benefit from training or vocational rehabilitation (e.g. because a previous job role is no longer possible due to the nature of the illness or condition, and the claimant has not got necessary experience or skills for a job role that would otherwise be possible).

In this group, the claimant advocate focusses on assisting the claimant to manage her condition well, with an emphasis on allowing and providing time and space for recovery. Support is provided for the claimant at home (as in social care and PIP, but extending beyond these benefits as explained above). The claimant is supported to engage in social activities, voluntary work and training without being expected to consider jobs or job offers. Where a training course has direct

applicability to job roles, the government will pay for claimants in this group to take part in such a course. The claimant cannot be asked to take up a job during a training course, even if the claimant recovers during the course, as such a requirement would put people off starting beneficial courses.

- 5) Where a claimant cannot work even part-time and is unlikely to become able to work in the near future, either through recovery or rehabilitation, she enters the 'work capacity – long-term' group. In this group the claimant is not expected to meet with a claimant advocate to explore options for moving into or towards work. Claimant

### Questions – groups

7. What do you think of these different groups?

- a) Is the principle of having different groups correct and appropriate?
- b) Do the different suggested groups cover most health conditions and situations, or have some been left out?
- c) Are the suggested groups ambiguous or over-lapping?
- d) What do you think the relative sizes of these groups might be? For example, when ESA was developed it was expected that fewer claimants would be placed into the Support Group than into the Work-Related Activity Group – at the current time, more claimants are placed into the Support Group.

8. What are the potential risks for deadweight (claimants being given help when they would have returned to work without it) compared to prolonging worklessness by not providing support soon enough? How can both risks be appropriately managed?

The sickness benefit group does not alter the amount of benefit the claimant receives, but provides an indication to the claimant and the claimant advocate of what can be expected from the claimant. We recommend that the basic rate of sickness benefit is adequate not just for long-term subsistence but additionally provides sufficient income for social participation. Claimants then receive a top-up incentive for engaging with a claimant advocate; this also compensates claimants for the time, energy and money invested in engaging with a support system. Claimants in the long-term group receive this top-up automatically without any engagement.

Claimants can move fluidly between all the sickness benefit groups. These are not strict groups, but merely provide an indicator to the claimant and the claimant advocate of what capacity the claimant has for work at that time, and what type of support is likely to be most beneficial at that time. Claimants can move to other groups if they become appropriate or if further discussions and trials of work or work support show they are necessary. For example:

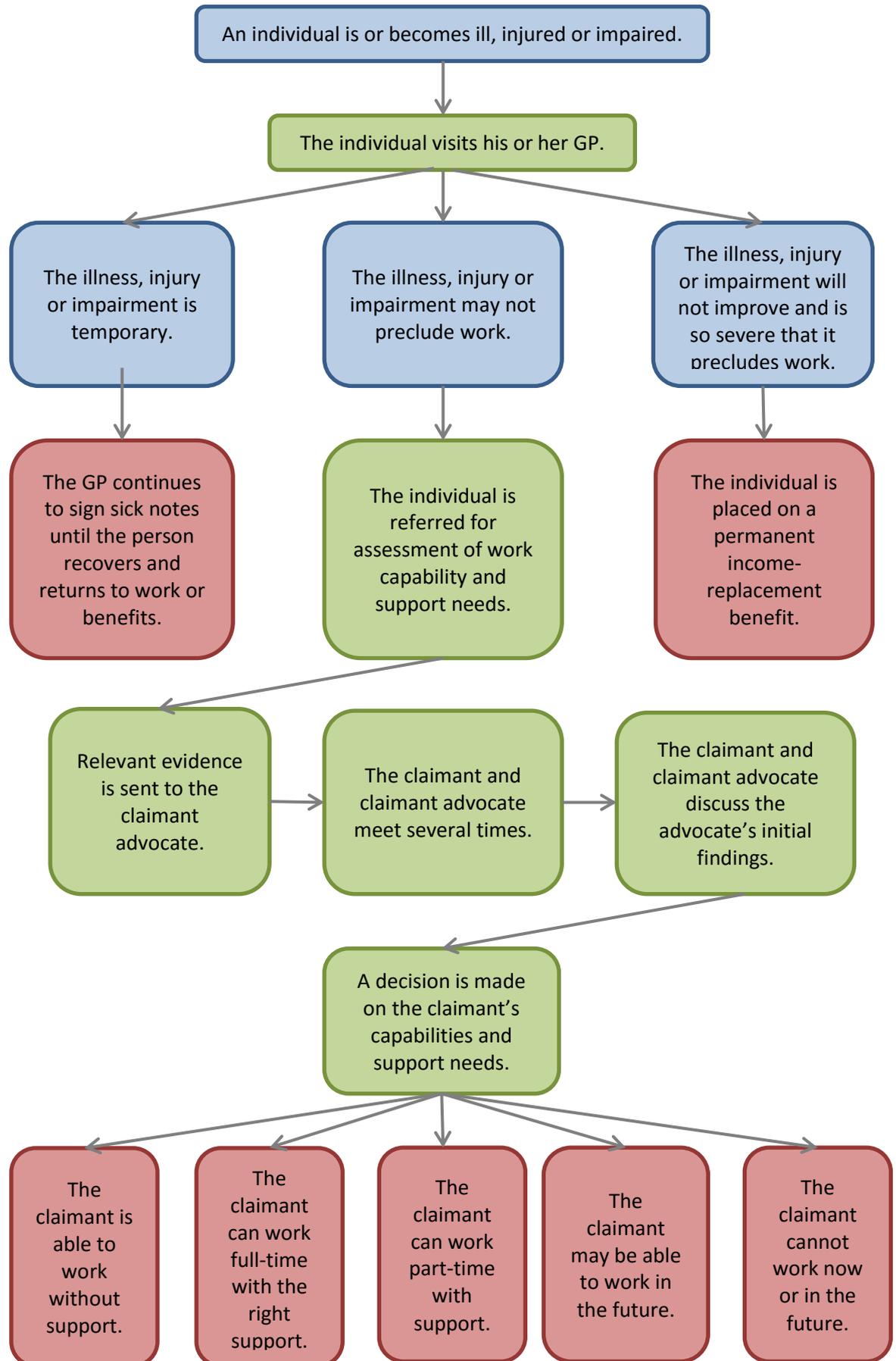
- 1) A claimant may start with capacity for full-time work but experience a deterioration or change in home circumstances that means full-time work is no longer possible. The claimant therefore is now assisted to look for part-time work only.
- 2) A claimant may be considered to have capacity for full-time work, but discussions with employers, repeated job rejections or difficulty finding appropriate jobs

shows that it would be beneficial for the claimant to undertake training for a specific job role. The claimant is supported to undertake this training and is not asked to look for or take-up any jobs during this time.

- 3) A claimant is undergoing chemotherapy for cancer. The claimant is allowed to fully recover from the cancer and the chemotherapy before looking for work. The claimant may need some assistance to find work due to the time spent out of work whilst undergoing and recovering from chemotherapy.
- 4) A claimant is considered likely to benefit from rehabilitation. Rehabilitation measures unfortunately prove unsuccessful, and the claimant is moved into the long-term group.

**Question – final comments and suggestions**

9. Do you have any other concerns, comments or suggestions?



## Consultation Questions

### **Question – underlying principles.**

1. What do you think of these principles? Should any be changed or removed? Should there be other principles?

### **Questions – a triage system**

2. What do you think of the GP-and-triage system proposed here?

- a) Who should have an initial role in signing someone off as too sick or disabled for work?
- b) Should there be a triage system for further assessment as proposed here, or should the initial assessment be the only assessment? How would this fit with concerns from GPs that they are not the right people to be carrying out long-term assessments?
- c) If there is a triage system, how should it work? Would the four suggestions work?

### **Questions – the assessment process (based on survey responses)**

What do you think of the following suggestions for an assessment process:

3. What do you think of the proposals for what evidence is included?

- a) Should evidence be automatically collected from some professionals, and if so who?
- b) Who should be responsible for collecting evidence – the claimant, claimant advocate or DWP?

4. What do you think of the suggestion that there should be more than one meeting to discuss support needs?

- a) Would this be helpful? How many should there be?

5. What do you think of the suggestions for the decision making process?

- a) Should the decision maker be the person who made the assessment (the claimant advocate)?
- b) Should the claimant advocate discuss the preliminary decision with the claimant before the final decision is made?

**Question - criteria**

6. What do you think of these criteria?
- a) How easily could these criteria be used to make consistent, fair and accurate decisions?
  - b) Would these criteria be both sensitive (correctly identifies people who can't work or who struggle to work) and specific (doesn't identify people who can work as unable to work)?

**Questions – groups**

7. What do you think of these different groups
- a) Is the principle of having different groups correct and appropriate?
  - b) Do the different suggested groups cover most health conditions and situations, or have some been left out?
  - c) Are the suggested groups ambiguous or over-lapping?
  - d) What do you think the relative sizes of these groups might be? For example, when ESA was developed it was expected that fewer claimants would be placed into the Support Group than into the Work-Related Activity Group – at the current time, more claimants are placed into the Support Group.
8. What are the potential risks for deadweight (claimants being given help when they would have returned to work without it) compared to prolonging worklessness by not providing support soon enough? How can both risks be appropriately managed?

**Question – final comments and suggestions**

9. Do you have any other concerns, comments or suggestions?

## References

Benstead, S. and Nock, E., 2016 *Replacing Employment and Support Allowance – Part One: Support needs of people with chronic illness*. Ekklesia

Hale, C., 2014. *Fulfilling potential? ESA and the fate of the Work-Related Activity Group*. Mind.

Hale, C., 2016. *The impact of Universal Credit on people with ME/CFS*. Action for ME.

Harrington, M., 2010. *An Independent Review of the Work Capability Assessment*.

Meershoek, A., 2012. Controlling access to sick leave programmes: practices of physicians in the Netherlands. *Social Policy and Administration*, 46(5), pp. 544-561.

Nevile, A. & Lohmann, R., 2011. *"It is like they just don't trust us:" Balancing trust and control in the provision of disability employment services*, Canberra: Social Policy Action Research Centre.

Welfare Conditionality, 2016. *Written evidence from the Welfare Conditionality: Sanctions, Support and Behaviour Change project*, York: University of York.