

What the doctor ordered?

CAB evidence on medical assessments for incapacity and disability benefits

Summary

The welfare reform green paper¹ places new importance on the role of decision-making in the awarding of incapacity benefits, for people who cannot work because of illness or disability. Medical assessments form the basis for decisions about entitlement to incapacity benefits. They are also used to decide eligibility for disability benefits paid to help meet care or mobility needs. The welfare reform green paper proposes to transform the gateway to benefit, by reforming incapacity benefit, revising the assessment process, and by rolling out the more pro-active and work-focussed *Pathways to Work* programme.

Citizens Advice Bureaux have long been aware of flaws in the process and quality of medical assessments and the decisions based upon them. Far too often, incorrect decision-making causes substantial drops in income whilst clients have to go through an arduous and lengthy appeals process.

Over half a million medical examinations for incapacity and disability benefits were carried out last year. However, the current system of medical assessments and decision-making is not working satisfactorily for claimants or the Department for Work and Pensions (DWP). Far too many original decisions to refuse or withdraw benefits are incorrect, and the reconsideration process is not working effectively. Too many cases go to appeal and success rates are very high – almost 60 per cent – for both disability living allowance (DLA) and incapacity benefits at oral appeal hearings; around 70 per cent when clients are represented by advisers.² People with mental health problems appear to be especially likely to suffer from low quality assessments.

A quantum leap in the quality of medical assessment and decision-making is needed for welfare reform objectives to be realised, so that:

- applicants could be spared distress and hardship when they are wrongly denied benefits to which they are entitled
- the DWP would save resources devoted to unnecessary reconsiderations and appeals
- the Appeals Service would have fewer appeals to deal with
- advice agencies would spend less time helping clients challenge poor decisions.

¹ DWP (2006) A new deal for welfare: empowering people to work

² DWP Quarterly statistics for the Appeals Service, June 2005

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Key points

- The Citizens Advice service assists large numbers of people who have been refused incapacity and disability benefits, or have had these benefits withdrawn. Our evidence suggests that the quality of the current system of medical assessments and the quality of decision-making is not acceptable, and that there is great scope to improve the experience of these clients. This briefing recommends a number of ways to achieve this.
- Too often evidence from the Atos Origin doctor is preferred over other evidence supplied by practitioners who are more familiar with the applicant's condition. Better use could be made of evidence from applicants, the people providing them with health and social care, and the applicants' carers.
- The administration and quality of medical assessments by Atos Origin still needs to be improved. CAB clients lose benefits immediately if they miss an assessment, even though they often have good cause.
- We continue to receive complaints about the conduct of medical examinations. Jobcentre Plus, the Disability and Carers Service (DCS) and Atos Origin should establish a task force with stakeholder organisations to improve the way medical examinations for incapacity and disability benefits are conducted and decisions are made.
- Procedures for stopping incapacity benefits should be improved to ensure that claimants receive adequate notice of the withdrawal of their benefits and constructive help from Jobcentre Plus to deal with the situation.
- The Personal Capability Assessment (PCA) does not assess mental health conditions adequately. A full review of descriptors and processes in the PCA should be carried out by DWP, with the involvement of advice service organisations and other stakeholders. More information should be provided to people undergoing the PCA.
- DWP should focus more strongly on providing a better service to people with mental health problems and improving the assessment of people with mental health problems. DWP should appoint a mental health champion.
- Systems used to complete assessment reports are inflexible and generate standard responses. The use and development of computer-aided decision-making in medical assessments for incapacity benefit should be subject to a transparent review involving stakeholders including Citizens Advice. This should be done before a similar system is introduced for examinations for disability benefits.
- We welcome the review of the decision-making and appeals processes for incapacity benefits announced in the welfare reform green paper. A similar review is needed of disability benefits. Both should be conducted openly and involve all stakeholders.
- Many CAB clients find that disability benefit awards are made for relatively short periods, and come up for renewal quickly and a long way in advance. The Disability and Carers Service should review their practices on the length of disability benefit awards, renewal procedures and the extent to which they need to use medical examinations by Atos Origin.

Disability and incapacity benefits

People with health problems or disabilities may qualify for a complex range of financial help, including benefits aimed at replacing earnings, helping meet the extra costs of disability, and means-tested help.

Incapacity benefits

Under the current system, employed people are entitled to statutory sick pay (SSP) after they have been unfit for work for more than three days, up until 28 weeks of incapacity. After that, they can claim incapacity benefit (IB), administered by Jobcentre Plus, at the short-term higher rate (currently £68.20 a week). People who are self-employed or not employed can only claim IB once they have been ill for three days, at the short-term lower rate of £57.65 a week. After a year of incapacity, IB increases to the long-term rate of £76.45 a week. There are age additions to the long-term rate for people whose incapacity began before age 45. In some circumstances, an IB recipient can receive an increase for an adult dependent.

People who are medically incapable of work, but do not have enough national insurance contributions to qualify for IB, can get income support (IS) if they pass the means test. This generally provides a lower income than IB, starting at £56.20 a week for people over 25. People whose incapacity benefits are stopped following a Personal Capability Assessment can either claim jobseeker's allowance (JSA) of £56.20 a week, or, if they decide to appeal against the decision, can receive income support at a reduced rate of £45 a week.

The number of working age people claiming incapacity benefits rose steadily over the period from the late 1970s. It reached a plateau at 2.83 million between November 2002 and February 2004, and has since fallen back to 2.72 million (August 2005), representing 7.4 per cent of the working age population. The number of people receiving contributory IB or severe disablement allowance has been falling since 1997 and currently stands at 1.81 million.³ The number of people who are incapable of work but do

not have enough national insurance contributions to qualify for IB continues to grow. In May 2005, there were 976,000 people in this position. They receive national insurance credits, and many of them are dependent on income support for their income.

The welfare reform green paper announced major changes to the system of incapacity benefits from 2008. New claimants after that date will claim a new employment and support allowance (ESA). Existing IB recipients will continue under the current arrangements so that people on the old benefits will outnumber those on ESA for a number of years after 2008. This underlines the importance of rectifying the problems with medical assessments described in this report for **everyone on incapacity benefits**, and not just making improvements for people on ESA.

Disability living allowance

Disability living allowance (DLA), administered by the Disability and Carers Service (DCS), has two components, care and mobility, awarded at different levels, and is designed to help disabled people meet the extra costs of their disability. It is not available to people whose disability arises after the age of 65, although existing DLA recipients continue to receive it past the age of 65.

In May 2005, 2.72 million people were receiving DLA compared with 2.19 million in May 2000. The main conditions recorded for DLA recipients are arthritis, learning difficulties, mental health difficulties, back ailments, muscle / bone / joint disease and heart disease.

Over 400,000 DLA claims are decided each year, with about half resulting in awards and half in rejections. In 2005, Atos Origin carried out 86,000 medical examinations for DLA, indicating that medicals are called for in just over 20 per cent of applications. In the year to February 2005 there were 201,000 initial awards, 11,000 made on reconsideration and 28,000 at appeal. There are substantial regional variations in the proportion of the population receiving DLA, with more than twice as many receiving the allowance in Wales as in the South East of England.⁴

³ DWP Incapacity Benefit / Severe Disablement Allowance Quarterly Statistics, May 2005

⁴ DWP Disability Living Allowance Quarterly Statistics, February and May 2005

Attendance allowance

People who develop care needs after 65 may qualify for attendance allowance (AA). There is no benefit to assist with extra mobility needs over the age of 65 (although the *Mobilise* campaign is working to change this⁵). The number of people receiving AA has been growing more slowly than for DLA, from 1.38 million in May 2000 to 1.53 million in May 2005 – an increase of 10 per cent in five years. There has been a marked increase in the proportion of people getting the higher rate and a reduction in those getting the lower rate, indicating that increasing numbers of very dependent older people are living in the community. Of all the AA recipients 66 per cent are aged over 80.⁶

The success rates for AA claims are much higher than for DLA claims, with less than a quarter being rejected. Decision makers are also much less likely to ask for medical examinations – Atos Origin conducted 6,000 medicals for AA in 2005, only about one and a half per cent of applications. The major reasons for payment of AA are arthritis, frailty, heart disease, mental health conditions and strokes.⁷

The number of new claims has remained relatively constant at about 400,000 a year. It is disappointing that there has not been a greater increase in awards of AA, since take-up rates are thought to be very low. A National Audit Office (NAO) report estimated that the take-up of attendance allowance in 1996-97 (the most recent data) was between 40 – 60 per cent.⁸ Since the NAO report, The Pension Service has said it aims to help older people to get all the benefits to which they are entitled, and announced the introduction of a 'one call, one number' telephone application process. These are welcome developments but do not yet seem to be making a large impact on the number of AA awards.

Medical assessment and decision-making

Deciding who is entitled to disability and incapacity benefits is much more difficult than

for most other benefits. Claims for jobseekers allowance, for example, may be decided on the basis of a person's income, national insurance contributions and availability for work. For DLA and AA, DWP staff must decide if the claimant has care and/or mobility needs that would qualify them for the particular benefit. For incapacity benefits, the DWP decision maker must decide if a claimant meets the tests of the Personal Capability Assessment (PCA) – designed to assess if the claimant's functional limitation is such that they should not be expected to seek work in return for benefit, or if an existing recipient continues to pass the PCA.

There are problems both with the medical assessments that are conducted and the decision-making processes which these assessments contribute to. Since 1998, medical assessments and advice for DWP have been provided under contract. Atos Origin was successful in 2005 in being re-awarded the contract for a further seven to twelve years. If the contract is extended to the full twelve years, it will be worth in excess of £850 million. In 2005 over half a million medical examinations were carried out under the contract.

Disability benefits

DWP decision makers must decide if an applicant meets the qualifying criteria for a disability or incapacity benefit. Claim forms for the disability benefits – DLA and AA – ask the claimant to provide detailed information on his/her care (and for DLA only) mobility needs, to provide a statement about their needs from someone who knows them, the name of their GP, and details of hospital and other health professionals dealing with them. The decision maker can then decide on an award on the basis of that information, or can seek further evidence from the GP, carer or other health professional, or from the applicant.

The decision maker can also make use of doctors provided under contract by Atos Origin to obtain the expert medical advice that they require when deciding a disability benefit claim. This can be in the form of consideration of the papers or an examination of the claimant.

5 www.disabilityalliance.org/aamob

6 DWP Attendance Allowance Quarterly Statistics, May 2005

7 *ibid.*

8 NAO (2002) Tackling pensioner poverty: encouraging take-up of entitlements HC 2002-03, Session 2002-03

Most decisions on AA are made on the basis of the information provided on the claim form and less than two per cent of claimants are given a medical examination. By contrast, over 20 per cent of people claiming disability living allowance are subject to a medical assessment by a doctor working for Atos Origin, before a decision is made on their entitlement to benefit. **We recommend that the Disability and Carers Service should commission a comparative investigation into the reasons for these great differences in the use of medical examinations between DLA and AA, with a view to identifying ways to improve the quality and efficiency of the decision-making processes for both benefits.**

Incapacity benefits and the Personal Capability Assessment

Claimants initially need to submit a medical certificate from their GP. Depending on their circumstances, and whether they live in a *Pathways to Work* pilot area, in due course a claimant will become subject to the PCA. The PCA aims to assess the effects of a person's medical condition on their capacity to do any paid work in the open market, for at least 16 hours a week. People are deemed to have 'passed' the PCA if they are found incapable of work. The test can be passed in one of three ways:

- being exempt from the assessment by virtue of the severity of disablement. There are currently a number of qualifications for exemption, including receipt of the highest rate care component of DLA, terminal illness, or being registered as blind.
- satisfying the assessment by scoring sufficient points on the basis of a series of descriptors of ability to perform prescribed activities related to physical and mental health.
- being treated as satisfying the assessment because an "exceptional circumstance" (such as being likely to undergo major surgery in the next three months) applies.

When a PCA becomes due, the decision maker must decide whether the claimant is exempt from the PCA. In many cases, the decision maker will, at this stage, seek medical

advice from a medical services doctor, who may in turn seek factual information from the certifying medical practitioner (usually the claimant's own GP). The claimant may be exempted from the PCA on the basis of the response. If the decision maker thinks that an applicant or recipient of incapacity benefits may be fit for work s/he must get a PCA medical examination conducted before benefit can be refused or withdrawn.

Under the welfare reform proposals, the PCA will remain crucial in deciding who will get incapacity benefits. The scope of the medical examination will be extended to include an assessment of the claimant's ability to work in the future.

The impact of medical assessments

Citizens Advice Bureau (CAB) advisers find that decision makers almost invariably accept the findings of medical services doctors when they have carried out a PCA examination or an examination for disability benefits. They will prefer these findings to evidence from the claimant's own doctors. Evidence from bureaux shows that this leads to an unacceptable number of incorrect decisions, affecting both incapacity and disability benefit claimants. The consequences are very harsh.

People lose the benefit for which the examination was conducted. Often they also lose premiums in means tested benefits and carers lose carer's allowance. There are long waiting periods for appeals during which people are either without benefits, or have to live on 20 per cent less than the income support rate. People with mental health problems can be particularly badly affected since CAB advisers find that these clients may not be able to face the stress of an appeal, and accept an adverse decision although the adviser considers an appeal would succeed. These are typical examples of cases regularly described by Citizens Advice Bureaux:

A client lived on reduced rate income support for two years and nine months whilst waiting for an appeal to be heard.

A client with asthma and mental health problems failed an assessment and was

left to live on an income of £46 per week. The client won his appeal, but was told wrongly by Jobcentre Plus that he had to reapply for income support and incapacity benefit.

A client with multiple health problems failed an assessment and appealed. Four months later the client was still living on an income of just £20.50 per week, after reduced benefit was eroded by crisis loan repayments and hostel service charges.

A client failed an assessment and his benefit stopped. Jobcentre Plus wrongly advised that he could not claim JSA, and the client was struggling to survive on £40 per week.

A client with severe mental health problems lost benefit after an examining doctor said she “didn’t look mental”. The client had to live on £39 per week whilst awaiting an appeal set for six months hence.

Families can also be drastically affected:

A lone parent with three children had a history of self-harm and several suicide attempts as well as physical disabilities. The client’s DLA was reduced to a lower rate, after previously receiving the higher rate. The client also lost a severe disability premium from income support, and her family income fell by £102.98 a week.

A family with two children included one partner with long-term mental health difficulties and complex care needs. DLA was reduced from the higher to the middle rate, they also lost carer’s allowance, and the family income dropped by over £300 per month.

It is particularly frustrating for bureaux to have to advise people with genuine illnesses or disabilities who face repeated benefit refusals and appeals. In some cases, people with manifest needs and entitlement have given up claiming rather than face the ordeal of a further appeal or appeals.

A client with an unchanging condition failed her PCA three times yet each time

convincingly won her appeal. During each of the appeal periods, her income dropped substantially as a result of the reduction in income support and the stopping of her disability premium. Subsequently her income fell from £77.95 a week to £44.50 for a total of 90 weeks over three periods in the past five years. Her benefits were backdated each time she won her appeal, but did not compensate her for long periods of extreme hardship.

A client’s severely disabled son’s condition had worsened since she first applied for DLA on his behalf, but his award was reduced from higher to middle rate care on renewal. DWP told the client that, as her son was now nine, he needed less care than he did as an infant. She is the sole carer for her son who needs 24 hour care. The client felt completely worn down by the response, and unable to fight any more.

Problems with the Personal Capability Assessment

The PCA is a primarily a functional test based on capability to perform a range of specified activities, known as ‘descriptors’. There is a set of descriptors for physical disability and a second set for mental disability. A person’s ability to perform activities associated with the descriptors results in a numerical score which determines whether the person passes the PCA and remains entitled to incapacity benefits.

For physical disabilities, the PCA awards points on the basis of a person’s capability in fourteen areas: walking on level ground, walking up and down stairs, sitting, standing, rising from a chair, bending and kneeling, manual dexterity, lifting and handling, reaching, hearing, vision, continence, and remaining conscious without having an epileptic fit or similar seizures.

For mental disabilities, points are awarded on the basis of descriptors covering four areas: completion of tasks, daily living, coping with pressure, and interaction with other people. The 25 mental health descriptors cover

statements such as: 'cannot answer the telephone and reliably take a message', 'needs encouragement to get up and dress', 'mental problems impair ability to communicate with other people', 'overlooks or forgets the risk posed by domestic appliances or other common hazards due to poor concentration', 'does not care about his appearance and living conditions' and 'is too frightened to go out alone'.

A total score of ten or more from all the mental health factors means that a person is deemed incapable of work. This can mean that a person who would find it impossible to go to work because of agoraphobia will still be deemed capable of work by this test. The mental health descriptors are also used for people with learning disabilities and we believe that this is simply not appropriate.

The first stage in the PCA process is for the client to complete the IB50 form. This is strongly weighted towards an assessment of the effect of physical, rather than mental, disabilities. There are 10 pages of detailed questions about physical disabilities. There is then a single page headed "information about anxiety, depression and other mental health problems." Most of this page is devoted to obtaining information about how often the client receives treatment and the contact details of health service staff who provide this. A box measuring 16cm by 7cm allows the claimant to set out "any problems you have with your nerves or any other mental health condition and the type of treatment you receive. Include things like problems you have with normal day-to-day activities because of your mental health condition and problems you have dealing with other people." It seems that DWP does not expect people's mental health problems to be very extensive, or difficult to describe. It is open to decision makers not to ask people with mental health problems to complete an IB50 and instead seek information from their GP or psychiatrist, but the lack of balance in the form is a concern.

The DWP instructs doctors conducting mental health assessments for the PCA not to ask direct questions on the descriptors, as this will "invariably produce false results".⁹ Instead, they should obtain information on the client's

mental state through open questions about their everyday activities and experiences. Examples of recommended questions include:

- What do you think is wrong with you?
- How do you pass the time?
- Tell me about your social activities.
- What stops you from doing things?
- How do you think work would alter things for you?

The doctor has to build up a picture of the person's mental health from this generalised discussion. Bureaux regularly report cases in which clients feel that they have not been given the opportunity to fully explain the impact of their mental health problems to the Examining Medical Practitioner (EMP).

A CAB client had a history of anxiety and panic disorder and depression. He had problems looking after himself – such as not eating if he is alone – and could not cope with official or medical situations. He also had a back problem. The decision maker asked the EMP to seek more detail about his inability to prepare a main meal. Despite this, the EMP did not directly address these questions, or explore the client's mental health problems at all, focusing rather on his back problems.

It wasn't until after the examination that the client realised that the questions hadn't all been about his back, but he'd answered them as if they were, with no reference to his mental health problems. The client felt very pressurised by the lack of flexibility in the questioning and was not very coherent in his answers.

His claim was turned down, as was a request for reconsideration and the family are struggling to pay bills. The stress of applying for benefit and the subsequent appeal has led to a worsening of his mental health, and he feels the whole process has put him back months. He now rarely feels able to leave the house, and cannot continue with the therapeutic work he was undertaking.

Claimants do not receive a full copy of the descriptors, nor the precise tasks that they cover, or the 'points' attached to each activity. This means people do not know how their ill-health or disability, and their impact on their lives, is relevant to the assessment.

The green paper recognises the need to reform the mental health aspects of the PCA. This is welcome but does not go far enough. It is now more than eight years since the PCA was introduced in its current form. We are not aware of any research to assess whether or not it is good at accurately assessing who is and who is not capable of work. **We consider that both the physical and the mental health aspects of the PCA should be reviewed. We recommend that a full review of the PCA should be carried out by DWP. This should be done in a transparent way, with full involvement of advice service organisations and other stakeholders. This should include reviewing the content of the IB50 form and the way in which it is used with people with mental health problems.**

Medical examinations

In 2005, decision makers asked Atos Origin to carry out 480,000 PCA medical examinations, and 86,000 for DLA and 6,000 for AA.¹⁰

Assessing the impact of a person's health condition upon his or her ability to work, or mobility and care needs, is difficult and requires the exercise of considerable judgement. The Atos Origin contract requires that doctors follow standards of conduct, which include maintaining a non-adversarial manner and performing the examination in a way that avoids unnecessary discomfort.

Despite this, CAB evidence indicates that the conduct of some examinations still leaves much to be desired, causing substantial hardship and distress to benefit claimants and their families. Many clients report encountering rude or insensitive examining doctors:

A client found the doctor extremely rude and ignorant. During the examination the doctor started to lecture the client on family planning, and also made her

go into the bedroom and strip down to her underwear. The client felt extremely humiliated by the doctor.

A man was appealing against a decision to stop benefits after a PCA. He was kept waiting an hour and 20 minutes, before being told he should go home. He insisted he should be seen. The EMP spent just 15 minutes with him, and made little eye contact, concentrating instead on his computer. When the client pointed out a mistake on the form, he was told to be quiet.

A woman had been so intimidated by an EMP that she delayed three years before claiming help with mobility needs. The bureau estimated that the client had lost out on a large amount of benefit.

A client who had been in receipt of IB for three years after a mental breakdown, failed a PCA with nine points. The doctor was aggressive in tone and intimidating, demanding yes/no answers, and did not allow the client to explain their condition.

Doctors frequently appear not to give sufficient consideration to mental health problems:

A Somali torture victim with mental health problems was very dissatisfied with her medical examination. She felt that the doctor had not paid proper attention to her mental illness. She felt rushed, and thought the doctor was dismissive. The process of appeal is exacerbating her condition.

A client with severe mental health problems scored zero points in a medical. The client felt that the doctor took very little information and spent very little time on the assessment. As a result of this decision, the client's mental health deteriorated significantly.

The Atos Origin contract also specifies that doctors are required to allow the claimant sufficient time to give their relevant medical history, disability or loss of faculty. Despite this, clients report examinations that were rushed and/or incomplete:

A client who is a lone mother with multiple physical and mental health problems failed her PCA, yet she had been on incapacity benefits for the past six years. The examination was very rushed. The client also reported that the doctor told her not to reveal problems about her mental illness as this would put her children at risk of being removed by social services.

A client suffering from serious mental health problems reported that their PCA took only five minutes. The form officially recorded the length of examination as 12 minutes, yet according to the client the doctor left the room during the examination. The doctor asked only closed questions, and produced an inaccurate and inadequate report. As a result of the report, the client's mental condition deteriorated rapidly, putting him in a high suicide risk category. His IB was reinstated three days later.

Bureaux continue to report that doctors produce inaccurate reports, giving an incorrect assessment of the claimant's abilities, and reporting incorrectly what the claimant has said about their own conditions:

A client had been on DLA for 12 years. An EMP visited, and told her to stay in bed because her ankles were so swollen. The client told the EMP that she could not walk any distance because the swelling causes her to fall. In his report, the EMP stated that she had no problem walking, and her benefits were stopped. The CAB is helping her to appeal the decision.

A client suffering from visual disturbances, mental confusion and breathing problems attended her PCA. The doctor did not know what to make of her case, and only gave the client six points, but advised her to appeal as in his opinion she wasn't capable of work. The client now has to appeal.

A bureau assisted a young woman with ME to appeal a decision that she was capable of work. She lives with her parents and her mum attended the PCA

with her. She was asked what she enjoyed doing and answered that she enjoys cooking and baking. The client and her mum interpreted this as a polite question designed to settle her down for the medical and assumed she would subsequently be asked about the problems she had doing this. The EMP used the 'evidence' that she cooks to justify disagreeing with what the client had claimed in the descriptors on standing, lifting, reaching and manual dexterity. In fact, the client actually bakes and cooks with great assistance from her family – she has a chair in the kitchen and the family do the fetching and carrying, lifting, peeling and chopping, the putting in and taking out of the oven. She oversees the baking and does some of the much lighter work.

This illustrates how answers can be taken out of context. **If an EMP is going to use an answer as evidence, he should ask the client to explain in more detail how they do something. Clients who have problems will have developed strategies for coping, which they are unlikely to be able to make up on the spur of the moment.** Any evidence used by an EMP when they have clearly not explored how a client actually achieves the activity should be disregarded as potentially misleading evidence.

Clients also report feeling pressured by doctors to sign medical reports that they have not read:

A client with multiple severe health problems received a home visit for his medical assessment. The visit lasted about 45 minutes during which the doctor only asked only a few questions and appeared to be in a rush. The client attempted to provide additional information about his condition yet was told that it was unnecessary. At the end of the examination the doctor asked the client to sign the report form, the client said he needed his glasses in order to read the form first, yet the doctor encouraged the client just to sign without them. The client had high rate care DLA reduced to middle rate care.

We recommend that Jobcentre Plus, the Disability and Carers Service and Atos Origin should establish a task force with stakeholder organisations, including Citizens Advice, to bring forward recommendations on how to address these current deficiencies in medical examinations for incapacity and disability benefits.

Administration of medical assessments

The Atos Origin contract sets out standards concerning the administrative arrangements for medical examinations, including that at least seven days notice should be given for most appointments. Despite this, many bureaux report problems concerning the timing of medical assessments:

A woman applied to renew DLA, but missed her appointment because she was in hospital. She called the EMP to apologise and explain what had happened. She told the CAB adviser that the EMP was very off-hand and did not seem to understand that she needed regular spells of hospital care. The EMP said he could only visit the next day, which was not convenient for the client. The EMP said that if she did not accept this date, her application would fail. This has caused serious distress to the client and delay to her claim.

A client was expecting a visit by an EMP early in the afternoon, but he did not arrive until 8.45pm, and then was accompanied by his wife. The client was distressed by this as the timing was hugely inappropriate and personal details were discussed in front of the doctor's wife.

The contract also specifies that reasonable requests to accommodate 'special needs', including a doctor of the same sex, or for an interpreter, to be complied with. Many Citizens Advice Bureaux clients also complain that they are not allowed to be accompanied by relatives:

A woman was not given the opportunity to be examined by a woman doctor. She also felt that the assessment was too

short and that she wasn't given a fair hearing.

A CAB client was upset when she was not allowed to sit in on her son's medical assessment. He had learning disabilities and a mental age of 10-12 years. DLA was reduced and carer's allowance refused, although she is his full time carer. The client was forced to sign on as unemployed, even though she could not work.

Citizens Advice recommends that DWP and Atos Origin instruct EMPs that they should only contact benefit claimants during normal working hours to arrange to visit for a medical assessment. Medical examinations should normally only be carried out during these hours, and not in the evening or at weekends, unless the claimant specifically requests this.

Computerised decision-making

Since 2004, EMPs have used a computerised expert system to guide their questioning and record their findings during a PCA. DWP and Atos Origin say that that this helps the EMP to give the decision maker advice that is "logical, consistent with the evidence, and clearly justified".¹¹ It is hard to say whether the new system has improved the quality of PCA medicals. However, bureaux advisers have expressed concerns that:

- doctors pay more attention to the computer than the client
- the system is inflexible and gives rise to inappropriate stock phrases in reports
- options for investigation and findings are blocked off by the system inappropriately
- doctors sign off reports without checking what they say, because the phrases in the report have been generated by the system, not by the doctor.

A client reported that the computer broke during her PCA. She believed that the report was written after the examination, as it bore no resemblance to the client and failed to record anything she said about her condition. No points were awarded and she then

had to face the unnecessary stress of an appeal.

A client said that the doctor who performed her PCA appeared unable to use the computer, and many details were incorrectly recorded. The client was awarded no points, when three years ago she had been awarded more than sufficient points to qualify. Medical services revised the decision when a complaint was made.

DWP has announced¹² that it plans to work with Atos Origin to extend this computer system to examinations for disability benefits. **We recommend that DWP and Atos Origin should carry out a transparent review of the current computer-based PCA system and consult stakeholders on the findings. This should be done before a similar system is rolled out for examinations for disability benefits.**

'Failure to attend'

Failure to attend a medical examination appointment 'without good cause' can lead to the termination of person's incapacity benefit. The contract requires Atos Origin to offer a further appointment to people who do not attend their first appointment, even if the claimant has not provided any reason for their non-attendance. After a further missed appointment, Atos Origin is required to return papers to DWP with "the documented reasons for non-attendance." At this stage, a decision maker will decide whether the client had good cause to be unable to attend both appointments. If it is decided they did not have good cause, benefits will be stopped immediately.

On the face of it, these arrangements should provide some protection for the person who is genuinely unable to attend the PCA examination. In practice, bureaux see many cases where ill and disabled people have their incapacity benefits stopped for failure to attend. These cases include people with mental health problems which make it difficult for them to comply with DWP's expectations, for example because they do not open their post, cannot remember appointments or experience panic attacks.

Our evidence suggests that some decision makers fail to recognise that these problems may constitute 'good cause' for non-attendance. More safeguards are needed, perhaps similar to the safeguards in Pathways to Work areas, where claimants with mental health problems are not sanctioned for failing to attend work-focused interviews unless they have received a visit from a personal adviser to discuss the situation.

A client with severe mental illness was admitted to hospital, and missed a medical examination. Following discharge the client phoned Medical Services but was told he was too late, and could not have another appointment. The client lost his benefit.

A client failed a PCA and subsequently lost benefit, when his train was delayed on the way to an appointment. The doctor saw the client for just a few minutes, and they talked about football.

A CAB client's benefits were stopped on two separate occasions because he was unable to get to PCAs. The client's GP supported a request for a home visit, stating that his mobility was very poor. After weeks of letters back and forth, this was arranged and the client started to receive his benefits again. On the day of the home visit, it took the client three minutes to answer the door. When he got there, the doctor had gone and the client's benefits were stopped yet again.

A client received a call saying she would have to attend a medical examination. No appointment was made so the client was awaiting a letter. The client then received a decision letter suspending her benefit.

The DWP has issued new guidance to decision makers, following a recent Commissioner's Decision which considered the notice requirements that have to be fulfilled before a claimant, who has failed to attend or submit to a medical examination, can be treated as capable of work.¹³

We recommend that DWP should monitor cases in which people have had their

¹² DWP (2006) Decision Makers Guidance Memo Vol. 3, 01/06

¹³ DWP (2006) Decision Makers Guidance Memo Volume 3, 1/06; Commissioners decision CIB/2221/200515 *ibid.*

benefit stopped for failing to attend a PCA, to identify the extent to which they had good cause not to attend.

We also recommend that DWP and Atos Origin should develop, in consultation with stakeholders, a protocol to protect clients who have difficulty in complying with the arrangements for PCAs from summary withdrawal of benefits for non-attendance at a PCA.

Appeals and reconsiderations

People who think that the decision on their claim for social security benefits is incorrect can ask for the decision to be reconsidered. They can also ask for the decision to be considered by an appeal tribunal. The National Audit Office reported that 0.3 per cent of jobseekers allowance decisions and one per cent of all income support decisions in 2002-03 were taken to appeal, but six per cent of all incapacity benefit decisions and eight per cent of all disability living allowance decisions went to appeal.¹⁴

Judgements on eligibility for DLA, AA and IB are more complex than those required for JSA or IS, so a higher percentage of reconsiderations and appeals might be expected. But it is also clear that there is considerable room for improvement in the quality of initial decisions and reconsiderations for disability and incapacity benefits. The DWP's own assessment concluded that only 55 per cent of decisions on DLA and AA were correct in 2001-02.¹⁵ In the year to February 2005, 39,000 out of 240,000 DLA awards (16 per cent) were the result of reconsiderations or appeals against initial refusals. This is an unacceptably high proportion. CAB advisers spend large amounts of time helping people who have been refused these benefits, or had them withdrawn, to challenge those decisions.

When a claimant appeals, DWP automatically considers the decision again. If the refusal of benefit is confirmed, the claimant can then appeal. More than half of DLA appeals are decided in favour of the claimant, and this figure is rising.¹⁶ In the quarter ending June

2005, the success rates of claimants at oral appeal hearings were 46 per cent for AA, 57 per cent for DLA and 58 per cent for IB PCA appeals.¹⁷

One bureau carried out an analysis of 96 PCA failure cases it had dealt with in part of 2004. They found that the average PCA had taken only 25 minutes (a range of 15 to 69 minutes), even though 58 per cent included a mental health assessment. The bureau had taken 39 cases to appeal, with a success rate of 65 per cent. Thirty-four appeals were outstanding.

The President of Appeal Tribunals, Judge Michael Harris, has repeatedly drawn attention to the need for DWP agencies to improve the quality of their decision-making by learning lessons from appeal tribunals.¹⁸

An analysis found that in 25 per cent of overturned cases "the medical report underestimated the severity of the disability". Also,

"In 168 (22 per cent) [of the overturned sample] cases the tribunal took a different view of the same medical evidence and ...chairmen highlighted the value of the appellants' evidence and the over reliance of decision makers on medical reports alone...In 69 (9 per cent) overturned cases all the medical issues had not been addressed in the medical report, in 28 (4 per cent) the advice in the report was not adequately justified and in 24 (3 per cent) it was not considered that the advice in the medical decision report was consistent."

Judge Harris also noted that

"Mental health issues again caused some concern and it was felt that mental health issues were not given sufficient weight. . . . In some cases it was said that their medical examinations were not thorough enough."

This was Judge Harris's fifth report and he is clearly exasperated at the lack of improvement in the quality of DWP decision-making:

14 NAO (2004) Getting it right, putting it right: improving decision making and appeals in social security benefits

15 *ibid.*

16 *ibid.*

17 DWP Quarterly Statistics for the Appeals Service, June 2005

18 The Appeals Service (2005) President's report: Report of the President of Appeals Tribunals on the standards of decision making by the Secretary of State

“The themes in the ... reports have remained the same and the question for both the agencies and the Department is: What have you done with the feedback to identify areas for improvement and implement initiatives to improve this situation? ...There seems little point in my colleagues and I providing more feedback or the Department commissioning further studies from the Appeals Service or their own Standards Committee when no discernible improvement in decision-making is the result.”

The DWP’s Standards Committee has also concluded that the current arrangements are not working effectively and recommended that DWP should contact people by phone to clarify and obtain more information, and should give clear written explanations following any reconsideration. The Committee has also called on DWP to “follow their own guidance on attendance of presenting officers at appeals”, and work with “The Appeals Service to develop mechanisms for giving feedback to decision makers on reasons for tribunal decisions.”

The National Audit Office has produced two reports on DWP medical services in the last five years, in 2001 and 2003. The 2003 report¹⁹ said that good progress had been made since the earlier report and went on to call for further improvements in six areas. These were:

- make better use of IT to reduce processing times
- integrate a wider range of evidence (e.g. from hospital consultants, occupational therapists, social workers and community psychiatric nurses) into the assessment process
- develop better feedback on the outcome of appeals, to help doctors and decision makers to learn from appeal outcomes
- clarify and promote the role of Medical Services in advising decision makers
- tackle the problem of non-attendance for IB medical examinations
- address weaknesses in accommodation used for examinations.

In 2004, the Government set out measures it was taking and was planning, in response to a Public Accounts Committee report. The Committee had called for regular feedback to Medical Services doctors on decisions reached and the results of appeals, in order to improve the quality of medical evidence and the standard of medical reports. In response, DWP set out 10 pieces of action, including the development of the computerised system for conducting and reporting PCAs. The action does not however include providing regular feedback to doctors on the results of appeals when they have advised on the initial decision.

The DWP issued new guidance in November 2005, which emphasises the key role that reconsideration plays in the decision-making and appeal process.²⁰ It stresses that reconsideration is a crucial and mandatory part of the process, introduced to ensure that, where cases have been decided incorrectly, they can be put right quickly and easily by a decision maker rather than having to go to appeal. It is welcome that this guidance has been issued, but it is a very modest response to the problems that exist and it is disappointing that it took so long to emerge after the NAO report.

The welfare reform green paper recognises that improvement is still needed in the decision-making and appeals processes for incapacity benefits. It announces a review to improve the clarity of communication of reasons for decisions, ensure there is comprehensive reconsideration of a decision before it proceeds to appeal, and that all new evidence is taken into account at reconsideration.

We welcome this review, which is long overdue. It should address how to improve the quality of the medical evidence and be conducted in an open manner, giving all stakeholders an opportunity to participate. A similar review is also needed for disability benefits.

Obtaining further medical evidence

A practical problem facing clients who wish to challenge benefit refusals is the difficulty of obtaining medical evidence to challenge the assessment by Medical Services. Bureaux often

19 NAO (2003) Progress in improving the medical assessment of incapacity and disability benefits HC 1141
20 DWP (2005) Decision Makers Guide Memo Vol. 1, 11/05

support clients in this situation and will usually wish to seek further medical evidence, for example from the GP or a hospital consultant where this is appropriate. There are two problems in obtaining such evidence. First, the doctor may not find time to do a report in time for the appeal Tribunal. Second, s/he may not be willing to do a report or may only do so for payment (many GP practices insist on this). Clients who are eligible for Community Legal Service support may get help with such charges, but other clients are unable to pay or can only do so with great hardship. This situation is unfair and prevents people from putting the best case at a Tribunal.

A client wanted to appeal the refusal of his DLA. He needed his GP to provide a medical opinion, but was told that this would cost £70. The client was on income support and had been getting higher rate mobility and lower rate care until he reapplied and was turned down. The drop in income had already caused considerable hardship, and the client would struggle to pay the £70, especially as there was no guarantee of success. The bureau suggested that a sliding scale of charges, or an option to pay by instalments might help in situations such as this.

We recommend that all appellants against benefit refusals should be entitled to have reasonable costs of obtaining medical evidence to support their appeal reimbursed.

Problems with disability benefits decisions

CAB advisers report that decision makers for disability benefits do not always contact the most suitable source for evidence especially with regard to mental health issues, where social workers, community psychiatric nurses and psychiatrists are likely to know more about a client's needs than her/his GP. The questionnaires sent to GPs do not always ask about the appropriate activities. They ask about washing, dressing, toileting and feeding but, for example, do not ask about communication difficulties, which is a crucial issue for a deaf or hearing impaired person.

We recommend that the Disability and Carers Service should review with representatives of the medical profession and with disability organisations and other stakeholders, such as the Citizens Advice service, how better use can be made of information from all those caring for a disability benefit applicant in making a decision on the claim.

Most awards of DLA are for a fixed period. Six months before the end date of the award, the Disability and Carers Service invites the DLA recipient to re-apply by completing a new application form. Bureaux have expressed concern about awards being made for unreasonably short periods. Also that the renewal process could be made simpler, so that only changes of need have to be reported.

The timing of the renewal process should also be reviewed. It is understandable that the Disability and Carers Service wish to initiate the process in good time for a continuation decision to be made before the existing award runs out, but DLA recipients find it unsettling to be asked to reapply when their award still has 6 months to run. This feeling is heightened when they are reminded of the need to respond soon after getting the renewal forms.

A client felt harassed by renewal demands even though her DLA had five months still to run. She found form-filling a real obstacle, and was anxious not only about not getting her renewal but also losing her current award prematurely. Losing her DLA would mean she would lose her Motability car. This process is repeated every two or three years, which results in considerable stress for the client.

We recommend that the Disability and Carers Service should review with stakeholders (1) how they can ensure that awards are made for the longest period appropriate to the applicant's condition; and (2) their procedures for renewing DLA awards to make the process as straightforward and non-threatening as possible.

The Disability and Carers Service has recognised that there is significant scope for improvement in its decision-making. It is making efforts to improve the training of decision makers and the guidance available to them.

DCS is introducing external accreditation to provide a greater degree of professionalism in decision-making and appeals. The Customer Case Management system is also being developed to provide new electronic guidance, with the aim of helping staff make quicker, more accurate and consistent decisions.

Conclusions

The welfare reform green paper sets out proposals to engage people who claim incapacity benefits to assist them in getting back to work. It recognises that the approach to this large group of people has previously been too passive and negative. *Pathways to Work* pilots promise a more positive approach for new claimants, who must participate in a series of work-focused interviews and draw up an action plan for seeking to get back to work. They may also be given access to a rehabilitation services provided under special arrangements with the NHS, along with increased support from Personal Advisers and a back-to-work credit.

The green paper's proposals for a new employment and support allowance draw heavily on this approach. But the new arrangements will not succeed unless they also recognise the need for reform in two crucial areas that the green paper scarcely addresses:

- improved quality medical assessments
- a more modern approach to those who have to rely on the state for their income.

The evidence and recommendations in this report address the first point. On the second, a more sympathetic and communicative approach is needed. The green paper acknowledges that the current arrangements for incapacity benefits fail recipients because DWP has taken virtually no interest in providing constructive help to people receiving the benefits. DWP simply decides whether a person qualifies for these benefits, gives them

a work-focused interview in areas with the full Jobcentre Plus service, and pays them until the person stops claiming or the DWP decide, through a PCA, that they no longer qualify.

Benefit is then instantly withdrawn, even if the person has been receiving incapacity benefits for many years. Bureaux report that clients are usually given no notice by DWP, and no discussion or offer of help to deal with the situation. This is an inhumane and outdated approach. It would be in line with employment law if DWP had to give recipients a week's notice that they are to lose the benefit, for every year that they had been receiving it.

As long as the quality of decision-making on these benefits remains so poor, recipients should be kept on the benefit until the reconsideration/appeal process is completed. Those who do lose their entitlement correctly should be assisted to claim jobseekers allowance without any break in their entitlement. This would also protect housing and council tax benefit entitlement in many cases.

Finally, the Citizens Advice service is extremely concerned that so many of the cases cited in this report affect people with mental health problems, who face real difficulties receiving and retaining the benefits to which they are entitled. DWP needs to focus much more strongly on what it should do to prevent such injustice.

We recommend that DWP should appoint a senior person to act as a mental health champion to scrutinise policies and practices across the department and its agencies to seek to ensure that this client group is not discriminated against.

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