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Dear WCA Independent Review Team

Re. The Work Capability Assessment: A call for evidence - BSRM Response

I respond to this call for evidence in my capacity as a Consultant in Neurorehabilitation and as the secretary for the Vocational Rehabilitation Special Interest Group of the BSRM (British Society of Rehabilitation Medicine). In preparing this I have listened to the experiences of rehabilitation professionals working in both general rehabilitation services and specialist vocational rehabilitation settings who have attended workshops, and to the particular experiences of many patients known to myself and colleagues who have attended a WCA.

While as rehabilitation professionals we welcome any approach that considers anyone, whatever their disability, could work, the main emphasis of my response is that we have very significant concerns about the WCA for the following reasons;

- a.** It has not been applied in an appropriate way to those with long term neurological conditions, in particular those with persisting cognitive problems and severe neurologically based fatigue.
- b.** There has been an underestimate of the emotional impact of the WCA process on people who have had difficulty with adjustment after developing their condition/having an accident. This can be devastating and result in rehabilitation and return to work taking even longer.
- c.** The WCA process does not currently include the need to seek evidence from any involved rehabilitation professionals.
- d.** The WCA interview does not allow for rehabilitation advice to be offered or referred on for, even if the assessor feels this might be appropriate. This is a missed opportunity.
- e.** The WCA as currently conducted may not be an appropriate use of national resources. Considerable time is used by clinicians in responding to appeals and or accompanying clients attending assessments. This is currently necessary to ensure people with significant cognitive and emotional problems are appropriately represented, however the same time may be better used in working with a client and their family to facilitate maximal recovery and return to appropriate occupation of time and work when it is possible.

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With reference to the appeals data included in your consultation we feel that the July 2010 data on ESA appeals, demonstrating that 40% of appeals heard to date have been upheld, would suggest that the assessment process is not sufficiently specific or reliable. Furthermore the figures do not include those still waiting for an appeal to be heard. The emotional impact on the person with the condition during an appeal should not be underestimated and can be devastating resulting in recovery and rehabilitation taking even longer. The cost implications to the DWP as well as other statutory services, in particular the NHS, in processing appeals would seem significant.

Feedback from attendees as well as accompanying professionals suggests that the assessors are either actively directed to restrict their assessment interview to a short set of questions or that they have limited understanding/training in interviewing and assessing the work capability of people with cognitive and emotional problems and neurologically based fatigue. Some people have said that the assessors are directed to avoid offering any rehabilitation advice. Reports of such assessments could be unreliable from those with marked memory impairment but they have been consistent with the professionals' observations of the same interviews. I understand that assessors do not perform a formal physical or cognitive examination. Reports from patients consistently describe being asked if they can stretch hands out, do squat thrusts and whether they can remember what they have done that day and do not usually ask (are not required to seek) information from treating professionals. This seems to be requested only if there is an appeal.

In addition to the above I have gained the impression that the WCA has limited capability to assess the impact of fatigue. Fatigue is extremely common in many neurological conditions but particularly marked during the first year of recovery from brain injury. What can otherwise seem to have been a mild traumatic brain injury can be accompanied by very disabling fatigue. Fatigue can be cognitive as well as physical and can result in exaggeration of any other persisting impairments. That is someone's cognitive performance can deteriorate rapidly during a day at work. In many cases there is good recovery over months but any underestimate of fatigue can result in people returning to work too early, underperforming and then jeopardising their longer term chances of staying in an existing job.

Question 1a: How effectively does the WCA correctly identify those claimants whose condition is such that they are unable to undertake any form of work related activity (the support group?)

We are concerned that the WCA, as currently implemented, will not reliably identify those people with complex but 'hidden' difficulties (e.g. complex cognitive-behavioural difficulties, memory problems, planning problems) following acquired brain injury that are unable to undertake any form of work related activity.

They may be obliged to attend groups that they are not cognitively and behaviourally able to attend. The reports of sanctions and or withdrawal of benefits if appointments for assessments or any support groups are not kept are not helpful and seem discriminatory.

The figures for appeals do not include data on diagnosis or types of impairment of those appealing after WCA but in our experience it is that group of clients who have most often had appeals upheld.

Question 1b: How effectively does the WCA correctly identify those claimants whose condition is such that they are currently unable to work due to illness or disability (the limited capability for work group?)

It is felt that the WCA is failing to identify people with complex but 'hidden' difficulties resulting from acquired brain injury (e.g. cognitive-behavioural difficulties) which result in them being unable to return to work at their previous level, at the time of the assessment. It is not acknowledging that the person may still be in a recovery phase (even years later) but may need further rehabilitation to reach their potential. Clients have been directed to seek alternative employment too early rather than encouraged to continue working in appropriate work placements with rehabilitation professionals to reach their maximum potential.

As a result some of our clients have had to attend appeals when their limited capability for work was both well known and well documented by rehabilitation professionals. The impact of the assessment and appeals process has in itself resulted in considerable distress and sometimes undone careful work on adjustment to an injured person's new capabilities.

Question 1c: What are the main characteristics that should identify claimants for each group, where these may differ from the current assessment?

There are major concerns about how the WCA is being carried out, in particular how some interviews have been conducted with the attitude of the assessor being reported as one "trying to catch people out" rather than attempting to document the physical and cognitive restrictions of the person.

It is felt that more weight should be given to external expert information, especially for people with cognitive impairment who may have difficulty in understanding their own difficulties as well as reporting them effectively. Furthermore we feel that for this group of clients, both clients and assessors should be actively encouraged to seek further advice from rehabilitation and occupational health professionals even if it has not been sought before assessment. This would help the assessor understand whether the claimant was likely to increase or decrease ability (and work capability) in the future.

Question 2: What evidence is there to suggest that any issues with the operation of the WCA are as a result of the policy design, and what evidence is there to suggest that they are as a result of the delivery?

Response to 1c is also relevant here.

From client and professional reports of attendance for assessment after brain injury we have gained the impression that;

- The assessors display limited understanding of cognitive impairment in general, and executive difficulties in particular, and how these might affect work capability. It is not clear if this is a result of insufficient assessor training or the way in which they have been directed to perform the assessments.
- There seems to be an assumption that people exaggerate their difficulties when many people with brain injury significantly underplay their difficulties. This underreporting of difficulty is usually due to a combination of an expectation and hope of further recovery and a lack of insight. The restricted insight itself being one of the impairments caused by the brain injury. As such, people with brain injury may not be able to provide an accurate account of their own restrictions.

- In addition, even where insight is not such a problem there seems to be a lack of recognition that people early post-injury, who are currently investing a great deal of effort in rehabilitation, are likely to be coping by tending to underplay the extent of their difficulties, still hoping for the best (usually a return to previous work).
- The assessors do not seem to appreciate the difficulty that people with cognitive impairment have in answering their questions with little apparent attempt made to actively encourage people with recent injury or disease to provide the information required to assess their work capability.
- The questions asked at interview seem to focus on very basic daily living tasks. In our experience this is unlikely to reflect a person's work capacity very accurately or adequately. There appears to be little focus on how the specific areas of ability evaluated within the WCA relate to work capability which we understand is the major focus of the assessment.
- There appears to be a lack of recognition of the need for additional information. In the case of acquired cognitive difficulties it is essential that additional information is duly considered. Our experience is that some assessors do not have the time to consider or do not take note of information available from external sources - even when other services have completed detailed vocational assessments and are currently actively engaged in providing vocational rehabilitation to assist the person towards work.
- Some members are concerned that policy may be influenced by a central expectation to move people off Incapacity Benefits and ESA.
- The BSRM would prefer to support an assessment process that accurately and fairly assesses a person's capacity for work.

Question 3: What is the best way to ensure that the effect of fluctuating conditions is reflected in the recommendation of the WCA?

Claimants and accompanying professionals report the assessor pressing for details of activity on one particular day and then telling the attendee that the assessor's impression is that if they can achieve that level of activity on that day they seem fit to work at all times. It may be more useful and accurate to encourage assessors to record whether a person's condition and thus function fluctuates from day to day, (as is most notably the case in conditions such as Multiple sclerosis or Parkinson's disease)

Question 4: What is the best way to ensure that the effect of multiple conditions is reflected in the recommendation of the WCA? Are there specific conditions that should be regarded as contributing to or adding additional weight to others, where both are present?

People with cognitive difficulties (particularly with severe memory loss or loss of insight) are likely to have more difficulty managing any physical problems than those without any significant cognitive dysfunction managing with the same physical and sensory impairments.

In other words there is a complex interaction which increases the resulting barriers to return to work more than merely the sum of the two problems. In practice this can be seen as reduced safety awareness or reduced problem solving ability such that safe work practices are undermined.

Question 5: What is the best way to give adequate weighting to additional (or initial) evidence outside of that gathered through the WCA? How can any changes be achieved without placing a burden on GPs and health care professionals, and without compromising their relationship with their patients?

If the information is requested in a specific and timely manner directly from the assessor prior to interview, with the consent of the patient, this may reduce the overall time contributed by health care professionals to support appeals and resulting difficulties from inappropriately conducted WCA assessments.

In particular, information should be requested from external sources on those with a high probability of having cognitive impairment and/or behavioural problems, such as those with acquired brain injury. Many services already encourage users to have their own copies of professional reports and thus attendees could be prompted to produce these ahead of assessment. Those with reduced insight, memory difficulty or planning and other executive impairments will however still require support and prompting to do this effectively.

Often much relevant information is already contained in service letters to GPs and others. Whilst responding to detailed requests for further information will require some additional time from healthcare professionals, we feel it is very important that any rehabilitation service involved with a client is given that opportunity to ensure accurate information and rehabilitation advice is made available to the assessor. This time will be well spent if it results in avoiding inappropriate decisions which can not only waste time for all concerned but which can have such devastating effects on the applicant when incorrect assessments are made. If such information is permitted and included early in the decision making process it should reduce the need for additional information and/or for professionals to support people through appeals processes.

Question 6: Is there any evidence to show that there have been particular problems with the WCA for any specific groups? These groups may include, but are not limited to, men and women, people from black and minority ethnic backgrounds, or people from differing age groups.

We have gained the strong impression that the current system disadvantages those with acquired cognitive and behavioural difficulties (e.g after a neurological condition such as brain injury), who often have difficulty in providing the required information and even understanding their own limits.

Question 7: Do you have any suggestions for how the WCA process could be improved to better assign people with health conditions to the most appropriate part of the benefits system?

Encouraging clients to send all relevant medical/rehabilitation professional reports, or give consent for these to be requested by the assessor, before attending a WCA interview may reduce the number of interviews needed or allow postponement to a more appropriate time in a clients recovery pathway.

We think that assessors could be offered more training, particularly on rehabilitation. There seems to be a need for improved training for assessors on the nature and implications of cognitive difficulties arising from neurological conditions, with a particular focus on the extensive restrictions arising from executive difficulties. Further improvement in the assessment process may be achieved by offering more training for assessors on how to interview and evaluate the work capability of people with such difficulties.

Where clients have complex cognitive and or communication difficulties and are still required to attend a WCA more time should be allocated to allow the assessor to develop better understanding of the person's situation and thus offer more appropriate advice.

A number of clients currently under my review have had a Work Capability Assessment and have agreed that I could use their experience as evidence if appropriate. I am happy to collate these vignettes if that would be helpful. It is not only the attendees that have reported dismay at the way in which the assessment was performed but professional colleagues who have expressed repeated concerns about how the assessment is being administered by the medical staff contracted to do it.

We would be happy to contribute to discussions about how such training could best be provided.

The views are those of myself, my colleagues in the Evelyn Community Head Injury Service and the Addenbrookes Neurotrauma Clinic as well as members of the VRSIG/BSRM, however as there has been limited time for the consultation they cannot be taken as those of the Cambridge University Hospitals NHS Trust.

Thank you for granting an extension to the deadline for submission of this response. We are very pleased to have had the opportunity to contribute to the consultation. I hope that the above comments are sufficiently clear. If not then please do not hesitate to contact me at the above and I will be happy to expand. As mentioned above many people have consented to my forwarding their particular experiences to you if that would be useful in the future.

Finally, the VRSIG (Vocational Rehabilitation Special Interest Group) of the BSRM would be happy to contribute both to further discussions on DWP approaches to supporting people back into work after injury or disease and to discussions on how to develop appropriate training for assessors.

Yours sincerely,

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On behalf of the BSRM