STATES OF JERSEY

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REVIEW OF THE CHANGES TO THE INCAPACITY BENEFIT SYSTEM

Presented to the States on 24th April 2007
by the Minister for Social Security

STATES GREFFE

Review of the Changes to the Incapacity Benefits System

Preface

In 2004 changes were made to the Social Security scheme's Incapacity Benefits, which are paid to help support workers through short-term illnesses and when they develop long-term health problems.

The then Employment and Social Security Committee gave an undertaking that an independent review should be undertaken to appraise the policy intent behind the changes and to identify ways in which procedure and communications could be improved. The review was also asked to consider the role of key stakeholders such as doctors and employers in supporting people with long-term health or disability problems in the workplace.

Professor Bruce Stafford of Nottingham University has undertaken the review and his findings are presented in the attached report. He is Professor of Public Policy at Nottingham University and has 20 years experience in applied social research and is currently leading an International Consortium in evaluating the UK's New Deal for Disabled People. Professor Stafford has undertaken extensive research on benefit systems and the transition from benefit to work.

I am pleased to present Professor Stafford's final report to the States, which does verify that we are moving in the correct policy direction and emphasises that, generally, work is good for you. Professor Stafford has made some recommendations on changes to processes and improved communications while acknowledging that the Department has continued to make progress in these areas. Work will now focus on how to take the recommendations forward.

I am grateful to Professor Stafford for his work and would like to thank all who participated in the review.

Senator Paul Routier
Social Security Minister

Review of the Changes to the Incapacity Benefit System States of Jersey

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Contents

List of Tables

List of Figures

Disclaimer

The views in this report are the authors’ own and do not necessarily reflect those of the Social Security Department.

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Abbreviations

ICF	**International Classification of Functioning, Disability and Health**
JACS	**Jersey Advisory and Conciliation Service**
JEND	**Jersey Employers' Network on Disability**
JET	**Jersey Employment Trust**
LTIA	**Long Term Incapacity Allowance**
NESSIE	**New Employment Social Security Information Exchange**
STIA	**Short-Term Incapacity Allowance**
OECD	**Organisation for Economic Co-operation and Development**
WHO	**World Health Organisation**

Summary

Introduction

S.1 The States of Jersey implemented a new incapacity benefit regime on 1 October 2004. The new scheme comprises three contributory benefits: Short-Term Incapacity Allowance, Long-Term Incapacity Allowance and Incapacity Pension. This report is a review of the operation of the incapacity benefit system.

S.2 The review's Terms of Reference are:

1. *To review the new incapacity benefit system in place to ascertain whether it meets with the policy intent as agreed by the States of Jersey; namely:*

    - *To provide immediate support for people with short-term, limiting illness*
    - *To enable people with a long-term health condition to return to work*
    - *To be less intrusive*
    - *To prevent abuse of the system (through disguised retirement and unemployment)*

2. *To review the associated guidelines, procedures and processes and support mechanisms and make recommendations as appropriate.*

3. *To identify areas where the role of key stakeholders and communications may be improved.*

S.3 The review involved gathering and analysing information from three main sources:

- published and unpublished documents, many provided by the Social Security Department;
- qualitative interviews with Social Security Department staff, incapacity benefit claimants and other key stakeholders; and
- administrative data provided by the Social Security Department.

S.4 The review reflects the nature and extent of the comments made by respondents, thus there is a focus on Long-Term Incapacity Allowance and relatively little on Incapacity Pension.

Meeting the policy intent

S.5 Amongst those interviewed there was widespread support for the principle

that people with a health condition or a disability should be encouraged to obtain sustained employment. There was also general support for the introduction of Long-Term Incapacity Allowance as an in-work benefit. Indeed, there is some recognition that paid work can improve an individual's well-being.

S.6 The review finds that in general the reformed incapacity benefit system is meeting its policy intent. Accordingly, broad policy aims should remain unchanged.

S.7 Key policy recommendations are that:

- Short Term Incapacity Allowance and Long-Term Incapacity Allowance should be renamed to signal more clearly to the public and claimants that Long-Term Incapacity Allowance is an in-work benefit and is paid as compensation for a loss of faculty. The suggested new names are Sickness Benefit and Work and Support Allowance, respectively. This change will require legislation.

- Benefit rules prevent Short Term Incapacity Allowance recipients from working, and Short Term Incapacity Allowance can be claimed for up to one year. Given that the longer someone is on benefit the less likely they are to return to paid work it is not, on balance, in the interests of most individuals to remain on Short Term Incapacity Allowance for up to one year. The maximum period of incapacity for Short Term Incapacity Allowance should, therefore, be reduced. Subject to further research on longer term outcomes for Short Term Incapacity Allowance recipients, a new maximum period of six months is proposed. A six months maximum:

  - ought to give sufficient time for the Department to work with Short Term Incapacity Allowance recipients needing support returning to employment;
  - is, arguably, sufficiently long enough so that those with more severe, longer term conditions do not feel that they are under undue pressure to return to work; indeed, they will move more quickly to the support provided by Long Term Incapacity Allowance; and
  - should enable the Department to assist the small minority of claimants (two per cent) who remain on benefit for more than six months and who whose chances of returning to work diminish over time because they become more detached from the labour market.

  At the end of the six month period, Short-Term Incapacity Allowance recipients would make a claim for Long-Term Incapacity Allowance and their percentage loss of faculty would be assessed.

- Jersey should continue to operate its early intervention scheme, because it represents best practice. However, the Department should intervene earlier at five weeks rather than the current ten weeks. Moreover, in the medium term the Department should consider developing its own formal screening tool to

identify cases for early intervention.

- Similarly, it should continue its early intervention scheme for those flowing on to Long Term Incapacity Allowance. However, the States should consider whether it would be cost-effective to require those identified as suitable for an early intervention to attend a meeting with an employment adviser

- The Department should review the existing Transitional Benefit arrangements with a view to giving Short-Term Incapacity Allowance recipients more of an incentive to engage in job search and obtain paid work. It is recommended that, in the longer term, the Department reviews whether the current arrangement should be replaced by a Return to Work Bonus paid to Short Term Incapacity Allowance claimants. The Bonus could be time limited and means-tested and only paid to those who had entered paid work of, say, at least eight hours per week. Recipients of the bonus would not also be in receipt of Short-Term Incapacity Allowance (or Long-Term Incapacity Allowance). The payment could be counted as income for any claim under the proposed Income Support system. However, the introduction of the proposed Income Support system, which incorporates work incentives, may negate the need for a new benefit for this client group. Accordingly, the Department should wait until it can assess the effectiveness of the incentives in the proposed Income Support system in encouraging people with disabilities or health conditions to move into employment before introducing a new benefit.

- The Department may wish to extend the range of items covered by its Adaptation Grant (to include, for example, alterations to premises and payment of fares for employees to get to work) and, in any event, more actively publicise the grant to employers and employees.

S.8 The Department will need to undertake further work to assess the cost-effectiveness of the proposals outlined in this review.

Review of guidelines and processes

S.9 The review found that many of the criticisms of the current system arise from the method of assessment used for determining percentage loss of faculty. The method of assessment used in Jersey to assess loss of faculty (a Baremas scale) is commonly used in other countries and is controversial. Criticisms of the approach include that Baremas scales are less satisfactory at assessing mental health conditions than physical conditions, the percentages awarded can be difficult to justify and to interpret in terms of the person's ability to work and compared to other approaches to assessment, they can generate a relatively high number of complaints / disputes and (successful) appeals.

S.10 This report recommends that the States replaces this existing methodology

with one that focuses on the abilities of the claimant to undertake everyday functional activities, such as, manual dexterity or coping with pressure. Simply revising the existing approach is rejected because any reforms would not satisfactorily address its fundamental weaknesses, and of the other approaches available a focus on ability to perform functional activities seems the most promising.

S.11 Medical Boards determine a Long-Term Incapacity Allowance claimants' percentage loss of faculty. Based upon the interviews undertaken for this review, the work of the Medical Boards and the percentages for loss of faculty determined in certain cases are probably the most controversial aspects of the incapacity benefit reforms. In determining a percentage loss of faculty, boarding doctors must adhere to the relevant legislation and can use unpublished official guidance.

S.12 Key recommendations for improving the work of the Medical Boards are:

- The Department should continue to encourage practising local General Practitioners to serve as boarding doctors and widen the membership of Medical Boards to other professionals in the health service. (Achieving the latter will require changes to the legislation.)

- Any boarding doctors will need to satisfy the Department that they have the necessary training to undertake assessments of disability and have an in-depth understanding of the relevant benefits. If the States accepts the recommendation that the existing Baremas scale methodology be replaced with one that focuses on the abilities of the claimant to undertake everyday functional activities, then the Department should expect doctors doing assessments to have the Diploma in Disability Assessment Medicine, which is provided by the Faculty of Occupational Medicine of the Royal College of Physicians.

- The Department should extend its dialogue with, and issue more guidance to, General Practitioners to give them a better idea of the information Medical Boards require to make assessments.

- The Department should consider employing an occupational therapist / nurse with occupational health knowledge who could advise staff on incapacity benefit related matters.

- The two year time limit before appeals to a Medical Appeals Tribunal can be made should be abolished.

S.13 The Department also needs to continue to give a high priority to developing the management reporting facilities of the computer system used to administer incapacity benefits.

Role of communications and key stakeholders

S.14 The interviews with respondents suggest that in general the public's level of knowledge about the incapacity benefit is low. Moreover, some representatives of third parties that come into contact with incapacity benefit claimants can also lack (detailed) knowledge about the incapacity benefit system. Recommendations to improve public awareness of the incapacity benefit system are that the Department should:

- provide more training courses on the incapacity benefit system to other agencies dealing with the client group;
- offer a one-off 'update' course to local General Practitioners; and
- continue to encourage General Practitioners to display relevant posters and literature on the incapacity benefit system and information about where to go for advice and support.

S.15 In addition, to improve public and health professionals understanding of the assessment system the Department should in the future be more transparent and publish guidelines and information (as it will be doing with the proposed Income Support system).

S.16 The two key non-departmental stakeholders in the incapacity benefit system are employers and General Practitioners.

S.17 In the time available it was not possible to recruit any employers to be interviewed as part of the review. However, employers have a pivotal role in the wider incapacity benefit system. Their policies and practices determine the management of sickness absence and the recruitment of people with health conditions or disabilities. According to some respondents many employers are exemplars of how to recruit and manage employees with a health condition or disability. However, respondents also claimed there is 'bad' practice, especially amongst some of the smaller sized employers. The review proposes that the Department conducts further research on employers' needs for advice and support.

S.18 General Practitioners also have a central role in claimants' behaviour in relation to the incapacity benefit system and doctors need to be encouraged to discuss returning to work with their patients at the earliest opportunity. To promote this change the Department could invite a UK General Practitioner from a incapacity benefit reform pilot area to give a presentation on his / her experiences of the increasing focus in the UK on returning to work, and with others establish a 'Healthy Workplaces' campaign in Jersey.

S.19 There are also additional services and support available to the client group provided by other organisations, such as the Jersey Employment Trust.

Conclusion

S.20 The review finds that the Social Security Department does seek to help people with a health condition or disability return to employment. The review finds that the staff involved with delivering incapacity benefits are committed to delivering a high quality service. Claimants can be complementary about the service they receive.

S.21 In terms of priorities the Department should focus its attention on the ten per cent of Short Term Incapacity Allowance claims that last for more than 32 days. The recipients of these claims may find it more difficult to return to employment and potentially could flow on to Long Term Incapacity Allowance. It is known that the longer someone is in receipt of an incapacity benefit the less likely they are to return to paid work. This implies that the recommendations focusing on reforming early intervention arrangements and reviewing the maximum period of incapacity for Short Term Incapacity Allowance claims are both interrelated and critical.

S.22 In addition, many of the weaknesses of the current system stem from the Baremas method of assessment used, its replacement could be used to establish a system that was more easily understood by the public as well as more clearly focused on what claimants could do and what was needed to help them to return to paid work.

1 Introduction

1.1 Background

1.1 The States of Jersey implemented a new incapacity benefit regime on 1 October 2004. The new scheme comprises three contributory benefits:

- Short-Term Incapacity Allowance, which is effectively an earnings replacement sickness benefit and is paid for up to one year.
- Long-Term Incapacity Allowance, which is a disablement benefit based on recipients' percentage loss of mental or physical faculty. The benefit is paid as compensation for a 'loss of faculty'. Recipients can work and retain entitlement to the benefit.
- Incapacity Pension, which is to compensate for loss of earning for those that are unlikely to work again, and is payable up to pension age.

1.2 The States of Jersey are committed to conducting a review of its incapacity benefit system. The 2006/8 Business Plan for the Social Security Department includes as a key objective: *'Reviewing the operation of the revised incapacity benefit system and acting on any recommendations'*. This report utilises a variety of sources to consider the workings of the incapacity benefit system and to make recommendations.

1.3 Although a few incapacity benefit cases have attracted adverse publicity, not all of the comments made during the course of the review were negative about the incapacity benefit system. Recipients could say either they had no complaints about the service they had received from the Department, or even praised aspects of the service.

1.4 Moreover, there was near universal support amongst respondents for the principle that people with a health condition or disability should be helped to return to work. Paid work was seen as promoting people's well-being and self-esteem. Having Long Term Incapacity Allowance as an in-work benefit is commonly seen as a *'good idea'*.

1.5 In this chapter, the objectives and conduct of the review are outlined in Section 1.2, and the structure of the report in Section 1.3. The background to the changes are summarised in Section 1.4, and the benefits themselves are outlined in Section 1.5.

1.2 Objectives and conduct of the review

1.2.1 Objectives

1.6 The objectives of the review were outlined in the Department's Terms of Reference, and are reproduced below:

1. *To review the new incapacity benefit system in place to ascertain whether it meets with the policy intent as agreed by the States of Jersey; namely:*

    - *To provide immediate support for people with short-term, limiting illness*
    - *To enable people with a long-term health condition to return to work*
    - *To be less intrusive*
    - *To prevent abuse of the system (through disguised retirement and unemployment)*

2. *To review the associated guidelines, procedures and processes and support mechanisms and make recommendations as appropriate.*

3. *To identify areas where the role of key stakeholders and communications may be improved.*

(Employment and Social Security Committee, Item No. A4, 22 July 2005)

1.2.2 Conduct of the review

1.7 This review has involved a mixture of research methods. Information for the review has been gathered from three main sources. First, published and unpublished documents, many provided by the Social Security Department, have been examined.

1.8 Secondly, qualitative interviews were conducted with Social Security Department staff, incapacity benefit claimants and other key stakeholders. The aim of the qualitative research was to collect data on different perspectives on, and experiences of, the incapacity benefit system. However, in the time available it was not possible to arrange any interviews with employers. The interviews were all held in May 2006 and were a mix of face-to-face and group interviews. A total of 39 people participated in the qualitative research. The respondents were promised anonymity and confidentiality, hence only broad characteristics of the sample are summarised in Appendix B. The incapacity benefit recipients who participated in the interviews were given a payment of £15 to cover their expenses. All interviews were conducted using topic guides, and the interviews were recorded using a digital voice recorder and were later transcribed for analysis.

1.9 Concerns can be expressed about the representativeness and generalisability of qualitative research, especially if sample sizes are relatively small. It is the case that qualitative research is not representative in the same sense as a quantitative approach using random sampling. However, this does not mean that steps cannot be taken to generalise from qualitative research. In this

study generalisability is achieved through:

- Purposively selecting people to take part in the research, and in particular not sampling unrepresentative informants.
- Comparing the accounts of different respondents with varying views and experiences. (Hence it was important that as wide a range of views and experiences as possible was obtained.)
- Combining the qualitative data with the administrative data (see below) and the documentary sources.
- In the interviews focusing on 'typical' behaviours and organisational processes, rather than unrepresentative ones.

1.10 Thirdly, administrative data were provided by the Social Security Department and subsequently analysed.

1.11 In addition, written contributions were sought from members of the public. An advertisement was placed in the island's newspaper, and there was coverage of the review on local radio and television, but only two responses were received.

1.3 Structure of the report

1.12 The definition of some of the key concepts underlying Jersey's incapacity benefit system can be contentious. Chapter 2 discusses the definitions of incapacity and loss of faculty as well as some of the issues around the method of assessment used in Jersey. A finding of the review is the relative lack of knowledge many people have of the incapacity benefit system in Jersey and this is considered in Chapter 3. Some of the characteristics of incapacity benefit claimants and of their claims are explored in Chapter 4. Chapter 5 covers delivery of incapacity benefits, whilst the services available to incapacity benefit recipients are outlined in Chapter 6. Chapter 7 considers the role of employers. The assessment of loss of faculty and the work of Medical Boards is considered in detail in Chapter 8. Some conclusions as well a summary of the recommendations are presented in Chapter 9.

1.13 The report reflects the balance of the experiences and views of those interviewed for the review. As such there is, within this report, a focus on Long Term Incapacity Allowance. Whilst aspects of Short Term Incapacity Allowance are covered, there is little coverage of Incapacity Pension.

1.2.1 Report conventions

1.14 The report includes selective use of quotes from the qualitative interviews. The quotes are meant to illuminate the knowledge, attitudes and behaviours of the respondents. Where appropriate the quotes have been 'smoothed' to make them more readable. This has been done by amending punctuation and removing some speech (signified by three dots '...'). All of the respondents in the research were

promised anonymity, and to ensure this no information is given about respondents who made each quote.

1.15 In the Tables, percentages are rounded up or down to whole numbers, and therefore may not always add up to 100.

1.4 The reform of incapacity benefit in Jersey

1.16 In the mid-1990s the States of Jersey undertook a wide ranging review of its then social security and health insurance schemes. In July 1995 recommendations for change were published in *Continuity and Change* (Social Security Committee, 1995) and then subjected to further debate and consultation. The recommendations were far reaching and covered contributory and non-contributory benefits. A number of the recommendations that affected the contributory system in general and incapacity benefits in particular were subsequently accepted and implemented by the States of Jersey.

1.17 The findings and recommendations in *Continuity and Change* that directly affected the incapacity benefit system included:

- A renewed commitment to the contributory principle. Contributory benefits are a *'right'* that are *'earned'* through paid work. Accordingly, incapacity benefits are not available to those not meeting the contribution conditions and claimants with only a partial contribution record do not receive the full amount of benefit.
- The individualisation of benefits.[1] A desire to further gender equality together with changes in family and employment patterns raised doubts about the relevance of the 'male bread winner' model underpinning the previous social insurance system. The recommendations sought to move away from *'… the concept of the male head of household with dependents' cover to a scheme based on individual entitlement.'* (Social Security Committee, 1995: 15). For incapacity benefit recipients this means that, except in certain circumstances, under the new scheme there is no increase in benefit for those with dependents living at home (the 'dependence increase').[2] Moreover, the option that allowed married women who were in paid work not to pay social insurance contributions has been abolished. This change in individual entitlement and contribution liability was not specifically about incapacity benefits, but affected all of the island's contributory benefits.
- That social security benefits should promote self-support not benefit dependency: a *'hand up not a hand out'*. Individuals were seen as having a responsibility to *'help themselves'* and in doing this they would preserve their self-worth and dignity:

  > *'Whatever the pressure on the economy may be, it is important that society continues to protect those who cannot help themselves and that the system*

encourages a climate of self-help rather than dependence where ever possible.'

(Social Security Committee, 1995: 9)

It was proposed that an invalidity pension (subsequently the Incapacity Pension) be introduced for those cases where it was clear that the likelihood of someone returning to paid work was negligible; and that an in-work benefit be established that would allow claimants the opportunity to return to work on a part-time or gradual basis following a period of incapacity (the Long-Term Incapacity Allowance). To facilitate the latter it was argued that an in-work benefit was needed that was tailored (or graduated) to improvements in the claimant's health; a simple capable:incapable dichotomy was deemed inappropriate for such cases. Instead reform would build upon the percentage loss of faculty approach of the then existing Disablement Benefit:

'Compensating for a loss of faculty, and allowing some benefit to be maintained during employment, might be more relevant to today's changes in attitude to employment and work practices.'

(Social Security Committee, 1995: 109)

Critically, the Committee thought that the incapacity benefit system should not act as a disincentive for returning to paid work.

- A related concern was that the then incapacity benefit system was being used to disguise both unemployment and early retirement (Social Security Committee, 1995: 106). This could arise because of the simple fit for work / not fit for work distinction applied to Sickness, Invalidity and Injury Benefits. It was hoped that the reformed system would address this problem.
- The payment of benefits for short periods of incapacity for those with minor aliments and injuries was seen as largely non-problematic (Social Security Committee, 1995: 107). (These cases are covered in the new system by Short-Term Incapacity Allowance.)
- That the previous system was confusing because benefit entitlement partly depended upon whether the cause of the incapacity was an illness or an accident. Jersey had two contributory benefits payable for incapacity due to illness (Sickness Benefit and Invalidity Benefit) and two for incapacity due to an accident (Injury Benefit and Disablement Benefit) (Social Security Committee, 1995: 16 and 104). It sometimes led to people with similar medical conditions being treated differently by the system because the 'cause' of the condition was different. Accordingly, the current, more simplified, incapacity benefit system does not distinguish between the origin of any incapacity – whether disease, accident or injury.
- To make the system less invasive and to reduce the frequency of Medical Board reviews, the boarding process was reviewed to improve the information flow for accurate decision-making.

1.18 Other recommendations made at the time included: increasing contributions

to plan for the demographic bulge, a more flexible retirement age, a move to a Survivor's (not just a Widow's) Pension, and the introduction of credits for Home Responsibilities Protection.[3]

1.19 Underlying Jersey's reform of incapacity benefit are two broad policy aims: promoting social protection through providing financial assistance for those incapable of work and encouraging social inclusion through helping people with a health condition or disability secure sustained employment. These two policy aims require different policy stances and must be 'balanced' as ultimately they are in tension (Overbye, 2005: 155). The current incapacity benefit system in Jersey can be viewed as its *'workable compromise'* between these two potentially contradictory policy aims.

1.5 The post 'October 2004' incapacity benefit system

1.20 The new system offers three types of contributory benefit:

- *Short-Term Incapacity Allowance* is a daily benefit paid when a Medical Certificate is submitted to the Social Security Department to confirm that the individual is unfit for (any) work due to sickness or injury. Recipients are not allowed to undertake any work, even voluntary work, because it is a replacement of earnings benefit. The benefit is payable for a minimum of two days and a maximum of 364 days. When payment of the benefit ceases, the person may claim Long-Term Incapacity Allowance if they have a permanent loss of faculty. Short-Term Incapacity Allowance is paid by cheque weekly in arrears. Recipients are also awarded contribution credits for each day of benefit; this protects their contribution record for any future contributory benefit claims. (However, credits are not awarded if the person has elected not to pay contributions.)
- *Long-Term Incapacity Allowance* is a weekly benefit paid as compensation for what is likely to be a permanent loss of faculty when compared to someone of the same age and sex. Payment, however, is proportional to the degree of incapacity that arises from that loss of faculty. Claimants complete a claim form and are not required to submit Medical Certificates in order to receive the benefit. It is an in-work benefit, thus claimants are able to work whilst receiving Long-Term Incapacity Allowance. The degree of loss of faculty is assessed by a Medical Board and a percentage award given. Where a claimant has more than one loss of faculty the percentages awarded for each condition are summed, but the maximum award is 100 per cent. No benefit is paid if the assessment is less than five per cent. Benefit is paid directly into recipients' bank accounts four weeks in advance, unless their assessment is between five and 15 per cent, in which case it is paid as a lump sum. If someone in receipt of Long-Term Incapacity Allowance is in employment, then they, with their employer, would be required to pay their social insurance contributions, namely 12.5 per cent of their gross earnings up to the monthly earnings ceiling

(£3,138).[4] If they earn less than the earnings ceiling, then their contribution is "supplemented" through general revenues as if they had paid their full contributions - this is standard for all contributors. If they are working less than eight hours, then they do not pay contributions. If they are working more than eight hours, but earning below the lower earnings threshold (£663 per month[5]), then credits can also be awarded on a sliding scale dependant on the percentage assessment. For example, a recipient with a 20 per cent loss of faculty can be credited with three months of contributions, someone with 50 per cent credited with five years and anyone with an assessment of 75 per cent or more credited with 45 years of contributions. However, if the person has chosen not to pay contributions then they will not receive any credits. Benefit can be paid until pension age.

- *Incapacity Pension* is a replacement of earnings benefit for someone who because of their loss of faculty is unlikely to be able to return to the workplace. Claimants must first claim Long Term Incapacity Allowance, and a Medical Board assesses the person's loss of faculty. If the Medical Board determines that the person is unlikely to return to work then the individual is given a claim form for Incapacity Pension. Benefit is paid on contributions paid and those deemed to be paid up to the age of 65. Recipients are not allowed to undertake any work (paid or voluntary). Claimants are interviewed after their assessment of their Incapacity Pension entitlement. The benefit is paid four weeks in advance into recipients' bank accounts.

1.21 All three benefits also have varying contribution qualifying conditions. For all three benefits the full weekly personal rate at the time of the Review in 2006 is £153.23.[6]

1.22 Individuals can have a claim for Short Term Incapacity Allowance at the same time as a claim for Long Term Incapacity Allowance, provided each claim is for a different ailment and the maximum paid is the standard rate of benefit.

1.23 When the new system was established some people retained their rights to their then existing benefits. Thus recipients under the old system did not have to transfer to Long-Term Incapacity Allowance. These people can now be unclear about whether they should transfer to Long Term Incapacity Allowance. If they did transfer, then they could engage in paid work, which would allow them to earn more per week. However, they can be reluctant to make the move because the outcome of the Medical Board and the resulting amount of benefit they would receive are uncertain – they could lose out financially.

1.6 Wider policy

1.24 The incapacity benefit system operates within a wider policy environment. Related policies include:

- The proposed Income Support scheme - Jersey is planning to replace most of its non-contributory benefits and the Parish Welfare scheme with a means-tested Income Support scheme. Recipients receiving less than the full Long Term Incapacity Allowance might then have an entitlement to Income Support. Entitlement to Income Support will require claimants to be available for work, so to top-up Long Term Incapacity Allowance, claimants will have to demonstrate that they are looking for employment. However, until the new Income Support becomes operational recipients may have to seek help from the Parish Welfare system, which is often seen as stigmatising.

  Some interviewees attributed some of the controversy over the incapacity benefit system to the failure to introduce the incapacity benefit system at the same time as the proposed Income Support changes. As a consequence some people have had to resort to the Parish Welfare scheme, including individuals who previously never had any dealings with Parish Welfare. Of course, under Income Support some Long-Term Incapacity Allowance claimants will also have to claim a means tested benefit for the first time. However, the Income Support system should be more transparent with more published information about it than the existing system.

- Housing rent subsidies - Long Term Incapacity Allowance is now treated as income when the Housing Department calculates entitlement to rent subsidies. (It will also be treated as income in the proposed Income Support system, thus creating a more equitable system across social security as a whole.)

- Health Insurance Exception - Patients in Jersey have to pay for their medical expenses and are subsidised to an extent through the Health Insurance Scheme. The Health Insurance Exception scheme then allows certain people who are on a low income and either not in employment, or are in work for less that 25 hours per week, to visit their General Practitioner and receive prescribed medicines free of charge. Health Insurance Exception is not an individualised benefit, it is household based and entitlement is based on a family's circumstances and not on an individual's medical condition. The scheme is available to people not in regular work because of sickness or disability who are in receipt of an Incapacity Pension, or in receipt of Long Term Incapacity Allowance and have been on an incapacity benefit continuously for six months and have an assessment of 75 per cent or above. Any Long Term Incapacity Allowance is counted as income in the means-test for Health Insurance Exception. Where Long Term Incapacity Allowance recipients do not have entitlement to Health Insurance Exception it is claimed that meeting the cost of medical expenses can be difficult and they can feel financially worse off. Recipients may then have to use Parish Welfare to cover some, or all, of their medical costs. With the introduction of Income Support, Health Insurance Exception will be replaced with an individualised subsidy that will be awarded

on clinical grounds.[7]

- Employment legislation - Legislation protecting the rights of employees in Jersey was introduced in July 2005. The legislation introduced protection against unfair dismissal, a minimum wage, minimum holiday entitlement, the right to written terms of employment, and a right to certain notice periods. The legislation covers people with a health condition or disability. However, there is no right to redundancy payments, maternity leave or sick leave, although legislation has been proposed and some employers in Jersey already offer such benefits. Moreover, a 'fair dismissal' can occur where an employee lacks the capability to do the *'kind of work'* for which they were employed and where the employer has acted reasonably. Here capability is defined in relation to the person's *'skill, aptitude, health or other physical or mental quality'*. However, while the employee may be dismissed through lacking the capability to do their present job, the legislation (and the Employment Tribunals) requires that the employer take steps to find alternative suitable employment.

  The Department is taking forward further employment legislation (on redundancy and transfer of undertakings) and supporting codes.

2 Concepts

2.1 Introduction

2.1 There are a number of terms used in discussions about incapacity, such as disability, impairment, loss of faculty and sickness. These terms can be defined in different ways and their meaning can be controversial. The aims of this chapter are to clarify some of the concepts used in later chapters and to place the assessment methodology used in Jersey in context.

2.2 In the qualitative research most respondents understood that General Practitioners through issuing Medical Certificates were assessing patients' incapacity for work, that is, their fitness or ability to work, and that Short-Term Incapacity Allowance was paid as a replacement of earnings for a period of incapacity. However, Medical Boards assessed loss of faculty, not a person's ability to do paid work, and Long-Term Incapacity Allowance is paid to compensate the individual for a loss of faculty. The amount of compensation received is proportional to the degree of loss of faculty.

2.3 The legal and administrative definitions of incapacity and loss of faculty are considered in the next section. Related concepts are discussed in Section 2.3, whilst Section 2.4 considers the method of assessment used in Jersey.

2.2 Legal and administrative definitions

2.4 The incapacity benefit legislation in Jersey refers to incapacity and loss of faculty, although neither term is defined. However, the legislation does state that, amongst other qualifying conditions, a person is entitled to Short-Term Incapacity Allowance *'… in respect of any day of incapacity for work during a period of incapacity for work.'* (Social Security (Jersey) Law 1974, Article 15(1)).

2.5 The legislation also states that, along with other qualifying conditions, an individual is entitled to Long-Term Incapacity Allowance if *'… as a result of a relevant disease or injury …[they are] … suffering from a loss of physical or mental faculty which is likely to be permanent …'* (Social Security (Jersey) Law 1974, Article 16(1)(c)).[8] Official, but unpublished, guidance defines loss of faculty as *'… any loss of power or function of an organ or part of the body which is a cause of inability to do things.'* It may be a mental or a physical loss of faculty. (A disfigurement is explicitly defined as a loss of faculty.) This definition of loss of faculty closely resembles the World Health Organisation's (WHO) definition of impairment (see Section 2.3).

2.6 The legislation requires the degree of incapacity to be expressed as a percentage (Social Security (Jersey) Law 1974 Article 16(5)(a)). The wording of both the legislation and guidance show that incapacity is seen as resulting from the loss of faculty:

> *'The extent of a claimant's incapacitation shall be assessed, by reference to the loss of faculty incurred by the claimant as a result of the relevant disease or injury …'*
> (Social Security (Assessment of Long Term Incapacity) (Jersey) Order 2004, Article 2(1).

The assessment is to be based on the *'whole'* loss of faculty, and to take into account the period of time the person has had the condition and might be expected to continue to suffer the loss of faculty in comparison with a person of same age and sex whose medical condition is *'normal'*. Whilst incapacity is not defined in the legislation, percentages for certain conditions are prescribed in secondary legislation (see Social Security (Assessment of Long Term Incapacity) (Jersey) Order 2004).

2.7 Similarly, the Department's guidance defines incapacity as an:

> *'Inability to do things or do them equally well as a person of the same age and sex whose physical condition is normal, which arises from loss of faculty.'*

These definitions of incapacity emphasise the individuals relative ability to **perform** normal activities of life. Incapacity is a restriction on, or an inability to, undertake paid work associated with a loss of faculty (or impairment). However, inability to follow a particular occupation is ignored in the assessment.

2.8 Aids such as spectacles, joint replacements are to be taken into account by Medical Boards when assessing degree of incapacity.

2.9 In summary, there are two underlying notions in the Jersey system, one for Short Term Incapacity Allowance based on incapacity and another for Long Term Incapacity Allowance based on percentage loss of faculty.

2.3 Concepts

2.10 In May 2001, the World Health Organisation (WHO) issued, the *International Classification of Functioning, Disability and Health* (ICF), to classify health and health-related domains (or aspects) (WHO, n.d.).[9] This framework is meant to be applicable to all people, whatever their health condition, and to be relevant across cultures, age groups and genders (WHO, n.d.: 8).

2.11 The ICF is structured around the following broad components:

- Body functions (including mental or psychological functions) and structures, which can be qualified by an impairment.
- Activities (related to tasks and actions by an individual) and participation (involvement in a life situation). Both activities and participation cover the life areas (or domains) listed in Table 2.1. In classifying a domain, an assessor considers an individual's '*performance*' (what s/he currently does in their current environment) and their '*capacity*' (or ability to execute a task or action in a standard or uniform environment). The difference between performance and capacity provides guidance on what can be done to the environment to improve performance.
- Contextual factors (both environmental and personal) interact with a person's health condition and influence his/her level and extent of 'functioning'. Environmental factors may act as facilitators or barriers. (Note, personal factors are not classified in the ICF, but included for completeness.)

Table 2.1 WHO ICF: Activities and participation life areas

Learning and applying knowledge
General tasks and demand
Mobility
Self-care
Domestic life
Interpersonal interactions and relationships
Major life areas
Community, social and civic life

Source: WHO, n.d., Table 2

2.12 In the ICF (WHO, n.d.: 3):

- *Functioning* is an umbrella term encompassing all body functions, activities and participation; and
- *Disability* is an umbrella term for impairments, activity limitations or participation restrictions. Where

    - Impairments refer to problems (that is, a significant deviation, anomaly, defect or loss) in body functions or structures. The WHO definition of impairment is medical and based on the biological sciences; as such it represents a recognised deviation from a biomedical standard in the population. Moreover:

        > '*Impairments can be temporary or permanent; progressive, regressive or static; intermittent or continuous. The deviation from the population norm may be slight or severe and may fluctuate over time.*'
        >
        > (WHO, n.d. [12])

        Impairments can be congenital, arise during childhood or result from accidents or diseases that may or may not be work related. As mentioned above, this definition of impairment is similar to that of Jersey's usage of loss of faculty.
    - Activity limitations are difficulties a person may have in carrying out activities.
    - Participation restrictions are problems someone may encounter in taking part in life situations.

    Both limitations and restrictions are assessed against a population standard or norm; with a person's performance and capacity compared against an individual without a similar health condition.

2.13 Functioning is seen as the positive or non-problematic aspect both of body functions and structures and of activities and participation, whilst disability is the negative or problematic aspect. An individual's functioning and disability are viewed as outcomes of the complex interaction between the health condition (disease or disorder) of the individual and contextual factors. Such a definition allows for the possibility of two individuals with the same impairment having different experiences of disability – one may be disabled because of their environment, but the other, in a different environment, is not disabled.

2.14 The emphasis on contextual factors in the WHO definition serves to highlight the importance of non-health related factors. The ability of someone to undertake certain work tasks will be affected by the type and severity of an illness and/or impairment, and by an individual's other personal characteristics and their environment, such as the provision of training, their qualifications and experience,

age, employer discrimination, etc. (Rowlingson and Berthoud, 1996; Waddell and Aylward, 2005: 38). Whilst these other factors are important they are excluded from the legal and administrative definitions of incapacity and loss of faculty. Accordingly,

> *'The limitation of any assessment is that it ultimately provides information about performance: it can never be an objective measure of what the claimant is **able** to do or **should be able** to do'.*
>
> (Waddell and Aylward, 2005: 29, emphasis in original)

However, the successful management of incapacity will require staff and employers to take these other personal, social and environmental factors into account.

2.15 In addition, distinctions can be made between disease, illness and sickness. Disease is a condition or pathology that medical science can diagnose (Alexanderson and Norlund, 2004: 16; Waddell and Aylward, 2005: 7), whilst illness is the subjective feeling of being unwell (that is, the symptoms that people experience) (Finkelstein and French, 1993 quoted in Waddell and Aylward, 2005: 7). Sickness is a social role that society grants to people with an illness or disease (Waddell and Aylward, 2005: 7). People performing the sickness role are allowed certain 'rights' such as not having to engage in normal activities like attending work. Typically, people taking on the sick role do have an illness or disease, although it can be taken on due to a misdiagnosis by a doctor or someone claiming to be sick (even claiming an incapacity benefit) when they know they are not ill.

2.16 The correlation between these various concepts, and with incapacity and impairment / loss of faculty, is poor (Waddell and Aylward, 2005: 8). For instance, people may feel ill, but doctors are unable to diagnose a medical condition, or people may have a disease but not feel unwell. Similarly, impairments need not lead to incapacity; indeed, many people with mental and physical impairment undertake paid work. Nor does incapacity status mean that people cannot do any work (Waddell and Aylward, 2005: 37). A person with a severe impairment can be classed as incapacitated, even if they had recently been in work and so demonstrated an ability to work. Rowlingson and Berthoud (1996) have argued that:

> *'The view that incapacity is directly related to severity of impairment therefore ignores the relationship between type of work task and type of impairment. Someone who is very severely impaired in one way may nevertheless be able to perform some tasks … It therefore makes little sense to talk in general about incapacity to work. The same person will have different levels of (in)capacity for different types of task.'*
>
> (Rowlingson and Berthoud, 1996: 22)

2.17 Furthermore, there is a tension between the sick role, which is mainly about the social acceptability of not working, and a more empowering, civil rights based definition of disability, which emphasises the right to work (Waddell and Aylward, 2005: 48).

2.4 Baremas

2.18 The method used in Jersey to assess incapacity is commonly used elsewhere, including a number of European countries as well as the USA and Canada. The method, known as 'baremas' (or impairment table), involves assessing impairments usually against a percentage scale. Baremas scales have a long history and date back at least to the medieval period. Often they are used for war pensions and compensation for industrial injuries and diseases.

2.19 The percentage awarded translates to a tariff for compensation for the impairment. However, by definition, the compensation reflects the severity of the impairment rather than the (past or future) earnings of the claimant.

2.20 The Jersey method of assessment resembles a 'classical' baremas scale, whereby the degree of incapacity is taken directly from the description of the impairment (Brunel University, 2002: 47). However, other systems incorporate 'disabling effects', so that the consequences of the severity of an impairment on everyday activities are explicitly taken into account. For a given impairment there will be a range of percentages associated with differential impacts on daily life. Taking into account the disabling effect of a condition can be necessary because the same impairment might be incapacitating in one work setting but not in another. For example a hearing impairment will be more problematic for a member of an orchestra than for a postal worker (taken from Marin, 2003: 2).

2.21 Baremas scales are controversial. Criticisms of Baremas scales include the following (Brunel University, 2002; Marin, 2003; Pozzo *et al.*, 2002):

- Baremas scales are less satisfactory at assessing mental health conditions than physical conditions.
- A partial percentage award can be difficult to interpret in terms of the person's ability to work – what does, say, 50 per cent mean in this context?
- How are different impairments to be compared and a percentage derived – how can, for instance, the loss of a finger be compared with depression?
- Determinations are difficult to justify.
    - The percentages assigned to given impairments can appear to be arbitrary. In cross-national comparisons different percentages can be allocated to the same impairment. Indeed, in some countries different schemes can have different percentages for the same condition. The set percentages for impairments can also vary over time, reflecting advances in medicine, increase use of aids and adaptations and changing public

perceptions about certain conditions.
    - The logic for determining the overall score for someone with more than one impairment is unclear. Should the percentages be simply summed, or should certain impairments be weighted or should the total percentage be determined in a more holistic fashion?
    - Assessment is not simply a technical matter. Some argue that unless the schemes are subject to public scrutiny they lack legitimacy or public support. A related point is that the development of the assessment instruments can be seen as granting power to certain professional groups (doctors and administrators), because it appears to be a technical, scientific issue. However, who receives compensation, for what and at what percentage are matters of public concern and hence also 'political' issues.
- Assigning percentages give the assessments a *'flair of objectivity'* (Marin, 2003:10).
- Compared to other approaches to assessment, they can generate a relatively high number of complaints / disputes and (successful) appeals.

2.22 There are other assessment systems including (Brunel University, 2002; Pozzo *et al.*, 2002):

- Procedural approaches where incapacity is assessed by undertaking a process were various medical, vocational and other options for returning to work are explored. Only at the end of the process might the individual be deemed incapable of doing paid work.
- Capacity profiling approaches that use criteria about the functional capacities needed for employment and have a threshold for incapacity.
- Earnings replacement methods that attempt to estimate earnings lost due to a health condition or disability.

2.23 What is accepted is that some independent method of assessing incapacity is required in the administration of incapacity benefits.

2.5 Discussion: Assessing loss of faculty

2.24 To some extent the criticisms of Baremas outlined in Section 2.4 mirror some of the concerns expressed about Jersey's incapacity benefit system, notably about the percentages for loss of faculty appearing to be arbitrary and difficult to interpret. In other words, some of the criticism levelled at Jersey's system is almost inevitable; it stems from the method of assessment used.

2.25 No method of assessment for entitlement to incapacity benefits is perfect. The States may, therefore, decide that the existing assessment scheme is satisfactory. However, a consequence of this is that a certain amount of adverse comment about the incapacity benefit system will continue. Alternatively, the

States may wish to address the criticisms that are to some extent inherent in the method used. There are two broad policy options open to the States. First, to amend the existing system, and there are two main changes that can be considered:

- Introducing 'disabling effects' to the official guidance, this would help to clarify what percentage should be decided particularly in cases where the existing guidance suggests a wide range of possible percentages. This might help reduce the perceived arbitrariness of the scheme. Policymakers might wish to examine scales used elsewhere, such as the Spanish scale used for civilian disability (see Pozzo *et al.*, 2002).
- Increasing the public's confidence and trust in the existing system by making the process and the assessment method used more open and transparent.

2.26 Or, secondly, to plan the replacement of the existing assessment method with one based on, say, functional activities. This would probably entail reviewing alternative approaches and, given the need for public support, an extensive consultation exercise on what approach should be adopted.

2.27 Either approach will require considerable inputs of resources and time, and a significant political commitment. It is important that if making any changes to the existing assessment scale, the States involve a wide range of stakeholders and the public. For example, if the States sought to revise the existing guidance and incorporate disabling effects, then Delphi type methods could be used with panels of experts and members of the public to build a consensus on the percentages for losses of faculty and functional capability.

2.28 However, any amendments to the existing system will ultimately only be 'tweaks' and the fundamental criticisms of the Baremas approach outlined above remain. The States should, therefore, give serious consideration to replacing the current method used to assessing faculty of loss. Of the other approaches available, one based on functional ability would appear to offer a way forward for the following reasons:

- Rather than being impairment-driven, it is based on what activities claimants can and cannot do in everyday life, thus the basis for the assessment is more easily understood by the public and claimants.
- It is clear from the assessment what activities the claimant can and cannot do; this information can help the claimant and those supporting him / her identify suitable employment and the aids and adaptation an employer would need to make to secure a return to paid work.
- A related point, assessors could – as in parts of the UK - produce a report that outlined what the person could do (a Capability Report) for employment advisers, as well as an assessment of the person's incapacity.
- The introduction of a functional ability approach for incapacity benefits would complement that proposed to assess disability for the new Income Support

system.

- The Department could build upon the expertise and experience of the UK's Department for Work and Pensions, who are revising their existing functional ability approach as part of its wider reform of the incapacity benefit system.

2.29 The UK uses an approach known as the Personal Capability Assessment, and Appendix A gives an indication of the main activities covered and examples of the 'descriptors' (or criteria) used in the assessment. The States will need to develop a similar scheme that gives a percentage loss of faculty.

3 Attitudes towards and knowledge of the incapacity benefit system

3.1 Introduction

3.1 The qualitative research shows that the public's understanding of the current incapacity benefit system is low and whilst some third parties (advisers and General Practitioners) have an excellent understanding of the system, others do not. The review highlights the need for the Social Security Department to offer training courses to those who come into regular contact with incapacity benefit recipients and for key third parties, like General Practitioners, to better signpost people to services provided by the Social Security Department and other agencies.

3.2 This chapter draws upon qualitative research in particular the views and understandings of benefit recipients, staff and other key actors. However, it does not cover the views of employers (because they were not included in the research), nor is it based on any statistical survey of the island's population. It considers respondents' attitudes towards paid work and receipt of incapacity benefits and then their knowledge of the incapacity benefit system and in particular their understanding of the concept of loss of faculty.

3.2 Attitudes towards paid work and receipt of incapacity benefit

3.3 Amongst respondents there was widespread support for the principle that people with a health condition or a disability should be encouraged to obtain sustained employment. There is general support for the introduction of Long-Term Incapacity Allowance as an in-work benefit. Indeed, there is some recognition that paid work can improve an individual's well-being.[10] (Working whilst in receipt of Long-Term Incapacity Allowance can also mean that claimants do not have to use Parish Welfare.) Respondents support for the principle of Long-Term Incapacity Allowance recipients being able to work was not unconditional, however. They thought it important that recipients have some say over their movement into employment, and benefit levels for those not in paid work should meet basic needs. The latter suggests that respondents did not fully appreciate that Long-Term Incapacity Allowance was paid as compensation for a loss of faculty. Other sources (that is, Parish Welfare when the Review was conducted and Income Support in future) were designed to address recipients' basic needs.

3.4 In addition, some respondents expressed the view that some recipients did

not support the work ethic underpinning the benefit system. It was thought such people believed that the social security system should support them in their daily activities. The extent to which such views are shared in the community is unknown. However, one benefit respondent was quite open about not intending to return to work immediately:[11]

> *'Well it had always been my intention to have a period off during the summer, six months sabbatical, and then go and look for another job …'*

(The issue of compliance and fraud is briefly considered in Section 5.3.5.)

3.3 Public knowledge of incapacity benefit system

3.5 Based on the respondents' statements, it would appear that, in general, the public's level of knowledge about the incapacity benefit system is low. Non-claimant respondents, with one exception, thought that the public's knowledge of the incapacity benefit was poor. Indeed, statements by respondents who were benefit recipients confirm that they can have significant gaps in their knowledge of the current system, for example:

- being unaware that the incapacity benefit system changed in October 2004, or stating the only change they noted was the design of the Medical Certificate
- knowing that the system had changed but being unaware as to why it had changed
- being unaware that you could claim Short Term Incapacity Allowance and Long Term Incapacity Allowance at the same time or have multiple Long-Term Incapacity Allowance claims (for different health conditions)
- being unclear about what was involved in moving from Short Term Incapacity Allowance to Long Term Incapacity Allowance
- not realising that if the percentage loss of faculty is 15 per cent or less the allowance is paid as a general lump sum, rather than every four weeks
- not knowing that Long-Term Incapacity Allowance recipients cannot submit a Medical Certificate for the same ailment for which they receive as their Long-Term Incapacity Allowance.

3.6 Possible reasons for the low levels of knowledge about the incapacity benefit system include:

- New scheme – the system is relatively new and it will take time for people to learn about the new arrangements.
- No need to know – people will only find out about the system when they claim, and encounter an issue whose resolution requires them to understand an aspect of the system.
- No major impact – for some recipients of Short-Term Incapacity Allowance the processing of their claim is straightforward, the amount of the benefit is not

dissimilar to the previous benefit and so for them no significant change in the incapacity benefit system has occurred. Moreover, for some recipients their employers continue to pay their salary for at least a period of time at full pay.

3.7 The one exception referred to above was a respondent who thought the public had a *'reasonable'* understanding of the incapacity benefit system.

3.8 That recipients do not have a detailed knowledge of the benefit system is a finding consistent with other studies (Stafford, 1998).

3.9 This lack of knowledge in the general public is less of an issue if there are good sources of information and advice available from third parties. Whilst some third party respondents had a good knowledge and understanding of the incapacity benefit system, there were, for the author, some surprising and significant gaps in some third parties' knowledge and understanding of the incapacity benefit system. In all these cases the respondents involved are in positions where they can and do give advice to claimants. For example, General Practitioners unaware that Long-Term Incapacity Allowance recipients do not have to keep submitting Medical Certificate to Social Security Department for the relevant condition, the respondent who thought the threshold for Long-Term Incapacity Allowance to be paid as a lump sum was 50 per cent loss of faculty, the respondent who said that for someone with a 30 per cent loss of faculty the contribution credit given was three months (when it is one year), or the respondent who was unaware that Long-Term Incapacity Allowance is an in-work benefit.

3.3.1 Recipients' understanding of percentage loss of faculty

3.10 Chapter 2 discussed the concepts of loss of faculty and incapacity. Short-Term Incapacity Allowance is awarded because the recipient is incapable of work, but Long-Term Incapacity Allowance is paid as compensation for a loss of faculty. It is clear that this distinction is not well understood by benefit recipients. They feel that the percentage loss of faculty relates directly to their ability to work. Accordingly, a determination of less than 100 per cent can be difficult for recipients to understand. This is illustrated by the following quotes from three respondents:

> *When you get a 50 per cent does that mean that person is 50 per cent able to work, or 50 per cent unable to work, …* [?]
>
> *… here comes the letter, 65 per cent and … which 35 per cent of me do they think can work? I'm 65 per cent unfit and … that … means that I can't work.*
>
> *… their ability to work isn't any different to the day before, the law now allows them to work, … but the condition doesn't*.

3.11 For some respondents the percentages awarded for loss of faculty lack

'common sense' and some people cannot understand why some claimants have not been given a higher percentage loss of faculty. It is alleged by some recipients that some General Practitioners / consultants find it difficult to understand the decisions of Medical Boards.

3.12 From a recipient's perspective the system must appear to be confusing. At what could appear to be an arbitrary point in time (which may not relate to the progress of their condition) they appear to receive conflicting messages from different parties, some of which may also conflict with their own assessment of their employability. Although the boarding doctors try to explain that they are assessing loss of faculty and not looking at ability to work, it is confusing for claimants. Their General Practitioner has given them a Medical Certificate and told them they are unfit for work, yet they attend a Medical Board that can determine a percentage loss of faculty and they receive a letter saying they can now find employment. Claimants do not understand why the Medical Board does not assess their ability to work, especially as the Social Security Department talks about returning to paid work.

3.13 When some Long Term Incapacity Allowance recipients contact the Social Security Department to complain about the percentage loss of faculty awarded it is apparent that many people focus on their inability to work. Staff have to explain that it is not about whether they can work or not work, but is about their loss of faculty. Nonetheless, Long-Term Incapacity Allowance claimants with a low percentage loss of faculty sometimes feel that they cannot work. This confusion over the assessment of loss of faculty and what it means in terms of fitness for work is a major challenge for the Department.

3.14 These misunderstandings and gaps in knowledge exist despite some attempts by the Department to give presentations to key groups, for example, to selected personnel in health the social services, the Mental Health Steering Group, Citizens Advise, and the Carers Association.

3.4 Discussion: Improving public awareness of the incapacity benefit system

3.15 The review shows that there is a relatively low level of public knowledge about the new incapacity benefit system, even recipients and relevant third parties can have significant gaps in their knowledge. It would be unrealistic to expect the Social Security Department to raise users and non-users general level of knowledge about the social security system. However, lack of knowledge about the incapacity benefit system is not randomly distributed in the population, opening the possibility that information can be targeted on those that most need the information.

3.16 The Social Security Department should actively promote the expertise it and

other agencies can provide to the client group. Customers' levels of confidence and competence will vary and this will affect how well they can interact with the Department and with support services (Bailey and Pryes, 1996). So, for example, a highly confident and competent customer should require less support and help that one lacking in confidence and experience of the system.

3.17 That some customers will prefer to seek information, advice and support from other agencies, reinforces the need for the Social Security Department to fund the provision of training on incapacity benefits for the staff of other organisations dealing with the client group. Courses may have to be offered, say, every two or three years. In addition, it might be useful if the Department ran a one-off course on the incapacity benefit system for practicing General Practitioners. (Any course for General Practitioners could also cover the proposed Income Support changes.)

3.18 Whilst it would be inappropriate for General Practitioners to advise their patients about the social security system, they possibly could provide better signposting of services offered by the Social Security Department and other agencies. General Practitioners should be encouraged to display relevant posters and leaflets in their surgeries, as well as being more proactive in outlining the benefits of returning to work to those patients where they judge this appropriate.

4 Characteristics of claimants and claims

4.1 Introduction

4.1 This chapter outlines some of the socio-economic and health related characteristics of claimants of incapacity benefits (Sections 4.2.1 and 4.2.2) and examines the duration of Short-Term Incapacity Allowance claims (Section 4.3). The discussion is based primarily on an analysis of administrative data for claims with a start date between 1 April 2005 and 31 March 2006. Results are presented separately for Short-Term Incapacity Allowance and Long-Term Incapacity Allowance claims. Some comparisons are also made with the working population of Jersey. The figures for the (working) population are taken from published 2001 Census data (Statistics Unit, 2002). Section 4.2.3, which covers the client group's perceived barriers to returning to paid work, is taken from the qualitative interviews and UK literature on incapacity benefits.

4.2 Claimant characteristics

4.2 Over the period April 2005 to March 2006, 17,206 people started a Short-Term Incapacity Allowance claim and 540 began a Long-Term Incapacity Allowance claim. The 17,206 claimants of Short-Term Incapacity Allowance made a total of 28,529 claims, whilst the 540 claimants of Long-Term Incapacity Allowance made a total of 564 claims.[12] Where claimants made more than one claim during the year, the data relate to the characteristics for their first claim.

4.2.1 Socio-economic characteristics

Gender

4.3 Claimants of Short-Term Incapacity Allowance and Long-Term Incapacity Allowance were more likely to be male than female (Table 4.1). In particular six out of ten Long-Term Incapacity Allowance claimants (62 per cent) were male. This is despite there being slightly more women of working age in Jersey than men (51 per cent compared to 49 per cent) (Statistics Unit, 2002). The higher proportion of men claiming incapacity benefits may reflect the gendered nature of work, they are more likely to have had higher paid jobs where social insurance contributions were paid than females. Moreover, this gender difference is not unexpected given that there are increased risks of industrial injuries in certain male dominated occupations (for example, construction). It might also reflect that some women still have Married Woman's elections and are not entitled to the benefit because they have opted out of paying contributions; although the right to opt out was removed when individual entitlement was introduced in April 2001.

Table 4.1 Claimant characteristics, April 2005 – March 2006

Percentages

	Short-Term Incapacity Allowance	Long-Term Incapacity Allowance	Total
Gender			
Female	47	38	47
Male	53	62	53
Age			
25 and under	16	8	15
26-34	24	15	24
35-49	41	38	41
50-retirement age	19	39	20
Martial status			
Married	38	34	38
Single	49	43	49
Separated/Divorced/Widowed	13	24	13
Contribution status			
Employee	93	92	93
Non-employee	7	8	7
Base: STIA and LTIA claimants with a non-disallowed claim start date between April 2005 and March 2006	*17,206*	*540*	*17,746*

Source: Social Security Department, Administrative data.

Age[13]

4.4 Claimants of Long-Term Incapacity Allowance were on average six years older (44 years) than those of Short-Term Incapacity Allowance (38 years) (see also Table 4.1). The age distribution for Short-Term Incapacity Allowance claimants is broadly similar to that for the working age population:

	STIA	**LTIA**	**Working Population***
25 and under	16	8	17
26-34	24	15	22
35-49	41	38	37
50-retirment age	19	39	24

* Author's calculations using Statistics Unit (2002), Appendix B, Table III

4.5 However, there were proportionally more Long-Term Incapacity Allowance claimants aged 50 and over (39 per cent) than in the overall working population (24 per cent). There were, correspondingly, proportionally fewer Long-Term Incapacity Allowance recipients aged under 35 than in the working population. This age profile for Long-Term Incapacity Allowance is not unexpected as poorer health and the prevalence of disability are known to increase with age.

4.6 Male claimants tended to be older than female claimants. The average age of male Short-Term Incapacity Allowance claimants was 40 compared to 37 for female claimants, and the corresponding ages for Long-Term Incapacity Allowance claimants were 46 and 41.

Marital status

4.7 Short-Term Incapacity Allowance claimants were marginally more likely to be married or single than Long-Term Incapacity Allowance claimants, who in turn were more likely to be separated, divorced or widowed than Short-Term Incapacity Allowance claimants (Table 4.1). Claimants of both benefits were more likely to be single and less likely to be married than the adult population of Jersey (where 30 per cent and 52 per cent of the adult population are single and married, respectively (Statistics Unit, 2002).)

Employee status

4.8 The overwhelming majority of claimants were employees (93 per cent), rather than self-employed.

4.2.2 Health and incapacity

Health condition

4.9 The Department uses ailment codes to classify the illness or injury of claimants. There are about 236 codes. The qualitative research suggests that data based on the ailment codes is not robust enough for analytical purposes. General Practitioners can on occasions write diagnoses on Medical Certificates that do not fully describe a patient's primary health complaint. What is written on a Medical Certificate is to some extent a negotiation between the doctor and the patient (see Section 5.3.1). The latter can be concerned that mental health conditions, such as anxiety or depression, are not stated on a Medical Certificate, because the form is seen by their employer and this may prompt an unfavourable reaction. General Practitioners can agree to such requests from patients because there is a risk of 'doctor hopping' that is, paying patients may opt to consult other General Practitioners.

4.10 A recoding of the ailment codes into five broad groups confirms that the ailment codes cannot be used for analytical purposes, because mental health conditions are probably under-reported especially for Short-Term Incapacity Allowance (Table 4.2). Data for Incapacity Benefit in the UK would suggest that around 39 per cent of longer term claimants will be incapacitated for mental health and behavioural reasons. Consequently, no further analysis using the ailment codes is presented here.

Degree of incapacity

4.11 For Long Term Incapacity Allowance claims administrative data are available for the percentage loss of faculty at the start of the claim. The typical percentage of loss of faculty for claims commencing between 1 April 2005 and 31 March 2006 was 55 per cent, with a range between zero and 100 per cent.[14]

4.12 Figure 4.1 shows the distribution of percentage loss of faculty by *claimant*. The table reveals that claimants were fairly evenly distributed across the four percentage bands.

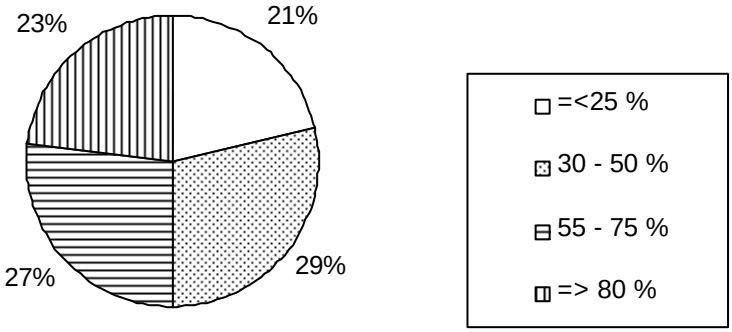
Table 4.2 Claimants' disability and health conditions, April 2005 – March 2006

Column percentages

	Short-Term Incapacity Allowance	Long-Term Incapacity Allowance	Total
Musculoskeletal	22	36	22
Chronic and systemic conditions	48	20	47
Mental health condition	7	30	8
Sensory impairment	<1	1	<1
Other	23	13	23
Base: STIA and LTIA claimants with a non-disallowed claim start date between April 2005 and March 2006	*17,206*	*540*	*17,746*

Source: Social Security Department, Administrative data.

Figure 4.1 Claimants' percentage loss of faculty at start of claim, April 2005 – March 2006



Base: LTIA claimants with a non-disallowed claim start date between April 2005 and March 2006 (n=612)
Source: Social Security Department, Administrative data.

4.13 Given that the likelihood of disability and poor health increases with age, it might be expected that older claimants would tend to have higher percentage loss of faculty awards; however, this is not the case. For example, older recipients (those age 50 or over) were as likely to have an award of 25 per cent or less as have an award of 80 per cent or more (Table 4.3).[15]

Table 4.3 Claimants' age by percentage loss of faculty at start of claim, April 2005 – March 2006

Row percentage

Age	Percentage of loss of faculty				
	25 and below	30-50	55 -75	80 and over	Total (Number)
25 and under	23	17	26	34	35
26-34	14	24	33	29	72
35-49	27	25	23	24	181
50 and over	17	35	29	19	196

Base: LTIA claimants with a non-disallowed claim start date between April 2005 and March 2006 and with a % faculty loss

Source: Social Security Department, Administrative data.

4.14 There were no significant differences in the initial percentage loss of faculty awarded and gender.

4.2.3 Perceived barriers to work

4.15 The client group is very diverse in terms of demographic characteristics and health conditions. Not surprisingly, individuals within the client group can face multiple barriers to returning to work. So whilst in the interviews respondents might highlight one or two barriers, policies aimed at helping people return to paid work have to be more nuanced and address a wide range of potential barriers. When claimant and non-claimant respondents were asked to identify the key barriers to employment for the client group they stated lack of suitable jobs then age discrimination. In general, it was the author who asked if disability discrimination was a barrier to employment, as it was not usually given spontaneously as a response. These perceived barriers are discussed in turn below.

Lack of suitable jobs

4.16 It was a commonly held view that there was a lack of suitable jobs for recipients of incapacity benefit. However, there are four elements to the rubric that there is a lack of suitable jobs. The first is that the recipients tend not to have transferable skills for the jobs that are available within the labour market. It was argued that the local economy is buoyant, but that (Long Term Incapacity Allowance) recipients lack the skills sought:

> *'… a lot of the people that have been on LTIA are people who have been in the building industry, and not necessarily have the transferable skills to take up a job in the finance sector. So it's finding appropriate work I suppose.'*

4.17 Certainly some Long-Term Incapacity Allowance respondents saw their

employment opportunities limited by their lack of skills. However, this situation was complicated by two additional factors:

- There was a perceived lack of funding for re-training programmes both within the Department and amongst other agencies. A related point was that respondents both within and outwith the Department thought that additional resources are required to deliver in-work support – support cannot always be completely withdrawn and some form of ongoing provision may be required.
- There was a view that older workers, especially those close to retirement age, would be unwilling to engage in re-training activities.

4.18 Secondly, there is a perceived lack of flexible job opportunities that would facilitate the gradual return to work, which is required if certain members of the client group are to achieve sustained employment and to supplement their Long Term Incapacity Allowance. Recipients of incapacity benefits:

> '… *very often … need short-term, part-time work, building up slowly towards the full-time job, that sort of thing.*

However, it was thought that employers want recruits who can *'hit the ground running'*, who can work full-time and undertake a variety of tasks (see Chapter 7).

4.19 Thirdly, it was believed that there is a seasonal influx of migrant workers who are prepared to accept low paid jobs and hence possible suitable jobs were not available to incapacity benefit recipients.

4.20 Fourthly, it was argued that even if a recipient had the required skills there was a lack of jobs for people who were in some way *'different'*.
For example, one respondent applied for a job at a supermarket, but was unsuccessful because, according to the supermarket staff, she was too experienced for the position. She has also registered with six employment agencies:

> '… *I've only had two interviews. And of course when you go for an interview they ask you how many days you've had off sick in the previous year and when I went to the last interview it sort of came up why I wasn't at work, and I said well I'm off work because of stress, I didn't go into what had caused it, you can't knock the company you're working for, it doesn't look good at the interview. But then the agencies were saying to me well you should have said, yes days off sick last year, but you shouldn't have mentioned that you were off sick because of stress, because they don't seem to want to take you on. It's very difficult to try and get into another job while you've been on incapacity.'*

4.21 Furthermore, some respondents who were recipients were dismissive of the jobs advertised on the Department's website, which could be seen as too low paid:

'… there's plenty of jobs in catering, or in the hospitality section, and various porters, night porters, the odd receptionist job coming up, and it's like all in that area.

There are, however, other sources for vacancies available on the island.

Age discrimination

4.22 Long Term Incapacity Allowance recipients tended to be older than both the general population and Short Term Incapacity Allowance recipients (Section 4.2.1). Non-recipient respondents believed that older workers found it almost impossible to find employment and recipients said that there was definitely age discrimination in the labour market.

Disability discrimination

4.23 Jersey does not have any legislation outlawing disability discrimination in the workplace, although such legislation is planned.[16] However, Jersey does have employment legislation that is seen as making employers more understanding of people with a health condition or disability. Under the employment legislation, employers can dismiss an employee on grounds of lack of capability, which arises when an employee is either not good enough to do the job or not fit enough to do the job. It was believed that employers are less likely to terminate an employee's contract of employment because of sickness absence than in the past. In the past terminating employment because of capability was *'almost automatic'*, now employers need a medical prognosis about an employee's return to work capabilities, to have discussed the issue with the employee, to have warned them that their job is at risk and the employer must make a proper business judgement.

4.24 Respondents' views on the extent of employer discrimination on grounds of disability were mixed. On the one hand, some respondents believed that there was little discrimination, or that they had no evidence of discrimination. This lack of disability discrimination was attributed to:

- the majority of employers knowing how to deal with disability issues;
- a buoyant labour market / low unemployment means that employers are likely to recruit people with disabilities;
- organisations like Jersey Employment Trust and Workwise are successful in influencing employers' practices (see Section 6.4); and
- Jersey is a relatively small community and this means that there might be less discrimination because people know one another.

4.25 On the other hand, some respondents were clear that there was discrimination in the labour market against disabled people, although it was often seen as occurring in small businesses (see Chapter 7 and BBC, 2003). Others

simply thought that a risk averse employer confronted by an able bodied applicant and one with a disability or health condition is likely to appoint the former rather than the latter.

4.26 In some cases discrimination against people with a health condition or disability was not thought to be '*deliberate*'. Rather,

> '… *I think it's because people aren't aware, they don't realise and it's a more ignorance thing.'*

Some businesses (such as, the larger (UK) chains) are seen as excellent and supportive in their dealings with disability issues. It was suggested that amongst other businesses more could be done to raise awareness of the needs of disabled people and how they can be met.

4.27 However, it is apparent that some respondents saw the discriminatory practices of some employers as intentional. It was observed, for instance, that some employers did not want disabled people to work in positions where they would deal directly with customers. By implication these employers were not prepared to challenge the stigma often attached to being disabled.

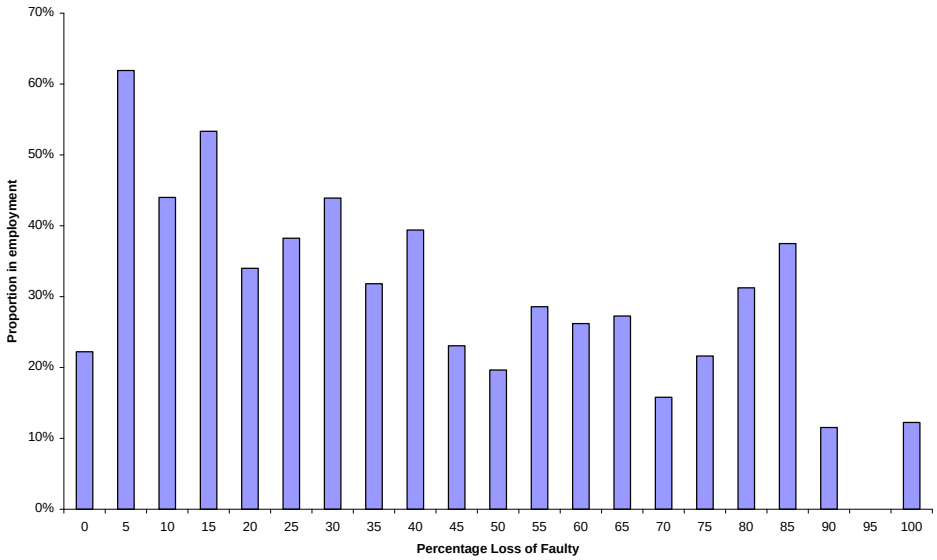
4.28 Based on UK research (Stafford, 2006) it is possible that those believing that there is no, or little, disability discrimination do so because they use a relatively narrow definition of disability. This definition, which is commonly held by employers, emphasises physical and sensory impairments. It is a definition that ignores, for example, people with diabetes or dyslexia. In the absence of contrary evidence, and based on UK research, policy makers ought to assume that, using a wider definition, there is discrimination on grounds of disability.

4.2.4 Long-Term Incapacity Allowance claims and paid work

4.29 A separate analysis of Long-Term Incapacity Allowance claims reveals that at some point over the period May 2005 to April 2006, 30 per cent (or 210 claimants) had undertaken some form of employment and paid social insurance contributions. Under the previous benefit system none of the claimants with long-term illnesses would have been entitled to work.

4.30 Although a third of claimants (33 per cent) who had worked at some point had a percentage loss of faculty of 55 per cent or above, most (59 per cent) had a percentage loss of faculty of under 50 per cent. Figure 4.2 shows that there was a tendency for those with lower percentage loss of faculty awards to be more likely to have worked at some point, although there is also a rise in the proportion in employment between 75 and 85 per cent.

Figure 4.2 Claims with contributions paid by percentage loss of faculty, May 2005 – April 2006



Base: 184 (Excludes cases where percentage loss of faculty is unknown)
Source: SSD Administrative statistics

4.31 The claimants who had worked also tended to be younger; for example, 48 per cent of those in work at some point were aged under 40 compared to 33 per cent of those with no recorded earnings.

4.32 The claimants' average contribution payments was £5,179 per annum. However, there was considerable variation around this average. Only 50 claims (or 24 per cent of those paying contributions that is seven per cent of all claimants) paid contributions above the contribution threshold.[17] For those with earnings above the contributions threshold it is unknown (without more in-depth analysis) whether they worked for the whole year or in a high paid job but only for a few months. It follows that three-quarters of those in paid work (76 per cent) were in relatively low paid jobs, or only worked for short periods of time. Claimants may have worked for short periods of time because they might have been trying out a return to work which was (initially at least) not successful, or doing small amounts of work as part of a planned gradual return to work, or were engaged in seasonal work.

4.3 Durations

4.33 By taking a cohort of Short Term Incapacity Allowance claimants whose claim commenced between 1 and 30 April 2005 it is possible to examine the duration of claims and the characteristics of the claimants. In this section, the calculation of the length of a claim is based on a seven day week, and so can include non-working days, such as weekends.

4.3.1 Claim durations

4.34 The average duration of the 1,147 Short-Term Incapacity Allowance claims

started in April 2005 is 21 days. However, the skewed nature of the distribution of the number of days (see Figure 4.2) means that the average is not a good measure of the typical claim, rather the mid-point or median of eight days is a better measure of the typical claim.

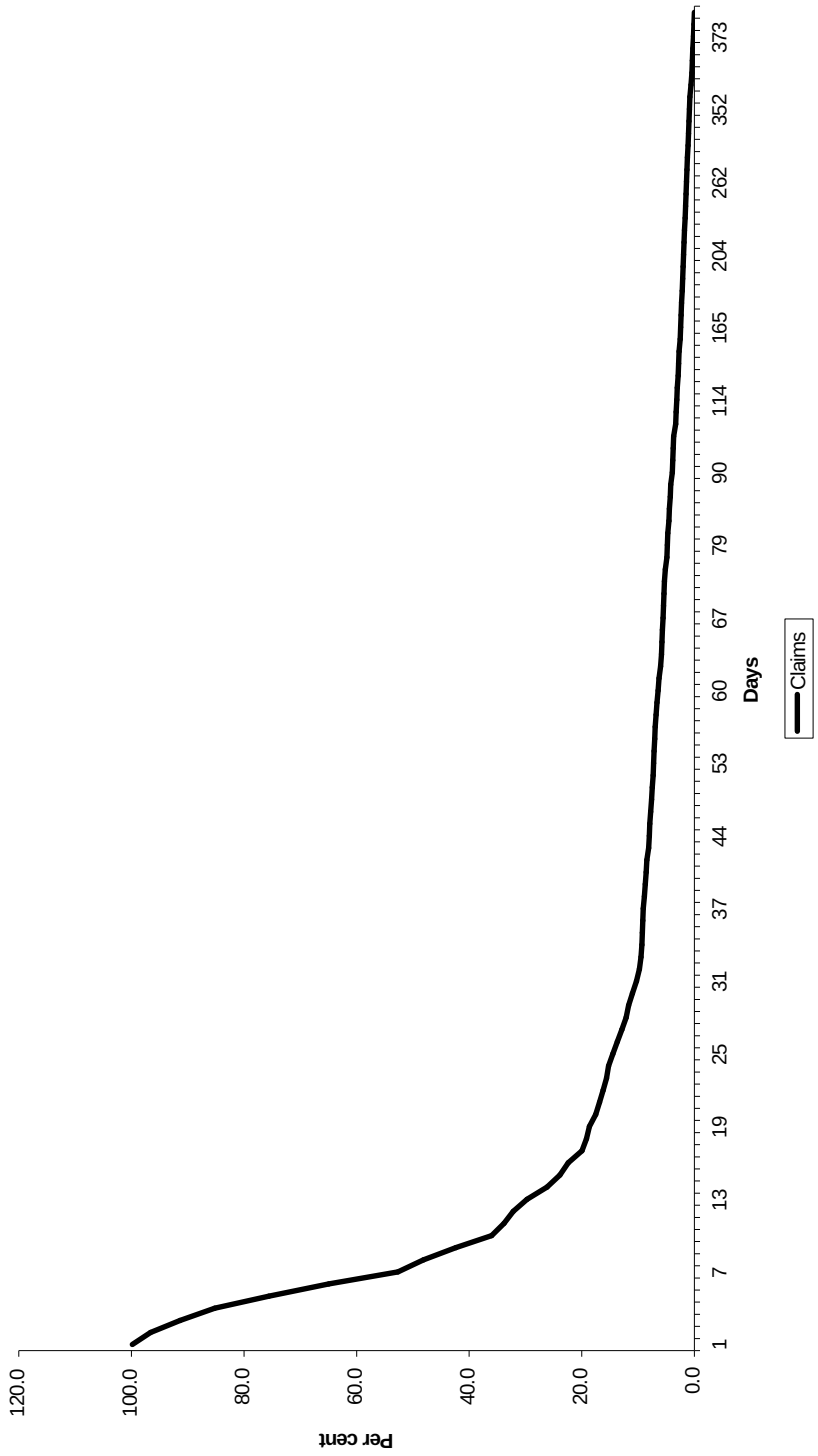
4.35 Most claims last only for a short period. Nearly half of claims (47 per cent) lasted for less than eight days. One-quarter of claims (26 per cent) lasted 15 or more days and only 10 per cent lasted longer than 32 days.

4.36 Two per cent of claims lasted for more than six months (182 days).

4.37 The concave shape of Figure 4.2 means that the probability of leaving Short Term Incapacity Allowance decreases with duration of time on the benefit. This diminishing probability could represent (Berthoud, 2004):

- State dependence (or duration effect) – that is, the recipients' conditions deteriorate over time (for instance, due to depression and loss of contact with the labour market people lose transferable skills and self-confidence) and consequently the likelihood of returning to paid work declines; and / or
- Omitted heterogeneity (or selection effect) – that is, different groups of individuals (for example, younger and older workers) have different exit rates, so that those most likely to leave benefit do so, but those harder to help remain on Short Term Incapacity Allowance.

Figure 4.3 Percentage duration of claims, April 2005



Source: Social Security Department, Administrative data.

The relative importance of these two significant effects is debatable (Overbye, 2005: 159-160), but duration effects are probably the more influential.

4.38 The shape of the graph in Figure 4.2 (that is, looking at where the slope of the line changes) suggests that there were five sub-groups of claim:

1. the 47 per cent of claims lasting up to eight days;
2. the 17 per cent of claims lasting eight to 10 days;
3. the 16 per cent of claims lasting 11 to 17 days;
4. the 10 per cent of claims lasting 18 to 32 days; and
5. the 10 per cent of claims lasting 33 or more days.

4.39 The median number days for each of these groups are: 5 days, 9 days, 14 days, 25 days and 77 days, respectively. It follows that most spells of incapacity end before the Department's early intervention procedures are used (see Section 6.2.1).

4.40 It is possible to explore the commonality of the characteristics of claimants in these five 'duration groups'.

4.3.2 Claimant characteristics by duration

4.41 The April cohort of claimants is fairly representative of people who had commenced a successful claim throughout the year, April 2005 to March 2006. A comparison of the distributions for the total column in Table 4.4 with that for the Short-Term Incapacity Allowance column in Table 4.1 shows that, with one exception, the percentages are similar for the selected characteristics. The exception is that there were proportionally more single people and fewer married claimants in the 'general' claimant population than in the cohort (49 per cent compared to 44 per cent and 38 per cent compared to 42 per cent, respectively).

4.42 There were some, but not many, differences in the characteristics of claimants in the five duration groups identified in Section 4.3.1 above (Table 4.4). Individuals claiming Short-Term Incapacity Allowance for less than eight days were more likely to be female (53 per cent) and single (51 per cent) than those claiming for longer periods. Those claiming for 18 to 32 days were more likely to be male (64 per cent) than for any other period of time.

Table 4.4 Claimant characteristics by duration group, April 2005

Column percentages

	Duration (Days)					
	<8	**8 - 10**	**11 - 17**	**18 - 32**	**33 >**	**Total**
Gender						
Female	53	49	44	36	48	48
Male	47	51	56	64	52	51
Age						
25 and under	17	11	8	8	6	13
26-34	29	19	24	21	22	25
35-49	39	47	42	43	46	42
50-retirement age	15	23	26	28	27	20
Martial status						
Married	39	45	48	44	42	42
Single	51	42	37	38	31	44
Separated/Divorced/Widowed	10	14	15	19	27	14
Nationality						
British / Jersey	76	74	76	73	74	75
Portuguese	12	13	13	10	11	12
Irish	3	3	2	4	4	3
Polish	2	1	0	2	2	2
Other EU	1	2	3	2	3	1
Other	7	8	6	10	7	7
Contribution status						
Employee	94	91	83	84	88	90
Non-employee	6	9	17	16	12	10
Base: STIA claimants with a non-disallowed claim start date in April 2005	*523*	*188*	*179*	*112*	*105*	*1,107*

Source: Social Security Department, Administrative data.

4.43 As might be expected, the proportion of younger recipients decreases as length of claim increases. That is, younger recipients are likely to leave Short Term Incapacity Allowance earlier than older recipients. For example, 17 per cent of those with a claim of less than eight days are aged 25 or under, compared to six per cent with a claim of 33 or more days. There is a similar decrease in the percentages for the next age group in Table 4.4, those aged 26-34 years. Whilst there is a statistically significant correlation between age of recipient and claim duration (Spearman's $r=0.207$; $p<0.01$), the association between age and duration of claim is not straightforward. Those aged 50 and over did not necessarily have longer claim durations. Although the proportion of older claimants increases for those claims lasting more than eight days, it is those aged 35 – 49 years who were more likely to have had a longer claim. For instance, 46 per cent of those with a claim of 33 or more days were aged 35 to 49 compared to 27 per cent of those aged 50 or over.

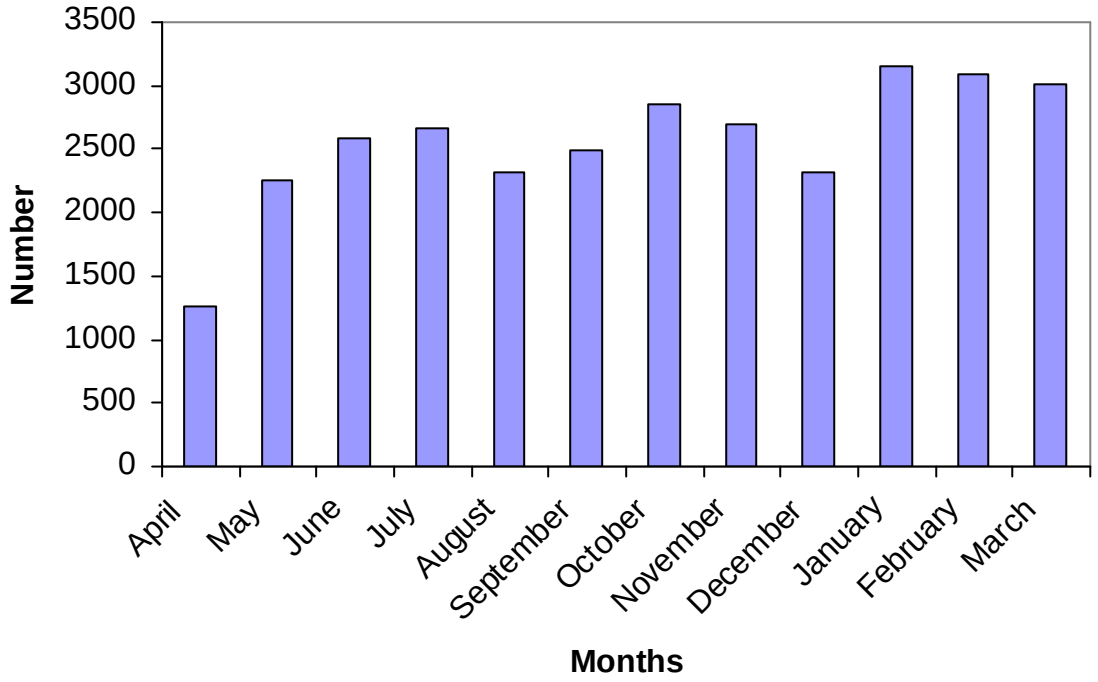
4.44 Moreover, the proportion that is single decreases as the duration of the claim lengthens. For example, a half of claimants with claims of under eight days are single (51 per cent) compared with nearly a third (31 per cent) claiming for 33 or more days. Further, the proportion of employees falls and that of non-employees increased for claims of more than 11 days.

4.45 The Department in the medium term will be able to track those that stay on Short Term Incapacity Allowance for a longer period of time in order to see what proportion move on to Long Term Incapacity Allowance. Such information should help with developing policy in this area.

4.3.3 Seasonal variations in Short-Term Incapacity Allowance claims

4.46 The evidence for a seasonal variation in Short Term Incapacity Allowance claims is mixed. In the qualitative interviews, one General Practitioner thought that there was a seasonal variation in the issue of Medical Certificates (even that in some instances it was an attempt to disguise unemployment). Another General Practitioner had not noticed any seasonal pattern in patients' requests for Medical Certificates. Although he did issue more Medical Certificates in winter months for acute illnesses, coughs and colds and so on, there was no seasonal pattern to those patients that go on to be off work long term. A third respondent maintained that there used to be seasonal peaks and troughs in claims, but recently the inflow has been high throughout the year. This may reflect changes in the island's economic structure. There is less seasonal tourist work, and hence fewer claims at the end of the summer season because people were *'depressed'* and had no work.

Figure 4.4 Start date of Short-Term Incapacity Allowance claims, April 2005 – March 2006



Base: Claims with start date 1 April 2005 – 31 March 2006; n=30,704.
Note: Data includes disallowed claims
Source: Social Security Department, Administrative data.

4.47 The administrative data (Figure 4.3) supports the view that, excepting April 2005, the inflow of claims over the year 2005-06 was relatively constant. There were troughs at Easter (April 2005), mid-summer (August 2005) and Christmas (December 2005), but the last two saw less steep falls in the number of claims. The reduction in the number of cases between July and August was 354 claims (or -13 per cent), and the November to December fall was 377 claims (or -14 per cent). All three troughs could reflect an increase in the demand for seasonal workers. However, the higher number of claims between January and March would also be consistent with more people suffering colds and flu. Moreover, the increase in the number of claims between May and July is not necessarily consistent with a possible increase in demand for seasonal work in the hospitality and catering industries at the beginning of the summer. However, the average duration for claimants commencing a claim in August was 18 days. That the average duration for August is shorter than the overall cohort duration of 21 days (see Section 4.3.1) might suggest that some claimants minimised their time on benefit because there was plenty of seasonal work.

4.4 Discussion: For how long should people be able to claim Short Term Incapacity Allowance?

4.48 If the overwhelming majority of claims last for less than 33 days (c.f Section 4.3.1), this raises the issue of whether allowing individuals to claim Short-Term Incapacity Allowance for up to one year is too long a period. There is evidence that the longer a person is economically inactive, the more distant they become from the labour market and hence the harder it is for them to return to employment.[18] There is also the related argument that there is an increased risk of depression the longer someone is in receipt of an incapacity benefit. The issue arises because recipients of Short-Term Incapacity Allowance are not allowed to work and, as acknowledged by some respondents in the qualitative research, this can make it harder for people claiming the benefit for longer periods of time to return to paid work, or even access rehabilitation programmes.

4.49 The advantages of paying Short-Term Incapacity Allowance for one year are that it does provide (potential) claimants with a high degree of security – they know that they can receive benefit for up to one year. In addition, the one year matches the period covered by the occupational sick pay schemes operated by some (larger) firms and the public sector (Social Security Committee, 1995: 107). Moreover, reducing the maximum period of incapacity for Short-Term Incapacity Allowance is likely to be highly controversial. People have paid their social insurance contributions, and there is an implied contract with the state whereby in return for contributions people have an entitlement to up to one year of Short Term Incapacity Allowance. Reducing the maximum period of incapacity could also be seen as undermining the contributory principle.

4.50 Nonetheless, on balance, reducing the maximum period of time that someone can claim Short-Term Incapacity Allowance is recommended. Allowing people to claim Short-Term Incapacity Allowance for up to one year and not allowing any participation in the labour market is probably neither in their nor Jersey's best interests. Although only a small proportion of Short-Term Incapacity Allowance claimants would be affected, shortening the maximum period of incapacity would be a strong signal about the importance of returning to work.

4.51 Proposing a new maximum period of incapacity for Short Term Incapacity Allowance is not easy and further research is required. The Department needs to investigate the longer term outcomes of Short Term Incapacity Allowance claimants in order to help it determine the benefits and costs of reducing the maximum period of incapacity. In particular it needs to determine the time period after which it is highly likely that any Short Term Incapacity Allowance recipient will flow onto Long Term Incapacity Allowance. The setting of a new maximum period of incapacity for Short Term Incapacity Allowance also needs to be set in the context of other reforms to the incapacity benefit system. Later on, it will be recommended that the Department commences its intervention scheme earlier (at five weeks) (see Section 6.6.1), if this is accepted then it is unlikely that the maximum period of incapacity should be more than six months. A six months maximum:

- ought to give sufficient time for the Department to work with Short Term Incapacity Allowance recipients needing support returning to employment;
- it is, arguably, sufficiently long enough so that those with more severe, longer term conditions do not feel that they are under undue pressure to return to work; indeed, they will move more quickly to the support provided by Long Term Incapacity Allowance; and
- it leaves the overwhelming majority of recipients (98 per cent) unaffected by the change.

5 Delivering incapacity benefits

5.1 Introduction

5.1 This chapter considers the structures and processes within the Social Security Department for administering incapacity benefits. However, the role of Medical Boards, Review Boards and the appeal system are discussed in Chapter 8, and the services available to incapacity benefit recipients to help them return to work are considered in Chapter 6.

5.2 Key issues highlighted in the chapter are the certification process (Section 5.3.1), and the Department's communications with claimants (Section 5.3.3).

5.3 The chapter draws upon the qualitative interviews with staff, General Practitioners and claimants, as well as documentary sources and the author's own observations.

5.2 Social Security Department

5.4 Since the incapacity benefit system was introduced in October 2004, the Social Security Department has reviewed its organisational structure and made changes. Further staffing and structural changes will arise from the introduction of the proposed Income Support system (Section 1.6).

5.5 Implementing a major change in public policy will always represent a significant challenge to policy and operational staff, users and other key actors. All policies encounter unforeseen problems when being implemented; there is no such thing as the perfect implementation (Gunn, 1978). There were, as would be expected, some difficulties encountered following the implementation of the incapacity benefit system in October 2004. For example, it was claimed by one respondent that staff training and written guidance were not always given the high priority they deserve in all sections of the Department. However, it is not clear that the difficulties the Social Security Department encountered were any worse or better than that faced by other benefit administrations implementing large scale reforms. The Department should not be overly criticised for changing policy and procedures in the light of emerging evidence, because this indicates that it is prepared to learn from experience and modify policy as required. Moreover, it appears that the Department has learnt lessons from reforming the incapacity benefit system some of which have been applied to the introduction of the proposed Income Support scheme.

5.6 The Social Security Department is located at Philip Le Feuvre House, La

Motte Street, St Helier. This office comprises a general reception area, reception areas and processing units for each of its four Zones - Family, Pensions, Health and Work – a reception area and examination room for Medical Boards, offices for cross-benefit and corporate services, and a call centre. Incapacity benefits are administered by the Health Zone, whose other responsibilities include the gluten free food subsidy, health scheme, Health Insurance Exceptions, people with a disability and carers, and the Jersey Travellers Guide to Health.

5.7 Within the Health Zone, approximately eight of the 16 staff focus on administering incapacity benefits. The staff complement comprises 11 advisers, who have considerable experience of the new scheme, and five assistants. Claims are processed at the 'back' of the office, and, on a rota basis, advisers deal with claimants' queries at the 'front' of the office in the Health Zone's reception area.

5.8 When the new incapacity benefit system and computer system were introduced, the Health Zone had *'a lot'* of contract staff, especially assistants to help with the restructuring of the organisation, and this inevitably meant that more senior staff spent a considerable amount of time on training new recruits because staff turnover amongst those on temporary contracts was relatively high. Staff turnover is now more stable.

5.9 The Work Zone is not staffed as a job centre, but it does include a vacancy display area, and can provide (adult) careers advice. Incapacity benefit recipients involved in the qualitative research had used services provided by Work Zone, including the on-line job vacancy service and training courses. The Workwise service is a special employment service that people with a health condition or disability can use. The services provided by Workwise are considered in more detail in Chapter 7.

5.10 For visitors the venue offers a well laid out, welcoming customer reception area.

5.11 There are no other social security offices on the island, although under certain circumstances some claimants can receive a home visit from staff.

5.2.1 Approach to administering incapacity benefits

5.12 Claims are processed using a computer system, the New Employment Social Security Information Exchange (NESSIE), which seeks to process claims with as little staff intervention as is possible. NESSIE queues cases ('alerts') that require staff attention.

5.13 Notwithstanding, the use of an automated system it is not easy to produce regular monitoring reports that can be used to monitor the workloads and actions of staff. Managers have to request an audit report, but even then it can be difficult to identify someone's performance. However, amendments to NESSIE that will improve its performance monitoring functionality are planned.

5.14 In addition, there was a view expressed by respondents from both within and outwith the Department that if the Department was going to help an increasing number of people with health conditions and disabilities into work there would – even if resources are better targeted – be a need for increased resources. However, respondents were not asked to provide any, nor did they offer, details on additional resources they thought necessary. Moreover, conducting a cost-effectiveness analysis is beyond the scope and remit of this Review.

5.15 There were also slightly different perspectives on internal communications. One view was that the personnel involved in internal discussions on proposals should be broadened in scope to include representatives from a wider range of units. Another view was that at meetings those attending could be more open about issues that affect their areas of work. A third view was that the introduction of the new Incapacity Benefit system has improved communications within the Social Security Department, there is now a better understanding of the work, and of the client groups, of different parts of the organisation.

5.2.2 Social Security Department staff workloads

5.16 Staff process a large number of claims for incapacity benefit each year. The turnaround times are believed by respondents to be improving – one respondent estimated an average of 3.5 days per claim.

5.17 Staff workloads are demand driven and one respondent thought they were *'high'*, although they have been higher in the past. Processing staff respond to 'alerts' generated by the business rules incorporated in NESSIE (c.f. Section 5.2.1). This means that advisers and assistants deal with a diverse range of alerts. As a consequence staff sometimes feel pressurised.

5.18 Long-Term Incapacity Allowance cases tend to generate more alerts and queries than Short-Term Incapacity Allowance claims, because it is more difficult to set business rules that would allow automatic processing for this benefit. Advisers process the more complex cases.

5.2.3 Computer system (NESSIE)

5.19 As already mentioned, incapacity benefits are administered by NESSIE, which is a bespoke system introduced in January 2005. The system runs most of the Department's social security benefits and interfaces with the Department's payments system (Navision).

5.20 NESSIE should provide straight through processing, from scanning an application to payment. However, one respondent estimated that only a half of claims would be processed without a staff intervention. Although management information reports on the proportion of cases that are processed can be produced, reports are not regularly produced.

5.21 There have been some problems with the functionality of the computer system. For instance, NESSIE was not designed to deal with Long-Term Incapacity Allowance recipients having a Short-Term Incapacity Allowance claim for a different condition. However, the computer system does now allow Short-Term Incapacity Allowance claims to be run in conjunction with a Long-Term Incapacity Allowance claim. There have been other issues, such as duplicate payments, that have been successfully resolved.

5.22 Nevertheless, the management and performance reporting facilities of NESSIE still appear to be nascent and could be enhanced. For example, as the processing is automated, staff do not always get the opportunity to examine claims carefully and determine whether there should be any control actions set early on in the claim. Thus staff can no longer check automatically for *'seasonal claims'*, for example, when hotels close at the end of the summer to check if someone submitting a claim might be do so because their employment had ceased. The implication is that fraud is undetected. Whilst the system can be interrogated, staff ought to be able to access information held on the system more easily in order to investigate possible fraud cases.

5.3 Application process

5.3.1 Certification of incapacity by General Practitioners

The certification process

5.23 To claim Short-Term Incapacity Allowance individuals require a Medical Certificate from a General Practitioner or a hospital doctor/consultant. The Medical Certificate is the claim form for Short-Term Incapacity Allowance. A recipient's first Medical Certificate for a period of incapacity is for maximum of four weeks, certification can then be for up to 13 weeks. Accordingly, being signed off paid work for a year does not necessarily involve that many interactions with General Practitioners or issued Medical Certificates.

5.24 General Practitioners will *'usually'* know if a patient is in receipt of an Incapacity Benefit, as many consultations are about renewing a 13-week Medical

Certificate, and General Practitioners know that issuing a Medical Certificate will usually result in a claim for Short Term Incapacity Allowance. In addition, their practice computer system will detail any impairment(s) that the patient might have.

5.25 Certification takes place in a context where patients pay charges for medical services. Patients are seen as an *'asset'* to General Practitioners, and doctors do not want to undermine their relationship with them. General Practitioners interviewed were aware that a patient may change their doctor if they are unhappy with the service they provide. However, patients moving practises is believed to be rare; one estimate was that about five per cent of patients will change General Practitioner each year. Nonetheless, this financial regime helps to structure the General Practitioner-patient relationship so that the decision whether to grant a Medical Certificate is more of a negotiation between doctor and patient. For General Practitioners it is important that the patient feels that they are not being pushed into returning to work before they are ready to do so. General Practitioners believe that most patients are keen to return to work, but a few are thought to adopt a 'sick role' (see Section 2.3).

5.26 General Practitioners and patients are equally likely to raise the issue of certification. For General Practitioners a number of factors are taken into account in the negotiation, including is a certificate a medical necessity, the patients' circumstances and whether they have requested a Medical Certificate. General Practitioners consider the nature of the consultation *'… and the type of patient, who they are, what they're trying to achieve.'* The General Practitioner will adapt their style to the patient and respond to how the patient presents their condition. Sometimes agreeing to sign people off work for a short period is used as a bargaining point so that, for instance, antibiotics are not prescribed.

5.27 Where there is a disagreement between the two parties about whether a Medical Certificate should be issued, General Practitioners will tend to issue a sick note, although a Medical Certificate can be issued for a short period of time to ensure an early review of the case. This is because if a patient states they are not fit for work, it is *'very hard'* for General Practitioners to argue the contrary. Although General Practitioners might not refuse to issue Medical Certificates, they might try to convince patients that they do not need time off work.

5.28 Many patients do not want a certificate, some worry about losing their jobs and are not always willing to accept a Medical Certificate. Such sickness presenteeism is thought to be common in the finance industry, amongst employees in more senior management positions, the self-employed and those working for a small business who might feel that they need to be present at work because of commitments made to others and/or they might lose out financially. Those believed to be more likely to accept a Medical Certificate are those working for a large organisation who may adopt the view that a short absence will not adversely affect them, colleagues or their employer, and those doing more

'mundane' jobs.

5.29 In general, General Practitioners do not discuss the patient's return to work. Respondents who were recipients typically said that when they first visited their General Practitioner about their health they did not recall having a discussion about returning to work. In the limited time available for a consultation, asking about a patient's ability to work is not viewed as a primary consideration by some General Practitioners. Indeed, some General Practitioners do not perceive it to be their role to encourage people to return to work.

5.30 However, the consultation can cover the nature of the work patients undertake as this can affect the length of time for which the certificate is issued; for example, the timing of the patient's next shift. Nevertheless, deciding how long to sign someone off work is *'tricky'*. The decision involves using rules of thumb, judgement about individual case and guess work.

5.31 For some General Practitioners the *'onus'* for encouraging people to return to work rests with Medical Boards, and not with General Practitioners. The expectation is that Medical Boards and the Social Security Department will *'force'* the issue and get patients capable of some work to return to employment. Medical Boards are for General Practitioners a *'last resort'* that can be used to review cases, plus for the public sector there are independent medical assessments conducted by Capita.

5.32 That the certification process is relatively complex and can be difficult for General Practitioners to administer has been found in other studies (see Hiscock and Ritchie, 2001).

5.33 The completed Medical Certificate is forwarded to the Social Security Department, possibly via an employer. The Medical Certificate can be posted or hand delivered to reception staff; if the latter, then it should be checked by staff.

Problems with Medical Certificates

5.34 Some respondents identified the following four main concerns with Medical Certificates:

- Misleading diagnoses (and hence incorrect Social Security Department ailment codes) are sometimes used on Medical Certificates to conceal from employers the nature of the patients' health conditions. Occasionally, patients are worried about what their employer will either read in to, or take from, the diagnosis on a Medical Certificate. General Practitioners, who see their primary duty is to their patients, will sometimes write a diagnosis that is acceptable to the patient, for example, nervous exhaustion is diagnosed rather than stress. Such diagnoses are perceived as covering the condition. However, there is a belief that some General Practitioners can go further than this and diagnose, say viral illness rather than depression.

- Some General Practitioners were initially reluctant to use the Social Security Department's own ailment codes. General Practitioners use a different classification system (Read Codes) for health conditions to the Department, but when the Department was specifying NESSIE local General Practitioners were not operating computerised systems.[19] Staff on occasions have had to enter an aliment code based on the diagnosis on the Medical Certificate. However, in a small number of cases it is believed that the stated diagnosis, and hence the assigned aliment code, is not a complete summary of a patient's main condition. This error could mean that reports generated by the computer system for ailments are misleading and that some individuals are not targeted for an early intervention when this could be beneficial for them (see Section 6.2).

- Medical Certificates are sometimes issued inappropriately and in effect conceal unemployment or early retirement. As mentioned above the certification process involves a negotiation between General Practitioner and patient, and on occasions it is possible that people who are not as unwell as they claim do receive a Medical Certificate. Some claimants have told staff that their General Practitioner has signed a Medical Certificate because they were unemployed. However, some General Practitioners will write to the Social Security Department stating they have doubts about the nature of their patient's ill-health.

  It was also alleged that Medical Certificates are sometimes being issued in order to enable Long Term Incapacity Allowance claimants to top-up their benefit. There was a belief that when patients move on Long-Term Incapacity Allowance and receive a percentage of their benefit, General Practitioners are prepared to issue Medical Certificate so that the patients can claim Short-Term Incapacity Allowance in order to top-up their benefit. One respondent thought doctors were unaware of the consequences when they were issuing Medical Certificates to help a patient 'top-up' their Long Term Incapacity Allowance.

- General Practitioners can enter the wrong date for the termination of a period of incapacity. Short Term Incapacity Allowance respondents reported that they had encountered delays in the payment of their benefit because their General Practitioner had entered the wrong date in their first Medical Certificate for a period of incapacity. For instance, one respondent encountered problems because his General Practitioner had signed him off for more that the required 28 days for a first certificate (three months). It was only after he had telephoned the Social Security Department after four or five weeks after submitting his Medical Certificate that he discovered the General Practitioner's error and that a new certificate was required. (That the Social Security Department had not informed him of the wrongly dated Medical Certificate was his only criticism.) This problem should no longer arise as the end date of the certificate is noted on the payment cheque stub.

5.35 There were also some other difficulties with some Medical Certificates early on. For example, General Practitioners not putting figures in the boxes, but just writing over the Medical Certificates or patients' postcodes not entered in the correct box. However, these initial problems seem to have been satisfactorily resolved.

5.3.2 Scanning of claims

5.36 The claimants' completed Medical Certificates are scanned into NESSIE by the Social Security Department's scanning team. Subject to contributory conditions being satisfied and the Medical Certificate raising no concerns it is processed by the system, staff are unlikely to intervene and see the claim and the recipient will receive a payment (a cheque in the post). Such automated processing is seen by some as an advantage of the computer system because of the high volume of cases that have to be processed, and there is more time for staff to examine the more complicated cases.

5.37 However and as already mentioned in Section 5.2.3, some claims are not automatically processed. Even if all the information is available and provided in the right boxes, claims can also generate queries because of the poor quality of the claimants' and / or doctors' handwriting.

5.38 Accordingly, some respondents were critical of NESSIE. However, another view is that the system has led to more efficient turnaround times and overall less costly administration.

5.3.3 Social Security Department communications with claimants

5.39 In general, non-staff respondents assess the Department's communications with claimants on matters to do with incapacity benefits as good.

Leaflets

5.40 One third party respondent said that the literature produced by the Social Security Department on the incapacity benefit system is *'very good and quite clear'*. The information necessary for claimants is seen as being made available.

Contacting the Social Security Department

5.41 According to staff the claimants' main concern when contacting the Department is their benefit, especially if a claim has been disallowed or the claimant has moved from Short-Term Incapacity Allowance to Long-Term Incapacity Allowance and the amount of benefit they receive has decreased. In addition, claimants, especially those of Long Term Incapacity Allowance, can display a degree of confusion about the incapacity benefit system (this is discussed further in Section 3. 3).

5.42 Often married male claimants will ask their wives to contact the Department to talk to staff about their partner's claim. However, staff are restricted in what they can say by their Oath of Secrecy and data protection legislation.

5.43 Claimants tend to perceive the frontline staff at the main reception desk as helpful, although they believe that these staff have a lower level of knowledge about the system than the advisers. However, these frontline staff can (and do) refer people to the Health Zone for further advice and support.

5.44 The Health Zone's reception area is manned by one or two advisers/assistants, who deal with an estimated 50-60 visitors per day. Reasons for contacts include people:

- seeking help with completing their Medical Certificate, and Long Term Incapacity Allowance and Health Insurance Exemption claim forms, especially if English is not their first language;
- wanting advice on entitlement;
- complaining about the amount of their Long Term Incapacity Allowance award; and
- submitting requested supporting documentation.

5.45 Visitors can be referred to other services including Parish Welfare, Workwise, Citizens Advice Bureau, their General Practitioner, etc.

5.46 The staff manning the Health Zone desk are typically seen by claimants as being *'very good', 'very friendly'* and *'reasonably knowledgeable'*. Whilst some of this expressed satisfaction is probably due to an 'outcome effect' (they achieved in large measure what they wanted from the visit), it will also reflect the quality of the service provided.

5.47 Only one respondent reported problems with advice given by reception services. His Medical Certificate was returned by the Social Security Department because it was incomplete, he visited the office and was assured by staff that it was completed correctly, but a few days later the certificate was returned as being incomplete. Subsequent visits did resolve the issue.

5.48 Third party respondents could be more cautious in their assessment of reception services. They highlighted that some people are reluctant to seek help from staff in establishing their entitlement to benefits and with getting help with completing application forms. Some claimants reportedly have a *'fear of officialdom'*; believing that a visit might jeopardise their claim. In addition, it was thought by some third party respondents that disabled people did not necessarily feel confident when dealing with staff.

5.49 *Telephone calls:* Claimants can contact a call centre with general queries. Calls to do with more complex cases or issues are transferred to Health Zone advisers and assistants. Often the calls to advisers and assistants are queries about the payment of the allowance and about the percentage loss of faculty awarded for Long Term Incapacity Allowance.

5.50 In general, claimants were satisfied with the service they received from call centre operators. From the claimants' perspective they either deal with the query or pass the call to someone who can help. The operators are:

> *'… quite good, they're courteous and seemed to be able to pass me to the right person relatively quickly.'*
>
> *'I think it's fair to say they're well trained, they seem to know what you're talking about, as opposed to a lot of other places.'*

One claimant said that he sometimes has to wait before a telephone call is answered by the call centre, and another felt the Department could have more operators at certain times.

5.51 A third party respondent alleged that incorrect information for a range of benefits, including Incapacity Benefit, can be given by staff to people over the telephone. This incorrect information related to entitlement to benefits and has occurred on *'several occasions'*. However, during the course of the interview it was apparent that this respondent also had gaps in their knowledge of the incapacity benefit system.

5.3.4 Claiming Long-Term Incapacity Allowance

5.52 After a year of Short-Term Incapacity Allowance, people are invited to claim Long-Term Incapacity Allowance. Claimants said that the transfer from Short Term Incapacity Allowance to Long Term Incapacity Allowance is straightforward. There appeared to be no problems with the claim form for Long-Term Incapacity

Allowance.

5.3.5 Payment of incapacity benefit

5.53 Short Term Incapacity Allowance is paid by cheque and Long-Term Incapacity Allowance by direct payment into bank accounts. Since the Social Security Department started printing the period the cheque covers on it there appear to be no major payment issues for claimants. In addition, the Social Security Department informs claimants when their Medical Certificate expires.

5.54 Long Term Incapacity Allowance recipients are not necessarily aware that the amount of benefit they receive can be reduced following their assessment by a Medical Board. There was fairly widespread recognition that the change from full benefit to a percentage is *a 'little bit blunt'* and for the claimant can happen fairly quickly:

> *'The problem is there's a very big drop potentially in income if they haven't actually secured work when they come to switch after 364 days … to long-term incapacity allowance … if it's 50 per cent you have 50 per cent less income potentially per week which if you're talking about living on £76 or whatever is not much money because your rent could be the same amount or thereabouts.'*

Financial difficulties can increase once the payment of any occupational sick pay ceases.

5.55 Moreover, when recipients of the previous Sickness Benefit scheme were transferred to Long-Term Incapacity Allowance, not only might they have received less than 100 per cent in benefit, but some also lost their dependency increase:

> *'So there was a lot of anxiety and annoyance at the scheme, for the fact that they were going from one day to the next and they might have lost in some cases £200 a week, but it wasn't because of the LTIA per se, it was because of the individualisation of benefits.'*

This in turn has generated some adverse publicity for the incapacity benefit system.

5.56 This situation may be exacerbated for people with a fluctuating condition like chronic fatigue syndrome:

> *'… someone may be able to work for several weeks or months, then they might hit a bad patch, … the pressure on someone with certain illnesses because if they feel they can't make up that percentage allowance they're not going to have enough to live on. It may affect their ability to work, I think it's as serious as that …'*

5.57 To the extent that Short Term Incapacity Allowance claimants receive a letter after claiming benefit for ten weeks (see Section 6.2.1) outlining the incapacity system should mean people are more aware and prepared for what a possible move onto Long Term Incapacity Allowance could entail. Moreover, in future claimants qualifying for Income Support will receive some financial support that will help to smooth the change in their income, but there may still be a drop in their total benefit. The proposed Income Support system should provide a more integrated 'package' of support to claimants and so avoid some of the financial traps and disincentives found in the current system.

5.58 Some claimants were believed by several respondents to be unhappy or *'disappointed',* even annoyed at the reduction in their benefit following a Medical Board.

5.3.6 Compliance and fraud

5.59 Some respondents alleged that incapacity benefits are being misused by some. For example, Short Term Incapacity Allowance is being used as an unemployment benefit when seasonal work comes to an end. Long Term Incapacity Allowance may also being used as an early retirement benefit.

5.60 The Social Security Department has a section that deals with non-compliance with social security system rules by employers or individuals, including fraudulent benefit claims. The section has four inspectors, two of whom deal predominately with benefit fraud. The Social Security Department has a fraud policy that seeks to prevent benefit fraud at the earliest opportunity, to deal appropriately with detected fraud and to recover overpaid monies.

5.61 The most common form of fraud is working in receipt of benefit. Under the new system, recipients cannot work whilst receiving Short-Term Incapacity Allowance, but can work if in receipt of Long-Term Incapacity Allowance. Where recipients are in receipt of both benefits, the Short-Term Incapacity Allowance requirement that they do not work overrides the in-work aspect to Long-Term Incapacity Allowance. This can be confusing for claimants.

5.62 Staff from the compliance section can conduct home visits. The need for a visit can be triggered by a variety of events, including the early intervention procedure, risk assessment, anonymous telephone call, etc. The intention is to visit the person in their own surroundings unannounced and observe what activities, if any, they are undertaking. Staff will also check if the individual is claiming the right benefits, whether there are additional benefits to be claimed or services like Workwise that could be used. On occasions a visit may lead to an assessment by a Medical Board.

5.63 The Social Security Department does seek to recover owed monies, and as a last resort will seek to prosecute (usually where the amounts involved are high or for repeated offences). Criminal prosecutions are usually sought through the

Magistrates Court, and Civil Courts can be used to recover overpayments. There are about one to two criminal actions and about 30 Civil Court actions per month. Criminal prosecutions can lead to binding over orders, probation and sometimes custodial sentences.

5.3.7 Adjudication

5.64 Cases can go to adjudication for review and if authorisation is required, for example, if there has been any manual intervention on a case that could affect the payment of the claim. The adjudicators also provide a legal interpretation service within the Department and provide advice to staff and customers.

5.65 The section's responsibilities include dealing with incapacity benefit claimants dissatisfied with their award (including disallowances). The section deals with reviews and appeals of incapacity benefit claims. Approximately 60-70 per cent of section's workload is to do with Incapacity Benefit.

5.4 Discussion: Service delivery

5.4.1 Computer system

5.66 Various upgrades have been made to the computer system and other changes are planned. Nonetheless, there is a need for better management reports from the Social Security Department's computer system, and the Department should continue to prioritise developments in this area.

5.4.2 The role of General Practitioners

5.67 General Practitioners have a key role in helping patients return to paid work. Patients can look to doctors for advice about their ability to undertake employment. (Indeed, UK research shows that being told by a doctor not to return to work was a major barrier for incapacity benefit recipients returning to employment (Stafford *et al.*, 2006: 59).) The message that 'work is healthy, and workless is unhealthy' – even though not true in every instance – is one that General Practitioners in Jersey could be more active in promoting. General Practitioners probably could do more to signpost patients to benefit services, and surgeries could for instance, include publicity material from JET, the pain clinic and Workwise.

5.68 To help develop a culture in which General Practitioners were more active in encouraging patients to return to work, the Department could (possibly with the Health and Social Services Department):

- encourage one or two local General Practitioners to champion the message that 'work is healthy, and workless is unhealthy';
- invite a General Practitioner from a UK Pathways to Work pilot area to give a presentation on his / her experiences; and / or
- introducing a 'Healthy Workplaces' campaign within Jersey that highlighted for

General Practitioners and employers the importance and benefits of rehabilitation services and job retention.

6 Services and interventions

6.1 Introduction

6.1 The Social Security Department seeks to help people with a health condition or disability return to employment. It has put in place early intervention programmes to identify and assist those likely to return to employment as well as providing services to the client group through Workwise. A key issue for the Social Security Department is the timing and nature of the early intervention. Additional services and support are available to the client group from other organisations.

6.2 This chapter considers the support available both within and outwith the Department. The chapter is mainly based on qualitative interviews with staff from a variety of organisations.

6.2 Early interventions

6.3 It is not uncommon for social security administrations to have procedures that aim to identify customers who could benefit from an employment programme or some form of support. The interventions in Jersey are designed to try to identify those who could return to work. Two critical issues are:

- The criteria used to identify cases for any subsequent intervention – a variety of manual or computer assisted methods can be used to screen recipients; however, whether such screening tools are effective is contested (see, for instance, Overbye (2005);Thornton and Coren (2005)).
- Timing of the intervention - if the intervention is too early there is the problem of 'deadweight', that is, time and resources may be unnecessarily spent on individuals who would have found work without the aid of the intervention, but if it is too late the task of helping people return to work may be greater than it would otherwise be due to duration effects (c.f. Section 4.3.1).

6.4 The Social Security Department has two different approaches to early intervention; one for Short-Term Incapacity Allowance (Section 6.2.1) and another for Long-Term Incapacity Allowance (Section 6.2.2).

6.2.1 Short-Term Incapacity Allowance

6.5 Since March 2006, a panel of Social Security Department staff meets fortnightly to review Short Term Incapacity Allowance claims that are about to have been in payment for 10 weeks. The aim is to intervene and offer appropriate support and assist people to return to work, to ensure that recipients are aware of their future benefit entitlements and to explore if they are able to move on to

Long-Term Incapacity Allowance.

6.6 The panel comprises staff representatives from across the Department: Adjudication, Compliance, Health Zone, and Workwise / Work Zone. It is thought by staff that representation from across the Department is valuable and collectively their expertise is greater than the sum of the individual parts.

6.7 The panel does not use a formal screening tool. However, staff believe that those making the move into work are more likely to have ailment codes for nervous disorder / anxiety / stress and back pain. Analysis by the Department showed that these ailments covered circa 70 per cent of claims and this is why these codes have been targeted. Other ailments will be targeted when resources permit. The panel examines each case and decides on a course of action. The panel has a number of options:

- Arrange a 'sick visit' by the Compliance section (c.f. Section 5.3.5)
- Arrange a Medical Board
- Send a letter outlining the support available from the Department (including Workwise, liaising with an existing employer, and helping to access an occupational therapist)
- Outline the Department's Transitional Benefit arrangement (see Section 6.3)

Cases are also reviewed and progress noted at the following meeting.

6.8 **All** cases (that is, irrespective of ailment code) receive a letter outlining the support available and that Short Term Incapacity Allowance is payable for a maximum of one year.

6.9 Although the procedure is recognised to be *'resource heavy'* and has operated for only a short period of time, it has identified a wide range of issues. Outcomes include approximately four transitional benefit claims, some cases closing, and some referrals to the drug and alcohol team. The majority of cases are referred to Workwise.

6.10 One view was that more compliance and adjudication issues have been identified through the early intervention process than was expected. For example, claimants had returned to work (one to two weeks) before the end of their Medical Certificate, or returned to work after "sick visit" from the Compliance section of the Department (see Section 6.3.5).

6.2.3 Long Term Incapacity Allowance

6.11 Staff from Workwise have been reviewing every new Long-Term Incapacity Allowance claim for each month since January 2006. The process involves making a decision about whether contacting the recipient is appropriate. Recipients are screened out of being contacted because of the nature of their ailment or for other reasons. The screening process includes consulting staff in the Compliance and

Adjudication sections to ensure, for instance, that claimants seeking a review of their percentage loss of faculty are not approached by Workwise. Some recipients are sent a standard letter detailing the support that Workwise can provide, whilst others are contacted with a view to making an appointment with a Workwise adviser. The standard letter lists the following examples of support an adviser can provide:

- help in finding a job that is less physically demanding
- help in negotiation with an employer to provide some additional equipment to help the recipient do their current job
- advice on career changes and opportunities for re-training
- help with CV writing or interview techniques.

The standard letter includes a Workwise contact telephone number.

6.12 For all recipients, staff adopt a holistic approach. For those where an appointment might be possible the preferred initial mode of contact is the telephone; as contact by letter is perceived to be more threatening. When telephoned, the recipients' initial concerns are about their benefit, however, staff reassure individuals that it is recognised that they might not be ready for paid work, outline the support and services available and explore whether they would like an appointment now or in the foreseeable future. Those visiting Workwise can be anxious about the appointment.

6.13 The number of claimants contacted by letter or telephone varies each month (Table 6.1). Over the period January to April 2006, 18 per cent of new Long-Term Incapacity Allowance recipients received a telephone call, and 61 per cent a letter from Workwise staff. As a small number of those receiving a telephone call did not receive a letter, the total proportion of claimants contacted is higher than that suggested in Table 6.1, at 65 per cent. For those visiting Workwise, staff explain the reason for the meeting, reassure the claimant that their benefit is safe, and then discuss the services available.

6.14 Of the 136 new Long-Term Incapacity Allowance claims over the first four months of the intervention, 20 recipients (15 per cent) attended an appointment at Workwise. However, this represents 23 per cent of those contacted by telephone and/or letter. Of those contacted and for whom there is information, the reasons for not making an appointment with an adviser include already in employment, too unwell, pregnancy, and already being current Workwise clients.

Table 6.1 Long-Term Incapacity Allowance early intervention, January 2006 – April 2006

Number

Month	New claimants	Telephoned	Letter sent	Attended an appointment at Workwise
January	43	13	38	9
February	32	0	16	4
March	26	0	5	1
April	35	12	24	6
Total (No.)	136	25	83	20
(%)	100	18	61	15

Base: New Long-Term Incapacity Allowance claimants for each month

Source: SSD Administrative data.

6.15 Thus the Long-Term Incapacity Allowance early intervention is generating some clients for Workwise. It is also identifying clients that need to be referred to other agencies, such as the Jersey Employment Trust (JET), Jobscope (the mental health part of Health and Social Services), and Skills Solutions.[20]

6.3 Transitional Benefit (Pilot)

6.16 Short Term Incapacity Allowance claimants whose claim is more than ten weeks but less than nine months old may opt to be considered for Long Term Incapacity Allowance paid at 100 per cent for three months. Making this transition means that former Short-Term Incapacity Allowance recipients can try and obtain work. Making an earlier claim for Long-Term Incapacity Allowance is usually initiated following discussions with the recipient by Health Zone or Workwise staff. Individuals wishing to follow this route must submit a claim for Long Term Incapacity Allowance.

6.17 Take-up of Transitional Benefit is low. The financial incentives for moving to Long-Term Incapacity Allowance early in a Short Term Incapacity Allowance claim are unclear. Indeed, once recipients have moved to Long Term Incapacity Allowance they cannot reclaim Short Term Incapacity Allowance for the same condition.

6.18 Administering Transitional Benefit involves a "work-around" in NESSIE. Staff have to create a dummy Medical Board in order to generate the necessary paperwork and payment. However, difficulties can arise, for instance, for Call Centre staff because 'false' information has been entered into the system.

6.19 It was claimed that a few recipients under the initiative felt they were not

given the correct advice, and made the wrong decision to transfer to Long-Term Incapacity Allowance.

6.4 Rehabilitation services

6.20 Within Jersey rehabilitation services are provided by Workwise (who administer the Adaptation Grant and the Therapeutic Work Scheme) and the Jersey Employment Trust. It is understood that the services provided by these two organisations are currently under review.

6.4.1 Workwise

6.21 Workwise is a supported employment programme. Eligibility for the service is broader than that for those claiming incapacity benefits. Workwise addresses people who are marginalised in the labour market and have problems securing open sustainable employment. As well as people in receipt of incapacity benefits, its client group includes ex-offenders, women returners, some young people and those who have misused drugs. Many of these people are also disabled and have health conditions, although they are not necessarily in receipt of an Incapacity Benefit.

6.22 More recently, most of its clients have been identified through the Department's early intervention initiative with the incapacity benefit caseload (see Section 6.2). Other clients can be self-referral or referrals from other agencies (for instance, the Pain Clinic). However, Workwise is becoming more proactive in seeking clients and more targeted on who it will assist. Previously, clients had to meet 'ready to work' criteria before they were supported. Now the test requires clients to be closer to the labour market and is whether they are 'ready for interview' (see Table 6.2).

6.23 Workwise can provide a range of help, including a job coaching service, a cognitive therapy course (to address anger management), help with confidence building, training courses to develop basic literacy and IT skills, and Adaptation Grants. (Further information on the job coaching service and on the Adaptation Grant is given below.) In addition, the service has strong links with other agencies involved with people with special employment needs.

Table 6.2 Workwise 'ready for interview' criteria

1	**Punctuality – getting up in time for work**
2	**Attendance – Understanding responsibilities and consequences of getting to work on time/not turning up, and associated expectations, i.e. calling to report sickness**
3	**Personal presentation appropriate for workplace, including dress code, personal hygiene and grooming**
4	**Express realistic expectations about the work role, and to value work for work's sake, i.e. the internal motivator that drives work activity and behaviours. Coping with culture change from unemployed to employed status**
5	**Ability to identify own work strengths and gaps, and self express personal preferences**
6	**Participation and ability to follow an organised / structured lifestyle routine. The routine either both be organised and managed by the client; or the client willingly participates in the routine, through support from others. Planning action, timing of activities (i.e. habit / routine formulation) to include essential pre-vocational activities**
7	**Awareness and application of time management in terms of task sequencing, initiating continuing and terminating abilities. Identification of coping strategies to enable adequate time management, including appropriate means of seeking assistance**
8	**Ability to make informed choice regarding finances, including implications and responsibilities associated with coming off benefits. Workwise to state implications regarding benefits. Supporting / referring services to work through implications of informed choices with clients and their network of support, such as self-advocacy co-ordinator, CNT Professionals, Social Worker**

Source: Social Security Department

6.24 Workwise is staffed with three job coaches and three assistants. The (potential) demand for Workwise has recently increased, but resources have not matched this increase. Its increased focus on those likely to obtain employment is a reflection of this increasing demand. As a consequence, Workwise is gradually taking fewer referrals from other agencies where possible clients are further from the labour market.

6.25 Whilst Workwise can provide support and help to incapacity benefit recipients, it cannot guarantee clients jobs. Besides Workwise there are several other agencies trying to secure jobs for their clients. In effect there is a competition between agencies to find places for clients – not just people with a disability or health condition, but also other people who can find it harder than usual to secure employment. Indeed, the various agencies tend to work with certain employers and do not encroach on other employers that are known to work with other agencies.

Job coaching service

6.26 Essentially, Job Coaches work with people requiring some form of support to return to employment. The service has been operating since April 1998. The intention was that a Job Coach would provide intensive support and would then reduce the level of support given, with the Job Coach Assistants providing longer term support and regular contact to the client and employer. However, in practice clients do not cease to be caseloaded. The service has clients they have worked with for up to eight years. Indeed, the introduction of Long-Term Incapacity Allowance led to an increase in contact with some longer term clients because they had concerns about their benefits and the percentage loss of faculty awarded.

6.27 The criteria for selecting someone for support from a Job Coach are: is the person ready for work, and is there capacity within the Workwise team. The caseloads of Job Coaches are perceived by respondents to be relatively high, around 30 clients per staff member.[21]

6.28 Job Coaches help clients to identify their needs in the workplace and to socialise and develop a relationship with work colleagues. Clients can also raise non-work related issues, such as financial problems with their rent. These issues do have to be addressed if clients are to be in a position to return to work. However, there is a *'fine line'* between staff providing an employment support service and providing a *'social work'* service. Sometimes staff have to be *'hard'* with clients about the extent of the support they can provide, otherwise there was a belief that Workwise would have a large customer base for whom they could provide little employment support. This concern is also reflected in the raising of the work ready criteria used to identify clients to the 'ready for interview' test.

6.29 Clients are seen as preferring continuity in the Job Coaches they see each time. This means that the rapport between Job Coach and client is maintained and a client does not have to re-explain their situation to a new member of staff.

6.30 As well as supporting clients, Job Coaches will work with, and support, employers.

6.4.2 Adaptation Grant

6.31 Workwise administers an Adaptation Grant, which is used to purchase small scale aids and adaptations (such as computer aided voice recognition software, special chairs and keyboards) for people experiencing difficulties in their workplace. The annual budget for the scheme is relatively small (about £15,000). Furthermore, there is no budget for supporting physical adaptations to workplaces; although proposed disability discrimination legislation will help address this.

6.32 The scheme is reportedly not used much because of low demand. Moreover, a non-departmental respondent thought that the availability of grants for aids and

adaptations would not necessarily create employment opportunities for disabled people.

6.4.3 Therapeutic Work Scheme

6.33 The Therapeutic Work Scheme was designed to allow some people who had been in receipt of a benefit for a long period to retain their benefit (up to half of the standard rate of single benefit) and undertake paid work and receive a wage. The scheme was used to facilitate a gradual return to work.

6.34 In effect the scheme has been replaced for new incapacity benefit claimants by Long-Term Incapacity Allowance, which is an in-work benefit. In addition, recipients of Short-Term Incapacity Allowance wishing to work can use the Transition Benefit arrangement. However, as noted above, the financial gains (and associated risks) of Transitional Benefit may be uncertain to Short-Term Incapacity Allowance recipients.

6.4.4 Jersey Employment Trust

6.35 The Jersey Employment Trust was established in 2000 and it provides training development for clients with special employment needs so that they can enter open employment, or if in paid work, it helps ensure sustained employment. In the past the Jersey Employment Trust was more of a traditional sheltered workshop, but its focus is now development training (see Coxall, 2001). The Social Security Department is considering looking to the Jersey Employment Trust to provide training for suitable Long-Term Incapacity Allowance recipients, and Workwise would then provide in-work support. One respondent was concerned that this change in emphasis might mean that there would be fewer places on its programmes for people with learning impairments.

6.36 Jersey Employment Trust is mainly, but not exclusively, funded by the Social Security Department.

6.37 It has an annual caseload of 120 clients. The Trust's clients must have an interest in gaining or sustaining employment. Jersey Employment Trust will continue to work with a client provided they are progressing towards open employment. Demand for its services is believed to be greater than its capacity; although there is no data available on latent demand.

6.38 Not all clients will be in receipt of an incapacity benefit. Some clients are in receipt of Short-Term Incapacity Allowance. This is possible because the Trust agrees with the Department on a case by case basis that clients can still undertake education, training and placements and not contravene the 'no work' rule for Short-Term Incapacity Allowance.

6.39 Each client has an employment development plan, which is usually reviewed up to every six months, and works with an employment co-ordinator. The plan is developed with the client. Clients are mainly referred to the Jersey Employment

Trust by Workwise and Jobscope, although there are a few self-referrals. Referrals to the Trust are now co-ordinated by agencies (a joint referral service) so clients get to the 'right' organisation.

6.40 The Jersey Employment Trust has four training areas: administration, bicycle servicing, horticultural / contract gardening service, and wood recycling / French polishing. (The nurseries and bicycle servicing used to be more traditional sheltered workshops.) The Trust provides internal training and work experience / placements. The latter are aided by a support worker. Provision of in-work support is geared to the needs of the individual client, and is identified in the individual's employment plan.

6.41 The Jersey Employment Trust can access the Adaptation Grants funded by Workwise (Section 6.4.2). However, the Trust will also seek a contribution from the employer. The Trust is developing a *'lending library of adapted equipment'* for clients with a disability, such as specialised keyboards.

6.42 The Trust also offers services to employers in terms of placements and support and works closely with external agencies, such as social services, and the Department.

6.43 Last year over 20 clients moved into open paid work.

6.5 Other services delivered by other bodies

6.44 Incapacity benefit recipients have access to information, advice and support from a number of other organisations operating in Jersey. This section briefly discusses the work of some of these bodies, and their links with the Social Security Department. It is not meant to be a comprehensive account of the organisations or services available, rather it gives an indication of the level of help and support provided.

6.5.1 Citizens Advice Bureau

6.45 The Citizens Advice Bureau is based in an office in St Helier. Whilst it does not provide an outreach service, information is available on the Citizens Advice Bureau website. Moreover, there is a plan to rollout possibly six touch screen kiosks across the island.

6.46 Out of approximately 10,500 cases dealt with each year about 1,500 are concerned with social security benefits, but is not possible to estimate what proportion of these are concerned with incapacity benefits. Advisers aim to maximise clients' incomes from benefits, although staff cannot provide a better off calculation. Advisers do offer a debt counselling service and about a third of those using the service could be in receipt of Long-Term Incapacity Allowance. In addition, staff will help Long-Term Incapacity Allowance claimants request a

review of their awarded percentage loss of faculty. The Citizens Advise Bureau will also refer clients to charitable trusts or church funds for financial support.

6.47 The Citizens Advice Bureau relations with the Social Security Department are seen as *'very good'*.

6.5.2 General Practitioners

6.48 The General Practitioners input to the Medical Boards is discussed in Chapters 8.

6.49 As mentioned in Section 5.3.1, General Practitioners do not always encourage incapacity benefit recipients to return to work. This is notwithstanding conclusive evidence that worklessness is associated with poor physical and mental health (Coats and Max, 2005: 11). Moreover, General Practitioners, rightly, do not advise their patients about the benefit system, although they could possibly do more to signpost their patients to the services available. This information could complement the information they have specifically requested to help signpost patients about Income Support.

6.50 There were slightly mixed views on the Department's relations with General Practitioners with respect to incapacity benefit related matters. There is relatively little direct contact between the two – General Practitioners write Medical Certificate and reports for Medical Boards and the Social Security Department can fund some charges. At best the relationship was described as 'pretty good', but there could also be disputes over specific issues. Social Security Department concerns centre on the role of some General Practitioners in the certification process.

6.51 According to respondents, the introduction of the new incapacity benefit system did not (adversely) affect the doctor – patient relationship.

6.5.3 Jersey Advisory and Conciliation Service

6.52 The Jersey Advisory and Conciliation Service (JACS) was established in April 2001 to advise employers, employees and trade unions, to assist with resolving collective or individual disputes, provide impartial information and advice and so avoid the use of Employment Tribunals. (Trade unions in Jersey mainly represent public sector workers.) Recent employment legislation in Jersey, for the first time, protects employees from unfair dismissal, although fair dismissals include terminations on grounds of capability for the kind of work undertaken (see Section 1.6). Incapacity benefit recipients might use the service if they are in dispute with an employer.

6.53 One Short Term Incapacity Allowance respondent in the research had contacted JACS and had found the service *'very helpful'*.

6.54 Social Security Department staff can refer claimants to JACS, however, the

confidential nature of the service means that they do not get to learn about the outcome.

6.5.4 Parish Welfare System

6.55 The 12 parishes in Jersey administer a discretionary Welfare Grants system. Welfare Grants are means-tested, non-taxable grants payable to those whose income is insufficient to meet their basic needs. Parish Welfare provides a safety net for a wide range of client groups in differing circumstances. It will be replaced by the Income Support Scheme.

6.56 Support is available to incapacity benefit recipients as well as other groups such as the unemployed, lone parents, ex-prisoners, carers and pensioners. Long-Term Incapacity Allowance recipients would be expected to look for work whilst claiming Parish Welfare. To be eligible for Welfare Grants applicants must have been either born in Jersey (native) or meet residency conditions (non-native), that is, have lived in Jersey continuously for that last five years, or, if aged 55 or over when arrived in Jersey, to have lived on the island for ten years.

6.57 Welfare Grants are based on weekly scale rates, which are lower than the rates for social security benefits. The welfare scale rates are the amount it is decided someone needs to live on (excluding housing costs). The welfare scale rates are determined by the Social Security Department, and used by all the Parishes; although formally the scale rates are advisory. As a discretionary system, payments may be above, at or below the scale rates. Money, say £5 per week, can be deducted from Welfare Grants if it is believed that a claimant is not trying hard enough to find employment. Welfare Grants may also be used to meet medical expenses where claimants are not eligible for the Health Insurance Exception scheme.

6.58 Using the Parish Welfare System is seen by some as stigmatising. Indeed, some people are believed to prefer to live on a low income rather than apply for support. A consequence of the incapacity benefit reforms is that some recipients have had to claim Welfare Grants for the first time. This does create a:

> *'… resentment. … [T]hey're resentful of social security, resent having to apply for welfare, they resent having to come in front of people and discuss their affairs, because after all they have paid their contributions to social security over time, and why can't I have my benefits?*

Indeed, one view was that where Incapacity Benefit claimants receive the scale rate (£141 per week[22]) they can become so focused on their money being cut (from £153) that they become incapable of finding employment.

6.59 There was a feeling that the Parish Welfare system had provided *'an opt out clause'* for the Social Security Department. When the Department was unable to assist incapacity benefit recipients further staff could refer them to the Parish

Welfare system.

6.60 The introduction of the new incapacity benefit system has, it was claimed, increased the workload of the Parish Welfare system, although it is not possible to quantify or validate this increase.

6.61 Currently the States are proposing to replace the Parish Welfare system and various other non-contributory benefits with an Income Support scheme. Incapacity benefit recipients would then seek support under this new social assistance system.

6.6 Discussion: Service delivery

6.6.1 Early interventions

6.62 The Social Security Department has followed good practice in establishing early intervention procedures for both Short-Term Incapacity Allowance and Long-Term Incapacity Allowance claims. Such procedures are essential because it is well-established that the longer a person with a health condition or disability remains on benefit, the lower the likelihood of them securing paid work. The OECD in their review of disability and labour market policies concluded that:

> *'The most effective measure against long-term benefit dependency appears to be a strong focus on early intervention.'*
>
> OECD (2003: 162)

And go on to argue that if necessary the provision of vocational (re)training and rehabilitation should be provided soon after the incapacity in order to maximise the chances of the individual returning to employment.

6.63 For Jersey, a key issue is the timing of the early intervention for the Short-Term Incapacity Allowance caseload. As already mentioned in Section 4.3.1, only ten per cent of Short-Term Incapacity Allowance claims last for 33 or more days. Indeed, only six per cent last for 70 or more days (that is, when the ten week intervention is made). Those reaching this ten week threshold (70 days) typically remain on benefit for a total of 148 days, or around five months. However, the shape of the curve in Figure 4.2, suggests that the Department should intervene earlier, at around 33 days. If the Department was to intervene at five weeks (35 days), it would have to deal with up to nine per cent of the flow onto Short-Term Incapacity Allowance, who at present have a median duration of 84 days, or about three months. Whilst this would represent an increase in the number of cases reviewed and require more resources, bringing forward the timing of the early intervention for Short-Term Incapacity Allowance cases should be beneficial in terms of the numbers helped to secure employment.[23]

6.64 Not all of the cases reviewed during the early intervention process are

offered help or support. At present the Short-Term Incapacity Allowance panel rely upon the ailment codes to identify relevant cases. The Department could use a formal screening tool to identify cases that are suitable for assistance. It is important that screening tools use objective criteria to avoid 'creaming' by staff, that is, staff selecting recipients who would probably have secured employment without an intervention (Overbye, 2005: 161; Thorton and Corden, 2005: 180). However, using screening tools is not uncontroversial. Some argue that screening tools (in form of questionnaires or tests of capabilities) are often expensive and / or time consuming, may require professional expertise in their interpretation (Overbye, 2005: 160), are cumbersome, inefficient and not cost-effective (Thorton and Corden, 2005: 181). Indeed, the administrative data available may not be adequate to enable staff to predict future employment status (Thorton and Corden, 2005: 181).

6.65 However, Waddell *et al.* (2003) in a review of the literature for the UKs Department for Work and Pensions have a more sanguine view of the role of screening; they conclude that screening is possible. Waddell *et al.* (2003) summarise the purpose of screening as follows:

- *'Identifying people at higher risk of long-term incapacity versus those likely to return to work*
- *Predicting likely duration of sickness absence and return to work*
- *Identifying people who need extra therapeutic or rehabilitation help*
- *Identifying those obstacles to coming off benefit and returning to work that may by appropriate for intervention*
- *Identifying people likely to respond to (an) intervention versus those likely not to respond*
- *Informing a rehabilitation programme or other work-focused intervention*
- *Informing the decision-making process and case management'*

Waddell, *et al.* (2003: 5)

6.66 They review 28 screening tools and conclude that it is not possible to use a screening tool developed elsewhere. Rather '*… the construction and scoring of screening tools, is situation-specific – ie it varies with the particular social security or compensation setting and with the characteristics of the particular client group …'* (Waddell *et al.*, 2006: 20). Thus Jersey would have to develop its own screening tool using administrative data. Moreover, the reviewers found that socio-demographic variables, such as age, gender, and expectations about returning to work, can accurately predict both recipients at risk of long-term incapacity and who is likely to return to work in the short-term. Indeed, they suggest that any screening should be conducted between three to four weeks and six months after the commencement of a claim. However, the authors also point out that screening is not an end in itself, and that it is only part of a process needed to direct recipients towards work-focused interventions and rehabilitation programmes.

6.67 As the Social Security Department build up data on Short Term Incapacity Allowance recipients and benefit durations, it should consider developing a screening tool for its early intervention work. In designing a screening tool the Social Security Department could draw upon the evidence on the characteristics associated with exits from incapacity benefits (see, for example, Berthoud (2006), Stafford *et al.* (2006) and Waddell *et al.* (2006)).

6.68 A screening tool of the sort envisaged for Short Term Incapacity Allowance is unnecessary for the Long Term Incapacity Allowance caseload. Rather a different approach is required because of the length of time recipients have already been absent from the labour market. Currently, the Department reviews cases and screens out those for whom immediate contact would be inappropriate. For the remainder participation in any work-focused discussion is voluntary and this risks people who could be helped declining to attend an interview because, say, of low self-esteem or self-confidence or because after a year on Short Term Incapacity Allowance they have been detached from the world of work for too long. This risk could be minimised if selected Long Term Incapacity Allowance recipients were required to attend a work-focused interview with an employment adviser. If the Department followed UK practice, failure to attend the interview can result in a benefit sanction. This proposal does not require the recipient to participate in any rehabilitation or work-related programmes, only to attend an interview where an adviser can outline the support available from the Department and other agencies, and help identify the individual's barriers to returning to work. Attendance at subsequent work-focused interviews would be voluntary.

6.69 Such an approach would be controversial. It could be argued that merely having to attend an interview was placing undue pressure on vulnerable people. An invite to a work-focused interview could increase levels of anxiety and be stressful for some. Moreover, it could be argued that scheduled reviews of Long Term Incapacity Allowance cases mean that the proposal is unnecessary. However, recipients are not required to have any direct link with employment advisers as part of the scheduled reviews conducted by Medical Boards.

6.70 There is a risk that the introduction of work focused interviews for Long Term Incapacity Allowance recipients would only help a small number of cases. In other words, the net benefit may be small (or even negative). The information to conclude that there would be a positive net impact is not available. Accordingly, it is suggested that at this stage the Social Security Department consult with recipients, disability groups and others on whether suitably identified individuals moving onto Long Term Incapacity Allowance should be required to attend a work-focused interview. Clearly, this should only be undertaken if rehabilitation services feel confident that they have the necessary resources and packages of support to help any clients who subsequently need support. However, it should be pointed out that obliging Long Term Incapacity Allowance recipients to attend a work focused interview would be a relatively low cost intervention.

6.71 A requirement to attend a work-focused interview could also be a feature of the Short Term Incapacity Allowance early intervention procedure.

6.72 In summary, the review recommends that:

- Jersey should continue the 'good practice' of intervening early on in the life of claims.
- The timing of the early intervention for Short Term Incapacity Allowance cases should be brought forward to 35 days.
- In the medium to longer term the Department should develop a screening tool to identify those cases where support and advice from relevant agencies is most likely to lead to employment.
- The Department begins a consultation exercise with a view to making attendance at a work focused interview mandatory for those Long Term Incapacity Allowance claimants who under the current arrangements are contacted by letter or telephone. Some of those not meeting with an adviser might benefit from the services that the Department (and others) can provide.

6.6.2 Transitional benefit arrangement

6.73 Transitional Benefit provides a route back to work for Short Term Incapacity Allowance recipients (Section 6.3). However, the move onto Long Term Incapacity Allowance with payment of benefit at 100 per cent for only three months may be too risky an option for some. Whilst the demand for an arrangement that would allow Short Term Incapacity Allowance recipients to try out a period of work is unknown, take up of this option might increase if the potential loss in benefit due to a period of employment being unsuccessful was minimised. Recipients ought to know that they can try paid work without being penalised. Possible measures that the Social Security Department could consider are:

- Extending the three months to a longer period of time, say six months, and / or
- Replacing Transitional Benefit with a return to work financial incentive for Short Term Incapacity Allowance recipients who had been claiming benefit for, say, more than three months. The work incentive would be paid to recipients entering work of, say, at least eight hours per week and would be payable for one year. Recipients of the incentive payment would not also be in receipt of Short-Term Incapacity Allowance (or Long-Term Incapacity Allowance). The payment could be counted as income for any claim under the proposed Income Support system.

Of these options the last, the introduction of a Return to Work Bonus, is recommended. This is because extending the period covered by the existing arrangement is unlikely to make it any more attractive to claimants. However, introducing a new benefit may be unnecessary if the work incentives in the new

Income Support system are effective. Accordingly the Department should wait and assess the effectiveness of the Income Support reforms before considering whether a Return to Work Bonus is required.

6.74 The Pathways to Work pilots in the UK include a Return to Work Credit. The credit is worth £40 per week and is payable for a maximum of 52 weeks. Those eligible must have been on benefit for at least 13 weeks, and enter jobs of not less than 16 hours per week with earnings not more than £15,000 per annum. A qualitative study of the Return to Work Credit found that it did help some people enter employment (Corden and Nice, 2006). Some recipients said that they would not have returned to work, or not as quickly, if it were not for the Return to Work Credit. The Return to Work Credit helped with the costs of moving from benefit to work and gave recipients' financial confidence. However, the study also revealed that some recipients of the credit had only found out about it after they had obtained a job. Suggesting that any financial incentive needs to be publicised and promoted by advisers.

6.75 The Department would need to do some modelling to assess the cost-effectiveness of introducing a Return to Work Bonus.

6.76 Any policy changes to transitional benefit would have to be considered in light of any changes to the maximum period of incapacity for Short Term Incapacity Allowance (see Section 6.6.1)

6.6.3 Services

6.77 Several respondents said that if the Department is to achieve its aim of more people with a health condition or disability returning to work, then it will need to expand the resources allocated to relevant organisations, such as Workwise / Work Zone and the Jersey Employment Trust. There was a perception that more resources are required to improve the provision of vocational training and rehabilitation services.

6.78 The Adaptation Grant is little used and the funding available relatively small. However, research evidence for a similar scheme, Access to Work, in the UK suggests that for clients it helps promote job retention, and acts as an incentive for employers to hire and retain disabled people (Thornton and Corden, 2002; and Thornton *et al.* 2001). Access to Work funds a wider range of activities than the Jersey scheme, including alterations to premises and fares for employees. The demand for this sort of support might be expected to increase in Jersey due to the Department's aim of encouraging Long-Term Incapacity Allowance recipients to return to work and proposed disability discrimination legislation. The Department may wish to revamp the grant scheme and raise its profile in conjunction with the introduction of the proposed disability discrimination legislation, which might lead employers and employees to demand that reasonable adjustments be made to workplaces to help disabled people enter and retain employment.

7 Employers

7.1 Introduction

7.1 Employers have a pivotal role in the wider incapacity benefit system. Their policies and practices affect the recruitment of people with health conditions or disabilities and determine the management of sickness absence. In addition, they can be a source of work placements and work experience for Long Term Incapacity Allowance recipients. Although there can be a strong business case for employing people with health conditions or disabilities, many employers appear to adopt views that fail to recognise this.

7.2 The findings presented in this chapter are based on qualitative interviews with a range of respondents. However, they represent the opinions of non-employers as none of the respondents were interviewed as employers. Although some of the respondents had more than one role, and some were employers, there were no formal interviews with employers or their representatives. Nevertheless, a fairly consistent point of view about the role of different types of employers did emerge from the research.

7.3 The chapter begins by outlining the context to employment in Jersey (Section 7.2.1), then describes a typology of employers in terms of their responses to incapacity (Section 7.2.2). Employers and disabled people and their management of sickness absence are discussed in Sections 7.3 and 7.4, respectively.

7.2 Types of employer

7.2.1 Context

7.4 Jersey's economy is increasingly service orientated. Recent years have seen the growth of the financial sector, which now accounts for half of the economic activity in the island and employs over a fifth (22 per cent) of the workforce (Statistics Unit, 2005a: 8 and 19).

7.5 Employment levels in Jersey are high; in 2001 the economic activity rate was 82 per cent (Statistics Unit, 2005a: 17). In June 2005 about 60 per cent of the total population was in employment, of whom 88 per cent were employed in the private sector. The numbers in employment do, however, vary seasonally, being higher during the summer.

7.6 In December 2005 there were 4,948 private sector businesses in Jersey employing 42,890 people (Statistics Unit, 2005b: 42). Of these businesses, 74

per cent employed less than six people. These small businesses were mainly in the construction, wholesale and retail, and 'other' sectors [24] Only seven per cent of businesses employ more than 20 people, and over a quarter (28 per cent) of these are in the finance sector.

7.7 Recently, the growth in the Fulfilment industry has been useful source of employment for some Workwise clients.

7.2.2 Typology of employers

7.8 A threefold typology of employers can be identified:

- the multi-nationals who operate to best practice in the UK
- large local employers that are large enough and employing sufficient people to provide professional employment services, and
- small local business, *'... who really operate the old Jersey way, which is quite frankly to give as little away as is possible.'*

7.9 The number of employees in Jersey who have a right to sick pay is unknown. Nonetheless, it is believed that most staff with multi-national and large local employers have access to relatively generous occupational sickness schemes, which mirror the public sector schemes. Some of these employers offer six months full pay and then six months at half pay in any rolling 12 month period. There are numerous variations on this – and some employers, for example, have reduced the two six month periods to three months each. Access to occupational sick pay is not always a contractual right, sometimes it is discretionary. When employees access the occupational sick pay scheme the majority of employers then deduct from the employee's full pay the amount paid in Short Term Incapacity Allowance. Whether the amount paid in benefit is deducted from half pay varies; some deduct even if the amount of pay is relatively small, and some only deduct if the total of half pay and benefit is greater than the amount of full pay.

7.10 It was claimed that the more enlightened smaller employers will provide sick pay, say two weeks in any 52 weeks. However, there is a large, but unspecified, number of employees of small employers who receive nothing from their employer when on sick leave and are wholly dependant upon incapacity benefits.

7.3 Employers and disabled people

7.11 Respondents reported that there were examples of good practice in the employment of disabled people in Jersey. Some mentioned the work of the Jersey Employers' Network on Disability (JEND) established in 1998 to promote good practice amongst employers in employing disabled people. Its members are committed to providing jobs for people who have a disability. Members of JEND

also work with Workwise to maximise employment opportunities for people with a disability.

7.12 However, respondents also highlighted an employment culture that undermines the position of people with a health condition or disability in the labour market. It was claimed that some employers would simply not consider employing a Long Term Incapacity Allowance recipient, or indeed, anyone who was *'different'*. It was thought that such employers wanted staff that are multi-skilled, and there was a view that disabled people were unable to undertake more than one task / job. Indeed at its annual meeting in 2003, JEND claimed that the island's employers were still reluctant to hire disabled people, because they held pre-conceived ideas about the level of support disabled employees might require (BBC, 2003). This view would appear to still be current, as many (small) employers:

> *'… don't have the capacity or the time or the inclination to actually support somebody in the early stages of getting back into work, they want someone who will hit the ground and run basically, …'*

7.4 Management of sickness absence

7.13 One respondent estimated that the average sickness absence in Jersey was 10 days per employee. How employers manage sickness absence can affect their firm's productivity and costs as well as employment and health outcomes for the employee concerned.

7.14 Those employers paying occupational sick pay usually require a Medical Certificate after three days of absence. Businesses paying occupational sick pay (and Permanent Health Insurance) have a financial incentive to manage sickness absence, especially of skilled workers or those with specific qualifications.

7.15 Workplace Permanent Health Insurance is quite extensive amongst the multi-national and large local firms in Jersey, especially in the finance sector. The insurance premium is paid by employers. Permanent Health Insurance does polarise employee groups, some receive three-quarters salary protection until retirement age and others very little protection. So some employers are funding a conventional occupational sickness scheme and then supplementing it with Permanent Health Insurance.

7.16 However, respondents thought that, excepting a *'few enlightened employers'*, those employers who did not have occupational sick pay schemes tended not to be concerned about absence management. In general,

> *'… if somebody goes off sick I'm not sure there's any communication between the sick person and the employer, they just leave them alone, ….'*

7.17 According to another respondent, employers:

> *'… almost treat their employees as being effectively casual workers, "when they're there I'll pay them, but if they go sick then I don't pay them so why should I worry about it very much, I'll always get somebody else".'*

7.18 The experience of those respondents claiming incapacity benefits was mixed. One had had no contact from *'quite a large company'* and whilst she was hoping to return to work, was not intending to return to her current employer. Another had contacts with his now ex-employer, although the discussions were of a general nature and not about returning to work. However, another respondent, who was in receipt of Long Term Incapacity Allowance, still had regular contact with his employer and was planning to return to work with this employer, whilst another Long Term Incapacity Allowance respondent was made redundant because of his incapacity.

7.5 Discussion: A more active role for employers

7.19 When asked respondents agreed that employers in Jersey could do more to recruit and retain people with a health condition or disability.[25] Indeed, in other countries employers can be legally required to retain disabled employees (see OECD, 2003: 163). Employers have a major role to play in helping the Social Security Department secure its employment objectives, and the Organisation for Economic Co-operation and Development (OECD) argue that employers should be involved in promoting paid work for disabled people (OECD, 2003).[26] Policies should ensure that employers are involved in retaining workers with a health condition or disability.

7.20 There is a wide range of employers on the island and the type of support they need to assist people with a health condition or disability may vary. Accordingly, the Department should consider commissioning research on how the States can improve employers' sickness management procedures and should promote the business case for employing people with a health condition or disability.[27] This might entail a survey of employers and / or case studies of employers.

7.21 Whilst not wanting to pre-empt the findings from any further research, the qualitative research would suggest that some (small) employers require help to meet existing good practice in job retention and recruitment. One possible option would be a peripatetic occupational health service for small businesses to provide technical assistance, guidance and practical help with developing retention / return to work plans for individual employees.

7.22 In addition, the OECD (2003) have highlighted the role of financial incentives in helping to get employers more involved. This could involve transferring some of the cost of Short Term Incapacity Allowance to employers, for instance, requiring them to pay for the first few weeks of incapacity. This would be a controversial proposal – it would add to business costs, any re-insurance by businesses would undermine the policy and it might bias recruitment towards applicants who were demonstrably 'healthy'. Whilst this report does not propose this policy, the Department might consider if there are other policies, such as a revamped Adaptation Grant (Section 6.6.3), that could be used to incentivise employers in using rehabilitation services, making workplace adaptation and actively managing sicknesses absences.

7.23 Any policies to engage the more recalcitrant employers in ensuring sustained open employment for recipients of Long Term Incapacity Allowance will probably need to be backed by strong anti-discrimination legislation, which is not yet in place.

7.24 In addition, if employers are to be more active in promoting job retention, then some employees will need to attend rehabilitation programmes. However, many employers will not have their own rehabilitation programmes and will need to access those provided by the Department and other agencies. This in turn will have resourcing implications for the Social Security Department.

8 Medical Boards, Review Boards and appeals

8.1 Introduction

8.1 Long-Term Incapacity Allowance claimants have their percentage loss of faculty assessed by a Medical Board. If they are dissatisfied they can request a review and, if appropriate, instigate a formal appeal. Much of the adverse criticism of the incapacity benefit system made during the course of the review focused on the work of the Medical Boards and the percentage loss of faculty awarded in specific cases. Respondents' concerns included:

- doubts about the consistency of assessments for those with a mental health condition or a learning difficulty;
- that at Medical Boards some claimants minimise the severity of their symptoms and the impact of their condition on their daily lives;
- perceived variations in the percentage loss of faculty awarded to recipients with apparently similar conditions;
- that the determination of their percentage loss of faculty for people with fluctuations conditions depends on whether the Medical Board saw them on a *'good'* or a *'bad day'*;
- that the boarding doctors are not up-to-date in their medical knowledge.

8.2 These criticisms are addressed in this chapter. However, some of the comments made possibly reflect recipients' disappointment at the amount of benefit awarded following a Medical Board. Such comments reflect an 'outcome effect'. Those who receive a full award are more likely to be satisfied with the process and the decisions of the Medical Board than those who only receive a partial award. Although such responses are understandable, because of the financial consequences for claimants, exploring the work of Medical Boards is a key element in this review.

8.3 The next section discusses Medical Boards and Review Boards in general terms, before considering each in more detail (Sections 8.3 and 8.4). The appeals procedure is briefly covered in Section 8.5.

8.4 The chapter is based on the qualitative interviews, documentary sources and administrative data.

8.2 Medical and Review Boards

8.5 Claimants' percentage loss of faculty is determined by independent Medical and Review Boards. The members of each board are selected from a panel comprising mainly retired local General Practitioners. For Long-Term Incapacity Allowance cases, boards consist of two boarding doctors, and the membership rotates so different pairs of doctors attend each Medical Board session. However, one local doctor, a doctor from Guernsey and a consultant psychiatrist from the UK tend to deal with mental health cases. For Short Term Incapacity Allowance and invalidity benefit cases the boards comprise one boarding doctor.

8.6 About 40-50 claimants per week are assessed by seven to eight Medical Boards. Short Term Incapacity Allowance recipients ought to be boarded 4-8 weeks before the end of their claim. However, there is a lack of boarding doctors to hold a sufficient number of Medical Boards to meet the caseload. As a consequence the Department has had to extend some Short-Term Incapacity Allowance claims because Medical Boards cannot be held in time. About six claims per week are being extended. This situation is exacerbated by the relatively large number of review cases.

8.7 Where the extension leads to an overpayment of benefit, the Department is unable to recover the overpayment because it was responsible for the delay.

8.8 The Social Security Department lacks enough doctors for the caseload mainly because it is largely dependent upon recruiting locally retired General Practitioners. The Department has approached local practising General Practitioners but they are reluctant to become boarding doctors because of concerns about possible conflicts of interest. They, rightly, do not want to be in the situation where they assess current patients. In addition, not all retired General Practitioners want to undertake this sort of work.

8.9 For new board members, training comprises observing two / three boards, and then sitting with a more experienced doctor *for 'quite a long time'* before chairing a Medical Board. One respondent noted that it does take newly appointed doctors time to get use to the system.

8.10 In addition, the Department has provided the boarding doctors with self-learning CD-ROMs on general aspects of assessing disability, and other support (for example, on the benefit system). Staff from the Department and the boarding doctors also meet regularly (about every two months) to discuss any issues.

8.11 Reciprocal agreements with certain countries mean that in a few cases Medical Boards are conducted overseas. Officials in the country arrange the Medical Boards and the doctors' reports are sent to Jersey. However, percentage faulty loss is determined by the doctors in Jersey. This can be a time consuming process. The process works reasonably well, although the quality of the reports from one geographical area is a cause for concern because there is insufficient

information to determine a percentage loss of faculty.

8.3 Medical Boards

8.12 Medical Boards are mainly held for those claiming Long-Term Incapacity Allowance. They are also held to review existing Long-Term Incapacity Allowance claims (scheduled reviews), and in certain circumstances for recipients of Short-Term Incapacity Allowance. Recipients who submit multiple Medical Certificates can also be re-boarded.

8.13 Essentially, cases are allocated to Medical Boards in date order, although review cases (see Section 8.4) must be seen by two different doctors from those at the initial board. In addition, cases involving a mental health condition are seen by a board that can include a doctor with expertise in this area.

8.14 This section considers the conduct of Medical Boards, the information sources available to boarding doctors, the approach of some claimants' to the boards, determining the percentage loss of faculty, staff views on awards, possible reasons for variations and changes in percentage loss of faculty awards, split claims, and claimants' views of the Medical Boards.

8.3.1 Conduct of Medical Boards

8.15 The (two) boarding doctors meet with the claimant and any adviser(s) they bring normally in a room at the Social Security Department offices equipped for medical examinations. For claimants unable to attend Philip Le Feuvre House, visits will be made to the claimant's home. However, home visits for Medical Boards are infrequent; no more than one per week.

8.16 At each sitting of the Medical Board, the boarding doctors see five or six claimants. One doctor greets the claimant and introduces the board. The new incapacity benefit system is explained to the claimant. A doctor will then conduct the interview and write notes, and the other doctor will examine hospital records and use the computer to review previous reports and enter new details. The interview involves taking a statement from the claimant about their relevant medical history, and the claimant is asked to sign this statement. The claimant is then questioned about their ability to perform everyday functions. The questions reflect the nature of the claimants' health condition or disability. The boarding doctors do discuss what sort of work claimants could do – they encourage them to move *'sideways'*, to think about different types of work. They can also make claimants aware of what the Social Security Department can offer, in particular Workwise. Claimants confirmed that boarding doctors do discuss their usual work or occupation; although one claimant respondent thought the advice was not specific enough to help him find employment.

8.17 If relevant to the claim, the second doctor conducts a physical examination.

The claimant is then asked if they have any questions. After the claimant leaves the examination room, the boarding doctors discuss the case, award a percentage loss of faculty and determine a date for a scheduled review.

8.18 Medical Boards for Long-Term Incapacity Allowance claims tend to last half an hour and 20 minutes for Short-Term Incapacity Allowance and Invalidity Benefit claims. However, appointments with the consultant psychiatrist last about one hour to allow for a more in-depth examination.

8.19 Long-Term Incapacity Allowance claimants are informed of the percentage loss of faculty determined by the Medical Board by letter.

8.3.2 Information available to the boarding doctors

8.20 Some of the criticisms levelled at the incapacity benefits system, undoubtedly arise from the poor timing, access and at times quality of information the boarding doctors sometimes have about some claimants. It would appear that in some cases an 'incorrect' percentage loss of faculty has been determined simply because the initial Medical Board did not have all of the relevant information about a claimant.[28]

8.21 The boarding doctors are not given any paperwork about the cases they are to assess in advance of each Medical Board. Respondents saw no advantage in having details about a case in advance of a Medical Board. For a first board the doctors have the claimant's Medical Certificates and supporting documentation. For any subsequent Medical Boards for the claimant, the boarding doctors also have copies of the paperwork for all previous Medical Boards.

Hospital records

8.22 The supporting documentation comprises the claimant's file, including any letter from the claimant's General Practitioner, and, if appropriate for Long-Term Incapacity Allowance claims, any x-rays and medical records for non-psychiatric patients from the hospital (claimants give authority for this to happen as part of the application process). However, there is no arrangement for Medical Boards to have these hospital records for Short-Term Incapacity Allowance claimants.

8.23 The hospital's psychiatrists have been reluctant to release medical records about psychiatric patients to the Medical Board. As a consequence, for what many perceive to be a difficult sub-group for Medical Boards to assess, the boarding doctors have lacked what might be significant information. The Social Security Department has made progress in liaising with the psychiatric doctors to obtain information that can be used at Medical Boards. In future it is hoped that some psychiatric records will be released to the boarding doctors.

8.24 In addition, the letters sent by the Department to claimants point out that they can bring a third party to the Medical Board, and often claimants with a mental health condition bring a community psychiatric nurse, psychiatric social

worker or relative who can provide some relevant medical history. The Social Security Department also have some boarding doctors with experience of mental health conditions, including a consultant psychiatrist.

General Practitioners' letters / forms

8.25 The claimants' General Practitioners are invited (by a standard letter that is initially sent to the claimant) to submit up-to-date information on their patients. [29] The letter asks General Practitioners to complete a one side of A4 pro forma covering the claimant's medical history, current medication, current and planned treatments and any other relevant information. The form does not ask about the claimants' incapacity or ability to work, because it was devised primarily for the assessment of Long-Term Incapacity Allowance, which as already highlighted is not a benefit concerned with capability for work. The form should be returned to the Department within 14 days.

8.26 Initially, some General Practitioners did not respond positively to Social Security Department requests for up-to-date information about their patients that could be submitted to a Medical Board. In some cases this lack of, or late, response generated a subsequent request for a review of the case. The Social Security Department does pay a fee (£15 if they respond to the letter in time) to encourage General Practitioners to supply information. Over time the General Practitioners response to the requests has improved; at present, the majority of claims are supported by information from a General Practitioner. However, some General Practitioners' responses have on occasions lacked the detailed information required for a Medical Board.

8.27 Social Security Department staff try to get claimants' diagnoses correct on NESSIE, because the letter sent to General Practitioners requesting supporting evidence mentions the diagnosis for which incapacity benefit is claimed. This can lead to difficulties in situations where:

- the ailment code is incorrect;
- following the scanning of the Medical Certificate the scanning staff have been unable to read the General Practitioners handwriting and consequently have entered the ailment code for 'miscellaneous'; and
- the Medical Certificate does not record the key diagnosis, such as 'knee pain' being the recorded ailment when the patient's main health condition is alcoholism (see also Section 5.3.1).

8.28 The letter inviting further information is sent two to two and half weeks before the board appointment. This timescale can cause problems if a General Practitioner is on holiday.

8.29 General Practitioners can find completion of the form difficult. Its completion requires a General Practitioner to sift through a patient's medical records and

identify salient information. This might not be a straightforward task because typically they are the more complicated cases. From the perspective of some General Practitioners, it is not entirely clear what information the Medical Board requires. The Social Security Department has not issued any guidance to General Practitioners on how to complete the form.

8.30 The form can take a General Practitioner half an hour to complete. However, they probably need to complete only one or two per month.

8.31 The completed form is returned to the Social Security Department. Patients do not see the completed form. It is possible, of course, that General Practitioners complete the form in discussion with their patients.

8.32 The nature of the process is that General Practitioners do not tend to deal directly with the boarding doctors. However, the General Practitioners and the boarding doctors are likely to know one another reasonably well. Nevertheless, the boarding doctors are seen by General Practitioners as independent practitioners.

8.3.3 Perceived claimants' approach to Medical Boards

8.33 Respondents said that claimants, especially those with a mental health condition or a brain injury, get very worried / nervous before attending a Medical Board. Levels of anxiety can be exacerbated because claimants are aware that the outcome of the assessment is going to affect their benefit. Claimants can have financial concerns about how they and their families will cope if awarded less than 100 per cent percentage loss of faculty. Moreover, some claimants find everyday life stressful, without having to attend a Medical Board.

8.34 Claimant respondents highlighted that they did not receive enough information from the Social Security Department about the procedure and what was expected of them. For instance, whether in the waiting area they are expected to knock on the examination room door to let the Medical Board know they have arrived. However, the Department now sends a flyer explaining the Medical Board with the appointment letter.

8.35 It was claimed there is a *'macho façade'* at Medical Boards by some claimants. It was argued that such claimants needed to be more *'honest'* with the boarding doctors and not simply say they *'feel fine'*. The concern is that some claimants, especially those with mental health conditions or learning impairments, fail to convey the depth of the obstacles they would face in returning to work and are too keen to tell a Medical Board that they could return to work. This is seen to arise because they have learned to cope with their condition, and / or claimants sometimes want to *'please'* the Medical Board and can *'… put a very positive spin on how they're feeling on that particular day.'*

8.36 Social Security Department staff can inform claimants that they need to be

'honest' with the boarding doctors; otherwise it is difficult for the Medical Board to assess how their condition has affected them. In addition, attendance by a third party – family member, friend or professional – can aid a claimant in elucidating the difficulties they encounter. In addition, the local boarding doctors maintain that as retired General Practitioners with many years experience, they are well aware of how claimants' conditions can change over time.

8.37 A perceived consequence of this concern is that people have been awarded a lower percentage loss of faculty than would otherwise be the case. However, it is not possible to quantify this, or to say what proportion of requests for reviews these factors generate.

8.3.4 Determining the percentage loss of faculty

8.38 When assigning a percentage loss of faculty the two boarding doctors will discuss the percentage to be awarded. Usually, both doctors propose a percentage loss of faculty and they are often within five or ten per cent of one another. Although if there is a more senior doctor and a newer boarding doctor, then the former will tend to propose a percentage loss of faculty, which will then be discussed. Only rarely are the two boarding doctors unable to agree on a percentage loss of faculty, and ultimately if not resolved another Medical Board would be arranged.

8.39 The boarding doctors assign a percentage for each condition. The percentages for each condition are then summed and rounded up to the nearest five per cent to give the percentage loss of faculty for benefit purposes ((Social Security (Jersey) Law 1974, Article 16(c)). The aggregated figure can not be more than 100 per cent (Social Security (Assessment of Long Term Incapacity) (Jersey) Order 2004, Article 2(b)). Assessment is based on the medical condition represented by the ailment code on the initial Medical Certificate. Initially, boarding doctors were only allowed to assess for this initial ailment. However, the boarding doctors now assess conditions related to the initial ailment code. This change was introduced because there had been complaints about assessments strictly based on the initial ailment code, a condition which by the time of the Medical Board might no longer be the claimant's primary condition. So, for instance, a claimant with a Medical Certificate for back pain, who over time became depressed, would now be assessed by the Medical Board for both back pain and depression.

8.40 The form the boarding doctors complete to record their findings allows them to list any unrelated conditions, but no percentage loss of faculty is assigned to these conditions. However, it is possible that the claimant has a separate (successful) incapacity benefit claim for this unrelated condition. (That is, claimants can have multiple claims.)

8.41 In assigning a percentage the boarding doctors have to follow relevant legislation and they make use of official guidance, *Assessment Guidelines for*

Long-Term Incapacity Allowance, produced by the Social Security Department.

[30] Officially, a distinction is made between 'scheduled' conditions and 'non-scheduled' conditions. The percentage loss of faculty to be assigned to the former are prescribed by the *Social Security (Assessment of Long Term Incapacity) (Jersey) Order 2004*. Scheduled conditions are physical conditions, namely, amputations, loss of vision, and loss of hands, fingers, toes and feet. Non-scheduled conditions are 'other' medical conditions. The percentages for the scheduled assessments can be used as a guide for the non-scheduled assessments. Appendices to the guidance provide information, mainly taken from UK Medical Appeal Tribunals, to assist boarding doctors determine percentage loss of faculty for various conditions.

8.42 The legislation for scheduled conditions allows Medical Boards to adjust the prescribed percentages when *'reasonable'* to do so. For non-scheduled conditions, the guidance makes clear that information given on percentage loss of faculty is for guidance only: '*There is no intention to direct Medical Boards to particular levels of assessment in individual cases*'.

8.43 The percentages for the losses of faculty for more than one condition are summed. However, the summing of percentages for each relevant condition to give an overall figure is problematic. It cannot be assumed that the sum of the individual percentages gives a realistic percentage for the individual as a whole, and under the legislation this is what the Medical Boards are required to do (see Social Security (Assessment of Long Term Incapacity) (Jersey) Order 2004, Article 2(1)(a)). Indeed, the guidance itself acknowledges that for scheduled conditions the percentage for a multiple injury might exceed the sum of two or more percentages for each component injury.

8.44 Some respondents were concerned about the assessment of fluctuating conditions. For fluctuating conditions the guidance suggests that an *'average assessment'* be made for the relevant period. The boarding doctors were confident that they had sufficient knowledge and experience to be able to make these average assessments for fluctuating conditions.

8.45 The local boarding doctors are aware that 'physical' cases - aches/pains and musculo-skeletal conditions - are the easiest to assess, but that they find it *'very difficult'* to assess psychiatric disorders, anxiety and depression, which constitute a majority of the caseload. For the local boarding doctors the most difficult cases to assess are claimants with stress or anxiety, especially as the claimant may believe that their condition precludes them from engaging in any activity. Claimants' levels of stress and anxiety can range from *'virtually non-existent'* to '*pretty severe'*. Specific psychiatric diagnoses, such as chronic depression and bipolar disorder, by contrast, are seen as easier to assess.

8.46 A concern for the boarding doctors is that in part a claimant's anxiety is related to their financial worries, and if they reduce a claimant's percentage loss of

faculty it will add to their anxiety. However, in assessing percentage loss of faculty, the boarding doctors are, under the legislation, not allowed to take a claimant's finances into account (Social Security (Assessment of Long Term Incapacity) (Jersey) Order 2004, Article 2(1)(b)).

8.47 The boarding doctors description of how they decide on a percentage loss of faculty does suggest that they are, *de facto*, considering 'disabling effects', that is the impact of an impairment on everyday life for the individual (see Section 2.4). For example, psychiatric claimants may receive a higher percentage loss of faculty:

> *'… just because they have difficulty getting out of the house, they stay indoors, but somebody with backache, although they're handicapped they can get out and enjoy a social life. So we are taking all these things into consideration and for those reasons psychiatric cases often you will find will be assessed at a higher percentage.'*

Boarding doctors' views on the official guidance

8.48 The boarding doctors' views on the guidance issued by the Social Security Department were nuanced. In general, the guidelines were perceived as helpful, '*fairly comprehensive, … very good'* and seen as providing a starting point for physical assessments.

8.49 The interpretation of the guidelines for some conditions has been discussed with the Department and the boarding doctors do not always initially agree with the Department's understanding. The Department's aim in these discussions has been to ensure that the Medical Boards' decisions are robust and reliable. However, the boarding doctors thought that sometimes the Department was acting too quickly, and that some changes reduced the range within which they could determine a percentage loss of faculty (but see discussion below). Notwithstanding regular meetings with the Department where issues are discussed, the boarding doctors would on occasions have preferred more time to discuss the interpretation of the guidelines.

8.3.5 Staff queries about awarded percentage loss of faculty

8.50 Social Security Department staff see the determination of the percentage loss of faculty by the Medical Board. On occasions staff might query the percentage awarded, because they could not (at that point in time) easily reconcile the assessment outcome with previous decisions. It is important that staff do understand the determination of a percentage loss of faculty by the Medical Board as they may have to explain the outcome to the claimant. Cases were such queries arise are discussed with the boarding doctors.

8.51 There was also some staff praise for the effort, commitment and '*fairness*' of the boarding doctors' reports. Moreover, the input of the consultant psychiatrist is seen as *'excellent'* because his percentage loss of faculty for psychiatric cases was

believed to be more accurate than that previously available to the Department.

8.3.6 Reasons for variations and changes in percentage loss of faculty

8.52 The distribution of the percentage loss of faculty awarded for 2005/06 is discussed in Section 4.2.2. The analysis of the administrative data suggests that differences in assessments cannot be attributed to claimants' gender or age. However, this does not mean that other unobserved demographic characteristics are not associated with variations in percentages awarded for loss of faculty. An analysis of variation in percentage loss of faculty by ailment / health condition was not possible because of concerns about the reliability of the ailment code data.

8.53 Drawing on the qualitative research it is possible to speculate about other reasons for the perceived variations and changes in the percentage loss of faculty awarded by Medical Boards. These possible reasons are as follows (not in any order of importance or significance):

- Changes in percentage loss of faculty may mirror improvements or deteriorations in a particular claimant's health condition. One incapacity benefit respondent attributed a reduction in his percentage loss of faculty from 75 per cent to 50 per cent to an improvement in his mobility. Similarly, a recipient might have had physiotherapy following an operation, and so their percentage loss of faculty ought to be reduced. Although boarding doctors are asked to record the reasons for a change in an award, any third parties are possibly unaware of (anticipated) changes in the diagnosis of recipients.
- For some conditions a variation between cases is to be expected. Although legislation (Social Security (Assessment of Long Term Incapacity) (Jersey) Order 2004) prescribes some fixed percentages for certain physical conditions, for non-scheduled conditions the official guidance does show that the range of percentages for some conditions can be relatively wide. The guidance includes an appendix giving the low, high, average and the most common (mode) assessments for a variety of conditions considered by Medical Appeals Tribunals over an unspecified two year period. For example, for the following conditions the relevant percentages are:

Condition	Lowest	Highest	Average	Most common
Anxiety	**0**	**80**	**22**	**-**
Asthma	**2**	**80**	**23**	**10**
Epilepsy	**5**	**90**	**25**	**20**
Migraine	**0**	**30**	**7**	**-**
Vertigo	**1**	**20**	**6**	**5**

These ranges in percentage awards provide boarding doctors with a fairly high degree of discretion. Indeed, the legislation allows Medical Boards to modify the prescribed percentages for loss of faculty where this is reasonable. It is

possible that some of the observed variation in percentage loss of faculty awards for cases with apparently similar conditions is that the cases are not medically that similar, and / or variations reflect boarding doctors taking into account the 'disabling effects' of conditions (see Section 2.4). Alternatively, the guidelines are not always precise enough and permit too much discretion in certain circumstances. There might be less variation in percentage loss of faculty determinations if the guidelines explicitly incorporated 'disabling effects' (see Section 2.4).

- For a fluctuating condition the boarding doctors have, as required, made an average assessment that appears to others to be unfair, because at the time of the Medical Board the claimant's health appeared to be better / worse than implied by the overall percentage loss of faculty. Where there is also a wide range in assessments for the condition (see above), determining a percentage loss of faculty can be both problematic and apparently similar cases can have different percentage loss of faculty assigned. So, for example, for a claimant with a bipolar affective disorder who is only adversely affected one week out of four it is '… very difficult to assess it as a percentage'.
- Assessments for people with mental health conditions can be problematic for the local boarding doctors – they have a lack of experience of psychiatric cases (see Section 8.3.4). Claimants may have current or past mental health conditions and without a psychiatrist or someone with expertise in mental health conditions on a Medical Board it is possible that varying assessments will be made, especially as the guidelines do show that the Medical Appeals Tribunal have made a relatively wide range of assessments for mental health conditions. For the local boarding doctors the assessment of mental health conditions has not helped by there being no hospital notes for psychiatric patients (see Section 8.3.2). The boarding doctors have to rely on information provided by the claimant (and from any third party if in attendance) at the assessment.
- More generally, some assessments, especially early on, were flawed because of a lack of medical information. Whilst the General Practitioners of Long-Term Incapacity Allowance claimants were asked in writing to provide any supporting information, *'… a lot of doctors at that time weren't responding …'* or if they did respond it was after the Medical Board had met (see Section 8.3.2). The resulting assessments did lead to some adverse press coverage and to requests for reviews. However, this should be less of an issue as the majority of General Practitioners now reply to the Departments' requests for further information.
- A related point, some claimants who attended Medical Boards on their own had a reduction in their percentage loss of faculty because they had not adequately elucidated the difficulties they encounter (Section 8.3.3).
- The variation in percentage loss of faculty will partly reflect the dynamics of a new policy. Boarding doctors new to the system have been on a learning curve. By implication there ought to be less variation as they gain more experience.
- Ultimately, the guidelines are only advisory. Moreover, of necessity they do not provide guidance on all conditions.

- Decisions may appear to be inconsistent and arbitrary to those outside of the Department and the Medical Boards because the guidelines are not published. How Medical Boards determine percentage loss of faculty is not transparent.
- Sometimes a claimant is initially under- or over-assessed by a Medical Board. That this can occur is illustrated by Review Boards revising percentages for losses of faculty (see Section 8.4.1).

8.54 These possible reasons for the expressed concerns about determining percentages for losses of faculty are not mutually exclusive. One or more reason may be significant for different periods of time since the system was implemented. They also suggest that a variety of policy responses may be required.

8.55 However, a more fundamental possible reason for observed variations in percentage loss of faculty is that it is a consequence of the method of assessment used. The assessment of incapacitation is driven by a claimant's impairments (or loss of faculty). However, as pointed out in Chapter 2, the concepts of incapacity and impairment / loss of faculty are related but distinct. A more accurate and reliable approach might be based on performance of functional activities. This is discussed further in Section 2.5.

8.3.7 Split claims

8.56 As mentioned above, claimants are informed in writing of their percentage loss of faculty. However, where the Medical Board have determined more than one percentage (a 'split assessment'), the claimant is only given the total percentage; the figure is not disaggregated by condition / ailment code. Sometimes the Medical Board will determine a percentage loss of faculty for a condition, such as depression, for which the claimant did not submit a Medical Certificate. This reflects the boarding doctors' decision to assess conditions related to the initial ailment code (Section 8.3.4). However, for staff there are a number of consequences that arise from this practice.

8.57 First, only at a latter date might the recipient discover that they were allocated a percentage loss of faculty for this other condition, for instance, if they subsequently submit a Medical Certificate for the condition. This can be a surprise to recipients, especially if they have received an additional percentage for depression. However, simply informing recipients of the breakdown of their overall percentage loss of faculty so they know for which conditions they receive benefit is not unproblematic. For example, when a claimant is psychologically unprepared to accept that they might have another condition, such as depression or alcoholism.

8.58 Secondly, where a recipient submits a further Medical Certificate for a condition for which they have already received a percentage loss of faculty the processing staff have to link that Medical Certificate to the Long Term Incapacity Allowance claim. NESSIE does not process these linked claims automatically, staff

have to identify the case and where the condition has deteriorated manually type a letter requesting further medical evidence to the General Practitioner, wait possibly five weeks for a reply, deal with any claimant's payment queries, write a cover sheet and submit it to the Medical Board for consideration. Payment of any change to Long Term Incapacity Allowance can take up to, say, five weeks. Where, however, any subsequent Medical Certificate was for a 'new' condition then staff can use the system to adjust the Long Term Incapacity Allowance claim (to include Short Term Incapacity Allowance) and benefit is paid within two to three days.

8.59 The letter is sent to the claimant's General Practitioner because the Department is already paying benefit for the condition.[31] It explains that the patient is already receiving Long Term Incapacity Allowance for the condition and asks for further information. Not all General Practitioners reply to this request for medical evidence.

8.60 Thirdly and a related point, it creates more work for General Practitioners of these claimants and for Health Zone staff.

8.61 The claimant's General Practitioner is not informed of the percentage breakdown by condition.

8.3.8 Claimants' perceptions of Medical Boards

8.62 Unsurprisingly, given the public's low level of awareness of the incapacity benefit system (see Section 3.3), claimants are unsure about the role and purpose of the Medical Boards. Views expressed include that the Medical Boards are to establish the person's medical condition or their capabilities. Claimants do believe that there is a strong connection between the assessment and their ability to work. So, for example, a determination of 50 per cent is often taken to mean that only half of a person is able to work. Such observations were usually followed by the rejoinder, but which half, and /or the comment that it is that percentage that stops the rest of the individual from working. None of the claimants interviewed said that they saw the percentage loss of faculty awarded as compensation for their incapacity.

8.63 However and as already mentioned, the Department now encloses a flyer explaining the work of Medical Board with the appointment letter sent to claimants. This may help to reduce some of the claimants' misunderstandings about the role of the Medical Board.

8.64 Generally, the recipients were satisfied with the conduct of the Medical Boards. The boarding doctors were perceived to be *'very thorough'* and *'quite good'*. Third parties attending Medical Boards also perceived the boarding doctors to be thorough and *'reasonably friendly'*.

8.65 Notwithstanding concerns about the medical information available to Medical

Boards (Section 8.3.2), one respondent was *'amazed'* at the number of case files the doctors had at the assessment. However, one respondent also felt that the boarding doctors did not sufficiently understand the extent of the pain he was suffering.

8.66 A small number of incapacity benefit cases have attracted adverse publicity. Bad press can undermine claimants' confidence in the system. The qualitative interviews show that claimants can be *'fearful'* about the outcome of the Medical Board and the percentage loss they may be awarded. It can also be frustrating for staff highly committed to their work who know that stories about satisfied customers tend not to be reported in the media.

8.4 Review Boards

8.67 If claimants are dissatisfied with their percentage loss of faculty they may seek information or advice from, and / or complain to:

- frontline and / or senior Social Security Department staff
- politicians and / or media
- friends and / or relatives
- their General Practitioner, consultant etc
- advisory and support services such as social services, the Citizens Advice Bureau.

8.68 There was a view held by a variety of respondents that an intervention by senior figures, such as politicians, could secure for a claimant a change in the percentage loss of faculty. Such claims were made at a general level, and no specific allegations were raised. Indeed, no evidence was produced of someone's actual award being changed as a result of any such intervention. However, it is worrying that some respondents believed that the system was open to influence in this way.

8.69 Dissatisfied claimants could formally request a review of their percentage loss of faculty. Usually, claimants (incorrectly) refer to these reviews as appeals.

8.4.1 Reviews and initial percentages for losses of faculty

8.70 In general, and as expected, lower initial percentage loss of faculty awards trigger requests for reviews (Table 8.1). Three-quarters (78 per cent) of claimants requesting a review have an initial percentage loss of faculty of 50 per cent or less. Indeed, a half (48 per cent) have an initial percentage award of 30 per cent or less. Only one per cent of claimants seeking a review have an initial award of over 70 per cent.

8.4.2 Requesting a review

8.71 Claimants may request an independent review of their assessment within three months of their Medical Board provided they can submit further medical evidence to support their claim. So, for instance, if their General Practitioner did not initially provide further information for the Medical Board the claimant might seek a review. The Department needs a letter or a telephone call from the claimant saying they are dissatisfied with their assessment and a supporting letter from their General Practitioner or specialist / consultant with new medical evidence that shows the claimant was initially under-assessed. There is no review request form for claimants.

Table 8.1: Percentage loss of faculty initially awarded for claimants requesting a review, October 2004 – May 2006

Initial percentage	Number	Percentage
<10	8	6
10-20	39	28
21-30	20	14
31-40	22	16
41-50	19	14
51-60	11	8
61-70	10	7
71-80	8	6
81-90	1	1
>90	1	1
Base: Claimants requesting a review	*139*	

Source: SSD Administrative statistics

8.72 Where the request is made in writing, the claimant's letter is scanned into NESSIE as an 'appeal letter', and joins the adjudication work queue. Adjudication Officers examine the letter, and seek further medical evidence if not already provided. Claimants are sent a standard letter explaining the basics of the benefit. A letter is also subsequently sent to claimants confirming receipt both of their letter requesting the review and of the further medical evidence. General Practitioners who have provided further evidence are also kept informed about the case by letter. The Health Zone informs the claimant of the details of any Review Board. A Review Board is held by two different boarding doctors to those attending the original Medical Board. The claimant and their General Practitioner are also informed in writing of the outcome of the review and, if appropriate, the claim is backdated to the date of the original Medical Board.

8.73 Not all requests for a review result in a Review Board. To avoid unnecessary Review Boards the Social Security Department, once the claimant provides the

further medical evidence, asks the two doctors who conducted the original Medical Board whether the new information would change their original decision. If it does, the percentage loss of faculty is revised and the claimant informed of the revised percentage and asked if they are prepared to accept this new figure or wish to proceed with a Review Board. Where claimants accept the new percentage, cases can be determined with seven to ten days. Otherwise a Review Board is convened.

8.4.3 Number of review requests and the timing of reviews

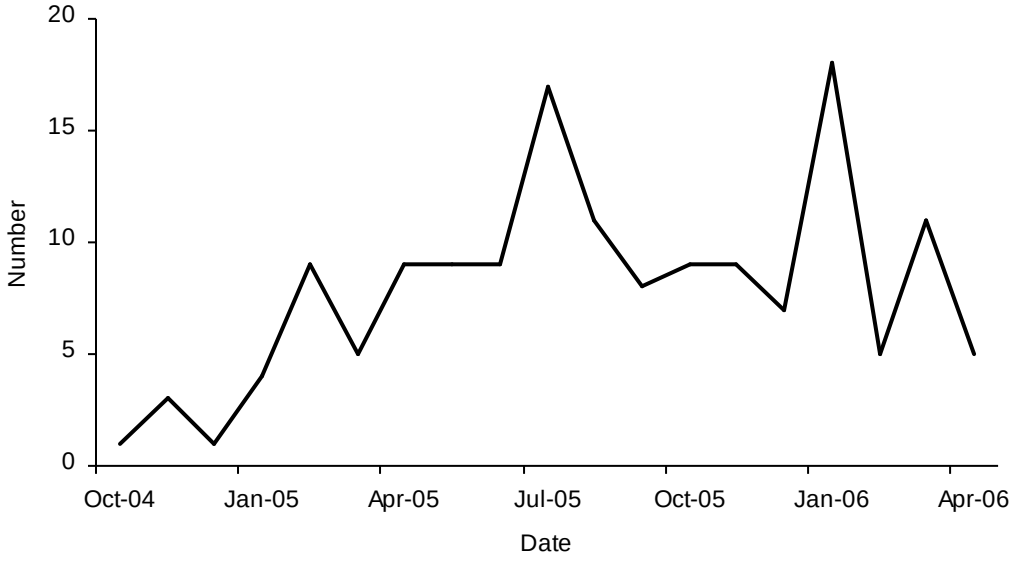
8.74 Staff respondents perceived there to be a relatively large number of reviews. Figure 8.1 shows the build up over time of requests from claimants for reviews. The top graph shows the number of requests by month over the period October 2004 to April 2006. On average the Department receives nearly eight requests per month for reviews. The peaks and troughs in the graph may be seasonal; however, there are no clear trends. The troughs in February and April 2006 support the view that the number of review requests has recently declined. This might be because:

- claimants are better aware of the Incapacity Benefit system;
- the dynamics of a new benefit - the transfer of claimants from the 'old' sickness benefit to Long-Term Incapacity Allowance probably generated a lot of review requests, because (as mentioned above) some claimants suffered a loss of benefit income and this reason for generating reviews is coming to an end;
- many claimants have had their scheduled review and their percentage loss of faculty has remained unchanged or is similar and they accept and understand the percentage loss of faculty awarded; and
- the boarding doctors now better understand the system and their reports better explain the percentage loss of faculty determined so that it is easier for staff to explain their decision to claimants.

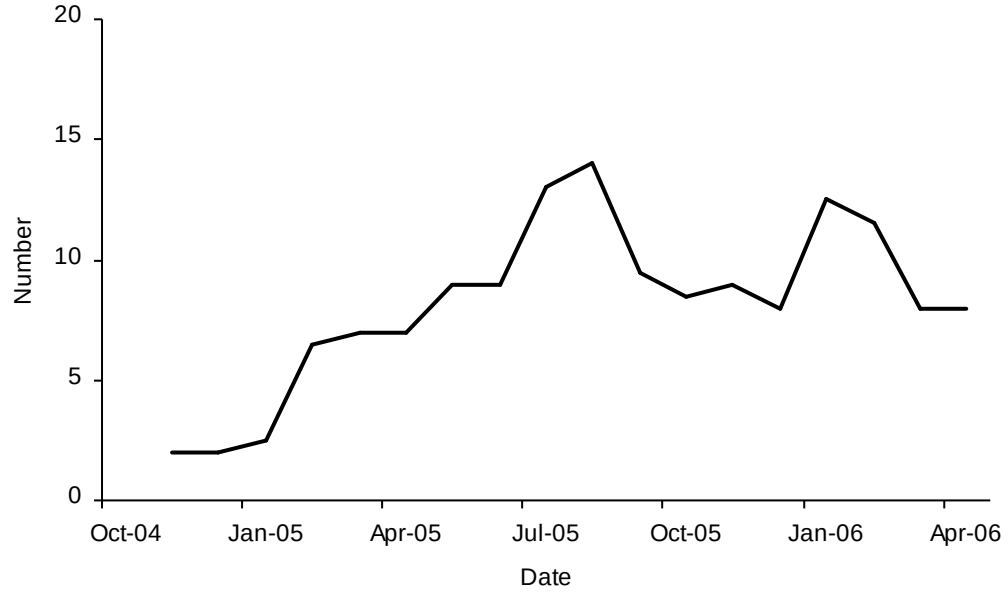
8.75 The bottom graph, which shows the two month rolling average for review requests, confirms that the number of reviews appears to have been decreasing since summer 2005. Although there was an increase during the subsequent winter, this rise is lower than the number of requests for the previous summer.

Figure 8.1 Review requests, October 2004 to April 2006

a) Number by month



b) Two month moving average



Base 150
Source: SSD Administrative statistics

8.76 The actual number of reviews requested will be an under-estimate of the number of claimants who are dissatisfied with the percentage loss of faculty awarded. One claimant respondent could not see the point in seeking a review, another feared that at review her percentage loss of faculty might be reduced to zero.

8.77 Not all of the cases in Figure 8.1 will lead to a Review Board. For instance, the claimant may not supply supporting medical evidence via their General Practitioner, or the claimant may subsequently submit a Medical Certificate (that is, a claim for Short-Term Incapacity Allowance) for an unrelated condition.

8.78 The review process is perceived as *'time consuming'*. The length of time between the request for a review and the date of the Review Board varies (see Table 8.2). For the period October 2004 to May 2006, a half waited over 40 days and a quarter (23 per cent) waited over 70 days. The average is 52 days.[32] Given that Medical Boards are set up two months in advance and some time is set aside for urgent boards / reviews, it is difficult to arrange Review Boards because this can only be done when the requisite new information is made available.

8.79 The main reason for the time taken is the lack of boarding doctors to hold more Medical Boards. In the past, delays could also be caused by the scanning team not recognising a claimant letter as a request for an 'appeal', hence the request for a review is not necessarily spotted until later on. Similarly, the associated letter from the General Practitioner might not be immediately identified.

Table 8.2: Number of days between date of review request and date of review board, October 2004 – May 2006

Days	Number	Percentage
1-10	5	4
10-20	7	6
21-30	26	23
31-40	18	16
41-50	10	9
51-60	13	12
61-70	7	6
71-80	6	5
81-90	7	6
91-100	2	2
101-110	2	2
111-120	3	3
over 121	6	5
Base: Claimants requesting a review	*112*	

Source: SSD Administrative statistics

Table 8.3: Percentage difference between the initial and revised percentage loss of faculty, October 2004 – May 2006

Percentage difference	Number	Percentage
-11 to -20	3	3
-1 to -10	3	3
0 (no change)	26	25
1 to 10	17	16
11 to 20	21	20
21 to 30	16	15
31 to 40	6	6
41 to 50	8	8
51 to 60	2	2
61 to 70	1	1
71 to 80	3	3
Base: Claimants with a review	*106*	

Source: SSD Administrative statistics

8.80 Most Long-Term Incapacity Allowance claimants securing a review gained -

70 per cent saw an increase (of between five and 80 per cent) in their percentage loss of faculty, including a fifth gaining between 11 and 20 per cent (Table 8.3). A quarter saw no change in their percentage loss of faculty. Only six per cent saw a reduction in their percentage award.

8.81 The percentage difference figures, unlike percentage changes, do not fully illustrate how important a review outcome can be for claimants. The percentage change figures (Table 8.4) show that 27 per cent of reviewed claimants gained by up to 40 per cent, a further 24 per cent gained by between 41 and 100 per cent, and 19 per cent gained by increases of over 100 per cent in their percentage award.

8.82 Not all of these increases are the result of actual Review Boards. As mentioned above, the original Medical Board doctors can revise their initial decisions in the light of further information.

8.83 Doctors on a Review Board know the previous percentage loss of faculty before making their new determination – the process is not 'blind marked'.

Table 8.4: Percentage change in the initial and revised percentage loss of faculty, October 2004 – May 2006

Percentage change	Number	Percentage
-21+	3	3
-11 to -20	2	2
-1 to -10	1	1
0 no change	26	25
1 to 10	1	1
11 to 20	5	5
21 to 30	6	6
31 to 40	16	15
41 to 50	3	3
51 to 60	4	4
61 to 70	4	4
71 to 80	3	3
81 to 90	1	1
91 to 100	10	10
101 to 110	0	0
over 110	20	19
Base: Claimants with a review	*105*	

Source: SSD Administrative statistics

8.5 Appeals

8.84 Any claimant can appeal to the Social Security Tribunal against the decisions

made. However, appeals on medical grounds are heard by the Medical Appeal Tribunal. In 2005 there were six appeals across **all** benefits. The relatively low number of appeals reflects a departmental strategy of using the review procedures. The review process avoids claimants having to undergo what could be a *'traumatic'* process and it reduces the number of, what would be expensive, appeal cases.

8.85 However, the legislation requires that Long-Term Incapacity Allowance claimants cannot appeal on medical grounds or against a decision of the Medical Board until two years has elapsed after the date they were first seen by the Medical Board, unless the appeal is approved by the Minister. To date there have been no appeals to the Medical Appeal Tribunal because Long-Term Incapacity Allowance has not been operational long enough for two years to have elapsed for recipients. When discussed with respondents there was no support for this two-year rule. It is perceived to be unfair; if a decision is wrong, then a claimant ought to have a right to appeal.

8.6 Discussion: Medical Boards

8.86 Whatever method of assessment is used in Jersey (Section 2.5), there will always be a need for some form of independent assessment of a claimants health condition or disability. Not least because self-report / assessment methods are known to be unreliable. There are six possible reforms for Medical Board-related issues.

- *Recruitment and training of boarding doctors*

8.89 There is a shortage of (about six) boarding doctors relative to the demand for holding Medical Boards. The Department currently recruits locally retired General Practitioners and doctors with expertise in health conditions who practise outside of Jersey. This ensures that no local doctor has to assess the percentage loss of faculty of a registered patient. However, with appropriate safeguards it might be possible for practising General Practitioners to take part in Medical Boards. The Department should continue with its efforts to recruit local practising General Practitioners and also consider widening the boards' membership to other retired and practising professionals in the health services, for example, senior nurses and community psychiatric nurses could serve alongside General Practitioners on Medical Boards.

8.90 A related issue is the training required to undertake incapacity-related assessments. Undertaking such assessments is becoming more specialised. In the UK the Faculty of Occupational Medicine of the Royal College of Physicians introduced in 1999 a Diploma in Disability Assessment Medicine. 'Disability analysts' in the UK assess the effects of a medical condition on a person's ability to undertake everyday activities. The UK Government is encouraging doctors who undertake such assessments to gain the Diploma. Given differences between the

Jersey and UK approaches to assessing incapacity it is not proposed that boarding doctors be encouraged to gain the Diploma in Disability Assessment Medicine. However, this might be an aspiration if, in the longer term, the States moved from the current Baremas method to a functional ability approach (see Section 2.5) then the Department should expect doctors doing assessments to have the Diploma in Disability Assessment Medicine. The Department also needs to be satisfied that doctors engaged in the assessments have an in-depth understanding of the relevant benefits. In any event, ensuring that boarding doctors receive appropriate training is important and public confidence in the assessments would be increased if accredited training could be provided.[33]

- *Better information sources*

8.91 The Social Security Department should issue guidance to General Practitioners to give them a better idea of the information boarding doctors require. However, this may be achieved by the detailed guidance the Department is issuing as part of the introduction of the Income Support system.

- *Improving transparency and information giving*

8.92 Some of the criticisms of the current system arise from claimants lacking sufficient information about the incapacity benefit system and what is expected of them. Claimants' understanding of, and level of support for, the incapacity benefit system would undoubtedly improve if the system was more transparent. This implies that the Department should in the future be more transparent and publish guidelines and information (as it will be doing with the proposed Income Support system). In addition, the Department should give more information to claimants, for example:

  - Telling them that they are to wait in the examination room reception area until called to attend their Medical Board, would alleviate some of the uncertainty and anxiety associated with claiming Long-Term Incapacity Allowance.
  - Some claimants do not know who they can bring along to a Medical Board. The Department, where it has the information, could inform professionals (other than General Practitioners) that their client was due to attend a Medical Board; although the claimant would have to give their informed consent for this to happen.

8.93 The Department should also review whether Long-Term Incapacity Allowance claimants should be told all the ailments for which they have been awarded a percentage loss of faculty (see Section 8.3.7). As in some instances this information will be highly sensitive and some claimants may not wish to know the breakdown of the award, whether people are told should be at their request. One option would be to include a question about disclosure of any percentage breakdown in the Long-Term Incapacity Allowance claim form. Claimants wanting further details could then be informed, by post, of the relevant figures following their assessment. The letter could also advise claimants with queries about their

assessment to see their General Practitioner, rather than Departmental staff, in the first instance.

8.94 These proposals should be seen as complementary to those outlined in Section 3.4, which addresses the public's lack of knowledge about the incapacity benefit system.

- *Provision of occupational health expertise*

8.95 Staff in the Health Zone and more widely within the Social Security Department would benefit from having access to an occupational therapist / nurse with occupational health knowledge. Processing staff could discuss individual cases with the adviser and policy makers could obtain advice on, for instance, methods of assessment. The adviser could also act as the main (but not only) interface between the boarding doctors and the Department on a day to day basis. The appointment need not be full-time, but it ought to reduce some of the tensions within the Department around the work of the Medical Boards.

- *Appeals to the Medical Appeals Tribunal*

8.96 Current legislation means that recipients cannot usually make an appeal to the Medical Appeals Tribunal until two years after their Medical Board (see Section 8.5). This restriction ought to be removed because it seems unfair to delay a person's right to appeal for this length of time. It is acknowledged that using the appeals system is expensive, but it can provide a decision around which different parties, even if they disagreed with it, will abide and it can be used as a precedent.

- *Banding percentage loss of faculty awards for benefit purposes*

8.97 Currently the total percentage loss of faculty for a claimant is rounded to the nearest five per cent, and benefit is paid in proportion to the resulting percentage. [34] One way to reduce concern about the extent of variation between apparently similar cases would be to introduce bands for the purposes of determining the amount of benefit paid. So, for instance, the percentages could be grouped into four or five bands and within each band recipients would receive the same amount of benefit. This ought to reduce the incentive for claimants to request reviews, as they would only gain financially if they moved to a higher band. However, this proposal is problematic. First, the percentage difference between original and reviewed determinations shows that any bands would have to be fairly wide to reduce the number of review requests. For example, 36 per cent of cases had increases of up to 20 per cent in their percentage loss of faculty on review (Section 8.4.4). Secondly, unless people are told their actual percentage they will not know if they are close to the threshold for moving into another band, and so may request a review anyway. But informing them of their actual percentage removes one of the benefits of the proposal, namely, to minimise concerns over the perceived variation in percentage determinations. Thirdly, if implemented on a 'no cost' change basis there would be 'losers' as well as 'winners' compared to the old system. Within each band those closer to the upper boundary are likely to

receive less benefit than under the existing system. If implemented so that there are no losers, compared to the current system, this would require an increase in the incapacity benefit budget. This in turn would mean an increase in social insurance contributions which would add to employers' labour costs. . So whilst banding the percentage loss of faculty for benefit purposes has its attractions it is not recommended at this stage.

8.98 The above recommendations need to be considered alongside the proposal that the method of assessment used to determine the degree of loss of faculty needs amending (Section 2.5).

9 Conclusions and recommendations

9.1 Introduction

9.1 The aim of this chapter is to discuss the findings outlined in earlier chapters in relation to the Terms of Reference and to summarise key recommendations. The chapter has three main sections that reflect the review's Terms of Reference, namely:

1. *To review the new incapacity benefit system in place to ascertain whether it meets with the policy intent as agreed by the States of Jersey; namely:*

    - *To provide immediate support for people with short-term, limiting illness*
    - *To enable people with a long-term health condition to return to work*
    - *To be less intrusive*
    - *To prevent abuse of the system (through disguised retirement and unemployment)*

2. *To review the associated guidelines, procedures and processes and support mechanisms and make recommendations as appropriate.*

3. *To identify areas where the role of key stakeholders and communications may be improved.*

9.2 It is acknowledged that the evidence base for some recommendations is incomplete and further analysis or research is required. Some of the proposals are changes that, if accepted, can only be implemented in the longer term. Some will require legislation and some will demand extra resources.

9.2 Does the new incapacity benefit system meet its policy intent?

9.2.1 Policy aims

9.3 The trade-off between the policy aims of social protection and social inclusion was mentioned in Section1.3. The former requires recipients to receive adequate financial support so that they have a decent standard of living, whilst the latter demands that they are given the support including financial incentives to enter or retain sustained employment. The two aims can lead to complementary policies, but there is an underlying tension between the two (Waddell and Aylward, 2005: 14). This tension can be resolved by ensuring that *'… financial support is balanced with more active support into work, tailored to suit individual needs.'* (Waddell and Aylward, 2005: 14). In doing this, however, it is important to realise that the incapacity benefit system does not operate in a vacuum. Other

policies need to be in place, to help create the environment or framework that would allow a 'balanced' incapacity benefit system that encourages people to return to work to be successful. These policies relate to:

- how the incapacity benefit system links with the wider benefit system, including housing support;
- the management of sickness absence by both employers and the health service; and
- employment and anti-discrimination legislation.

Ongoing policy developments and proposed legislation, notably on Income Support and anti-discrimination legislation, show that the States are making progress in creating this wider policy framework within which the incapacity benefit system operates.

9.4 More specifically, the policy aim of helping people with health conditions or disabilities to return to work is the right one. There is strong evidence that, in general, employment is good for people's well-being (Waddell and Aylward, 2005: 17; Waddell and Burton, 2006). Indeed, the evidence suggests that worklessness is harmful to an individual's health and is associated with increased risk of poverty and social exclusion. Of course, the link between paid work and well-being and social inclusion is not perfect. Some jobs, for instance, are dangerous and others lowly paid. Nonetheless, employment '… *is generally good for physical and mental health* ***provided*** *...:*

- *Jobs are available*
- *Physical and psychosocial conditions are satisfactory and provide a decent "human" quality of work*
- *Work provides adequate financial reward and security.'*

(Waddell and Aylward, 2005: 17, emphasis in original)

9.5 How this policy intent is signalled to the public is important, because it can influence expectations and hence behaviour. In this context the name for the in-work benefit, Long-Term Incapacity Allowance, is possibly unhelpful. At a suitable opportunity, the States should consider renaming the benefit in order to better emphasis that it is an in-work benefit and that is not paid to compensate for a loss of earnings due to an inability to work. This review, therefore, suggests that Short Term Incapacity Allowance be renamed Sickness Benefit and Long Term Incapacity Allowance be re-titled Work and Support Allowance. The former more clearly conveys to people the purpose of the benefit, and the latter emphasizes the connection with employment.

9.6 The reformed incapacity benefit system incorporated a wider policy change that affected other contributory benefits, namely, the individualisation of benefit entitlement. Many people appear to be unaware of this wider policy change until they claim an incapacity benefit. In general, respondents thought claimants had been used to getting the dependency increase, and that its removal under the new system had reduced recipients' household incomes and led to financial hardship. However, it was argued that it was less of an issue for those employees whose employers operated occupational sick pay schemes as they were not financially worse off. But for the self-employed, or those with employers who did not top-up their Short-Term Incapacity Allowance to full pay, the loss of the dependency increase did represent a real loss of income.

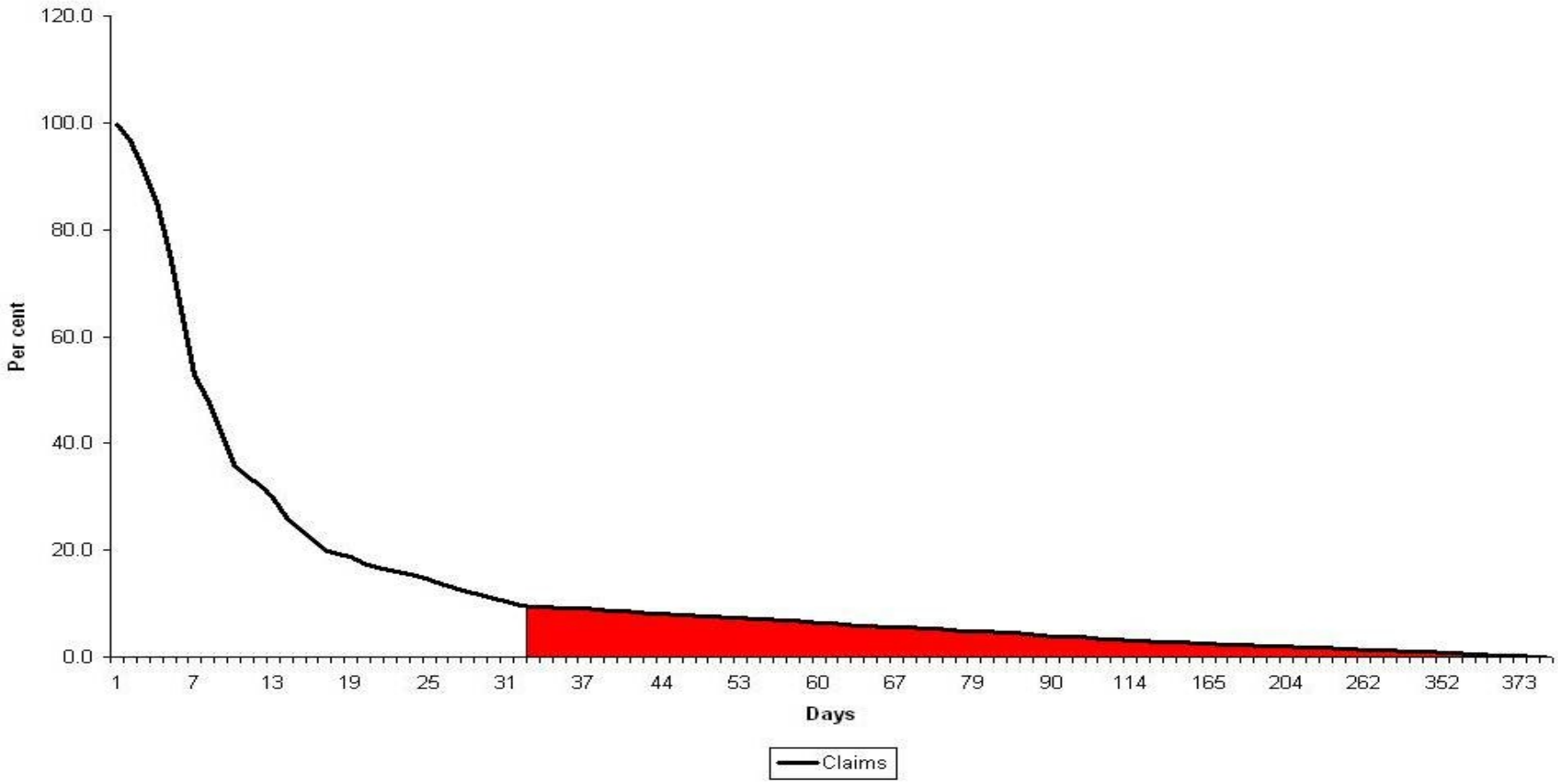
9.7 There was a difference of opinion about the extent to which the individualisation of benefit was currently a major problem for the incapacity benefit system. One view was that the public had now accepted individualisation of benefits. However, there still appears to be instances where male incapacity benefit recipients are surprised that they do not receive any benefit payment for their wife under the new system. The other view was that the removal of the dependency increase was still generating a lot of tension and problems for those administering incapacity benefits. Nonetheless, the individualisation of contributory benefits is a key feature of the benefit system in Jersey and the rationale for it is introduction remains, consequently it should continue as a feature of the island's incapacity benefit system.

9.2.2 Support for those with a short-term limiting illness

9.8 Figure 4.2, reproduced here as Figure 9.1, is key to understanding the extent to which the current incapacity benefit system meets its policy intent for Short Term Incapacity Allowance. The current system is successful in that most people claim Short Term Incapacity Allowance for only a short period of time. The duration of a typical Short-Term Incapacity Allowance claim is eight days. However, the Department should focus its attention on the 10 per cent of claims lasting longer than 32 days (the shaded area in Figure 9.1), especially the two per cent of claims lasting for more than six months (182 days). With other stakeholders, the Department needs to minimise the numbers reaching 33 days on Short Term Incapacity Allowance. Possible policy measures highlighted in earlier chapters of this report include:

- Continuing with the early intervention scheme, but intervening even earlier in the history of a claim at five weeks.

Figure 9.1 Short Term Incapacity Allowance durations


120.0
100.0
80.0
60.0
40.0
20.0
0.0
Per cent
1
7
13
19
25
31
37
44
53
60
67
79
90
114
165
204
262
352
373
Days
Claims

- As the Department acquires more administrative data on claimant and claim characteristics and longer term outcomes, it should develop a more formal screening tool to help identify those that would most benefit from its early intervention programme.
- Reviewing the existing Transitional Benefit arrangements with a view to giving Short Term Incapacity Allowance recipients more of an incentive to engage in job search and obtain paid work. It is recommended that, in the longer run, the Department reviews whether the current arrangement should be replaced by a Return to Work Bonus paid directly to Short Term Incapacity Allowance claimants. The Bonus would be time limited (say, up to one year) and means-tested and only paid to those who had entered paid work of, say, at least eight hours per week. Recipients of the bonus would not also be in receipt of Short-Term Incapacity Allowance (or Long-Term Incapacity Allowance). (However, the Department may wish to wait until it can assess the effectiveness of the incentives in the proposed Income Support system in encouraging people with disabilities or health conditions to move into employment before introducing a new benefit.)
- For those with longer term disabilities, extending the range of items covered by its Adaptation Grant and, in any event, more actively publicise the grant to employers and employees.

9.9 The role of employers and General Practitioners in supporting those with a short-term illness is also important and discussed further below in Section 9.4.

9.2.3 Enabling those with a longer term health condition to return to work

9.10 Figure 9.1 is also relevant to gauging the extent to which the current system meets the policy intent for Long Term Incapacity Allowance. Although people remaining on Short Term Incapacity Allowance for more than 32 days had a typical claim duration of 77 days, some flow on to Long Term Incapacity Allowance. Given that it is well-established that the longer someone is on benefit the less likely they are to return to paid work, it is possible that allowing people to claim Short Term Incapacity Allowance for up to one year is not helping *'people with a long-term health condition to return to work'*. The maximum period of incapacity for Short Term Incapacity Allowance should, therefore, be reduced. Subject to further research on longer term outcomes for Short Term Incapacity Allowance recipients, a new maximum period of six months is proposed. This would allow time for Departmental (and other) staff to help and support Short Term Incapacity Allowance claimants who do not quickly (that is, within say 35 days) return to work. It also means that those with longer term conditions move more quickly to Long Term Incapacity Allowance. The proposed change would affect a small number of claimants, as only two per cent remain on Short Term Incapacity Allowance for more than six months.

9.11 The early intervention scheme with those moving on to Long Term Incapacity Allowance is to be commended. However, of concern is the four-fifths

of claimants contacted by the Department with an offer of advice and support who do not take it up. One radical solution would be to require those identified by the Department to attend at least one work focused interview as a condition of continued entitlement to Long Term Incapacity Allowance. There may of, of course, be valid reasons why Long Term Incapacity Allowance claimants are unable to return to work. However, given that they have been out of the labour market for at least a year whilst in receipt of Short Term Incapacity Allowance (see above) their self-confidence and self-esteem may be low and a discussion with an adviser about their barriers to work and how they might be overcome could be beneficial. The Department should, therefore, investigate further the longer term outcomes of those remaining on Short Term Incapacity Allowance for more than 32 days and discuss with stakeholders the introduction of a mandatory work focused interviews for (selected) new Long Term Incapacity Allowance claimants.

9.12 Several respondents argued that more resources will be required if Jersey is to meet its policy objectives. The above proposals will require more resources, for both more staff and services. It was not the purpose of this review to collect the necessary data to assess the benefits and costs of these proposals and the Department will need to consider and model the cost-effectiveness of these proposals. The proposals may also lead to some cost savings, for instance, by reducing the maximum period for receipt of Short-Term Incapacity Allowance to six months.

9.2.4 A less intrusive system

9.13 The new incapacity benefit system is arguably less intrusive than the previous system. The intrusiveness of the system was not an issue raised by any respondents during the course of the review. In addition, the forms completed by claimants do not appear to ask any unnecessary questions and the Department is aware of, and sensitive to, data protection issues.

9.14 The new system has not been in operation long enough to identify trends in the number of reviews. As might be expected with a new system there was a build up in review requests that peaked around summer 2005. More recent administrative data indicated that the number of review requests has declined (see Section 8.4.3 and Figure 8.1).

9.2.5 Preventing abuse of the system

9.15 Several respondents claimed that there were instances of misuse of incapacity benefits. It must be recognised that there are people who will (intentionally or not) misuse the benefit system. Indeed, the Department has a section that deals with non-compliance (Section 5.3.6) and cases of misuse are detected, and one claimant respondent outlined behaviour that might or might not on closer investigation have been fraudulent.

9.16 This review was not designed to estimate the 'true' level of fraud in the

incapacity benefit system. The administrative data suggests that the evidence for a seasonal variation in Short-Term Incapacity Allowance claims, which might indicate misuse by seasonal workers, is not clear cut. The on flow of Short-Term Incapacity Allowance claims is relatively stable over the course of a year, although there are troughs around Easter, mid-summer and Christmas (see Section 4.3.3 and Figure 4.3). However, the average duration for claimants commencing a claim in August was 18 days. This is a period unlikely to be affected by seasonal illness, such as colds and flu, but when there is a seasonal demand for labour. That the average duration for August is shorter than the overall cohort duration of 21 days (see Section 4.3.1) might suggest that some claimants minimised their time on benefit because there was plenty of seasonal work. The evidence from interviews with respondents was also mixed, with some perceiving seasonal variations, other not and some believing that claims were becoming less seasonal.

9.17 Some of the recommendations of this review – notably on early interventions (see above) and management reporting (see below) should facilitate the tackling of misuse of the incapacity benefit system.

9.18 In summary, recommendations of the review relating to the policy intent are:

Policy aims	• **Policy aims should remain unchanged** • **Short Term Incapacity Allowance and Long-Term Incapacity Allowance should be renamed to signal more clearly that the latter is an in-work benefit and is paid as compensation for a loss of faculty. The suggested new names are Sickness Benefit and Work and Support Allowance, respectively. This change will require legislation.**
Short-Term Incapacity Allowance	• **Benefit rules prevent Short Term Incapacity Allowance recipients from working. Short Term Incapacity Allowance can be claimed for up to one year. Given that the longer someone is on benefit the less likely they are to return to paid work it is not, on balance, in the interests of most individuals to remain on Short Term Incapacity Allowance for up to one year. The maximum period of incapacity for Short Term Incapacity Allowance should, therefore, be reduced. Subject to further research on longer term outcomes for Short Term Incapacity Allowance recipients, a new maximum period of six months is proposed.**
Early interventions	• **Jersey should continue to operate an early intervention scheme** • **The Department should review Short Term Incapacity Allowance cases for an early intervention at five weeks rather than the current ten weeks**

	• **Over time the Department should consider developing its own formal screening tool to identify cases for early intervention** • **Jersey should consider requiring those Long-Term Incapacity Allowance claimants identified as suitable for early intervention to attend a meeting with an employment adviser**
Transitional benefit	• **The Department should review the existing Transitional Benefit arrangements with a view to giving Short-Term Incapacity Allowance recipients more of an incentive to engage in job search and obtain paid work. It is recommended that following the introduction of Income Support the Department reviews the current arrangement and considers whether Transitional Benefit should be replaced by a Return to Work Bonus paid to Short Term Incapacity Allowance claimants. The Bonus would be time limited (say, up to one year) and means-tested**
Rehabilitation services	• **Several respondents argued that more resources will be required if Jersey is to meet its policy objectives and the Department will need to undertake further work to assess the cost-effectiveness of the proposals outlined in this review.** • **The Department may wish to extend the range of items covered by its Adaptation Grant and, in any event, more actively publicise the grant to employers and employees.**

9.2 Review of, and recommendations on, guidelines and processes

9.19 The guidelines, procedures and processes followed in the incapacity benefit system are considered in Chapters 5, 6 and 8. In addition, Chapter 2 discusses the approach underpinning the assessment of loss of faculty.

9.20 The method of assessment used in Jersey to assess loss of faculty (Baremas) is commonly used in other countries and is controversial. Many of the criticisms of the incapacity benefit system and of the percentages awarded for loss of faculty reflect shortcomings in the underlying methodology. These criticisms are highly likely to continue unless the current method for assessing entitlement to Long Term Incapacity Allowance is reformed. There are two broad policy options: (1) amend the existing system so that it is more specific and covers the consequences of the severity of impairments on everyday activities ('disabling effects'); or (2) replace the method with an alternative approach. Both approaches will require the involvement of key stakeholders and the public if the

resulting method is to enjoy public support and trust. This report recommends that the States replaces the existing methodology with one that focuses on the abilities of the claimant to undertake certain everyday functional activities, such as, manual dexterity or coping with pressure. Replacing the existing approach is proposed because revising it would not satisfactorily address its fundamental weaknesses, and of the other approaches available a focus on ability to perform functional activities seems the most promising.

9.21 Medical Boards determine a Long-Term Incapacity Allowance claimants' percentage loss of faculty. Based upon the interviews undertaken for this review, the work of the Medical Boards and the percentages for loss of faculty determined in certain cases are probably the most controversial aspects of the incapacity benefit reforms.

9.22 In determining a percentage loss of faculty, boarding doctors must adhere to the relevant legislation and can use unpublished official guidance. The local boarding doctors acknowledged during the review that 'physical' conditions are easier to assess than psychiatric disorders, anxiety and depression.

9.23 Claimants dissatisfied with their percentage loss of faculty can, on producing relevant medical evidence, request a review by another Medical Board. Allowing people to request a review, rather than moving straight to an appeal, is undoubtedly in the best interests of claimants because an appeal process could be stressful for them. However, the two year time limit before appeals to a Medical Appeals Tribunal can be made is too long a period and should be abolished.

9.24 Notwithstanding the need to overhaul the method of assessing incapacity and the appeals waiting period there are a number of other recommendation made in respect to the operation of Medical Boards (Chapter 8). These recommendations include:

- To address the shortage of boarding doctors the Department should continue to encourage practising local General Practitioners to serve as boarding doctors and widen the membership of Medical Boards to other professionals in the health service. Any boarding doctors will need to satisfy the Department that they have undertaken the necessary training to undertake assessments of loss of faculty.
- To improve the information available to boarding doctors the Department should issue guidance to General Practitioners to give them a better idea of the information Medical Boards require to make assessments.
- To increase the pool of expertise within the Department an occupational therapist / nurse with occupational health knowledge should be employed who could advise staff on incapacity benefit related matters.

9.25 A number of respondents commented on the management reporting facilities of the incapacity benefit computer system, NESSIE. There was a perceived need

for better and more frequent management reports that could be more easily generated by the computer system. The Department has received a number of upgrades to the computer system and others are planned, and the Department should continue to make progress in this area.

9.26 In summary, recommendations of the review relating to reviewing guidelines and processes are:

Assessing loss of faculty	• **Many of the criticisms of the current system arise from the method of assessment used.** • **The States should replace the existing methodology with one that focuses on the abilities of the claimant to undertake certain everyday functional activities, such as, manual dexterity or coping with pressure.**
Medical Boards	• **The Department should continue to encourage practising local General Practitioners to serve as boarding doctors and widen the membership of Medical Boards to other professionals in the health service. Any boarding doctors will need to satisfy the Department that they have the necessary training to undertake assessments of loss of faculty** • **The Department should issue guidance to General Practitioners to give them a better idea of the information Medical Boards require to make assessments** • **The Department should consider employing an occupational therapist / nurse with occupational health knowledge who could advise staff on incapacity benefit related matters**
Appeals	• **The two year time limit before appeals to a Medical Appeals Tribunal can be made should be abolished**
Benefit computer system	• **There is a need for improved management reporting facilities**

9.3 Role of key stakeholders and communications

9.3.1 Communications

9.27 Communications about the incapacity benefit reforms are important because they affect the public's awareness and understanding of the incapacity benefit system. From the interviews with respondents it appears that the public's general level of knowledge about the incapacity benefit is low. Moreover, some representatives of third parties that come into contact with incapacity benefit claimants can also lack (detailed) knowledge about the incapacity benefit system. This low level of awareness is not unexpected; it is a characteristic of other benefit systems. The role of the Department in promoting awareness of the incapacity benefit system is inevitably limited, but it could:

- provide more training courses on the incapacity benefit system to other agencies dealing with the client group;
- offer a one-off 'update' course to local General Practitioners; and
- continue to encourage General Practitioners to display relevant posters and literature on the incapacity benefit system and information about where to go for advice and support.

9.28 In addition, to improve public and health professionals understanding of the assessment system the Department should in the future be more transparent and publish guidelines and information (as it will be doing with the proposed Income Support system).

9.29 Notwithstanding these recommendations, the interviews with claimants show that in general they are satisfied with the Department's leaflets and communications and with staff.

9.3.2 Other stakeholders

9.30 The WHO definition of health and health related domains (see Section 2.3) serves to highlight the importance of personal, social and environmental factors alongside more medical considerations. There is extensive evidence that helping people return to work requires support across the full range of health, personal, social and environmental factors (Waddell and Aylward, 2005: 42). Incapacity benefit recipients face multiple barriers in returning to work; indeed the relative importance of different barriers to an individual can change over time (Stafford *et al.*, 2006). Workwise and other agencies on the island cannot on their own support people with health conditions and disabilities into sustained employment, General Practitioners and employers also have key roles to play.

9.31 In the time available it was not possible to recruit any employers to be interviewed as part of the review. However, employers have a pivotal role in the wider incapacity benefit system. Their policies and practices determine the management of sickness absence and the recruitment of people with health conditions or disabilities. According to some respondents many employers on the island are exemplars of how to recruit and manage employees with a health condition or disability. However, respondents also claimed there is some 'bad' practice, especially amongst some of the smaller sized employers. The implication is that some businesses need to improve their management of sickness absence.

9.32 This review does not make specific policy recommendations for enhancing the role of employers, rather it is recognised that there is a need for further research on employers' needs for advice and support. Further research might show, for instance, a demand for a peripatetic occupational health service.

9.33 In general, General Practitioners do not discuss the patient's return to work. The issue of a Medical Certificate is essentially a negotiation process between the patient and their General Practitioner. The review does show that General

Practitioners need to be encouraged to discuss returning to work with their patients at the earliest opportunity. To promote this change the Department could invite a UK General Practitioner from a UK incapacity benefit reform pilot area to give a presentation on his / her experiences, and / or with others establish a 'Healthy Workplaces' campaign in Jersey.

9.34 In summary, recommendations of the review relating to the role of communications and other stakeholders are:

Lack of public awareness	• **The Social Security Department should provide more training courses on the incapacity benefit system to other agencies dealing with the client group** • **A one-off 'update' course should be offered to local General Practitioners** • **General Practitioners should as part of helping to promote their patient's well-being display relevant posters and literature on the incapacity benefit system and information about where to go for advice and support** • **The entire assessment process needs to be more open and transparent in order to secure public confidence**
Employers' role	• **Research on employers' needs for advice and support is required.**
General Practitioners' role	• **General Practitioners need to be encouraged to discuss returning to work with their patients at the earliest opportunity. To promote this change the Department could invite a UK General Practitioner from a incapacity benefit reform pilot area to give a presentation on his / her experiences, and / or with others establish a 'Healthy Workplaces' campaign in Jersey.**

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Appendix A: UKs Personal Capability Assessment

The Personal Capability Assessment

Physical and mental activities	**Examples of descriptors [#] (test points value)**
Physical activities	
Sitting in an upright chair with a back but no arms	
Rising from sitting in an upright chair with a back but no arms	
Bending and kneeling	
Standing without the support of another person; may use a walking stick	Cannot stand unassisted (15)
Walking on level ground with a walking stick or other aid if normally used	Cannot walk more than 50 metres with stopping or severe discomfort (15)
	Cannot walk more than 200 metres without stopping or severe discomfort (
Walking up and down stairs	
Manual dexterity	Cannot pick up a coin which is 2.5 centimetres or less in diameter with eit hand (15)
	Cannot turn a sink tap or the control kı on a cooker with either hand (15)
Reaching	Cannot put either arm behind their bac if to put on a coat or jacket (15)
	Cannot raise either arm to head as if tc on a hat (15)
Lifting and carrying by use of upper body and arms	Cannot pick up and carry a 0.5 litre cai of milk with either hand (15)
	Cannot pick up and pour from a full saucepan or kettle of 1.7 litre capacity either hand (15)
Vision in normal daylight with glasses or bright electric light with glasses if worn	Cannot tell light from dark (15)
	Cannot see the shape of furniture in th room (15)
	Cannot see well enough to read 16 poi print at a distance greater than 20 centimetres (15)
Speech	Speech cannot be understood by family friends (15)
Hearing with a hearing aid if used	Cannot hear well enough to understanc

	someone talking in a loud voice in a qu room (15)
Remaining conscious without having epileptic or similar seizures during waking moments	Has had an involuntary episode of lost altered consciousness once in the six months before the test is applied (8)
	Has had an involuntary episode of lost altered consciousness once in the three years before the test is applied (0)
Continence (other than enuresis)	
Mental health activities	
Completion of tasks	Cannot concentrate to read a magazine article or follow a radio or television programme (1)
	Cannot use a telephone book or other directory to find a number (1)
Daily living	
Coping with pressure	Mental stress was a factor in making th stop work (2)
Interaction with other people	Mental problems impair ability to communicate with other people (2)
	Gets upset by ordinary events and it results in disruptive behavioural proble (2)

Note:

[#] The descriptors presented in this Table are only examples of the descriptors for each activity in the Personal Capability Assessment. For a full list of the descriptors see DWP (2005). The test points are the number of points a claimant can be awarded for each descriptor, entitlement to Incapacity Benefit requires that claimants pass a point's threshold.

Sources: DWP, 2005

Appendix B: Summary details of respondents

Respondents were promised anonymity and confidentiality, consequently only their general characteristics are presented here. In summary, of the 39 respondents:

- Nine worked for the Department of Social Security
- 10 were incapacity benefit claimants
- 20 were 'third parties', that is, they had worked with the client group and / or dealt with members of the wider population with disabilities or health conditions.

Some of the 'third party' respondents were also employers, but where not interviewed in this capacity.

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[1] Jersey has pursued a gender equality agenda within social security for some time, for example, it equalised the retirement ages of men and women entering its pension scheme in 1975.

[2] Under the current incapacity benefit system, dependency increases are only paid if a partner is at home looking after a child aged under five years.

[3] Home Responsibility Protection does not give entitlement to either Short or Long-Term Incapacity Allowance, but allows entitlement to Incapacity Pension.

[4] The employee pays six per cent and the employer pays the remainder.

[5] Rates were revised in October 2006

[6] The rates were revised at the end of September 2006.

[7] Note Income Support will be paid to the household, but the health subsidy may be paid to any individual within the household.

[8] An Incapacity Pension can be awarded where the individual, as a result of the relevant disease or injury, is likely to be **permanently** incapable of work (Social Security (Jersey) Law 1974, Article 17(1)(c)).

[9] Health domains include seeing, hearing and remembering, whilst health related domains include education and social interactions (WHO, n.d.: 7).

[10] Such views are supported by evidence that worklessness is associated with poor physical and mental health (Coats and Max, 2005:11). However, it is also the case that so-called 'bad jobs' can occasionally lead to disease or injury (*ibid.)*.

[11] Depending upon the specific circumstances, the behaviour of this respondent could be fraudulent.

[12] Unless otherwise stated the figures based on the administrative data exclude disallowed claims.

[13] Age at date of application for incapacity benefit.

[14] Here typical is defined as the median or mid-point case. The mean was 54 per cent and the mode was 50 per cent.

[15] An analysis of the strength of the correlation between these two variables confirms that there was no significant association between age and percentage loss of faculty.

[16] Jersey does have a voluntary code, the Jersey Anti-Discrimination Promise, that business are asked to sign to tackle discrimination on grounds of race, sex and religion (BBC, 2006).

[17] For the year May 2005 to April 2006 the threshold for full year contributions was £7,692.

[18] In the UK, receipt of Incapacity Benefit for one year is a critical point in time - a person who remains on the benefit for this period is likely to stay on the benefit until they retire (Waddell and Aylward, 2005: 40).

[19] Read Codes are commonly used by General Practitioners in Jersey and the UK (Clinical Terminology Service, 2006). In the UK Read Codes are to be replaced by a new scheme, SNOMED CT.

[20] Skills Solution is a partnership that includes Jersey Employment Trust, Jobscope, Workwise and Interwork, which provides training and support services to disabled people. It is administered by JET.

[21] Differences in the nature of the services provided mean that it is difficult to find comparative workload figures. In other programmes, such as New Deal for Disabled People, advisers can have higher caseloads, over 100 (Stafford *et al.*, 2006).

[22] Rates for the period October 2005 to September 2006

[23] That this change to a five week intervention would be beneficial is a judgement by the author. In the absence of a comparison group, it is not possible to quantify this benefit, or measure the 'value added' of the proposal.

[24] The 'other' sector includes computing and private sector education and health providers.

[25] Best practice for managing sickness absence is given in HSE (2004).

[26] A similar point is made by the European Foundation for the Improvement of Living and Working Conditions (Wynne and McAnaney, 2004).

[27] A summary of the case for businesses can be found at the Employers' Forum on Disability, Realising Potential web pages at http://www.realising-potential.org/six-building-blocks.

[28] Decisions can be considered to be 'incorrect' in the sense that a subsequent Review Board changed the percentage loss of faculty awarded.

[29] By sending the letter to the claimant the Department is ensuring that the claimant has given their authority for their General Practitioner to write to the Department.

[30] The guidelines are not in the public domain.

[31] These letters are not sent to the General Practitioner via the claimant, nor are General Practitioners paid for replying to the request for further evidence.

[32] These figures are for total lapse time and hence include non-working days.

[33] The proposed Income Support system will use a 'functional ability' approach to assessing disability and some of training proposed for boarding doctors, for instance, on interactions with claimants and report writing, should also be relevant to the assessment of incapacity.

[34] Assuming the percentage is at least five per cent.