

Public Consultation – Personal Independence Payment: assessment thresholds and consultation

Response from Social Inclusion Unit, City and County of Swansea.

The Social Inclusion Unit aims to tackle social exclusion in Swansea by developing a greater understanding of the long term benefits that can be found by delivering socially inclusive services and tackling poverty. It also provides specific services around Welfare Rights work such as specialist advice and support for social workers, advisers, support workers and Members, and representation at a range of Social Security appeals. We made 101 successful DLA claims in the year ending 31/12/10, and of 107 DLA appeals only 12 were unsuccessful. Our clients have a wide range of disabilities, health conditions, and circumstances.

For more information on any aspect of this response, please contact Adele Jones, Welfare Rights Adviser – 01792 637401.

Consultation Questions

- 1. What are your views on the latest Daily Living Activities?**
- 2. What are your views on the weightings and entitlement thresholds for the Daily Living activities?**

We will concentrate on the biggest problems we see with the descriptors and points weighting of these activities, though we would like to make it clear that we feel that all the points weighting in these activities are too low, and do not reflect the importance of all these activities not only to basic daily life, but to the mental and emotional wellbeing of every person.

We find it extraordinary that Activities 1 and 2 give such small weightings to the need for help for what are surely the essential activities of preparing food and taking nutrition. To suggest that healthy and nutritious food can be prepared by always using a microwave (1c.) relegates those who can only use a microwave to some level below those of us who do not have a disability and are therefore entitled to a healthy, balanced diet. We would argue that only being able to use a microwave will severely limit access to a range of ingredients, and that therefore a higher weighting should be given to this descriptor. In addition, we find the wording of activities 1d, e, and f, to be unclear. Do these activities refer to preparing or cooking a simple meal in a microwave or at a conventional cooker? The difference between activity 2e and f should also be questioned. If a person needs assistance to manage a therapeutic source to take nutrition, we would argue that there is no difference in need to someone who needs another person to convey food and drink to their mouth – both situations mean that a person will not receive food without help, yet the difference in the points weighting means the difference between receiving the standard rate of care or not.

In the proposals for Activity 3, 'Managing therapy or monitoring a health condition', we find it concerning that the need for help to take medication is only awarded one point in 3(b). If a person needs daily supervision,

prompting, or supervision to take medication that otherwise means a deterioration in their health, we feel that the points weighting does not acknowledge the severity of the condition. Our suggestion is that a necessity for medication should be acknowledged as being as important as a need to manage 'therapy'. We find it worrying that a need to manage therapy can, at the most, allow people to reach the standard rate of the daily living component, which does not recognise that certain therapies may well be mitigating the risk of potentially life-threatening conditions. It does not reflect the fact that without help, people may be facing consequences as serious as severe harm or death. In addition, although the guideline to this activity states that supervision due to the risk of accidental or deliberate overdose is captured in the descriptor, we contend that the seriousness of the risk is not reflected by awarding one point for 1(b), and as a result that the consequences of serious mental health conditions are not recognised in this activity. We believe that the downgrading of the necessity of prompting and encouragement does not take into account the extensive caselaw that has arisen since *Mallinson* and will have an extremely negative impact on those with mental health issues who are currently entitled to the lower or middle rate of the DLA care component. We feel that this applies to all the descriptors which deal with personal care.

We welcome the addition of Activity 7, 'Communicating'.

We have serious concerns about some of the definitions laid out for Activity 8, 'Engaging Socially'. It is stated that for 'descriptor (d) (i), there must be evidence of an enduring mental health condition [...]'. We are concerned that there is no indication of what that evidence may be – is it enough that a person is prescribed medication by their GP, or does there have to be involvement from other mental health services? Does this mean that the evidence of friends and family is relevant, or not? We worry that this sort of statement confirms PIPs as a medicalised benefit and represents a move away from the social model of disability for which the government states its support. We also firmly believe, informed by our intensive and extensive work with those suffering mental health illnesses, that many people with mental health issues find it incredibly difficult to access, engage with, and maintain engagement with mental health services, and that in certain areas of the country there is a serious dearth of available services. Therefore, whether or not someone can obtain 'evidence' of their mental health condition may depend on something as arbitrary as whether or not they live in an area where services are available and accessible, and the subjective opinion of a GP. Ironically, the more a person is affected by depression, for example, may determine their ability to use services, articulate their problems, and therefore gain evidence in support of their PIPs claim. The fact that this can determine the view of how a person is affected by their condition is not necessarily just, and we would argue for a wider definition of 'evidence' than simply accepting medical or statutory service opinion. In addition, many people with mental health issues will not be able to engage properly with 'a person trained or experienced in assisting people to engage with social situations' and we would advocate for accepting the evidence of family and friends in this situation.

- 3. What are your views on the latest draft Mobility activities?**
- 4. What are your views on the weightings and entitlement thresholds for the Mobility activities?**

In the requirement for evidence of overwhelming psychological distress in Activity 1 of the mobility component of PIPs, we refer to the above argument. However, we feel that the higher weighting of each descriptor (than in the daily living activities) better reflects the impact of disability on people's abilities to get around outdoors, and allows those with mental health issues rather than physical health issues to possibly be entitled to the enhanced rate of mobility where they are currently confined to the lower rate of mobility however severely affected they are by their conditions.

We find that the descriptors included in Activity 11 – Moving Around are confusing and unnecessarily repetitive. We find it worrying that and we also believe that severe discomfort – including pain and fatigue – need to be explicitly referred within the activity. It is not enough to state that the activity should be able to be carried out safely, repeatedly, reliably, and in a timely fashion. The exclusion of severe discomfort could suggest, for example, that a person who can walk 100 metres and remain unharmed or uninjured should be excluded from this descriptor despite being in severe discomfort whilst performing the activity.

- 5. What are your views on how the regulations work regarding benefit entitlement?**
- 6. What are your views on how we are dealing with fluctuating conditions?**

We remain concerned that those suffering short, acute periods of impairment are still excluded from PIPs by the rules on fluctuation and variability in ability. To refuse benefit to anyone who is affected less than 50% of time is an imprecise and misleading approach to fluctuation, which will lead to inaccurate assessments of need. It also fails to take into account that the affected person cannot predict when they will be affected and so may need mobility and care support at all times. Even if a person is not always severely affected by their disability, the regulations do not take account of risk, especially in unpredictable conditions. We also worry about the need for evidence, as set out in the draft criteria, in certain conditions as we question above. Will it be necessary for people to prove that their conditions have a severe impact for more than 50% of the time and how will they be treated if they are unable to obtain the necessary evidence? We have already raised our concerns (above) about

- 7. What are your views on the definitions of 'safely', 'timely', 'repeatedly' and 'in a timely' manner?**

We believe that it is right that all the activities contained in the draft assessment criteria should be considered in light of whether they can be done safely, repeatedly, reliably and in a timely manner. Although the explanatory note states that these terms are defined in the notes accompanying the draft regulations, we believe that the terms need to be incorporated into the

regulations as a general provision, in order to ensure that these terms are taken into account in every assessment of the effects of disability.

8. What are your views on the definitions in the regulations?

We must reiterate at this point our strong disagreement with the definition of the term 'cook', which in Schedule 1 is defined as heating food above waist height. We do not accept that heating food can be deemed as cooking and contend that this definition does not complement the definition in the Schedule of 'simple meal'. We believe that this definition is socially exclusive and harmful.

9. Do you have any other comments on the draft regulations?

We are very concerned by the emphasis in the explanatory notes on priority for those with 'greatest' needs or challenges. It states that the assessment 'should enable us to target Personal Independence Payment on those who need it most'. Again this ranking of impairment and barriers is unhelpful. While it is clearly necessary to have a means of distinguishing between standard and enhanced rates based on two levels of likely costs, the current scoring proposal seems likely to go beyond this to excluding disabled people with support needs who are not considered to have severe enough challenges. Again, this does not take a social approach to disability, nor does it fulfil the DWP's stated aspiration to 'treat people as individuals' in the assessment. Our experience with the WCA and our current level of success in a high number of ESA appeals, leads us to think that such a prescriptive approach has been unsuccessful.