Northern Ireland
Assembly

Committee for Social Development

OFFICIAL REPORT
(Hansard)

Welfare Reform Bill: WAVE Trauma Centre Briefing

25 October 2012

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Alex Maskey (Chairperson)
Mr Mickey Brady (Deputy Chairperson)
Ms Paula Bradley
Ms Pam Brown
Mr Gregory Campbell
Mr Michael Copeland
Mr Sammy Douglas
Mr Mark Durkan
Mr Fra McCann
Mr David McClarty

Witnesses:

Ms Annette Creelman	WAVE Trauma Centre
Ms Amanda Deans	WAVE Trauma Centre
Mr Stuart Magee	WAVE Trauma Centre
Ms Philomena McCaughey	WAVE Trauma Centre

The Chairperson: I welcome Annette Creelman, Amanda Deans, Stuart Magee and Philomena McCaughey from WAVE. Thank you for being here this morning and for taking the time to make a submission. There are a number of specific issues that you want to draw our attention to, so the floor is yours.

Ms Annette Creelman (WAVE Trauma Centre): Thank you, Chair. I am the welfare advice worker with WAVE Trauma Centre. I am accompanied by my colleagues Amanda, Stuart and Philomena, who are also welfare rights workers. WAVE Trauma Centre welcomes the opportunity to contribute to the Committee's consideration of the Welfare Reform Bill. WAVE Trauma Centre is a cross-community charity that supports and helps those who have been injured, bereaved or traumatised as a result of the Northern Ireland Troubles. We have five centres operating in Belfast, Armagh, Ballymoney, Omagh and Derry/Londonderry.

Among the services we offer to our clients is welfare advice. We deal with a vulnerable client group, most of whom have been physically or psychologically injured, long term, as a result of the Troubles. Many rely on sickness and disability benefits and live in low-income households. That is why welfare reform is so important to our members.

I am aware that the Committee is scrutinising the Bill, clause by clause, and that you are hearing evidence from other stakeholders on various parts of the Bill. My previous submission to the Committee focused on the effects of time-limiting contribution-based employment and support allowance (ESA) for those placed in the work-related activity group (WRAG), particularly for the over 50s, and our concerns about the eligibility criteria for the personal independence payment (PIP), which is set to replace disability living allowance (DLA).

We would like to focus on some key points that we hope will mitigate some of the effects of the Bill. First, we want to look at clause 52, which deals with a time limit for contributory ESA. That is the biggest issue among our membership. Many of our clients have been on long-term incapacity benefit and have undergone migration to ESA. This has been an extremely stressful time for them.

The cessation of contributory ESA for those placed in the work-related activity group has implications for those who have other forms of income or savings, as they may not qualify for income-based ESA. Those who do qualify for income-based ESA may find that they are worse off if they receive other income such as industrial injuries benefit, which would be deducted from income-based ESA. Others may live with a partner who works or may have a small occupational pension that may exclude them from means-tested benefit. We fear that the sudden loss of that income will cause many low-income households to plunge into financial hardship, particularly with rising food, fuel and utility bills.

Despite waiting for an ESA appeal for up to six months and winning their case, an individual will find that their payment comes to an abrupt end, not because their condition has improved but because of this legislation. In my experience at WAVE, the majority of the clients that I have dealt with who claim long-term incapacity benefit have been over 50. Due to injury and disability, many have spent many years out of the labour market and lack up-to-date skills. They typically suffer from both physical and mental ill health.

The proportion of people over 50 without any educational qualifications is nearly double that for those in their 20s. The idea that ESA should be a temporary benefit, pending a claimant's return to work as soon as possible, will prove very difficult for that group, who will be competing for work with healthy and skilled young people, graduates, lone parents and those recently made redundant. They are unlikely to be an employer's first choice. Many of our clients will face a withdrawal of state assistance overnight when the legislation is enacted, regardless of how long they have worked or paid national insurance contributions. Many may experience financial hardship, and even risk losing their homes, before they reach retirement age.

Long-term claimants of incapacity benefit who are migrating to ESA will require longer periods of rehabilitation than those who have more recently left the labour market due to ill health and claimed ESA in the past year. We propose that those people are permitted a longer period on benefits and that more resources are put into training and condition management for that specific group. The one-year cut-off period is arbitrary and contradicts the Government's own research on the difficulties facing those who have been out of the labour market for long periods due to ill health.

We ask the Committee to consider introducing an exemption for those who have reached a certain age, in recognition of the difficulties they will face in finding employment, particularly victims and survivors of the Troubles. To that end, it may be helpful for the Committee to obtain statistical data from the Department on how many long-term incapacity benefit claimants over 50, over 55 and over 60 have migrated over to the work-related activity group and succeeded in obtaining employment through Pathways to Work and the assistance provided by the jobs and benefits office. That may be helpful to define a cut-off age. I will now hand you over to my colleague Stuart.

Mr Stuart Magee (WAVE Trauma Centre): Following on from what Annette was saying about the time-limiting of contribution-based ESA, one of the practical steps the Committee could scrutinise is the way in which the decision-making process to place claimants in the support group is implemented. Members will be aware that it has been increasingly difficult since March 2011 for claimants of employment and support allowance to meet the criteria of the support group. Therefore, there is a lack of expectation on them to conduct work-related activity. That will become more important with the introduction of the time-limiting. As members will be aware, those placed in the support group rather than the work-related activity group will be exempt from the time-limiting and will continue to receive their benefits.

The process for making that decision is a technical one, and it is added on to the end of the assessment for limiting capability for work. It is also a decision that many claimants do not really understand, and it is not very well explained to them. If claimants have already gone through an appeal process, many will not challenge the decision, because they are relieved to have got the benefit in the first place. The other reason they generally will not challenge the decision is that there is a small monetary difference of around £5 a week. However, that will become more important, because, after a year, that difference increases from £5 a week to £100 a week. Therefore, we envisage increasing numbers of appeals on those decisions, as well as on the previous decisions about whether someone meets the criteria of the benefit rather than just that of the support group.

We suggest that the Committee recommends to the Department that there is mandatory explanation that someone has been placed in the work-related activity group and the implications at the outset for the time-limiting of their claim to 365 days. If they do not challenge it at that stage, which can be three months into the claim, they cannot go back at the end of the 12 months and challenge it. We feel that there are many people in the work-related activity group who should not be. They are not capable of conducting work-related activity, and, therefore, should properly be placed in a support group. They may not be aware of the changes coming down the road towards them, but we feel that they should be made aware of them.

The Department could take a practical step in relation to the support group. At the end of the 365-day time limit, they should make it apparent to claimants that, if their condition deteriorates to such an extent that they should be placed in a support group, they can then go back and have a reassessment. If they were placed in that support group, their benefit would be reinstated, and they would receive the full amount again.

In our opinion, that step probably would not be that difficult to implement. It would be beneficial to very many chronically ill and severely disabled people, and it would make a major difference under household budgets.

The second point that I would like to deal with concerns clauses 55 to 58, and particularly the sanctions and strengthening of the existing sanction regime afforded to the Department. Clauses 55 to 58 give the Department considerably more power to set claimant commitments, which are a major part of the Welfare Reform Bill, as well as sanctions for failure to meet those claimant commitments.

In reality, we have found from our members that, because of the pressures put on jobs and benefits offices with dealing with the unemployed rather than with claimants of ESA, people are not really being asked to do all that much in terms of work-related activity anyway. The Government in GB have indicated that it is their aspiration to increase this type of activity, in particular through the work programme. They are targeting people who have been claimants of ESA and looking to try to get them back into work. There are practical difficulties with that, in so far as Northern Ireland is experiencing some of the most hostile labour market conditions for very many years. If implemented, we would be worried that many chronically and seriously ill people in the work-related activity group are going to be asked to conduct activity of which they are not capable.

The other issue that we see with those clauses is that they confer on the Department very wide-ranging powers — in fact, they confer on the Department all the power to decide what work-related activity the person is capable of. That is often going to be in the hands of a civil servant, who may have access to only limited medical information about the person, and may not fully understand their condition. If the sanctions regime is attached to that, there is a real concern for us that people who are ill and are incapable of such activities will be sanctioned. That reform will impact severely on the most vulnerable people, through no fault of their own. That concludes my part of the presentation. I will hand you over to Amanda, who is going to take you through some of our concerns around personal independence payment.

Ms Amanda Deans (WAVE Trauma Centre): Thank you. The third point that we would like to make today concerns part 4 of the Bill, which is the abolition of disability living allowance and the introduction of the personal independence payment. That is a major worry for our clients, because many quality for this benefit due to physical or psychological injury.

There are two main issues here: the criteria, and the actual assessment. We have deep concerns about the criteria for this benefit, particularly the draft descriptors, but we are aware that this is a matter for a separate consultation.

In regard to the assessments, we are very concerned that there may be a repeat of the mistakes that have been seen with the assessment for ESA. There are good economic reasons for that. The Government are paying private contractors millions of pounds to carry out a service that is not satisfactory. That would not be permitted in the private sector.

We understand that the contract for the assessment for personal independence payment in Northern Ireland has not yet been awarded, so there is still an opportunity to build in some clauses to ensure that there is no repeat of what we have seen with ESA. The process of assessment must be person-centred because it concerns some of the most vulnerable people in our society. To that end, we feel that it should be mandatory for the medical assessors to obtain up-to-date reports from GPs, particularly where the application for personal independence payment reveals that the claimant is undergoing hospital treatment or is under the care of a consultant in the past 12 months. That would help to inform the medical assessor and would provide the decision-maker from the Department with a separate piece of evidence. Unfortunately, under the current system for ESA, it is extremely rare for that to occur. We hope that the Committee will make that recommendation.

The Committee will also be aware that the Chair of the Public Accounts Committee has heavily criticised the Department for Work and Pensions contract with Atos Healthcare. We also ask the Committee to include something in legislation around compulsory monitoring of the performance of the medical assessors. Atos uses a variety of health practitioners to carry out work capability assessments. There have been numerous criticisms of those reports produced by nurses.

I would like to contribute something from my personal experience of representing people at tribunals in the Causeway area. The frustration is felt not just by the claimant, who is caused additional stress and anxiety; it is felt by the legally qualified member on the tribunal and the GP whom the claimant turns to when they are disallowed. For many clients who proceed to appeal, it seems to be an exercise that could be avoided — and an expensive one at that.

It would be of interest to see how many of these types of assessments end up at appeal and are overturned — cases where a properly qualified doctor or clinician relevant to the particular disability carries out an assessment. A monitoring exercise will be helpful to evaluate that. It is of particular concern that, recently, the charity Benefits and Work reported that bids by Atos for the personal independence payment assessments reveal that most of the health professionals will be physiotherapists or nurses, not necessarily doctors.

It is believed that Atos will have to assess well over one million claimants for personal independence payment — some on paper only — of whom at least a quarter are likely to have mental health conditions or learning difficulties. Yet the majority of health professionals involved will be private sector physiotherapists or nurses with limited knowledge or experience of dealing with these conditions.

In Scotland and Northern Ireland, Atos plans to use 500 physiotherapists, 200 nurses, 40 occupational therapists and 10 doctors. The NHS will provide 36% of the service. Atos says that that mix of health professionals was based on a number of considerations, including the cost differentials between the types of health professionals and the desire for the work among different types of health professionals. There is no mention of how many, if any, of the nurses will be specialist mental health nurses.

Ms Creelman: Finally, we would like to draw the Committee's attention to clause 87, which concerns the duration of awards for PIP. We hope that this clause will be utilised when someone's medical condition cannot change so that they will not be reassessed needlessly. Many of those with serious and long-term injuries find it frustrating and degrading to have to justify why they are in receipt of disability benefits and have to repeat again and again what happened to them. We ask the Committee to use its powers to ensure that that will not be the case for those with long-term injuries as a result of the Troubles, where it is clear that there will be no improvement in their condition.

The Chairperson: Thank you very much. I have a question about medical evidence. You have dealt with some of this. We have heard arguments over who pays for medical evidence on behalf of the claimant. Does your organisation have a view on that? Should that cost fall to the taxpayer, to Atos or to the claimant? Do you have a view on who should pick up the cost for the provision of that evidence?

Ms Creelman: The fact that many of the assessments are wrong and are overturned at appeal is an indication that Atos is not carrying out proper, detailed assessments of people's health conditions for ESA. The Government are paying Atos millions of pounds for these contracts. The cases subsequently have to go through the Department for review and appeal, which takes up civil servants' time, and through the Appeals Service, which is very costly. We feel that it is unfair that that cost should also be borne by the taxpayer. The taxpayer has already paid once in giving the contract to Atos to do the job. Our point is that, in the private sector, it would not be tolerated if a company were not carrying out its contract properly.

The Chairperson: Thanks for that; that is helpful.

Mr Brady: Thanks very much for your presentation. You raised a number of issues that I would not disagree with in any shape or form. The idea of limiting ESA to a year is not aimed at encouraging people to get back to work; it is about cutting benefits. That happened in 1996 when unemployment benefit changed to jobseeker's allowance, and it was reduced from a year to six months. That has been going on for a long time.

In relation to exemptions and migration, people have two hurdles. First, you have to get through the work capability assessment. You have given some examples, and I have come across a number of examples where people were just not clued into what was wrong with the person. That is a big issue.

On the age issue, the Department for Social Development (DSD) obviously has the statistics for over-50s, over-55s, and over-60s, and the decision-making process of the work-related activity group. The difficulty with the claimant commitment is that both partners have to sign it. If one of them refuses — and that person may have mental health or trauma problems — that nullifies the benefit for both people.

You mentioned that, at the moment, people in particular categories are not being forced to look for work. However, legislation will state that people have to look for work 35 hours a week. There is the whole issue of the cost that employers may charge people for letters that state they have been looking for work and all that that will involve. There are a number of issues that you may want to comment on.

Sanctions will be really draconian. Any research that has been done on sanctions shows very clearly that they are no deterrent. That is a fact. People can argue about that all they want, but the statistics are there.

We do not know who will get the contract for the personal independence payment. In Scotland, Atos has the contract. In Lanarkshire, they have re-contracted it back to the health service. So you have a private provider contracting back to a statutory provider that probably should have been doing it in the first place.

My colleagues on the Committee and I would argue that medical evidence should have primacy. There are so many cases in which the proper medical evidence is not seen until the appeal. I did a lot of appeals when I worked in the voluntary sector. People brought in X-rays but were told, "We cannot read that, because we are not qualified." Yet, as you say, there will be only 10 doctors. They are also talking about processing 1,000 cases a week in the transfer from DLA to PIP.

Back in 2007, when these changes started to come through, we argued about the qualifications that these so-called health professionals have. You might have a nurse with absolutely no experience in mental health, or a physiotherapist who has even less. How are they going to be able to assess someone with bipolar disorder or chronic, clinical or reactive depression? There are so many different things. Consider people who are in certain categories of conditions. In England, Atos has already found 32 people who were terminally ill to be fit for work, and they consequently died within a relatively short period. That is the kind of thing that we are up against. Obviously, the primacy of medical evidence is very important.

We are talking about displaced costs as well. The majority of people who fail the test will appeal. I am sure that you will be inundated with even more appeals, and, therefore, it will cost more in the long run. So it has a knock-on effect for the Department of Justice, because appeals are now done through the Court Service.

All of that is happening. Everything that you have said makes sense. The idea is to limit ESA. However, your partner might be working the prescribed hours on the minimum wage. We do not yet know how it is all going to work in respect of childcare, universal credit and the tapers. That is undoubtedly going to impact on people. Will you comment on some of those points?

Ms Creelman: We are concerned because not only will people be hit with losing their ESA and possibly their DLA, they will be hit by cuts in housing benefit. This is all happening very quickly and within a very short period. We are concerned about the impact of all of this. It is not just one or two things that are happening. A lot of things are happening within a very tight period.

People in our group are not going to be an employer's first choice. A 60-year-old is now expected to go out and look for a job because the retirement age has gone up to 66. They will be left with a drop in their household income of £400 a week. That is a lot of money, particularly for people who are coming towards the end of their mortgage, who have shortfall in an endowment, or who have children at university. It will not only be people on the income-based ESA who will be affected. It will also be low-income households that are just above the level of income-based benefit. That is a big concern for us.

Mr Brady: There is another point on that issue. If, for example, the male partner in a couple is five, six or 10 years older, the younger person will have to claim universal credit. That brings the older person into a completely different context and into the alleged work market. That will be another big issue.

Ms Creelman: It will have an impact on savings that may have been set aside.

Mr Brady: Yes, because pension credit is open-ended. Even if you got only a small amount of pension credit, it brought in the passported benefits. There is the whole issue of disability premiums and how they will work. The disabled child premium for those on tax credits will be halved from £58 to £28.

Ms Creelman: The transitional protection that is supposed to be offered to claimants who are moving to universal credit is very fragile. It will easily be lost if there is any sort of change whatsoever. You are talking about a very substantial loss of money if someone loses the severe disability premium, for example. That is a big concern.

ESA is the big issue that our clients are bringing before us. It is a about a shortfall in rent for those in the private-rented sector. Our concern is that, whereas there have been people who have had difficulties purchasing heating oil and whatever, the introduction of the Welfare Reform Bill will mean that people will have a problem just keeping a roof over their head.

Mr Brady: I want to ask you one final question about underoccupancy. You mentioned older people. There is no doubt that underoccupancy rules will affect older people whose family have grown up and left and may come back to visit at weekends. If there is one bedroom being used but two that are not occupied, the housing benefit will be cut by up to 25%. That is another big issue that I am sure will impact on a number of your clients.

Ms Creelman: Yes, it will impact, in particular, on older victims and survivors who are still in their house. Their children may have left home, and they have the security of having settled in their community. When you have come through something horrific in your life, stability is key. The last thing that you want is to be forced to move home. That is particularly the case if, for example, you have a support network or you have a mental health problem but have family members living nearby. It will cause an awful lot of difficulties. The Bill is huge, and the more you look at it, the more concerned you become at every aspect of it. It is a bit like a set of dominoes: if one benefit stops, there will be a knock-on effect. The knock-on effect of all the different regulations coming into force at the same time is a huge cause of concern for our members.

Mr Campbell: Thanks for the presentation. I want to concentrate on two aspects of the ESA issue that you raised, and I have considerable sympathy with both. One is the age issue and the fact that most survivors of the Troubles are in a particular age bracket. You seem to be concentrating on around the 50-year-old mark. I appreciate that everything has to have some sort of arbitrary nature, but, if the Committee were looking at that, how would you defend that position if a 48-year-old person equally claimed to be a survivor who was affected as much as the 51-year-old, who is entitled when they are not?

Ms Creelman: We know that the Committee and the Assembly are constrained by parity. There will probably have to be some cut-off point. We would welcome it if the Committee could put a case for victims and survivors to get some sort of treatment and have a longer period to allow them to rehabilitate. More effort should be put into that because those injured in the Troubles have been very much forgotten about, and people are continually contacting our centre for counselling and support even at this late stage. For a lot of people, things are triggered in later life, and they seek help. We want it for everyone, but we are also aware, when looking at the Bill, of the constraints. However, we welcome anything that the Committee could do for the vulnerable group that we represent.

Mr Campbell: My other point is about the bigger political issue, and you touched on it there for a second. You will be aware of the political minefield in defining a victim/survivor of the Troubles in a wider context. If that were introduced in the ESA context, can you see the difficulty that might emerge if, for example, people who describe themselves as a victim or survivor but, in fact, may been a perpetrator would qualify for what might be regarded as more favourable treatment than somebody else who perhaps is not regarded as a survivor or victim but who just falls into the category of trying to apply for assistance and help?

Ms Creelman: We are a cross-community charity, and we deal with all victims and survivors. We are focusing on the needs of someone who has a disability and the hardship that will possibly be caused because of the introduction of the reforms. We have not specifically looked at the issue that you raise.

Mr Magee: There is some precedent for criteria for financial assistance for victims and survivors through the Northern Ireland Memorial Fund. If the Committee wanted to look at some sort of criteria along those lines, we might argue that the criteria included there as a definition for financial assistance could be transplanted over fairly easily. However, I know that individual members have their own opinions on that.

Mr Copeland: Apologies for not being in for the start of your presentation. I want to talk about post-traumatic stress disorder (PTSD). Conditions such as that are usually directly attributable to the Troubles. I know from sad personal experience that there can be an awful time delay between the incident and the emergence of a condition. In our case, it was 27 years, and nightmares then became fairly regular. Do you think that these proposals favour or are against those who suffer from Troubles-related conditions, particularly post-traumatic stress disorder? Secondly, and this is probably more for the Committee to consider than the witnesses, the number of general practitioners employed by Atos came to my attention a few days ago, and it is scandalous, to be frank. Most people going to a capability-for-work assessment will have one fairly vital piece of evidence, and that is a sick line from their doctor stating that they are not fit for work. Then, an individual, who may or may not be qualified to the same level as their GP, suddenly draws a line through that and says that it does not matter. In a number of cases, particularly of those affected by PTSD and mental health issues, some such decisions have led to appeals that I attended, and I attend a fair number of them. I have seen a doctor at the appeal abandon it on the grounds that to proceed would prejudice the health of the person being examined.

At the contract tendering stage, was there any requirement on Atos to not just type the answers into a computer, which is apparently what they do, but to ensure that what they have done — by having such a small proportion of GPs, who are more expensive — is not a way of maximising the contract value? Is Atos applying a commercial decision to something that should be above commerciality? Have you any indication of the number of companies that have tendered for the Northern Ireland contract or how tightly tied down that contract is?

Ms Creelman: I am sorry; we do not have that information but we can certainly find it out.

The Chairperson: Those are questions that the Department might answer.

Mr Copeland: Can we establish that, because I think that it is fundamental. I thought that it was 50 GPs, but the figure that you quoted was 10. Is that in the whole of GB?

Mr Magee: I think that the 10 related to Lanarkshire, where the contract that was awarded went back to the NHS.

Mr Copeland: If someone has a piece of medical evidence from their GP, and someone who is not a GP places themselves above that, I personally cannot see how that is not open to some sort of review. Are you content that, on the far side of this — and this is sort of related to ESA — that the provision that we have here for the identification and treatment of PTSD, particularly in ex-military personnel, is adequate and fitting?

Ms Creelman: No. We find that the descriptors for ESA and the second draft descriptors for PIP do not seem to take on board the symptoms of post-traumatic stress disorder. We raised that with the victims' commissioners last year, and it is a cause for concern. The Minister at Westminster recently made a statement in which he suggested that there is a responsibility on claimants to supply evidence at the outset of their assessment. Our experience is that people do not really understand ESA. They are confused by the descriptors and they need assistance in even filling in the forms. They think that getting medical evidence may just amount to getting a quick note from their GP. They are not aware that the specific questions and evidence needed have to tackle the actual descriptors that will be considered by an appeal tribunal. Some people have literacy problems and do not understand these complex regulations. So I think that it is unfair to expect people who are already sick and disabled to have to run to doctors when they feel that they are a burden. Many of the claimants have to pay for obtaining the medical letters out of their already low benefit. I think that the responsibility at the outset to obtain such evidence really should be back with Atos or whoever the contractor is.

Mr Copeland: Chair, can we try to see those contracts to make sure that Atos is discharging the contract, wherever it is doing so, properly?

The Chairperson: That issue is one that is more between the Committee and the Department.

Mr Brady: I just want to make a quick point about the GPs. In Scotland and at its conference in Liverpool, their governing body, the British Medical Association, condemned the work capability assessment. That may be a factor in this.

Ms Creelman: That is in my first submission to the Committee.

Mr Douglas: Thank you for your presentation and for your briefing paper, which is very helpful. The paper mentions that many of the people who you work with were injured during the 1970s and 1980s. What is the age breakdown? How many people will this impact on? I am talking about people who are in their 50s and 60s.

Ms Creelman: The difficulty is that, although statistics have been kept on the people who were killed in the Troubles, statistics have not been kept on people who were injured. At WAVE, we have an injured group, and we have recently commissioned research. Again, even the researcher found that it is difficult to find accurate numbers on the number of people who were injured. The Northern Ireland Memorial Fund's database might be helpful. For instance, we know that around 400 injured people qualify for the high-rate care component of DLA. There is a difficulty there. Given that 53% of the deaths in the Troubles were civilians, it is probably fair to say that a large proportion of the people who were injured were also civilians.

Mr Douglas: My colleague Gregory raised a point about a cut-off point. You asked about people who are in their 50s and 60s. Have you looked at this from a legal point of view on discrimination or ageism? Would that cause major problems with equality legislation, for example?

Ms Creelman: I am not really sure. The difficulty is that, although there is age discrimination legislation and the Disability Discrimination Act, you have to take a realistic viewpoint about someone who is 60 with a disability competing for a job with someone who is younger and highly skilled. It may be helpful to have that legislation in place, particularly if there is a very buoyant market in which employers are looking for a lot of workers. At the minute, the job market is oversubscribed with well qualified people. We cannot forget that it will be harder for people who are older with a disability to obtain a job.

Mr F McCann: I will try to be brief. I am also a member of the Committee for Employment and Learning, and, yesterday, we posed a number of questions during our discussion on the new work programme. We said that the migration of a huge number of people from incapacity ESA straight into one of the working groups had not been taken into consideration. I asked whether the Department for Employment and Learning will be able to cope with the migration. The indication initially seemed to be that it will not, and the officials then said that they believe that they will be able to cope. It is a short time away from this being implemented, and the people who are supposed to provide the backup for it are unsure about whether they will be able to cope with it. I do not think that many of them have sat down to look at how you deal with quite a number of people — it could be a number of a thousand or more or less than that. The fact remains that the vast majority of people on DLA and ESA benefits are on them for mental health reasons. If they go across, they will be assessed, first, by people who may have been brought in to take up the overflow and, secondly, by decision-makers who have very limited experience. You do excellent work, and, in that work, have you come across anything on paper that tells you the level of training that decision-makers in the Department get on assessing people with various types of illnesses, especially people with mental health problems?

Mr Magee: To be fair to some of the decision-makers in the Department, I think that they are not being given the opportunity to make the right decisions in a lot of cases, because they simply do not have access to the right information about someone's condition. A lot of our members suffer physical and mental health problems, and a range of people could be treating them. If a decision-maker does not have access to that information and is given a scant report from Atos, they are not really given the opportunity to make the right decision. That flaw in decision-making is carried right through to appeal, and you only get the chance to put that right there. Someone will normally come for advice only once they have been turned down, and the decision has already been made at that point.

In reference to some of your points about the work programme and things like that, the frank answer is that we do not know how DEL and DSD are going to cope with the work programme. What we do have is a recent example from 2008 of the introduction of a benefit, ESA, and the attached work programme. Anyone who has worked in the advice sector since that time knows the endemic problems that were caused by that in respect of initial claimants in 2008 and the people who were migrated over.

Part of the work capability assessment was the work-focused health-related assessment (WFHRA), which was supposed to entail an assessment by a healthcare professional about how you can improve your chances of going back into work and the types of work you can do once you are found not fit for work. That was dropped for two years, and the deemed wisdom in the advice sector was that we would probably never see it come back. However, it is coming back through these proposals. The answer, in our opinion, is that we do not think that DEL has the resources to implement all the proposals in the Bill.

Ms Deans: I will just add to that, Stuart. This may answer some of what you have put to us. In respect of ESA and the assessment, I think there is evidence that the Department is under pressure, especially the decision-making service. On numerous occasions, I have seen cases where the GP has actually been contacted by the Department. The Department has good systems in place when it uses them. They can contact a GP by sending an ESA113, which replaced the AB113. That is a questionnaire that is sent to the GP. You do not often see it in a set of appeal papers, but I have see one that a GP has completed indicating severe mental health problems, low mood and difficulties with maybe six or seven activities. That, obviously, indicates that the client is severely disabled. However, after that has arrived at the Department, that person has still been required to attend an assessment where they have been assessed by a nurse and awarded zero points, and has then had to go to a tribunal. To my mind, that indicates not that the decision-makers are not doing their jobs but that they are under so much pressure they have overlooked that vital piece of medical evidence, and have gone straight to the Atos report and disallowed the benefit.

Mr F McCann: I think that that again raises the question that Mickey raised about the primacy of medical evidence in all cases.

Ms Deans: Absolutely.

Mr F McCann: Over the past couple of weeks, there has been a debate in the Committee about reports by the Human Rights Commission and by the Equality Commission, both of which are in front of us next week. They have voiced concerns about the direction that the Bill is going in. Sammy raised a question about legal action. I do not know whether you have been in touch with either group to raise the questions that you have raised here about the impact of the Bill, especially on ESA, and about how the switch from DLA to PIP will impact on the people you represent. Have you been in touch with the Equality Commission about section 75 considerations? Have you been in touch with the Human Rights Commission to see whether the Bill breaches human rights in respect of how it deals with people?

Ms Creelman: To date, no, but that is certainly something that we will look into. I definitely think that it is a good idea.

The Chairperson: Thank you. No other Members wish to speak. If the witnesses are happy that they have made their presentation — and they have helpfully and kindly provided us with a written submission — I thank them. I take it that they are content with the evidence session so far.

Just to make you aware, this is the Committee Stage of the Bill. Our schedule allows three days a week for dealing with this and we are due to complete our report on 27 November. Obviously, as we move through the evidence gathering sessions, we will take note of all that we have heard and deliberate on it, according to members' views. Then the Bill will go into the Assembly for further debate and discussion.

Thank you very much your contribution to this work.