



# Work and Pensions Committee

## Oral evidence: Health assessments for benefits, HC 128

Wednesday 11 May 2022

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Members present: Stephen Timms (Chair); Debbie Abrahams; Shaun Bailey; Siobhan Baillie; Nigel Mills; Selaine Saxby; Dr Ben Spencer; Chris Stephens; Sir Desmond Swayne.

Questions 211 - 275

### Witnesses

**I:** Dr Kieran Sharrock, Acting Chair of the GPC, British Medical Association; Aaron Dryden, Director of Carer Support, Carers UK; Minesh Patel, Head of Policy, Macmillan Cancer Support; and Mark Jackson, Policy Manager, Marie Curie.

**II:** Daphne Hall, Vice Chair, National Association of Welfare Rights Advisers (NAWRA); Hannah Nicholls-Harrison, Policy Co-Chair, Disability Benefits Consortium; and Caroline Selman, Research Fellow, Public Law Project.

Written evidence from witnesses:

[HAB0094 Macmillan Cancer Support](#)

[HAB0102 Marie Curie](#)

[HAB0034 National Association of Welfare Rights Advisers \(NAWRA\)](#)

[HAB0104 Disability Benefits Consortium](#)

[HAB0058 Public Law Project](#)



## Examination of witnesses

Witnesses: Dr Kieran Sharrock, Aaron Dryden, Minesh Patel and Mark Jackson.

Q211 **Chair:** Welcome, everybody, to this meeting of the Work and Pensions Select Committee in our inquiry on health assessments for benefits. A warm welcome to all four of the witnesses who have joined us for this first panel. Thank you all for coming. I am going to ask each of you to tell us very briefly who you are, both the three witnesses who are here in the committee room and the witness who is joining us virtually. Let's start with Dr Kieran Sharrock.

**Dr Sharrock:** Good morning. I am sorry I cannot be with you in person. I am a GP and I am deputy chair of the GPs' committee for England of the BMA.

**Aaron Dryden:** I am director of carer support at Carers UK.

**Minesh Patel:** I am head of policy at Macmillan Cancer Support.

**Mark Jackson:** Good morning. I am policy manager for England at Marie Curie.

Q212 **Chair:** Thank you all for being with us. Can I ask each of you how professionals in your organisations, or that your organisations represent, support people making health-related benefit claims? Just give us a brief account of what is being done at the moment. Let's start with Dr Sharrock.

**Dr Sharrock:** When people are making health benefit-related claims, they would usually attend their GP or contact their GP and ask them to provide a factual report on their behalf to the Department for Work and Pensions or whoever is administering their claim. That is often done directly by the Department for Work and Pensions or whoever is administering the claim, and we produce a factual report. We also support people by giving advice about return to work, if that is possible, and we provide fit notes to people basically stating how long they should be off if unwell for a short period of time. We can also provide on their fit notes details of how they could return to work in a phased way or with amended duties. It is generally just factual reports, though.

**Aaron Dryden:** At Carers UK we have a national helpline for carers, and regularly our top five most requested matters for help are benefit related, including medical assessments. We provide light-touch support, signposting people to resources that are available, and we produce a lot of guidance for carers that is available on our website and enables them to approach these processes in the best possible way.

**Minesh Patel:** At Macmillan we have a range of services. We provide a range of locally funded benefit advice services. We also have specialist



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benefit advisers on our helpline and they provide information on understanding benefits, helping people to navigate the application process and helping people with claims where needed. Similarly, we have information on our website. We have an online community, a whole range of different sources for people to get information and to understand the benefit system.

**Mark Jackson:** Very similar to colleagues from Macmillan and Carers UK, we have an information and support service via our website, which has a lot of information about the benefits that terminally ill people and their carers may be entitled to, and guidance on that. We also have a benefits calculator on the website where people can find out an estimate of what benefits they might be entitled to. They can also call our support line, where they can get advice about all aspects of living with terminal illness, including support with benefit claims.

**Chair:** Thank you all very much.

Q213 **Nigel Mills:** Dr Sharrock, can I start with you? Probably the most common refrain I hear from my constituents is, "My doctor, my GP or my specialist has told me I have X condition and that I cannot work, yet some health professional—of what background I do not understand—at DWP has told me I am fine. How can DWP overrule my doctor?" Would doctors like just to be able to decide somebody's welfare status, or is that not a job that you would like to have added to your workload?

**Dr Sharrock:** We certainly do not want anything added to our workload. We are already very busy. We are doing more consultations now than we have ever done before, so having extra stuff added on would not be welcome.

GPs are also not occupational health trained. Most GPs have done very minimal training in occupational health medicine and, therefore, we are not in the best position to advise people about whether they are fit or not to work. What we can do is to provide factual information about their medical condition, and we can obviously advise about management of said medical condition. We do not really understand how medical conditions impact on people's ability to work and, therefore, it is not something that a general practice is best positioned to do.

There is a shortage in this country of occupational health trained doctors and that is something we really ought to look at. Our occupational health committee at the BMA has called for a long time to increase the number of doctors who are trained in all specialties, general practice and hospital specialties, so that when people do have questions about their fitness to work, those occupational health trained doctors can do that.

I understand that there are trials going on in Scotland of a system whereby decisions about ability to work are made by people within the Department for Work and Pensions so that we can give factual information, but the decision about whether someone can work could be



made by a doctor or an occupational health trained clinician within the Department.

**Q214 Nigel Mills:** Thank you. When you say factual information, one of the things that I quite commonly see is where the GP has provided a list of dates they have seen the patient and a list of prescriptions that they have issued to that patient. Is that what you would generally expect a GP to do, or is there more on, "This patient has come complaining of being unable to walk, or unable to lift, or unable to sit for long periods and I have tried to help them this way"? What should a GP responding to one of these requests provide? Is it just purely the computer readout, or is there some information on how the condition is impacting the patient, if you have it?

**Dr Sharrock:** We can only provide the information that we have. If we have seen the patient to deal with a particular problem and we have made a record of what they have told us in terms of their ability to do various activities of daily living, then obviously we can share that information. Often that is not the purpose for the consultation. It may be much more around other symptoms or other conditions. We are then relying on what the patient has told us, and we do not have a formal way of assessing that. We do not have time to formally assess it during most consultations. As you know, our consultations are 10 to 15 minutes, generally, so we cannot do a full work assessment, ability to stand. That is much better done by someone who is trained to do the assessment properly.

Yes, we can only share the factual information we have. Normally, that comes in the form of a pre-generated form that is sent to the practice by the person who is administering the form and we complete that with the questions that are asked on that. It is not usual to just do a printout of the medical record. A patient can access their own medical records through their NHS app and things like that, so they can see all that information, but we provide information on a specific form that is sent to us by the Department for Work and Pensions or whoever else is administering their claim.

**Q215 Nigel Mills:** Is that form generally filled in by the named GP or is it filled in by other members of the GP team and signed off by the doctor at the end—or is that a practice choice?

**Dr Sharrock:** It will vary. My own practice is that I fill it in because I feel I want to be able to go through the patient's medical record. I go through and I look back over many years to see what the history is and I can fill in as much detail as possible. I cannot say what happens in all practices but it will vary, I am sure. Generally, there will be someone who is trained to do that, who will be able to go through the patient's medical record, complete the form, and then, if it is not a GP doing that, the GP will check it and sign it off.

**Q216 Nigel Mills:** How long does each one take? Is this a 10-minute job or is it



an hour's job? It might depend on the patient.

**Dr Sharrock:** Absolutely. In certain circumstances it is very clear. Someone has had a road traffic accident, they have whiplash and they cannot work as a result of an injury. That is a very easy thing because it is a one-off event that has caused the injury or the disability. For other people it is much more complex. They might have multiple medical conditions that all play into each other. Therefore, it can take quite a long time. I know I have spent two or three hours sometimes trying to sift through the information that we have and trying to find information out. Equally, I have spent 10 minutes. It can be anything from 10 minutes to two or three hours.

Q217 **Nigel Mills:** Is this a large part of your working week, or do you only get a couple of these to do so it is not a big deal?

**Dr Sharrock:** It can be a large part of the working week. We get a significant number coming through, unfortunately, so it can be. This is all, of course, on top of our clinical work. It is quite a distraction from seeing people who need to see a doctor. It is often the sort of thing you do at the end of the day or before you start your clinical work. It takes quite a significant chunk, but it obviously is not measured by what work we are doing on our appointment screen. NHS Digital measures GP work by looking at our appointments, but if you are doing paperwork like this, which takes two or three hours and is quite mentally tiring because you are trying to do the best for the patient, it is impacting on our ability to then see patients and do clinical work.

Q218 **Nigel Mills:** Is that why some GPs try to charge for this? I think that the BMA website says 30 to 50 quid or something you could charge for this. Do you think that is appropriate for someone trying to claim benefits?

**Dr Sharrock:** We would encourage people to not ask for extra information from their GP but to get the Department for Work and Pensions to do it. There is a mechanism within our contract and within the Department for Work and Pensions to fund this work. If a patient then says, "I want you to provide more information" but the Department for Work and Pensions has not requested it, then we would have to charge for that because it is taking me away from clinical work. It is work that I am doing. I have to still provide heat and light. I still have to have the receptionist, the person to type up the report or whatever. There is a physical cost of generating a form or a report, which is why we say it is much better if the request for the information comes direct from the person administering the claim.

Q219 **Dr Ben Spencer:** Before I start, I make the usual declarations. I am a non-practising doctor.

Following on from Nigel's questions, do you ever get into conflict with your patients in discussions around these reports? Do you ever have times when they come to you and say, "I am not happy with what you sent" or, "I want you to do XYZ"?



**Dr Sharrock:** Yes, unfortunately we do and this is one of the other reasons why we think that this is best handled by someone who is independent. I want to be able to advocate for my patient. I want to be able to support them and not have that barrier there. This is one of very few times in our relationship as doctor and patient where there may be some disagreement. We come to joint decisions about management for other conditions, but in this circumstance I might be saying, "It appears to me that you could be working" or, "I don't have the information I need to be able to say that you can't work. I can only provide factual information". Then the patient may come back to me and say, "Don't you know that I can't walk 200 yards down the road?" I say, "Unfortunately, I do not have that information in my medical record because that is not the sort of thing that we assess".

It would be much better for this to be taken away because I want to keep a good relationship with my patients, and all GPs want to keep good relationships with their patients so that we can advocate for them and so we can support them in the best way we can. Yes, that is a good reason why we would like this to be handled by an independent assessor who is properly trained in making these assessments.

Q220 **Dr Ben Spencer:** I am mindful of the GMC duties of a doctor, and the first and foremost one, which I have up as an aide-memoire: make the care of your patient your first concern. There is another one, which is: work with colleagues in the ways that best serve patients' interests. Is there a danger that there is a tension between the duties of a doctor when you are doing this work for the DWP and you are providing this evidence?

**Dr Sharrock:** I don't think there is a danger there, because all we are doing is providing factual information based on the information that the patient has told us and what we have seen when we have seen them. When we are providing that factual information, that is fact. If we have the facts wrong, in that there is something that we have not been told, it is only because it is a lack of information. There is always the opportunity for the Department for Work and Pensions to either make an independent assessment or come back to us and say, "You haven't given us X amount of information about this condition" and we can then go back and look for it or reply and say, "We don't have that information". All we can ever really do in this circumstance is do our best for the patient by providing as detailed information as possible.

Q221 **Dr Ben Spencer:** How about in terms of your duty of care? Do you see advocacy for patients in this context as part of your duty of care, or are you quite boundaried about that? You have a patient who comes to you and says, "You have provided the factual information. Thank you very much, but I am not getting anywhere, I am really struggling, XYZ. I want you to challenge this. I want you to drive my case forward. What is going on here? You are my doctor. No one else can help".



**Dr Sharrock:** In those circumstances, what I say to my patients is, "Give me the information I need. Tell me what you can and can't do and I will record that in the medical record. Then go back to the Department for Work and Pensions and they can then come to me and say, 'Do you have more information?'" It is not for me to actively challenge the Department for Work and Pensions because I do not know what has happened outside of my consulting room. The patient may have gone and had a full physical assessment, may have had lots of emotional tests and things and been assessed as fit to work or not, and I do not know what has happened outside of my room. I cannot challenge what another independent clinician has done, but I can provide further factual information that I have had shared with me.

Q222 **Dr Ben Spencer:** This is my final question. You are clearly absolutely expert in this and have a superb way of approaching it. Do you think all GPs take your approach? Is there a need for more training in the area?

**Dr Sharrock:** I think that benefits and occupational health are both areas where all doctors need more training, but then again I need more training in lots of things as well. I am an expert generalist. I can never be a specialist. I think that occupational health is a specialist condition. We have an occupational health committee at the BMA because the people who are on that committee are specialists in that area. I would like more training in this and lots of my colleagues would as well, but we should leave this to people who really know what they are doing. I do not want a brain surgeon treating my heart, and you do not want a GP doing occupational health medicine unless they have had the proper training.

Q223 **Chris Stephens:** Picking up from Dr Spencer's questions, Kieran, I have some quick questions for you. You mentioned that GPs are not trained in occupational health, but I am just wondering whether any guidance is given to GPs on occupational health or, indeed, providing evidence for people who are going through health assessments.

**Dr Sharrock:** Yes, we all receive basic training as part of our vocational training scheme, which is a three-year training scheme to become a GP. We are trained in how to complete the forms. We are trained in making basic assessments of someone's fitness to work. I think that training does not go far enough in many cases and, as I say, it is a specialist area. If I wanted to become someone who worked for the Department for Work and Pensions or an independent organisation that did occupational health, I would go through specialist training for that. I am sorry; I don't know if that answers your question.

Q224 **Chris Stephens:** It does, thanks. My next question is this. There have been reports that request forms from the assessment providers seeking further evidence can be confusing, not just for the claimants but for medical professionals, including GPs. What engagement has there been with the Department for Work and Pensions and assessors to ensure that the right evidence is provided?



**Dr Sharrock:** I would not necessarily say the forms are confusing, but I think sometimes they do not give us the room to give the information that is needed. I think that maybe we don't necessarily have the information that is needed because, as I say, we are treating the patient's condition and not necessarily asking about activities of daily living or the further and deeper impacts on their lives. In terms of engagement on the design of those forms, the BMA would always be happy to engage with the Department for Work and Pensions to help better design any paperwork to make it easier for the assessors to make a proper assessment but also for us to complete the forms.

Q225 **Chris Stephens:** I think that is important, and it is certainly something that the Committee will want to make as a recommendation. Thanks for that, Kieran. Turning to the rest of the panel, Mark, what support or advice is available for people seeking third party and medical evidence to support their claim?

**Mark Jackson:** The DWP's website states that for terminally ill people, if you need to obtain a form then you can go to your doctor or another medical professional and you can ask for a form in support. For the special rules claim, it clarifies who can sign that. It does not provide much more data, certainly in the first instance, and if you as a patient with a terminal illness are going to your doctor to ask them for the form that you need in support of a claim under the special rules for terminal illness, that then relies on the medical professional knowing what that is. As Dr Sharrock said, that is not something that all GPs are going to be hugely familiar with all the time. It is clearly the case that some will be doing that a lot more than others. I think that there definitely could be improved support for people, whether that is through advocacy or through better signposting in terms of who they need to approach and what they need to be requesting from clinicians or from other parties to provide evidence in support of claims.

Q226 **Chris Stephens:** Aaron, does the DWP guidance ensure that people seek third party evidence from the right person, or could the DWP make any improvements in that system?

**Aaron Dryden:** I think that carers particularly find this incredibly hard to navigate and the majority of carers themselves identify as disabled people. They very often lack the time or the energy to engage with these processes, so support for them is often vital in terms of getting the best possible outcomes. What carers tell us is that when they engage with medical assessments with their cared-for person, it is incredibly patchy how their input is received and whether it is welcome. I have evidence from one carer who stated that he felt he was forced to obtain power of attorney so that he could speak on their behalf because he was not able to informally feed in, even though there was a capacity issue. Guidance for everybody that enables carers' input would be vital and could possibly streamline the process for everybody.

Q227 **Chris Stephens:** Minesh, it is good to see you in person, not on Zoom.



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Can I ask you what your views are on the advocacy service that is proposed in the DWP's Green Paper?

**Minesh Patel:** It is an area where we are still keen to find out further details in terms of the scope, who is covered and modes of support. I think that, in essence, it is a good thing learning from other services like Help to Claim run by Citizens Advice, having that tailored support, helping somebody through the end-to-end process. It can be really complex, bearing in mind that when you are faced with a medical condition—with a cancer diagnosis—you are dealing with the emotional impact and the physical impacts. Having the support to guide you through that process is really important.

I would say that with any advocacy system, it is important to address some of the existing challenges. Advisers who we speak to at Macmillan tell us, for instance, that it can take a long time to get through to the DWP hotline to resolve quite simple queries, slowing down somebody's claim. Challenges with explicit consent can make it harder to resolve issues when somebody is acting on behalf of a claimant. With any system that we have, it is important to make sure that we are tackling these knotty issues that exist currently, but, in essence, having greater advocacy support and being clearer as to who it is for is a step in the right direction.

Q228 **Chris Stephens:** One of the concerns that has been raised with the Committee is that the Green Paper says that advocacy support should only be offered to those who need it the most, but obviously we have received evidence from a number of organisations that have a concern that that would mean some form of eligibility criteria and perhaps create access barriers for people who are already struggling around the complexities of the system. Should the advocacy support be a universal thing or should it be targeted?

**Minesh Patel:** From our perspective at Macmillan we would not want to narrow it down to a subset of people. People we speak to can experience a range of challenges with the benefit system, so we would want something universal, understanding how that fits in with the wider ecosystem of support and how a DWP-funded service, let's say, is working with other organisations to make sure you've got that signposting for more tailored and specialist support.

Q229 **Chris Stephens:** Mark, I see you were nodding. Obviously, Kieran mentioned earlier what is taking place in Scotland. Does your organisation have any views on the new advocacy service being provided under a contract in Scotland? Are there any parts of the Scottish advocacy proposal that you would not wish to see adopted elsewhere in the UK?

**Mark Jackson:** To my understanding, there has not been much feedback on the service to date since it was launched at the beginning of this year,



but we are broadly supportive of the principle. Colleagues in Scotland are supportive of advocacy across the system.

I would agree completely with Minesh. We would not want to see anything that narrows access to advocacy, especially for people who are terminally ill. Many of those people are going to have capacity or capability issues. If you have a progressive condition that causes you problems with mobility or cognition, for example, that is going to be an area where advocacy would benefit people. Similarly, for a lot of people this is going to be their first time interacting with the benefit system after they have been diagnosed with a terminal illness, so it is going to be unfamiliar to them. A lot of people with terminal conditions are older and may be at risk of being excluded by a system that is increasingly digital by default.

Certainly, where you are talking about people who are living with terminal illness, we would very much want to see all of those people being able to access advocacy if that is something that they would benefit from, rather than, as you say, having eligibility criteria, which has the risk of closing off access for certain people.

**Q230 Debbie Abrahams:** Good morning, everyone. I am going to start with Kieran. I am just trying to understand a little bit more about the process. Obviously, we have the fit for work assessment, which is different from the functionality assessment for personal independence payment. One of the complaints that has come to us from various DPOs and charities and so on is that one of the reasons for refusal, or for not getting the points that they need in the assessment process, is that people did not receive any evidence from their medical practitioner, whether that is from the GP or from their specialist. I am trying to understand the process. Is it automatic that somebody who has made an application will come to you or your equivalents to ask for those forms to be completed from the DWP? Do they come automatically from the DWP to you and then you have to get permission to access a patient's medical records to release that data to the DWP or the assessors? Could you help me with that? What is the actual process?

**Dr Sharrock:** My understanding is that the applicant makes the application for their benefit and then whoever is administering that at the Department for Work and Pensions generates a form, which is sent generally by e-mail nowadays to each of the people who need to fill it in. That could be, in my case, the general practice, or if a specialist needs to send it in, then it would go by e-mail to the specialist. We receive the form and it is given to whoever needs to complete it, either the medical professional or someone else who is in the best place to do it within the practice. We complete it and then it is sent back to the Department for Work and Pensions. It is not the applicant who approaches the practice or the specialist to complete it. It comes direct from whoever is administering it at the Department for Work and Pensions.

**Q231 Debbie Abrahams:** Okay. There seems to be some sort of attrition there



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between the application to DWP and then that request for information, or perhaps it is the type of information that is sent back. That is a query mark that we need to follow.

You have made the point that as a GP without specialist occupational health training it is difficult to come to some of the judgments in terms of what people can do. Are there GPs now with specialist occupational health training in your patch?

**Dr Sharrock:** Yes, there are GPs who are specialist occupational health trained and they work for the medical advisory service for the Department for Work and Pensions. There are also other health professionals, physiotherapists and so on, who have occupational health training. There are obviously doctors who are specially trained in occupational health medicine and that is their specialty.

Q232 **Debbie Abrahams:** But in your patch? I am just trying to understand what practical arrangements might be available in different areas that would help enable that more specialist advice around particular conditions and the functionality aspects. You are saying that that does not happen automatically—that that is something that may or may not happen in different areas?

**Dr Sharrock:** My understanding is that every area will have people employed by the Department for Work and Pensions medical advisory service to provide occupational health input.

Q233 **Debbie Abrahams:** No, I was meaning in terms of your GP network. You will have a GP with special interest in dermatology, mental health and so on, and some areas, as I understand it, also have a specialist in occupational health who may help with those, but it is not a consistent approach?

**Dr Sharrock:** That is correct. That would be down to local commissioning arrangements.

Q234 **Debbie Abrahams:** You are acting chair of the GPs' committee at the BMA and you mentioned the other committee on occupational health. What cross-working would you do around health assessments on this with your equivalent committee?

**Dr Sharrock:** We would obviously talk to each other. We have talked to each other about me attending today. There are certain things that we work together on. For instance, if it was this work around improving the forms, the occupational health committee would look at those forms as well as us and see if there is anything it can add that would support the doctors and support the patients in having those forms completed easily, obviously alongside the Department for Work and Pensions.

Q235 **Debbie Abrahams:** Okay. Apart from the forms, what else would you want to see? If you were starting from scratch, in liaison with your occupational health committee what would you like to see?



**Dr Sharrock:** We would like to see more occupational health trained doctors and other health professionals who are occupational health trained. As I say, there is a shortage in this country of doctors who have that training. Unfortunately, there is a shortage of all doctors of all sorts, isn't there? We have to prioritise, but occupational health is very important to patients. If it is prioritised by them, then we should look as a nation at how we support doctors to become occupational health trained.

Q236 **Debbie Abrahams:** Thank you very much. Turning to my other colleagues, do you want to comment on the evidence that is currently being provided in the assessments? Perhaps we will start with Aaron.

**Aaron Dryden:** Yes. I would like to provide a slightly contrasting picture. A lot of carers tell us that the reasons why they can be successful at appeal is that they access outside help from an organisation that will very often focus on obtaining the correct medical evidence. Rather than having the DWP approach the medical practitioners directly, the onus will be on either the patient or the person supporting them to chase that up to identify which specialist and which practitioners to approach. That can often be a critical success factor and it means that there is a lot more work going on there outside of the DWP, which has been criticised by carers for not being proactive in initiating those assessments being made. That is something that is definitely a big thing on the carers' agenda.

**Minesh Patel:** I have two points in answer to your question. First, what we hear from advisers is that sometimes the evidence that clients receive is not always fit for purpose. It can be sometimes a printout of somebody's medications. There are points around making sure there is clearer guidance as to what people are expected to provide and where possible to talk about the impact of the condition. I hear what Dr Sharrock was saying about some of the challenges with what GPs know, but where the information is available sharing that is important.

For us at Macmillan there is a wider point in terms of the assessments as a whole. Sometimes they can feel very narrow, very focused on set descriptors; making it more of a holistic conversation, giving more weight to testimony from the claimant, carers, family and friends so you have a more holistic picture to start to understand the impact of somebody's condition. What we are seeing is that when cases go to tribunal, oral testimony is important. How can we take what is happening at that stage and start to implement it at an earlier stage in the process so people are not having to go through the appeal process?

**Debbie Abrahams:** That is very helpful.

**Mark Jackson:** I would completely agree with Minesh and Aaron there. Terminally ill people have told us exactly that—that the descriptors are very narrow and they lack a lot of nuance. If you are assessed on a good day, as it were, or if you have capability to do something but it is challenging for you, that is not always reflected. There is a guy we have



been working with who said he is asked questions in his assessment like, “Can you walk 100 metres?” or, “Can you wash?”, and that sort of thing. He can do that, but because of the nature of his condition, it is challenging for him to do it. Often you can walk 200 metres but it takes it out of you. You then have to sit down for half an hour as a result, or something. That is not always reflected in the descriptors, which can be quite binary and tick-box. It is very much the case, as Minesh said, that that often comes out during the tribunal or appeal process and is responsible for decisions being overturned.

For terminally ill people, those delays are often completely inappropriate. Every moment matters when you are living with a terminal illness. It is already 22 weeks on average before a decision is made in the initial case on a PIP claim, for example, let alone if that then has to go through an appeal or a tribunal process that can take months. Very often in the case of people living with terminal illness, they ultimately die before the outcome of that appeal comes through. They are often overturned and payments are backdated—fine, but it is too late at that point. I would completely agree with Minesh that the learning there is to try to bring some of that nuance through earlier into the process so that the DWP can be getting those decisions right first time. Two-thirds of cases are overturned at the tribunal, which suggests to us that they are not reliably getting those decisions right first time at the moment.

**Q237 Debbie Abrahams:** Thank you very much. During the pandemic, which we are still in, what were the benefits in terms of the change of the assessment process? Are there things that we can learn from that that might be continued?

**Mark Jackson:** Certainly, the move to introduce remote assessments has been very beneficial, obviously in the context of the pandemic, but again going forward a lot of people living with terminal conditions are going to have mobility issues or other challenges that mean it is very difficult for them to get to a face-to-face assessment. Being able to do that via telephone or video call has been very beneficial for a lot of people living with some of those progressive conditions. That is definitely something that we would want to see the Department retain as an option for people. Ultimately, the question should be “How would you like to be assessed?” rather than offering one route and pushing people down it as a default.

**Q238 Debbie Abrahams:** Yes. That flexibility, is that something you both agree with?

**Minesh Patel:** Definitely. For us at Macmillan, some people prefer a telephone assessment, let’s say if they struggle with anxiety or if they have fatigue and cannot travel. Other people prefer face to face. They feel they can more visibly demonstrate the impact of their cancer diagnosis. There is not a one-size-fits-all approach. It is about making sure you have that choice and making sure people have a method that suits them.



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The other thing to say in terms of changes with the pandemic is we did see some cases being decided on the basis of the initial application, and if you know what the entitlement is going to be, just decide that rather than have to go through the assessment process, to make things simpler.

**Aaron Dryden:** Unfortunately, carers' experiences have been quite mixed with virtual assessments. One carer called Edward shared with us that virtual assessments worked really well for his disabled child who has autism and is non-verbal with a very clear set of challenges, but less so for his partner who has a series of fluctuating non-diagnosed health conditions that can vary very much. That did not work so well virtually. It is somewhat mixed, so the choice would be welcome.

**Debbie Abrahams:** Choice is the key word there. Thank you so much.

**Chair:** We have a quick point from Dr Ben Spencer.

**Dr Ben Spencer:** Dr Sharrock wants to come in, so do you want to go first and then I will ask you my question?

**Dr Sharrock:** I was going to answer the last question by saying that one of the things that GPs found very beneficial during the pandemic was the move to a longer period for self-certification when people were unwell. When people are currently unwell they can self-certify for seven days, but during the pandemic that was increased to 28 days, which meant that they could self-certify and they were not having to contact their GP to get an extension to their self-certificate. If that could be reinstated or lengthened maybe even to 14 days, that would then reduce the number of times patients had to contact their doctor or their practice and that would then free us up to do other clinical care for patients. It is a small change from seven to 14 days but it would make a big difference to our capacity.

**Debbie Abrahams:** Thank you, Kieran.

Q239 **Dr Ben Spencer:** You have given some very powerful evidence and I was just reflecting on it. You are here in your role in the British Medical Association. Do you think that your views that you have given us today would be shared by the Royal College of General Practitioners, if we had a representative in front of us?

**Dr Sharrock:** Yes, I am sure they would be. I have spoken with Professor Martin Marshall about things like this, and we see eye to eye on this sort of thing. General practice is a generalist specialism, but we do not have the training to do occupational health. Yes, some GPs do have that training and obviously they work in the medical advisory service, but in most circumstances the curriculum for general practice that is set by the Royal College does not cover in-depth occupational health.

**Dr Ben Spencer:** That is really helpful. Thank you.

Q240 **Chair:** Aaron, can I put a point to you? You told us about supporting



people to challenge a refusal by going to find the appropriate health evidence. We have heard from Dr Sharrock that at the moment, the DWP gets the evidence that it has asked for. Are there people that the DWP ought to be asking for evidence, who they could straightforwardly ask who they are not asking at the moment?

**Aaron Dryden:** Very often, a carer or the claimant themselves is the best person to identify who has a good understanding of their condition—the GP or the specialist or any other health professional that they have seen that has that access to information. What I would guard against, though, is prejudging that because a claimant has an unpaid carer working with them, they would be able to do that work of identifying it and co-ordinating it. Often carers do not have that capacity, unfortunately.

Q241 **Shaun Bailey:** Kieran, I wanted to touch on a response that I think you gave to Nigel Mills. I think there was broad agreement that it would be beneficial for people to be assessed by professionals who are experts in those specific conditions. Obviously, as a general practitioner you have quite a broad practice base. In your view, what is the trade-off between having the expertise—because we know there is a training gap there that needs to be filled—and ensuring we get these assessments through the system? I know one of the pushbacks from the Department would probably be, “We need to ensure that people get through quickly and they get the benefits they are entitled to”. From your perspective, what is the trade-off between having that expertise there and ensuring that people are assessed by people who have expertise in their condition, but getting them through the system as well? I am curious to get your perspective on that.

**Dr Sharrock:** There is certainly still the benefit of getting factual information from general practice about someone’s health condition. The trade-off with having a specialist there is that if people train to be specialists, they are not going to be working in another specialism. At the moment, we clearly have too few health professionals of all types, particularly doctors and particularly general practitioners. Training GPs to be occupational health doctors means that we then worsen the crisis in general practice. That is the main trade-off.

If I was doing this in my practice, we have already discussed the risk of it being a barrier between myself and my patient and it affecting our relationship. If I do have occupational health training and I assess someone and say, “I think you are fit to work” and they disagree with me, then there is automatically a risk of that damaging that relationship. That is why we would advocate for independent and properly trained people to do the assessment.

That may, of course, mean more for the patient—to have to go and have another assessment or fill in other paperwork—and that is another negative, isn’t it? Just getting factual information from the GP is quite easy. The Department for Work and Pensions sends us the form, it gets



completed and it goes back. Asking for an extra assessment is an extra burden for the patient.

Q242 **Shaun Bailey:** I totally get that, but I think the nub of that point is that the Department should probably be focusing on the quality of the assessment and the process that follows to ensure all that information can be gathered—refining the process to enable it to get that factual information expediently so that the patient or the service user is not impacted or left with delays.

**Dr Sharrock:** Yes, and I think that the rest of the panel have said that often the patient holds the information that we don't. It is getting that information from them and asking the specific questions about, "Can you walk 100 metres and what happens when you do?" It is getting that nuance that you do not get from the forms and the paperwork at the moment.

Q243 **Shaun Bailey:** That is really helpful. Turning to the rest of the panel, one of the comments we have seen in our call for evidence is around outsourcing some of this, particularly the notion of outsourcing it to the third sector. It is interesting, Kieran, what you just picked up on there around third sector organisations having that expertise but also having that relationship with service users and patients to get that additional information. Do you think there is the capacity there in the third sector and the charity space to perhaps take on some of this work? I do not want to lead you to an answer one way or the other, but do you think there is a way in which you could draw out more of that information than is the case in the current set-up?

**Aaron Dryden:** The sector has been significantly affected by the withdrawal of legal aid for welfare benefits. It is generally an understaffed part of the sector with poor pay and progression opportunities. It is very hard to think structurally how things could change, but I do think that the third sector is well placed and it does get the results for people when it is accessed.

**Minesh Patel:** It is a really interesting question. I think the third sector can definitely play a role in aspects of the process. There is an element of still retaining independence from a benefit system. For us at Macmillan, we do not necessarily have a view of whether it is government, contractors or third sector who deliver the system. For us, there are three key things that we would want to see from any system. The first is around improved claimant trust and engagement, which is a massive challenge for lots of people where they often feel they are being interrogated or have to prove their impairment or condition. The second is that it delivers accurate results, so decisions being made right first time and avoiding them going to tribunal. The third is around the speed of the process and how you balance getting good, robust evidence with making sure you can make decisions quickly and easily. Those would be the three tests for us, whoever is delivering a system.



**Mark Jackson:** Similar to Minesh, our view is that it matters less who is conducting the assessment—whether that is the private sector, the Government or anyone else—than what that assessment looks like and what a person is being assessed against. Again, the point Minesh was making about nuance is definitely something we hear from terminally ill people. The detail is not being picked up by the descriptors. Similarly with who is being asked for further information; if there is an assumption that you are always going to a general practitioner, for someone living with a terminal condition, that is not always the most relevant person. A specialist may be better to tell you how that condition affects a person's daily life. If they are living with terminal cancer, their oncologist might be better placed. If they are living with motor neurone disease or another neurological condition, their specialist neurologist might be the better person.

For us, the key other test that I would add to Minesh's test is to reduce the assessment burden on the claimant. Terminally ill people tell us that they find the process often very burdensome, very challenging. It is a long process. There are a lot of forms, a lot of assessments. I am sure you can imagine that when you are living with a terminal illness, it is the last thing you want to be doing. I think the balance can be moved over, whether that is evidence being provided by family carers or through specialist clinicians or through other sources rather than those more formal face-to-face assessments.

Q244 **Shaun Bailey:** From what you guys have said, it sounds like it is not so much about the third sector doing the operational day to day on this, but about the Department, as it is constructing these assessments, taking on board and accepting the nuances that come with this—Mark, I think you touched on the word “nuance”—and feeding that into its process more broadly. Am I understanding that correctly?

**Mark Jackson:** I think that is right, yes.

**Shaun Bailey:** Fantastic. I will leave it there.

Q245 **Chair:** Can I just follow that up? Do any of you think it would be a good idea to bring all this back into the DWP? At the moment it is Capita and Atos and Maximus who are doing it. Do you think it should come back, or do you not really mind who does it?

**Minesh Patel:** We do not have a view, as such, but what will be interesting is seeing what plays out in Scotland and how that system works.

**Chris Stephens:** We are coming on to that shortly.

**Minesh Patel:** Then, with two different styles of system running, you will have a better basis, with two different styles of system running, to see the impact of that, how it delivers and how that compares with what is happening across the rest of the country.



**Chair:** Nobody else wants to argue either way on that?

**Aaron Dryden:** I will just say that a lot of carers tell us that the fact that they are separate organisations often leads to confusion around timescales, who they should be chasing, where things are, and they sometimes feel batted between the organisations. Perhaps insourcing would be an opportunity to reduce that.

**Chair:** On Scotland, Chris Stephens.

Q246 **Chris Stephens:** Thank you, Chair; that was perfect timing. I have some questions about the approach in Scotland. Aaron, I will start with you. Would you support a move towards a system that relies to a far greater extent on third party evidence? What do you think of the approach that the Scottish Government are taking, which will have significantly fewer face-to-face assessments, each carried out by qualified assessors?

**Aaron Dryden:** Carers Scotland welcomes the changes that are being implemented and is looking at them with great interest. The ability to have a more holistic engagement with third parties would be something that should bear significant fruit for claimants. Borrowing somewhat from the Mental Capacity Act, where there is a duty to get a circle of people's input into decisions that are made, anything that brings better third party input in and reduces face-to-face assessments is welcomed, as long as the success rate is high.

Q247 **Chris Stephens:** Mark, in Scotland the adult disability payment assessments will be audio recorded as standard. That will be the standard approach. How significant is that?

**Mark Jackson:** Again, I am not aware of the particulars of the adult disability payments approach. My understanding is that the roll-out is relatively recent and it is something we are watching with interest.

To go back to the principles, I would agree with Aaron. Wherever possible the DWP should be seeking evidence in a way that does not require a face-to-face assessment. Terminally ill people tell us that that is often very burdensome and very inappropriate. When you have a limited time left to live, that is not how you want to be spending your time. If we can come to the same conclusions, we can come to the same decisions, and we can do that reliably with information coming from third parties, whoever that is, without requiring someone to be either on a video call or going into an office to be assessed face to face against those descriptors, when often the information could be confirmed via another route.

For example, if you are living with a condition like motor neurone disease, the way that affects a person is pretty clear. If a specialist certifies that that is the condition you have, you can draw some pretty obvious conclusions about the person's likely capability against some of those descriptors. There wouldn't potentially be a need for that person to then go through a formal assessment. Wherever possible, we should be



looking to reduce the assessment burden on individuals who are living with those conditions, especially where they are terminally ill.

**Q248 Chris Stephens:** Minesh, we have received highly supportive submissions from Mind and the MS Society on Scotland's new system. Is there any aspect of the Scottish system where there is a concern or where there may be some detriment to applicants? Is there anything about which you think, "Maybe that might not work"?

**Minesh Patel:** I would echo the positives that both Aaron and Mark have spoken about. One particular challenge might be around how, when you are spending time looking at a whole range of different sources of evidence, you make sure you are still processing claims in a timely way. It feels like in the Scottish system there is going to be much more consideration given to different types of evidence, and that is great. It is striking that balance and making sure that people still get paid quickly and on time. Hopefully, if you have that more holistic assessment of somebody's condition and how it impacts them, in theory that should result in fewer claims then going to tribunal. We are interested to see what the outcome is—it is very early days—as we start to get more evidence and to understand the impact.

**Q249 Chris Stephens:** Looking at the adult disability payments, which started in March, they will go Scottish-wide in August. What should this Committee, both Governments and maybe even the Social Justice and Social Security Committee in the Scottish Parliament look at to see what is working and maybe what is not working? What are the issues there?

**Minesh Patel:** I would suggest looking at three things. I think this comes down to those tests that I was describing. The first is whether the system is resulting in more people receiving an accurate decision first time and assessing how many claims are going to tribunal and of those which are successful. The second is looking at the speed at which people are getting paid, particularly when you bear in mind that many people living with cancer will be faced with a financial impact as a result of their diagnosis—on average, almost £900 a month—so that speed is really important.

The third is trying to understand the claimant experience. We have heard from other people that it can feel like a struggle, and it can feel like you are there being interrogated, having to prove that you deserve the support. It is trying to find a way to gather feedback from people as to how they are finding the process, because they will be the ones who will be best placed to talk about how it is working or not.

**Chris Stephens:** Alleviating the stress and anxiety that claimants go through and building trust in the system are the key elements here. Thank you. That was as neutral as I think I could be, Chair. *[Interruption.]* Kieran has his hand up. Sorry, Kieran; I did not see you.

**Dr Sharrock:** When that system is being looked at, I would really appreciate it if you could look at two things in relation to general practice.



One is whether the new system has had an impact—either positive or negative—on the doctor-patient relationship, and also on the bureaucratic workload for general practice. If the new system increases that, that would be something that we need to find a mitigation for.

**Q250 Selaine Saxby:** Good morning. Minesh, building on the evidence that you sent through looking at the delays in the system—I know we have already touched on this—is there anything you would like to add? We have heard there are long wait times for PIP and delays in referrals to work capability assessments. How is this impacting people with cancer?

**Minesh Patel:** It is a real challenge. As I was saying earlier, when you are faced with cancer, you often have this huge burden of additional costs. Then you are facing delays with either receiving your personal independence payment or getting referred for a work capability assessment. What we are seeing is long delays with people receiving their form to apply for a work capability assessment. Anecdotally, we are hearing of people waiting a long time to then get that actual assessment.

It is not entirely clear what is driving this, whether it is a DWP capacity issue or whether it is to do with systems and processes, elements of which are automatic and some are manual. For us, this is about trying to review end to end what is happening. It is possible that some of this is a bit of a legacy from the peak of claims during the pandemic and the disruption caused there, but it is imperative that DWP looks at this to make sure people are getting that assessment on time and getting other benefits paid as quickly as possible.

**Q251 Selaine Saxby:** Thank you. We have talked quite a lot about the delay element, so I am going to move on to terminal illness and the issues people with a terminal illness might encounter when applying for support. In particular, the six-month rule has recently changed to the 12-month rule. Have you had discussions or any understanding of when those rules might be changed for PIP?

**Mark Jackson:** First, Marie Curie would welcome the decision the Government have made to scrap the six-month rule for access to the special rules for terminal illness and move to 12 months. That is a real step forward, and we were very pleased to see that there was a Bill announced in the Queen's Speech yesterday that will give effect to that for PIP and attendance allowance. That will implement the final changes to the law there.

There are two points I would make on the special rules. First, whether the timescale is 12 or six months, we need to be clear that accurately predicting life expectancy is very challenging. There has been a lot of academic evidence that has shown that the accuracy of clinicians' prognostications around life expectancy is wrong anywhere from one in four to three in four times; and over a longer timescale it can sometimes be more challenging. It needs to be very clear that that is a guide.



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The form talks in terms of the surprise question, "Would you be surprised if this person died within a year?" We gave the Department feedback when that form was being developed that we would like to see that de-emphasised a little and it made quite clear that this is not a hard and fast 12-month rule, if you like. I believe the form refers to the 12-month criteria. We have had feedback from clinicians that the six-month rule was often interpreted much more rigidly than perhaps was the intention. That is not some feedback the Department took up, but we continue to believe that that could be improved in terms of the guidance to clinicians.

Secondly, we should be clear that extending from six to 12 months reduces the problems the six-month rule caused but it does not solve them outright. There are still going to be people who are unable to claim via the special rules for terminal illness who will be living with terminal conditions. It is a big step forward but people are living longer with terminal illness. There will be people who are living with terminal conditions who are not able to claim through that route, which is why it is absolutely imperative that the wider disability benefit system is streamlined and the burden of assessments on people is reduced as much as possible. There will still be people who are living with their final illness who may have a little longer than a year to live who will have to go through that route as well.

**Q252 Selaine Saxby:** Is there anything that anyone else would like to add? If not, I was going to ask Kieran: are there any improvements that you feel are needed to the DS1500 form or the assessment process for terminally ill people to support medical professionals in their role?

**Dr Sharrock:** I think the point has just been made around the prognostic difficulties about saying whether someone is going to survive for a long period of time or not. For me, it is giving that flexibility. We have a question, "Would you be surprised if this person died within the next 12 months?" and another question we ask is, "Would I be surprised if they were alive after 12 months?" That is sometimes useful to also include in the thinking. Those flexibilities and understanding that it is not a black and white answer would be helpful.

**Q253 Siobhan Baillie:** Our next panel is going to be looking at challenging benefits decisions, something Mark has already talked about. We know that a significant number of decisions are overturned at tribunal and DWP says that that is because new evidence suddenly emerges at that stage. I can see people in the back smiling and shaking their heads. We have heard quite a lot of evidence on this already. For the people you represent, what has been their experience of providing evidence when a claim reaches a tribunal and what should DWP learn from everything we understand about the need to gather information and evidence earlier? Is that achievable?

**Mark Jackson:** It goes back to what we talked about earlier. Often what comes out through the appeal and tribunal process, that sort of oral testimony, is the level of nuance is not always captured initially in the



descriptors from face-to-face assessments. There is often also evidence provided by third parties, often specialists, that leads to the decisions being changed. The learning for the Department from that is: the earlier that can be obtained and can be built into the initial assessment process, the better, and that is likely to lead to better decisions being made first time and therefore fewer decisions turned over on appeal.

That really matters for terminally ill people. Very often, if a case reaches a tribunal, the result of that is money being paid backdated to someone's deceased family members, so we want to see those decisions being made right the first time so that the purpose of the disability benefit system is being met during their final illness; and that at the most vulnerable time, they have the support they need rather than having to wait a very long time often, with funds not coming in until it is too late.

**Q254 Siobhan Baillie:** Notwithstanding—the most important thing—the stress on the claimant of having to challenge and go to a tribunal, which is scary for lots of people, it is also a huge cost to the taxpayer. Minesh, is that your experience?

**Minesh Patel:** Yes, I echo what Mark said. In some cases, there may be new evidence but, on the whole, it is about the claimant having the space to give that oral testimony, to provide clarification, to talk about their condition in a more rounded way. When you are faced with a cancer diagnosis, it impacts you in so many different ways; financially, mentally, physically. Then to have to go through several stages to get what is really important financial support, particularly in the context currently of the cost of living crisis, getting people access to that money as quickly as possible is important, so we would definitely support fixing the initial assessment.

The personal independence payment appeal rates are 68% in favour of the claimant, and for ESA it is 60%. Those figures have remained largely the same for a good number of years, so something clearly is not working earlier on in the process. It is great to have this discussion today about assessments.

**Aaron Dryden:** I want to highlight that a lot of carers come to us or other agencies for support only at the appeal stage. Arduous though the application process is, they often go it alone at that point, so having access to some support, including advocacy, could be a critical success factor at appeal.

**Dr Sharrock:** I would like to see more factual information included in the initial information we provide. The forms ask about people's ability to do activities of daily living but often we do not have that information, so encouraging people to provide that information to their GP practice in advance of making a claim as part of the claimant process—perhaps having have this discussion with someone in your practice, or even sending us an e-mail to say "This is how my disease is affecting me at



the moment, and I am making a claim”—would be helpful to us because we can include that when we complete the paperwork.

Q255 **Chair:** Do you think the application form should invite people to specify somebody or some people who could provide additional information that would help at that early stage? Might that assist?

**Minesh Patel:** Potentially it would be useful. When people are filling out the form, it is not always entirely clear what evidence they should be gathering, so if there is a way to make that more explicit and give some clear examples to get that more holistic and greater range of evidence, that could be useful in terms of assessing somebody's entitlement.

**Chair:** Thank you all very much indeed. That has been very helpful and a very useful session. We are grateful to all four of you.

## Examination of witnesses

Witnesses: Daphne Hall, Hannah Nicholls-Harrison and Caroline Selman.

Q256 **Chair:** We now invite the second panel to join us. Can I ask each of you very briefly to tell us who you are?

**Daphne Hall:** I am the vice-chair of the National Association of Welfare Rights Advisers and I also work for Rightsnet, the social welfare website. We host a discussion forum of advisers which is UK-wide. We have a lot of input and that helps us to identify systemic problems.

**Hannah Nicholls-Harrison:** I am one of the policy co-chairs for the Disability Benefits Consortium, a coalition of over 100 organisations, DPOs and charities across the UK that are specifically interested in welfare rights and the benefits process.

**Caroline Selman:** I am from the Public Law Project. We are an access to justice charity that among other things provides second-tier advice, including through our welfare rights hub. We also carry out research, which is my area. I am a researcher at PLP. We have a particular focus on benefit sanctions that has included, in addition to that, speaking to people about their experience of assessment.

Q257 **Chair:** Most appeals against refusals of health-related benefits are upheld by tribunals. DWP says it is often because new evidence is provided to the tribunal. Do you agree that is the key reason, and how do you think the evidence that is needed could be gathered earlier in the process?

**Daphne Hall:** I do not agree with that point. Often, at the tribunal, the evidence has already been there; the difference is, as was alluded to in the other panel, that the tribunal has a different culture from the DWP. They start from a position of believing claimants. If there are inconsistencies in the evidence, yes, they will explore it, but the first thing is they want to know more. It is a much more holistic view. They



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listen to what the person says and they respond to it, and this creates a much fuller picture. That is the difference.

Generally, it is the evidence from the claimant that changes it, because the tribunal takes the time to listen to them. That is the problem; the culture is what needs to be changed earlier on. It is not that tribunals have a significantly longer time. Most tribunals are about 40 minutes, and a health care assessment may be a little bit shorter, 30 minutes, but they do have the time. It is more about how they approach it. They are not looking at the evidence as a whole.

There is some interesting evidence from the DWP's own holistic decision-making, which I could come to but I don't know if you want me to defer to the others. I will speak briefly, and you can stop me if you want.

In 2019, the DWP started this new holistic decision-making and it has changed. More decisions get turned around at mandatory reconsideration now because they take a more holistic view. They look at evidence more in the round, and that has changed. You can see from the statistics that the number of successful mandatory reconsiderations has gone up. That begs the question: why is that holistic decision-making not happening right at the start? Why does that have to work for mandatory reconsideration or the appeal tribunal? There is no reason why that same approach could not be taken right at the start.

**Chair:** Hannah, do you want to comment on this?

**Hannah Nicholls-Harrison:** I completely agree with what Daphne just said. The primary reason that decisions get overturned on appeal is that tribunals engage much better with evidence. It is usually available from the start of the claim. We know it is said that decisions are overturned due to new oral evidence being available, but it is really that if the assessor had carried out a full quality assessment in the first place, that evidence would have been available.

Another factor could be if the claimant was able to see the assessment report earlier to identify any errors or inconsistencies with it in the report; we think that would make a big difference. The biggest thing is that people are given more time to explain themselves and their condition and the impact it has on their lives at tribunal.

The final piece is having that appropriate or specialist support and knowledge that understands the impact that someone's disability or health condition has in their day-to-day life, which is really important. The combination of those three things results evidence being approached in a completely different way.

**Caroline Selman:** I echo much of what was said in the previous session about the importance of being able to take a more nuanced approach and listening to oral evidence, whether that is about the weighting that it is given or the opportunity to listen to it and possibly take it into account



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that is notable at tribunals. I echo what Daphne said about the cultural point as well—about the willingness to hear it and understand it from a starting point of belief.

In circumstances where there is potentially evidence coming forward at a later stage, I would also flag what came up in the previous session about access to advice. Often people access advice at a later stage in the process and are more likely to access advice and support at that point where they are going to a tribunal, when they might have until then persevered on their own. At that point, the additional support people can get with gathering evidence and understanding the potential evidence you need to put forward is something that DWP have cited in their own evidence about health and disability payments, identifying the role that advice providers play in earlier advice in evidence coming forward at an earlier stage. That could be things like people knowing they can use a subject access request for medical evidence or better understanding what it is they need to evidence.

I have spoken to claimants who perhaps have not always well understood the point that they are not necessarily just trying to evidence their condition but also how it impacts how they are able to go about their day-to-day activities. People can end up in situations where they are trying repeatedly to evidence their condition without getting to what has been described to me as the “hidden language” of what is being looked at and what they are seeking, whereas at the point where they seek advice, they would get help and support with that.

So, two things: greater willingness to listen to oral evidence and the point about the stage at which people are accessing advice and support to gather that evidence.

**Q258 Nigel Mills:** How often do you see claimants having filled the form in themselves and not put very much on it and then when they get turned down, they then try to gather the evidence they need? Is that still a regular problem?

**Daphne Hall:** Yes, and the forms are really difficult if you have not accessed them before and if you do not have any help. In talking about their own condition, people are so used to living with that condition that sometimes they do not think of all the things they should put down and it needs somebody from outside of that to help get the information out of them. It is very typical of somebody who has done the form on their own that they can be quite minimally filled in. Sometimes it is just the tick boxes that are filled in and the free text boxes are not filled in at all. It is only accessing advice that teases the information out and helps people to present it.

I want to go back to what Caroline Selman was saying about signposting advice at a really early stage. We have told DWP a number of times about a website, [advice.local.uk](http://advice.local.uk); put your postcode in and it will tell you all the different advice agencies in your area. That should be at the top of every



form. So when they send the form out it should have “We recommend you get advice. Just put your postcode in”. I know not everyone can go online, but hopefully they might find somebody that could. It is just one line and it would help people to access advice. All sorts of different agencies—law centres, independent advice agencies, Citizens Advice—are on there, and it is kept fully up to date. Getting support early on makes a huge difference.

**Q259 Nigel Mills:** In my experience, you get the emotional reaction of an individual who is diagnosed with a new condition, or has an accident, or something happens, and they are told they can claim PIP or whatever else. They make the claim thinking “I have the condition, so I must get it”, and then they get turned down and think, “So, I do not have this condition, then, do I?” How do we get claimants to know, at the very start of this process, that they need to have more than condition and prescription medication on the form? That is something you see a fair amount of. How do we get them to have that understanding that you need to put how the condition affects you, not just what you have?

**Daphne Hall:** It is a functional assessment, not a medical assessment, which goes back to what the other panel said. Sometimes, medical evidence is not the best evidence, because it is factual; it is medication and this, that and the other. Every condition will affect a different person differently. A person may have an interaction with several different conditions and one particular medical consultant will not see the holistic picture. Often, a carer or support worker, a non-medical person, will have a much better idea of someone’s functional ability than a technically medical person.

**Q260 Nigel Mills:** It is quite hard if you are managing the condition yourself or it is just you and your partner, and the GP does not really know and you have not seen anybody else. Who can give evidence that understands the system in that situation? It is really just yourself, is it not?

**Daphne Hall:** The claimant is the key person but sometimes they need support to get the information out; it is about asking the right questions. That is what a tribunal does. They are inquisitorial. Somebody will say something and the tribunal do not just take it at face value but will look behind it, and that is a skilled thing. That is what an adviser will do. They will help tease the information out to give a fuller picture.

**Q261 Nigel Mills:** Do you think everybody who gives supporting evidence understands what they are trying to do? You sometimes see this and it becomes another list of factual points about when they have seen them. Do people get that we are talking about functions and the impact on people, not how many appointments they have had and whatever else? Is that clear to people when they give their support?

**Caroline Selman:** I would come back to whether what is being looked for is well understood—whether it is understood that you are being asked for an understanding of function or a description of what is happening.



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Another point, which was touched on by the previous panel more fully than I could, was about what individual medical practitioners feel they are in a position to be able to provide.

**Hannah Nicholls-Harrison:** It is not very clear on the claim form who is responsible for gathering supporting evidence, whether it is the individual or the assessment provider. The DWP needs to make it clear that providing the contact details for a GP will not necessarily guarantee that they will be contacted. It also needs to be much clearer that individuals should be encouraged to obtain up-to-date evidence.

As Caroline, Daphne and the last panel discussed, we need medical practitioners to better understand what is good quality evidence. Often GPs are not able to provide that kind of evidence and give factual diagnosis about the management of the condition—not about the day-to-day activity, which is best to come from the claimant. We often hear that decision-makers give much more weight to the medical assessments than to the claimants' own account of their conditions.

**Daphne Hall:** The other thing we see is that assumptions are made. The classic one is, particularly in mental health, "not on any medication, no specialist input, therefore not a mental health problem." There is case law that says those facts are not indications that there is no mental health problem. There are all sorts of reasons why a person might not be on medication or might not be receiving specialist input. They have changed the guidance for health care professionals but we still see that coming up time and time again.

Another example is, "drives a car, therefore can do such and such" but not looking into whether the car has been modified or how long they sit in the car, or anything else. They are cut-and-pastes; we see exactly the same wording on submission after submission. That is clear evidence that they are not looking at the individual. They are just seeing, "drives a car" and slap that sentence in. "No medication": clearly not a problem. They are very cruel assumptions and they slam the individual down and it can be quite destroying to receive that in a letter, "You do not qualify, we do not believe you, you do not really have this condition." That is what it feels like to people—"I am a fraud"—and that is terrible.

Q262 **Nigel Mills:** Can I ask about the use of third party evidence? It was never clear to me whether the assessor was meant to go through all that and use it in the report or if the decision-maker was meant to use the report and then compare that with the third party evidence and come to a decision based on all of it. What do you think is the right process and what do you think is happening at that first decision point?

**Daphne Hall:** Often the health care professional does not see all the evidence. I think they should. They should have been able to look at any evidence sent in and that should guide their questioning because then they are stepping outside the box a bit and saying, "I see this", and go into that holistic thing. Yes, it should all be there and yes, the decision-



maker should then look at everything as well, including the health care professional report. That is a bit what the holistic decision-making did. I know that in the health transformation programme they have going now, in two very small areas in Marylebone and Birmingham, they have the health care professional and decision-maker sitting on the same floor so they can talk to each other. DWP says that has been helpful, and it makes sense. If something is contradictory in the health care professional's report, the decision-maker can actively say, "This doesn't make sense. What is going on here?", using all the information in a much more effective way. It is not necessarily always that the information is not there. It needs to be about not taking information at face value but going behind it.

**Q263 Nigel Mills:** I am sure you see the same as I do—some that you think are a judgment call that is quite hard, and then some cases get a refusal and make you think "How on earth did they ever come to that?", because there is just no logical way that, having met this person, you could ever have come to that outcome. You wonder how it has come through an assessment and a decision-maker when the evidence is pretty clear.

**Daphne Hall:** Some classics I have heard are, "not made good eye contact" about a person with a visual impairment, or "well-turned out" when every time I have met that client, that would not be the phrase I would use. Comments can seem not to match up with the person I am seeing because they are so off-the-wall wrong.

**Q264 Nigel Mills:** The point of having a decision-maker is not that they rubber stamp the assessment but that they check it and read it. I wonder what the data shows for how many decisions are changed by the decision-maker compared to what the assessor recommends. I have not seen data on that.

**Daphne Hall:** Not at the first stage. Since they brought in the holistic thing, we have seen it at the MR stage, but I am not sure. They are supposed to be doing it, but I do not think we have the stats. We do not have any stats for universal credit work capability assessments, which the Office for Statistics Regulation has written to the DWP about. Because now most work capability assessments come under universal credit rather than ESA, we need to see staff, so we are missing a whole chunk of information there as well.

**Nigel Mills:** Caroline, did you have anything to add?

**Caroline Selman:** No, but I would agree with what Daphne said.

**Q265 Sir Desmond Swayne:** The DWP says they have made the mandatory reconsideration much more holistic. Do you have any evidence that it has worked out that way?

**Daphne Hall:** Yes, I was looking at the graph of the statistics this morning. It used to be that about 20% were turned round at mandatory reconsideration. It went up to about 60% during Covid-19. It has now



dropped to about 36%. That is for PIP. We do not have very good stats for WCAs. It showed improvement but then dipped considerably back down, which is a considerable concern. I feel like maybe we are losing a bit of it. I do not know if there has been a lot of turnover of staff, or maybe there is a training issue. It was very encouraging that it was improving, but I go back to the point that it should not be at the MR stage; it should be at the first stage. But there was a demonstration that there was a bit of a culture change.

**Q266 Sir Desmond Swayne:** Is there any more they could usefully do to improve?

**Daphne Hall:** Yes. Where shall I start? I think they should do it a lot earlier on and encourage the claimant to provide further evidence and not just clinical evidence. If claimants have somebody, a support worker or a family member, who could write a statement about how they help them or something like that—as advisers we will sometimes collect evidence like that, but DWP do not seek it out and they do not support the claimant or advise them to do that, or fund advice or signpost people to advice that will help them. It is a lot for the claimant to do; it is a lot for a person to take on when they are terminally ill or with whatever health conditions they have. Sometimes they need support with that, and there is not enough support for people. There is not enough advice, legal aid and everything.

**Q267 Sir Desmond Swayne:** On the support that is available, what do you think of the proposals in the Green Paper for advocacy, and what experience or prejudice do you have about the system now being provided under contract in Scotland?

**Daphne Hall:** What needs to be clarified—it is not clear to me from the Green Paper—is the difference between advocacy and advice. In my mind, advocacy is helping somebody to say what they want to say. Advice is broader than that; it is looking at all the different options and saying “This is what will happen,” and that is very different from advocacy. I am not clear about what the Green Paper is talking about. Advice and advocacy play very important roles, but they are different and I think that needs to be clear.

I think the Scottish system—correct me if I am wrong—is more about the advocacy rather than the advice. I think advocacy is very important, because sometimes it is about trying to get the information out but sometimes it is more than that; it is advice as well.

**Q268 Sir Desmond Swayne:** The provision in the Green Paper, as I understand it, is only for those who really need it. Will it be sufficient and how do we define that?

**Daphne Hall:** I think it is for an individual to say whether they need or want advocacy or for it to be offered. I do not think it is for the DWP to say they do not think a person needs advocacy and can do it for themselves. What will they judge that on? It will just be another task,



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another hurdle to be jumped. If advocacy is there, it should be free and independent and available to everybody in the same way that advice should be.

**Sir Desmond Swayne:** Do the other two witnesses have anything to add on that brief conversation we have had?

**Caroline Selman:** I would very much echo what was said about the difference between advocacy and advice. Both are important, but advocacy is not necessarily filling the gap in terms of providing access to specialist advice, which was touched on in the previous session and in other Committee sessions; it is one of the issues that people face. In conversations I have had through research interviews, people frequently identify difficulties in being able to access advice at the point they would like to be able to. There are examples of people who have previously accessed advice but find that it is harder to access now as a consequence of various cuts and impacts on those services. Much of that has been exacerbated by aspects of the pandemic where people have been forced to adapt their services, with certain forms of advice—particularly face-to-face advice—being less readily accessible to people who really need it. While looking at additional routes for how, for example, advocacy can be introduced into the system, that is against a broader backdrop of significant reduction as a consequence of reductions in the provision of legal aid and in the budgets of local authorities, who are often the providers of core funding for organisations. That all means that people lack accessible advice.

To come back to some of the points that Daphne was making about the importance of signposting people to advice, our concern is that often there does seem to be an increase in DWP's attempts to signpost, which is welcome, but it is not always accompanied by consideration of whether there anything to signpost to, which is not consistent geographically. Access is very lumpy across the country. In my part of London, you may have relatively good access, albeit not sufficient, to different services. If you are in another part of the country, you may not. It is good to look at additional ways around that through things such additional provision, but it is still against a much broader, starker backdrop.

One final thing, on a point I am sure the Committee is well versed in, is that while advocacy is important, it is also important to first and foremost try to get to a system where people do not need other people to support them to navigate it.

**Hannah Nicholls-Harrison:** There needs to be fully funded local provision of comprehensive welfare rights, advice and advocacy for all prospective claimants. We know that there is inequality in what services are available in different geographic areas and for different groups of disabled people.

The DBC is part of an alliance of organisations that includes the Association of Mental Health Providers, the Association of Directors of



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Adult Social Services and the organisation that Daphne is representing, which has called for a fully funded new duty on councils to provide comprehensive welfare rights and money advice for all existing and prospective claimants. The alliance thinks it is important that local authorities conduct up-to-date audits of what advice and advocacy services are available locally. We can then look at whether advice services have been protected or sacrificed due to the pressure from cuts to local council funding and develop strategies to address any variation.

The other aspect we need to consider is whether this is a DWP-run advocacy service, because DWP cannot represent claimants in appeals or in claims against themselves. That would not make sense. The advice needs to be independent and available for all claimants.

**Daphne Hall:** Funding advice would save money in the long run. I think this Government are sometimes slow to appreciate that. Funding things really well at the start saves so much money, not to mention distress for individuals. If the Government could plough money in at the beginning, it could make a lot of difference.

Q269 **Sir Desmond Swayne:** What do you think of the shocking practice whereby appellants are nobbled before they get to the tribunal?

**Daphne Hall:** Lapsed appeals?

**Sir Desmond Swayne:** Yes, lapsed appeals.

**Daphne Hall:** It is a bit of a double-edged sword. If somebody is pending an appeal and somebody from the DWP contacts them and can give the claimant what they were looking for without having to go to an appeal, that is obviously great news and saves a lot of time and stress. The concern is that people sometimes are given a partial offer, not everything they were looking for, and they don't know what to do and are unsure what their rights are. Legislatively, at the moment, they can accept it and they get a new decision, but if they want to appeal it further, they have to submit a new appeal. It is quite a logistical process to get through and people may be unaware that they can do that—that it is an option.

There is now guidance with the Public Law Project that if there is a representative, they should contact them. That is still not happening consistently.

Clearly, a decision can be changed and the earlier it can be changed the better but if somebody has an appeal going and it is not everything they want, that appeal should be allowed to continue without having to start the whole process again and go to the back of the queue. People could accept the decision, so at least get some money, maybe get their standard rate daily living but still go on with their appeal to discuss their mobility needs. We need to be much more on a statutory footing, not



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these rather haphazard calls—maybe to the claimant, maybe to the representative—so a much clearer process.

We welcome anything that will help the decision to be made sooner and get money to the claimant sooner, but we do not want somebody's rights to be taken away from them or for them to feel that those rights are being taken away or that they have no choice.

**Caroline Selman:** A client appeal brought a while back led to a change in guidance. Our concern is always about whether guidance will definitely be followed consistently in practice. We were asked a few months ago at a DWP stakeholder engagement meeting about how lapsed appeals were performing in practice post that guidance. We would say it is extremely important that it continues to be monitored and scrutinised to understand how it is being experienced by claimants and also whether assurances, safeguards in that guidance are being consistently followed. There needs to be engagement not just with us, a second-tier organisation, but with frontline grass roots organisations including, for example, NAWRA, which is very good at representing and reflecting a range of different views.

Lapsed appeals are obviously happening at a very late stage in the process. One of the things we were quite concerned about or disappointed by in the health and disability Green Paper was that it was the only measure that was being put forward as a way to reduce or deal with some of those barriers about getting to mandatory reconsideration and appeal. Our two observations on that would be, first, that resolving things at sooner stages is better than at an even later stage, but it is still at a very late point when you are lapsing it at that point. It must also be quite disconcerting for claimants when they have gone through all the stress of building themselves up to going to an appeal and suddenly it stops and you are not quite clear why. People are glad if they have a good outcome, but it can be a slightly disconcerting process still when you have been through quite a long period of anxiety and uncertainty and not having funds.

Likewise, for lapsed appeals to be put forward as the only concrete thing from that perspective is slightly disappointing. Much more could be looked at in terms of accessibility, mandatory reconsideration and the appeal process.

**Hannah Nicholls-Harrison:** All I would add is that when we were gathering evidence specifically for this session, a fair few of our members wrote in to say that they had represented claimants who felt pressured by DWP to accept an award that might have been lower than they were entitled to. That is obviously something that we are concerned about. There was not always the opportunity to ask why they were being offered something different than they were maybe expecting, clearly explaining to the claimants specifically when they might have additional communication requirements, including having someone to support them. While we welcome the intention to improve the lapsing of appeals, we



need to be really sure that the guidance is being consistently put in practice.

**Caroline Selman:** I will make one brief additional point, which I think was also flagged by Mark Jackson in the previous session. DWP is also using the reduction in the number of appeals as a metric of success for improving things further upstream, but it is really important, when talking about that, that number of lapsed appeals is included within that figure. According to the latest PIP statistics, about 15% of decisions that had been appealed were lapsed. To count that as things having been resolved much earlier is inaccurate, and it is important to make sure that statistic has been taken in account when you are looking at how early things are being resolved.

Q270 **Chris Stephens:** Regardless of whether what I would refer to as a deal or no-deal offer is accepted or not, we are still going to tribunals and a significant proportion of DWP decisions are overturned by the tribunals at appeal stage. DWP says that 63% are because of new oral evidence being presented at that stage but only 15% are due to additional documentary evidence being provided. Daphne, if I could start with you, what could and should the DWP learn from this about the evidence it need to gather at earlier stages in the process?

**Daphne Hall:** This is about the inquisitorial approach of a tribunal. If the claimant says something, the tribunal looks into it further. Having been to some assessments, I can say that does not happen there in the same way. If I am with somebody in an assessment, I might push it that way but the person on their own will not. It is incumbent on the health care professional to go further. We heard in some of the evidence from the GP that that is how you get evidence. When someone goes into a GP, they usually just say one thing and the doctor asks some supplementary questions to tease that information out. That is what needs to be done at the very first hurdle; it should not have to go to a tribunal.

**Chris Stephens:** Hannah, I presume you would agree with that?

**Hannah Nicholls-Harrison:** We agree. There needs to be a fundamental cultural change that primarily consists of believing the claimant in the first instance and trying to understand using additional evidence to corroborate their own account, rather than trying to catch them out in an assessment.

Q271 **Chris Stephens:** What surprises me, Hannah is that there appears to be no commissioned research since 2012 on the reasons why appeals are successful. What information, if any, do you think would be derived from revisiting that and having the research as to why appeals are successful?

**Hannah Nicholls-Harrison:** Research is always welcome, but we already know some aspects of why the tribunal process works much better for claimants than the traditional approach in the first instance. It involves how we deal with evidence in the first instance and how we



consider people's oral assessment of their own condition. It involves how we deal with supporting evidence, and whether we are giving more weight to medical evidence from people who don't necessarily know. As the previous panel was saying, how does a condition impact day-to-day life? Are we weighting what we would like to see more heavily than the supporting evidence as given by carers and family members, and that people who know the claimant—maybe occupational therapists or whatever, and additional people who understand a person's condition—are able to give? That should be the evidence used to corroborate the claimant's account, rather than a simple yes/no based on assumptions about someone's condition.

**Q272 Chris Stephens:** Caroline, the tribunal panel will have specialist knowledge and experience which will reflect on its decision-making. How can the Department of Work and Pensions replicate that earlier on in the process, and can it be done cost-effectively?

**Caroline Selman:** My sense is that it is perhaps less about that expertise at the panel stage so much as it is about what we have been talking about previously in this session—the openness and willingness to listen; taking a more nuanced approach that perhaps allows somebody to provide a fuller account; and a culture of being more willing to listen to and understand that. The key is to ensure that happens at an earlier stage in the process.

Thinking further upstream about the new operational approach that was introduced in 2019, taking more oral and written evidence at the mandatory reconsideration stage, we do see an improvement at that point. When you introduce that at the earliest possible stage, you are allowing for a more rounded sharing of how a claimant understands and can genuinely articulate how they experience their condition and how that condition impacts on their life. The point is again about the culture and whether that is understood and taken into account

Coming back to questions in the previous session about the comparison with Scotland, that is not an area we have been directly involved with but I have been following it. My understanding is that much of the focus has been about trying to change the perception, and it being based on respect and wanting to listen, and that kind of cultural approach. That is almost as important as practical changes. Is the person sitting on the other side of the table, or on the other side of the room, coming from a starting point of genuinely wanting to understand what is happening and how it is affecting you? Or are they assuming that you are not eligible, and you somehow have to prove that you are? Whether that is or is not the case, it is certainly how claimants express that they experience that process. Their sense is that the starting point is an assumption that they are trying to claim something that they are not entitled to, as opposed to a good faith position of wanting to understand what they are entitled to and how something impacts and affects them.

**Daphne Hall:** Can I just add one thing?



**Chris Stephens:** Of course.

**Daphne Hall:** I think Aaron has referred to this. At the healthcare assessment, the assessors are often reluctant to allow anyone who comes with a claimant to speak, whereas the tribunal will speak to the claimant first but then to the other person. That evidence from the carer or family member might be really valuable. An openness to also using that evidence could make a difference.

**Chris Stephens:** It could be someone from a charitable organisation helping a military veteran. I think that is an excellent point, thank you.

Q273 **Chair:** Daphne, you have made the point that the introduction of holistic decision-making around mandatory reconsideration seems to have helped in some sense over the last two or three years.

**Daphne Hall:** It made a difference, yes.

**Chair:** Have any of you had experience of suggesting to DWP improvements in this process, and if you have made suggestions, what sort of response have you had?

**Daphne Hall:** As stakeholders, we make suggestions often. Sometimes they are taken well; sometimes not. I have had quite a lot of input into the Health Transformation Programme, as I know others have.

It is very slow with the DWP. You can make a suggestion and the people we deal with are often extremely receptive to what we say but we do not see them play out. An example is asking them to put that [advicelocal.uk](http://advicelocal.uk) address on all their letters. It is on one page of [gov.uk](http://gov.uk) at least. To me, it seems extremely simple and it would help people to get access to advice, but it has not happened although we have probably been going for a few years with it now.

Bureaucracy within DWP is very slow. Interestingly, because we are having some meetings with Maximus and Atos, sometimes there is a little bit more flexibility in there. The people that we deal with in the DWP are very helpful. The problem is more with the machine behind it. I am not criticising the people we are in contact with. Our stakeholder meetings are very productive and open, and they take feedback, but the problem is with the machine behind them and getting things changed.

Another example is with Universal Credit. The UC50, the form that starts the work capability assessment, is not reliably sent out, so sometimes people are on Universal Credit for months and have not even started the work capability assessment process.

NAWRA did some research with the Central England Law Centre. Central England Law Centre did the research and we presented it. We had been having meetings with them. We suggested a very simple thing to them, which was that when somebody submits a fit note, something should automatically go in a journal saying, "You should be sent a UC50 form



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within four weeks”—that would tell people what the work capability assessment process is and what to expect—“and if this does not happen, let your work coach know”. We cannot get DWP to do it. It would just be putting that in someone’s journal when the fit note is submitted. The DWP say to us, “Well, if the UC50 does not happen, they just need to let us know,” but the person does not know about the UC50. They think that they are submitting fit notes and they have told the DWP that they are not fit for work. They do not know about the work capability assessment process, and why should they?

It is little things like that, with the process not even starting. We made what to us what seems like an incredibly simple suggestion, but we had a meeting back in October and we are still in e-mail conversations with them to say, “Could you just get this very first step done?”. That is the sort of frustration we feel sometimes. As I say, it is not necessarily about the individuals at all; it is about the machinery behind them, and it is very slow sometimes.

**Chair:** Very interesting, thank you.

**Caroline Selman:** One of our key concerns is about not just the quality of mandatory reconsideration decisions but the barriers to people asking for mandatory reconsiderations in the first place, for reasons that I know are very familiar to the Committee—be it, for example, the length of time the process can take, or also the uncertainty around that time and the lack of the clear timelines. Those both exacerbate the uncertainty for people. There is also a very practical barrier in terms of people not quite knowing where things have gone and needing that mandatory reconsideration notice to perhaps progress to the next stage of appeal. Those are things that have been recommended by us and many others, including this Committee, and it is fairly frustrating those recommendations have not so far been taken up by DWP.

I note again that as part of devolution in Scotland, there has been an instruction of time limits for mandatory reconsideration north of the border. It will be interesting to see any impact that has on reducing barriers to mandatory reconsideration and also to appeal.

Regarding direct engagement with DWP, we are currently doing a piece of research about barriers to mandatory reconsideration and appeal in a different context, which is sanctions. In relation to that, I would say we have had some good engagement from the policy team but we are not yet at the stage of trying to get them to take on some of the recommendations. It remains to be seen how that goes from there.

**Hannah Nicholls-Harrison:** I will add to what Daphne said. We have a really great relationship as the Disability Benefits Consortium and many of our members work very closely with DWP on all sorts of different areas, whether it is the change to looking at the severe disability criteria, some of the guidance around terminal illness or the Health



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Transformation Programme. We work very closely with DWP and on an individual basis, and we have a really positive relationship.

The problem, as Daphne said, is that sometimes you bring a problem to an individual who is very well intentioned and says, "I am going to bring it up the chain and work it across the board" and it kind of disappears. You follow it up but you are not really sure, and months later you are not making progress and there is no transparency about where things go to die, where ideas are losing some traction.

We do see progress on some things. We have been advocating for a while that assessments should be recorded, that the process to get assessments recorded should be a lot easier and that you should not need to bring those two recording devices to an assessment, which was the previous practice. We are seeing those kinds of improvements.

We would like to see that people receive a copy of their assessment report in the required format to improve that scrutiny and to help raise the standards of the specific report. We would like to see that the reports are written in accessible language. Currently, if you do receive a copy of your assessment, you may not know what it means and it is hard to compare it with your own circumstance.

Those are some things that we have been making some recommendations about for quite a long time. Hopefully with the Health Transformation Programme and some other things, we will see some movement on that. On an individual level it is challenging with the size of DWP to know exactly where a request or a concern is being dealt with.

**Q274 Nigel Mills:** I have a couple of slightly different questions. The first one is: does the panel think there is scope for merging the ESA and PIP assessments? I know not everybody on PIP is unable to work, and not everybody on ESA gets PIP, but there are a lot of people who get both. I know that the tests are different, but, in essence, the evidence is largely the same and a lot of the questions look quite similar to me.

Is there scope for having one assessment and one process that gets you two decisions, rather than putting people through two processes every three years, which seems quite stressful and unnecessary?

**Daphne Hall:** From a practical point of view, one of the difficulties of having just one assessment is that you often do not need to be assessed at the same time for the two benefits.

**Nigel Mills:** It could be harmonised, couldn't it?

**Daphne Hall:** There is definitely scope for sharing information. You go to an assessment and a load of information is collated so that if you then apply for the other benefit, they do not need to call you in for another assessment because they have enough there.



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Rather than saying “It is one assessment for two benefits”, it could be a bit more general. They could say, “We are doing an assessment of your health conditions, and we will store that information and share it across the benefits to make things easier later on.” It could be perhaps a bit more general, if you see what I mean. The less often people have to go for assessments, the better, although obviously some conditions are progressive.

**Hannah Nicholls-Harrison:** We are a coalition of over 100 organisations, so there may be some variety in people’s views on this. By and large, we have heard from our Green Paper response that there is very little support for combining PIP and ESA, but, as Daphne says, there is scope for sharing data where it is appropriate, provided that there are data protection safeguards and specific pieces of evidence, or evidence from specific claims, are only shared with the consent and explicit permission of the claimant.

Q275 **Nigel Mills:** Do we think we are getting better at making decisions without assessments when there is clearly no need for an assessment based on the application form or other evidence submitted, or are we still defaulting to assessment nearly every time?

**Daphne Hall:** PIP got a lot better under Covid, and PIP were quite good at doing paper-based assessments under Covid. Unfortunately, work capability assessments were not, and that was another thing we fought hard for in the stakeholder meetings. We said, “Surely you can do some more paper-based assessments,” because there was a huge backlog, but we struggled with that.

I definitely think there is scope for doing more paper-based assessments, getting more holistic evidence from other sources and using that, because generally the standard of a healthcare professional report is not good evidence. I am not saying that for all of them, but we see an awful lot that, to put it bluntly, are not worth the paper they are written on. Obviously, as advisors we tend to see the ones that have gone wrong, so it is hard for me to say. Certainly, way too many healthcare professional reports are just ineffective and almost dangerous, because they are just not reporting what a person has said, they are not accurate and they are leading to wrong decisions. The assessment process we have is not in any way currently helping.

**Chair:** Any more points from Hannah or Caroline?

**Hannah Nicholls-Harrison:** From my perspective, Daphne has covered it. The paper-based assessments under PIP were beneficial during Covid and we certainly hope that continues, because where there is a considerable amount of supplementary evidence, that should be enough to make a decision.

As Daphne also said, the assessment process as it stands often does not serve its purpose.



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**Chair:** Thank you very much. That concludes our questions.

Thank you all very much for the information you have given us. I will make the point I should have made to the earlier panel: if there is something else that occurs to you afterwards—a point you would like to make to us, or something that we perhaps could have asked you about but did not—please do let us know. We would be very interested in any further observations you may have.

Your evidence to us has been extremely helpful, and we are grateful to you for being willing to give us the responses you have given. That concludes our meeting this morning.