

Work and Pensions Committee

Oral evidence: Health assessments for benefits, HC 128

Wednesday 20 July 2022

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Members present: Sir Stephen Timms (Chair); Debbie Abrahams; Neil Coyle; Steve McCabe; Nigel Mills; Selaine Saxby; Dr Ben Spencer; Chris Stephens; Sir Desmond Swayne.

Questions 445 - 526

Witnesses

I: Chloe Smith MP, Minister for Disabled People, Health and Work, Department for Work and Pensions; Katie Farrington, Director General for Disability, Department for Work and Pensions; and Gill Holmes, Director of Contract Management and Partner Delivery, Department for Work and Pensions.

Written evidence from witnesses:

- [Department for Work and Pensions](#)

Examination of witnesses

Witnesses: Chloe Smith MP, Katie Farrington and Gill Holmes.

Q445 **Chair:** Minister, thank you very much for joining us this morning and for being willing to give evidence to us in our inquiry on health assessments for benefits. I know that one of your team is joining us virtually. Minister, do you want to introduce your team to us?

Chloe Smith: Yes, gladly. I am accompanied by Katie Farrington and Gill—whose surname I have promptly forgotten.

Katie Farrington: Holmes.

Chloe Smith: Holmes. I am so sorry, I apologise to you, Gill. Perhaps on that level of performance, I had better ask each of you to give your own job titles.

Katie Farrington: Hello. I am very pleased to be here. I am the Director General for Disability, Health and Pensions in DWP.

Gill Holmes: Apologies that I could not make it to Westminster today due to travel restrictions. I am the director responsible for the contracts for health assessments as well as employment programmes and local authority grants, but today focusing very much on the health assessment contracts.

Q446 **Chair:** Thank you and welcome to all of you. I will start with the first question. We have lots of questions for you about health assessments for benefits but, Minister, can I ask you first of all about something different? We had an exchange in DWP questions last week about the planned improvements to Access to Work. Could you give us an update on progress with those and set out when people who use Access to Work can expect to see some changes?

Chloe Smith: Yes, gladly. Thank you, Chair, for recalling that exchange and giving me a chance to add a few points for the Committee.

I am absolutely determined that Access to Work should be there to support disabled people in work, should be readily available and should be able to provide a full range of support. To put some context around it, we spend in excess of £100 million on this; that is the 2021 figure. That supports over 37,000 people. What we want to do is to reform it and continue to improve it. We are doing that by turning it into a more digital service. The rationale for that is that it needs to be able to be more streamlined and more accessible. We are starting with the first phase of a transformation in the payments process that is being delivered this year.

We are also making other improvements, including piloting adjustment passports, which I believe is what we referred to last week. These are to



help to support and empower disabled people to have a more structured conversation with employers and potential employers about their disability and fundamentally to speed up the process and reduce the need for assessments. The passport would carry that information with the person as they go, which we hope will be convenient to the user but indirectly also to employers. That passport in a couple of different types is already up and running, and I could perhaps follow up with a note for the Committee, if you would like, on what those types are and how they help.

We are also continuing to develop a mental health support service under Access to Work, which we are excited about. We think that this is key to enabling people to sustain employment. We are looking at ways to continue to ensure that the service provides tailored mental health support.

Chair: Thank you very much. We will certainly be keen to follow progress with that and we would welcome your follow-up note and perhaps any information you can tell us about when these improvements will take effect and when people can see them. That would be very welcome.

Chloe Smith: That would be great, yes. Thank you.

Q447 **Chair:** On the subject for today, our survey of people who have been through health assessments to apply for benefits has elicited 8,500 responses. You will not be surprised that they have been overwhelmingly negative about the experience. Do you see much prospect of turning that around in the next two or three years?

Chloe Smith: I certainly hope so. First of all, I am glad that the Committee has been seeking views from people who use our services because this is very much in line with how we wish to operate and to continually improve. It is, of course, absolutely essential to understand the experience of claimants, so that survey and your wider inquiry is very important in that.

I will start addressing this question by again putting the figures in the broadest context, then addressing how we are improving our services. As you will know, we run a large-scale service that supports around 5 million people every year and delivered a record £26 billion of support for disabled people and people with health conditions in 2020-21. The key point is that we want these people to be able to have a good experience of our services and get the right decision on their entitlement.

We want to understand that experience and to keep improving it, so we undertake regular surveys of claimants ourselves, and indeed so do our providers. To give some examples, the most recent DWP customer experience survey, which covers April to December 2021, shows that 82% of customers were either very satisfied or fairly satisfied with the overall service they receive. I hope that that begins to put the survey work that you are doing in additional and helpful context.



Our assessment providers are subject to customer satisfaction targets, and that is another important tool for being able to demand those standards and then seek improvement where it is needed. They have consistently exceeded those targets of 90% for PIP and 92% for the work capability assessment. Again, to put the 8,000 in context, those figures I am citing imply that over 750,000 people in the last contractual year are satisfied with their service. That is for both PIP and the WCA.

None the less, I recognise that not everybody has the experience we would like them to have, so I will turn to the improvements that we are seeking to make. I will invite Katie to supply more detail on how the Department is doing these things.

In headline terms, since 2018, when I think you were last looking at these matters at the Committee, we have introduced telephone and video assessments. We will no doubt have a conversation with the Committee about how those form part of our ongoing service offer. We have introduced a flexible approach to handling requests to change assessment channel without having to ask for new evidence. We have removed unnecessary PIP reassessments for people over state pension age or on the highest rates with needs that will not improve. We have changed the special rules for end of life to enable more people who are nearing the end of their life to get fast-tracked access to benefits. This is something that I am particularly passionate about. As you will know, the legislation to complete that work is currently going through the Houses, although we were able to begin with secondary legislation to get to that goal faster, which I am absolutely determined to do.

We have also introduced a clinical governance quality standards framework to systematically improve the quality and consistency of all our work that involves healthcare professionals. We have adopted measures recommended by independent reviews, for example, the function first approach recommended by Paul Gray for PIP assessments. We work continuously with our providers to drive the improvements that may be needed in assessment services. For example, that includes new or enhanced quality checks on assessment reports and a redesign of the PIP assessment report to support better decision making. I will pause there, Chair, and either Gill or Katie would be delighted to go into more detail as we go through.

Q448 Chair: I think that the other details will be picked up in further questions. Can I put a couple of specific points to you? One thing I know you have been looking at is the idea of a support and advocacy service to support people. Is that something that you would expect to introduce in the next year or two? Do you think that will be a big help here?

Chloe Smith: Yes, this is a very interesting concept and, as you know, is something that we spoke about in our Green Paper last year. I suppose I ought to say at the outset that the context is that we published the Green Paper last year. We have had a response of 4,500 opinions and views, which we are very grateful for—and again that forms part of that



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fundamental need to listen to people, take views and respond and improve. I can say at the outset of our discussion this morning that we are still on track to publish the White Paper, but given that today is the last day but one before recess I should say to you that I do not expect that will be before summer recess. I anticipate that coming in September.

As part of that work, we will be able to bring forward more information about advocacy. As you know, in the Green Paper we set out our intention to test an advocacy service. We think that this is most helpful for people who might be struggling to navigate the benefits system and/or other Government services who may not have access to sufficient support. In the Green Paper we set out the principles for what we think the service might look like and asked what kind of support people might need and how we might identify people who would benefit most from that support. A test of this is currently under way in Kent. That will show whether it is feasible for us to deliver such a service and whether it offers value for money.

As I say, I will be able to come back with much more comprehensive information on that in the White Paper, but I can also add that we do, of course, have services akin to this already; for example, the Universal Credit help to claim offer, which you have probably gone into detail on with some of my colleagues.

Q449 Chair: That is helpful. We look forward to hearing more about that in the White Paper in September.

I have one other specific point. I will quote one person responding to our survey, who said, "The assessment was completed by a nurse that had never heard of my condition. She said she Googled it 5 minutes before seeing me. You cannot understand a complex condition with a 5 min Google." I know that you will be familiar with one idea that has been put to us, that people ought to be invited, if they wish, to specify their primary impairment and to request that their assessor should have some expertise in that condition. The new flexibilities made possible by Zoom and so on might make that a more practical possibility in the future than it was in the past. Do you think the Department might consider some facility along those lines?

Chloe Smith: I recognise this point and, first of all, I am concerned to hear the example that you give. While obviously I cannot deal fully with an individual example on the spot, I will say that that kind of response from the assessor is not necessarily what I would expect in providing that person with reassurance, confidence and a level of comfort in the moment.

In general, I hope that we will be able to pick up on that kind of exchange in feedback and, if necessary, complaints made to providers and then we look to improve the service from there. I just want to say that about the example that you gave. I do not think that is the standard we are looking for. To address that, we are ever increasing the training



and information that is used by our assessment providers. I might ask Gill to come in and explain more about how we do that. We have quite a bit of detail that can be provided and Gill is best placed to talk about that.

More broadly on whether we might reform the system to the point of allocating specialist providers to every type of applicant or application, we spoke about this in the Green Paper. Again, I expect to be able to come back and say more about this in the White Paper. I will say at this point, however, that I think there is a depth of consideration that is needed. I want people to be able to have an assessment that is as specialist as we can make it, but I am unwilling to place any constraints on the overall system that might slow it down or make people receive a slower response or, indeed, make other people receive a slower response. Those are some of the considerations that I am applying to this particular idea. May I turn to Gill for the—

Chair: I think that some of these points will come up in further questions, so let's come back to them if they arise in those. Sir Desmond Swayne is next.

Q450 Sir Desmond Swayne: I am interested in what scope there may be in work capability assessments and PIP assessments for moving to more paper-based determinations. The question arises as to what extent the existing contractual arrangements with the providers constrain that. How do you feel about the possibility of moving away from the almost default position of in-person or video/telephone assessments?

Chloe Smith: Katie is eager to answer, if I may pass straight over.

Katie Farrington: Thank you for asking this question. Our default position is a paper-based approach. The first thing the assessor will do when they get the paper application is to seek to make a judgement on the basis of the application if they possibly can. That is what we do first. It happens in about 15% to 17% of cases. Then if the assessor thinks they need more information, they go to an assessment. At the moment, those are overwhelmingly happening through telephony or video assessment rather than face to face. I think the latest figures show it is about late 70%, early 80% are done through telephony or video assessment and only about 5% face to face. That is a bit of a consequence of Covid, where at the beginning of the pandemic we shut down our face-to-face assessments to protect our customers and moved quickly to the telephony approach.

Your question was about whether we think there is scope to do more on paper and whether the contracts prevent that. I will hand over to Gill to talk about the contracts, but generally just to reinforce our approaches, we use the paper wherever we can and often it will be that the assessor thinks that they need more evidence than is there on the form from the customer and the medical evidence that has been provided by the GP alongside.



Gill Holmes: I will talk about PIP first and other questions about WCA, but I think it is relevant across both types of health assessment.

In PIP we have introduced a check to make sure that the providers are using the most appropriate delivery route for assessing the claim, paper-based being one of them. We do not have any targets for how many should be paper based, how many should be face to face and how many should be video. It is about what the right assessment delivery approach for that particular claim is. That is what is really important, to make sure that we get the right information sufficient for the decision maker to make a decision. From a contractual point of view, there isn't anything in there that stops us increasing paper based. For WCA we do not have that check in play. It is something we will be looking at, particularly probably during FAS as we roll that out.

We are always working with suppliers to make sure that we try to have sufficient information to do as many as possible paper based. We want this service to be as smooth as possible, for us to be able to make the right decision with the information. Only if we need to speak to the customer do we then go for telephone or video or face to face, and that judgement is made by the healthcare professional.

Q451 **Sir Desmond Swayne:** We have heard from a number of witnesses that it is not clear how the supporting evidence, and particularly expert evidence, is being used to determine the outcome of the claim. Is there anything that can be done to clarify that? In particular, is any work going on to try to improve the quality and supply of the additional information, particularly expert information?

Chloe Smith: There is considerable work going on on exactly this point. Katie, would you like to talk about that?

Katie Farrington: Yes. It may be helpful if I briefly summarise the way we use the medical information. The Committee will have heard from the evidence it has received that these are functional assessments. It is a question of what effect your health condition has on your daily life or on your ability to work rather than on the condition itself. That might change quite a lot. For one patient who has HIV it might have quite a big impact on their daily life, and for another patient who has HIV it might have a very different impact. What our assessors are trying to do is to take the evidence from the customer, take the medical information alongside them, and then form a judgement, often on the basis of an assessment.

As the Minister was saying, we work very closely with the GP community to try to make sure that we are working in partnership with them on what information we need and how to make sure we are not adding unnecessary burdens on to those professionals. We think that that medical information, alongside the information we get from the customer, is an essential part of the process.

Q452 **Chris Stephens:** I probably should note first that I have tabled a Private



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Member's Bill around some of these issues, Minister.

In 2018, the Department told the previous Committee that it would introduce default recording for PIP assessments. The view that we have had from the current PIP contractors is that they are in favour of an opt-in recording model, but they have also told us that while they support making recording more accessible, they are still waiting for the Department to make a decision on whether recording should be opt-in or opt-out. Minister, has the Department made that decision yet?

Chloe Smith: We are running the model of giving everybody the option to either request a recording in advance or to record the assessment themselves. We think that is the right balance, in the sense that recording assessments can indeed improve trust in the process for some claimants. I accept that concept, but it is also true that it is not desired by or appropriate for everybody. We think that the ability to choose to do it is sensible and strikes the balance between those things.

Chair: Sorry, that is opt-in rather than opt-out, is it?

Chloe Smith: Yes, that is correct. That is the model that we are using. Having said that in preamble, we are not intending to move to an opt-out model.

Q453 **Chris Stephens:** Therefore, if people go to an assessment, they should have their interview recorded if they wish. No one should be turned down and told, "We don't have any recording information"?

Katie Farrington: Certainly, if the customer has requested it in advance, they can have their interview recorded. The other change that we made in January is to make it much easier for customers to record their own assessment if they wish to do so. Previously, and you may have heard this, people used to have to bring along double tape-recorders so that they could take away one copy and leave the other copy with the assessor. We no longer require that, so if customers want to record their assessment on any device that they want, we will allow that to happen. Yes, in answer to your question, if the customer requests in advance to have their assessment recorded, that is absolutely available.

Q454 **Chris Stephens:** Are claimants notified before they go into an assessment that that is available to them? There is no point the Department telling us that some can be recorded in advance if claimants do not know about it. Is it made clear to claimants in letters that they can have their interview recorded?

Katie Farrington: I think that is a fair question. Yes, it is. There may be a question of whether we do that as clearly as possible, and as part of the continuous improvement that the Minister has looked at, we need to continue to look at making sure we are doing that in as user-friendly a way as we possibly can.



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Chloe Smith: Again, that has been a subject that we put out quite openly in the Green Paper and we will be able to come back with more on in the White Paper.

Q455 **Chris Stephens:** Thank you. We have continued to hear that people should be sent copies of their assessment reports with their decision letters. The Department's view, as I understand it, is that that should only be done on request. As I understand the Department's position, it does not want to provide claimants with material that they do not want. My question is: how can you know that people do not want to receive the report if they have not seen it?

Chloe Smith: Again, I think it is trusting people to make a request if they wish to. I am comfortable with that as a concept. When claimants receive a letter from DWP informing them of the outcome of their claim, they can request a copy of their assessment report. I have no reason to doubt that claimants would do that if they wished to.

Q456 **Chris Stephens:** It sounds like it is a case of DWP not wanting to send it, so what is the reason? I am struggling to find a reason why any claimant would not want the assessment report to be with their decision letter, so surely that should be done by default.

Chloe Smith: It is a very good debate point, and again for me a consideration that comes into this is one that I mentioned a moment ago. I am endeavouring to run a system that gets the quickest decisions to the largest number of people at all times. As we said at the outset, it is a very large system with very large numbers of people in it. I would be very cautious of taking a decision or accepting an argument that risked slowing the system down for everybody. At present, I am comfortable that the request basis that I have described for getting the assessment report meets all those different objectives. Again, this is something that we put out for discussion through the Green Paper and we will be able to say a little bit more about it in the White Paper in short order.

Q457 **Chris Stephens:** This is my final question at this point. We are also aware of individuals who receive assessment reports for other people. We have had gentlemen being told they were pregnant; I remember that being told to us at a previous Committee. What is the reason for that happening?

Chloe Smith: On the face of it, that would sound like a mistake, which ought to be properly investigated. I don't know whether Katie or Gill has a better explanation.

Katie Farrington: That sounds like an error to me. I would be very happy to look at the examples if you have them.

Q458 **Chris Stephens:** An individual should not be receiving a report about someone else.

Katie Farrington: Absolutely correct.



Chloe Smith: Clearly not. I think that is absolutely obvious.

Q459 **Dr Ben Spencer:** On the assessment reports, when we were talking, certainly when I was talking, to some people who had gone through the process when we went on our trip up to Scotland, one of the concerns that they raised was around what I would call procedural justice, in that they feel that having gone through the assessment there is no opportunity to challenge at an early stage what is in the report, especially if there are simple misunderstandings and so on. The report is presented as a bit of a fait accompli.

When I used to be a doctor, whenever writing assessment reports I used to, as much as possible, put them in front of my patients before submitting them to say, "Here is the report". Obviously, you cannot do it in all circumstances but as much as possible, "Here is the report. Could you look through it? Is there anything that is concerning to you that we can talk through before it is submitted as a final report?" Notwithstanding your concerns about slowing things down, a process like that would take a lot of grief and strife out of the system so that it feels a bit more collegiate, working with the person who is going through this assessment process. Have you thought about adopting a system like that?

Chloe Smith: It is a very good point and there are perhaps two areas that we might talk about here. One is how we work with GPs. We touched on it earlier. Of course, there is also the consideration about how to make that as streamlined as possible for GPs. Your colleagues in that profession now might remark that they are keen to fulfil that function in as efficient a way as they possibly can because of the other pressures in their work.

Q460 **Dr Ben Spencer:** They have said to us quite clearly that they want nothing to do with this process. They feel it should be the independent assessors who are doing this. It was more the independent assessments. Well, I say independent assessments; it is the assessment process reports that I was thinking of.

Chloe Smith: Yes, and that is the second thing we ought to say in response to this, which is how the health transformation programme is exploring ways to do the things you are talking about. Katie might be able to start on this.

Katie Farrington: The Chair may want to cover this later on, but briefly the health transformation programme is looking in small scale in a couple of sites, Marylebone and Birmingham, at this journey. I will say more about this later, but one of the things it is looking at is if we phone up the customer once the decision has been made and explain it to them over the phone, does that help them to understand it a bit more? Does that create the opportunity that you are describing, just to clarify any points of misunderstanding that may have arisen, and could that then lead to fewer challenges down the road? At the moment, as the Committee will have heard, we have this process of mandatory reconsideration, where people can come back and challenge, and some do. If there are points of



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misunderstanding, we would absolutely seek to clear them up as early as possible.

Q461 Selaine Saxby: Good morning. Some sources have reported that PIP claimants are waiting up to five months for decisions on their claims. What is being done to bring down the PIP backlog and how are you ensuring that future claimants do not have to wait so long for a decision?

Chloe Smith: Thank you very much for this question. This is one of the central issues in my portfolio at the moment, and I am spending a great deal of time focusing on it, working with the operational side of the business—and Gill will be able to come in on that—and the policy tools for improving the situation as well, which Katie focuses on. Both Gill and Katie will know that I have pressed them extremely hard to focus on customer journey time. This is for me a very important measure.

If I start off overall, and then I will pass on to my colleagues to round out the answer, it is worth saying that the PIP service in fact is in context holding up incredibly well in light of the demands placed on it by the pandemic and historically high levels of new claims. We have over that period been able to introduce remote assessment at pace while prioritising new claims, ensuring that people waiting for a review do not go out of payment. While all that is happening, the latest statistics show that while the number of new claims registered was 57,000 in August 2021 and 60,000 in April 2022, the end-to-end journey time for a new claim fell from 26 weeks in August to 20 weeks at the end of April 2022. There is improvement in the customer journey time and I want to sustain and drive that.

Although there is improvement, none the less, that is still too long, in my view. I am absolutely focused on working with the assessment providers to increase capacity—and that is one line of discussion perhaps we might have—as well as improving many different aspects of the processes that make up the overall components of the journey time, as well as looking at and understanding the rise in demand that is happening at the same time.

Q462 Selaine Saxby: Are you looking at anything like an assessment rate for PIP claimants, given the length of time? Twenty weeks is still a long time for people if they feel that they should be getting more money than they are, given everything else that is going on right now.

Katie Farrington: Thank you for this question. It might be helpful if I explain why we are not doing that, if that is all right. We do give an assessment rate for customers waiting to go through the work capability assessment. As you will know, that benefit is a little bit different. It is designed as an income replacement, so for people on low incomes or out of work. There we are able to quite quickly assess somebody's income and try to give them an assessment rate very quickly.



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PIP is a bit more complicated. We are trying to work out the impact that the health condition has on somebody's daily life. About 40% of the people who apply for PIP get an award, so about 60% do not. The risk there is if we were to give someone an assessment rate up front and then later find out down the journey that they are not entitled to the sum, we would end up having to go after them and recover the amount of money, which does not feel like the right thing to do for the customer. Hence, as the Minister is emphasising, her drive has been in trying to shorten the journey time for new claims and to get people the money they are entitled to as quickly as we can.

Chloe Smith: The other side of the coin that Katie described is, of course, that we backdate PIP claims. For the 40% who are correctly entitled, we make sure that they have not lost out through that period.

Q463 **Selaine Saxby:** You have spoken about the customer journey time in those answers. Does the Department have targets or service standards on decision making for these benefits or any internal performance indicators?

Chloe Smith: I am happy to say up front that we do not have an overall target for the PIP journey time. I am conscious that that is a discussion point that has been here at the Committee and I think I can be clear on that. My drive is to get it down as low as I possibly can, but I am not operating that on a target basis at present. However, within the journey and within the elements of it there are quite a few different standards and sections. I might pass to Gill to come in on how we handle those.

Gill Holmes: There are a couple of things to cover. I will cover first the work that the providers are doing to try to reduce the journey time. As to things that we have done already, we have had a comprehensive end-to-end review of their processes to make sure that it works as efficiently as possible. This is as a consequence of bringing in telephony assessments. All of the backroom processes needed to be looked at again. We needed to make sure that that process was running effectively. We had some support from the Cabinet Office to help us to do that and we conducted those during the summer. That has helped to improve the journey time within the provider space.

We have also been working with the providers on a real commitment to drive up the number of healthcare professionals being recruited. It is quite a volatile area to recruit in. There are challenges around the numbers of healthcare professionals in the marketplace. I also think that the call from the NHS to support the vaccine programme was very tempting to healthcare professionals, understandably.

We have been working with the suppliers right across PIP and WCA to do two things, to look to increase the number of healthcare professionals we recruit and to drive down the attrition rates to make sure that once we have recruited trained people we keep them, and that we look at productivity that is effective but supportive to the healthcare



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professionals. Productivity is not about driving people too hard; it is about making sure we have the right amount of work being conducted by the healthcare professionals to enable them to still be able to support their ongoing learning and training. I think that is key.

At the moment, what we call street to seat, from recruitment to having somebody fully up and running, is around six months. That is a long time with a lot of training and accreditation involved in that. We are working with suppliers on whether we can improve that to make healthcare professionals who come into this work effective more quickly, but all with a backdrop that we do not want to have an impact on quality.

There is an awful lot that we have been doing, and for my team our focus has absolutely been on how we can make sure that we improve the volume of claims that are being assessed each week but also that we maintain and improve the quality of the assessments that are coming through. That has been the key programme in PIP and WCA, particularly since we have come out of the key elements of Covid. Obviously, when Covid hit it was about how we continue the assessments, and we stood up telephony in PIP within a matter of weeks. They are some of the key things that the providers are doing for that.

Katie Farrington: Is it possible to round out the picture on demand briefly?

Chair: Briefly, if you would, yes.

Katie Farrington: The Minister has given some figures on that, but for the first quarter of 2022 we had more claims for PIP than we have ever had—200,000 claims in that period compared with 135,000 claims for the equivalent period in 2019. We are seeing extremely significant demand for this service. I won't set out the details, but to put it in context this is a service under high demand and we are trying to bring the journey time down as much as we can.

Chair: It has gone up by 50% in three years, has it? Yes, okay. Thank you.

Q464 **Neil Coyle:** Thank you all for being here this morning. Did that comprehensive review you just mentioned examine at all how long it was reasonable for a disabled or vulnerable person to be waiting for a decision on key support?

Chloe Smith: Is that a question to Gill?

Neil Coyle: It was Gill who mentioned the comprehensive review.

Gill Holmes: The review focused more on the processes and looking at the key touchpoints within the provider space. The things that we looked at were how many times a case has been looked at before a decision was taken around which delivery channel is going to be used and whether the training is efficient and able to deliver the assessments. We have looked



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at the accreditation process and the onboarding process. It is more around the processes and procedures that sit behind the assessment to make sure that providers are running as efficiently as possible.

That has not finished. We have started that piece of work. We have a real commitment from the suppliers and the Department for continuous improvement. Positively, the providers will come back to us with things that they want the Department to look at. It is not just a focus on the provider, it is how we can work together to look at the policies and the processes we have to make sure that we can make this as efficient as possible but still maintaining the quality level.

Q465 Neil Coyle: This is not new and, Minister, I think you said that you have pressed hard to make the process more efficient, but you have also confirmed a 20-week wait. Is that consistent across the country? Are there pockets where that is worse or is it uniform in Norwich and in Bermondsey, for example?

Chloe Smith: I do not have that data to hand. If Gill has it, she may be able to come in.

Gill Holmes: I cannot give you the data in numbers, but one of the things that telephony has allowed us to bring in is a virtual queuing system. In the past, if you were based in Cornwall or Devon as a healthcare professional, you could only deal with claims from Cornwall and Devon because it was face to face. Now, of course, because we have so much of our work done by telephone, somebody in Cornwall can assess somebody over the phone in Newcastle. I think that has brought some real benefits for us in respect of recruitment and waiting times.

That is not to say that for some customers who have specific needs or requirements that we need to set up there might be some slight delays or they have not responded. There will be, I am sure, some cases that fall out of that that the providers are having to deal with, but I think that the telephony process has enabled us to have a much more consistent delivery time across the country.

Q466 Neil Coyle: But there is no reason anyone should be waiting any longer in one place than another. Do you know how many people are waiting for a decision in Norwich, for example?

Chloe Smith: I can supply geographical data to the Committee if that is helpful. We might perhaps just talk about what form it is wanted in.

Q467 Neil Coyle: I am thinking of a practical example. A disabled person wants to apply for PIP. They put the form in and then they have to provide medical information, their PIP2 form. Can you tell us how many PIP claims are terminated because a claimant does not return that form in time? They have one month.

Katie Farrington: Perhaps I will say a bit more about this. You are absolutely right, it is about the process. We send out the form and ask



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people to return it within one month. We give them a reminder within two weeks and at that point we extend the process by a further two weeks, so that is six weeks in total. If the customer wants more time, we would give them more time. The overall figure for the lifetime of PIP is about 13% cases that have not been returned but, of course, we sometimes see people applying repeatedly. Maybe they do not fill in their form and return it on time, despite those reminders, but they could obviously come forward and apply again.

Q468 Neil Coyle: Is it a similar figure for UC, ESA and new style ESA as well?

Katie Farrington: We don't have the figures for UC. We do have the figures for PIP.

Neil Coyle: If you could provide them afterwards, that would be helpful.

Katie Farrington: I am sorry—

Q469 Neil Coyle: You just do not have them at all?

Katie Farrington: We do not hold those figures. We do have the figures for PIP. We do not have the figures for UC.

Q470 Neil Coyle: Who has the figures? This is a key process you oversee. Who has that figure?

Chloe Smith: I think it is a commonly known fact that our various systems are capable of providing various different types of data, so we are simply saying to you that we do not have that type of data.

Q471 Neil Coyle: Are you working to make sure you can access that data in future to ensure that the process is robust and that people are not penalised for reasons I will come on to?

Katie Farrington: If I could perhaps just add, if it is helpful, the processes are a little bit different. For PIP we close the claim if the customer does not reply, whereas in UC we do not close the claim. We continue to keep the customer on Universal Credit. It is just a slightly different system there. They are slightly different benefits, as the Minister has described.

Q472 Neil Coyle: I am assuming that there is no one in this room who is unaware of Covid or the pandemic we have had. What is the average wait time to see a GP in your constituency, Minister?

Chloe Smith: Chair, I am not sure my constituency is quite relevant to this line of questioning.

Q473 Neil Coyle: Let me give an example and I will explain it. I have just looked on the NHS app on my phone. If I want an appointment at the Artesian, my GP clinic in Bermondsey, it is more than 16 weeks. My point is that I do not know what your wait time is in Norwich, but if you know that it takes too long to see a GP, longer than a month, perhaps there is a reason to change this process to stop penalising disabled people trying



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to get their information in on time.

Chloe Smith: I think the broader point is that there are two things. First, there are ways in which we want to get a range of good evidence in for a PIP application. We have touched on that and we can perhaps go into that in more detail. I don't think that it only has to hinge on what a GP may say. Secondly, and much more broadly, we do, of course, as the Government want to be able to ensure that people can see a GP when that is needed. There are much broader plans going on to improve that, but that is perhaps for a different Committee.

Q474 **Neil Coyle:** The NHS is struggling. It was struggling before Covid; it is struggling even more now. DWP is putting pressure on people to go through the NHS to provide this information that they cannot provide within the timescale set out by the Department. I am asking you what you are doing to change the process or improve it to extend that timeframe or to change the process to prevent that being the case and the huge cost that that is having on the NHS.

Katie Farrington: There are two slightly different bits of this process. There is the customer returning their own form that they fill in. That is the process where we give them the month and then the further two weeks. They do not need a GP for that. That is their own form and their own evidence. That comes back to us.

We then source the further information from the GP. I think that we suggest a five-day turnaround for that and, again, we will chase it if it does not come back. You are right that the NHS is under pressure. We try not to penalise the customer. If we do not have all of the evidence from the medical practitioner but we think we have enough evidence from the customer to go ahead and do the assessment, we do that.

Q475 **Neil Coyle:** My concern is broader. It is not just penalising the customer, it is penalising the taxpayer. The Department has said that the reason for mandatory reconsiderations and appeals and the huge cost that goes with that, hundreds of millions of pounds, is because people have not provided the medical information at the start of the process. The process is part of the problem. The Department provides information to us saying that the mandatory reconsideration stage will give decision makers additional time to proactively contact customers if they think additional evidence may support the claim. Instead of changing the process and changing that timeframe, you are burdening taxpayers with additional costs for the Department and mandatory reconsideration and through tribunals where there is a massive backlog and delays. It is a penalty for disabled people, it is a penalty for the Department and it is a penalty for the taxpayer.

Chloe Smith: I share those concerns. That is why—

Neil Coyle: What are you doing about it?

Chloe Smith: Exactly, that is why we are doing a number of things to make sure we get the right decision to people at the earliest possible



time, and we can come on to how we do that through the mandatory reconsideration toolbox and how we are trying to reduce the burden of appeals. There is something important to explore here, which is how we are working closely with GPs to improve our services. There are a number of ways we do that; for example, a regular GP forum in which we can take their insights into how we can successfully get a sensible set of medical evidence that fulfils what is needed for the claimant and what is sensibly needed for the taxpayer.

A related example about how we are relieving pressure is the announcement we recently made about extending the professionals who can certify fit notes. We are acutely conscious of the pressure on GP services. We want to make sure that everybody is getting what they need out of the system and that is why we are in that case extending the types of professionals who can take part.

Q476 Chris Stephens: I want to turn to decision making and improving quality. Minister, the Department still loses the vast majority of appeals over PIP that come before tribunals and the most recent data available on ESA appeals shows the same pattern. The last formal research the Department carried out on tribunal losses was in 2012, before PIP was introduced. Would there be value in repeating similar research now so we can establish what the Government have learned so far and changes in policy?

Chloe Smith: I am pleased that you are looking at this because we, too, take this extremely seriously. We were able to start taking some actions from the research already carried out, and perhaps it might be helpful if I work through what those actions are and then where we think that places us today.

That research in 2012 was a pilot scheme where tribunal judges provided DWP with high-level reasons for the overturn of decisions. That was absolutely invaluable in helping the Department to identify the main categories of reasons why decisions are overturned at appeal. Following that pilot, the Department now routinely collects information on the reasons for PIP decisions being overturned at appeal and this information obviously then gives us insight into trends, which is very important.

I can state quite clearly, sitting here today, that we know that the main reasons that decisions are overturned on appeal are threefold: first, tribunals drawing a different conclusion based on the same evidence; secondly, cogent oral evidence provided by the individual; and, thirdly, new written evidence provided at the hearing.

All that insight helps us to make improvements to our decision-making process. We have introduced a new approach to decision making at both the initial decision and the mandatory reconsideration stage. That is what we have already touched upon, giving decision makers more time to proactively contact customers where they think additional evidence will support the claim. A similar approach applies at the appeal stage as well.



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What has that new approach resulted in? It has allowed for a greater proportion of decisions being changed at mandatory consideration, which in turn has contributed to a reduction in the proportion of decisions resulting in an appeal being lodged. By way of evidence on that, only 7% of initial decisions made in 2020-21 have seen an appeal lodged against them, compared with 9% in the previous year and 10% three years previous.

We have used that 2012 research and have gained insights. We have applied those insights to what we are doing and we have made improvements. There will be more to do, but I hope that gives an overview of how we have responded and where we now stand.

Q477 Chris Stephens: In the last five years the number of DWP benefit decisions appealed has fallen quite considerably, but the success rate has risen from 55% to 70%. It does look like the Department is not learning much, doesn't it, Minister?

Chloe Smith: There is some broader context to give about the success rate of appeals overall, but Katie may wish to come in on this.

Katie Farrington: Yes. Shall I share that data if that is helpful, Minister? Across the lifetime of PIP, we have had about 9% of decisions go to tribunal and a bit more than half of them successful, so that is 5% overall. For ESA, it is similar but it is slightly lower, so 3% going to appeal and again more than half successful, so 2% overall. Within the context of the benefit, these are quite small percentages.

We absolutely want to learn the lessons and put them into everything we are doing, particularly as we design the new health transformation programme, and make sure—and the Minister has described this a little bit—that as early as possible in the process we are helping customers to understand what evidence we need to make decisions, with a view to trying to get the decisions right the first time for the customer.

Q478 Chris Stephens: All right, but that does not explain why in the last five years the number of appeals has fallen quite considerably but the success rate is going up from 55% to 70%. What has been going on in the last five years to explain that?

Katie Farrington: What we have been trying to do is to look through the journey of the process. What happens at the beginning? What does the decision maker do at mandatory reconsideration? What are the lessons learned from mandatory reconsiderations, which we feed back monthly to providers? Then, as the Minister has described, what are the lessons we can learn from the cases that are overturned at tribunal and how can we constantly improve our processes and build that into the design of the new service?

Q479 Chris Stephens: Minister, I think you said that one of the reasons for appeals was oral evidence. Is this oral evidence that is given at the first assessment?



Chloe Smith: It would be given at various stages in the process, but that statement is relevant to the reconsideration and tribunal stage.

Q480 **Chris Stephens:** It supports recording for all interviews, doesn't it? It also probably supports the submission of written evidence. It probably supports the question I asked earlier about assessment reports being given to all claimants as part of a default. I think that we would like to see some more objective research and analysis published.

If I can turn now to the work capability assessment outcomes, what is preventing the Department from publishing data on the outcomes for Universal Credit claimants on work capability assessments?

Chloe Smith: The Committee will have seen the note that the Secretary of State sent to the Chair following his letter in June. She replied on a number of points around data. As you will know, she explained that there are no plans to develop the official statistics on Universal Credit claimants going through a WCA. We will be keeping that position under review, but as she said very clearly, she anticipates that there will be fewer resources available and will not be committing to developing new statistics at this stage.

Q481 **Chris Stephens:** Dr Geiger in his evidence to us described the Department's failure to publish work capability assessment statistics as unacceptable, and said that it makes it difficult to tell whether and where problems may exist in the system or where improvements have been made. That seems to me to be a compelling reason to publish. Minister, what is a compelling reason for not publishing?

Chloe Smith: I have emphasised the reason that the Secretary of State has already given and I don't have a great deal to add to it. I appreciate the point that the professor makes, and the totality of the evidence that this Committee has taken, including what the professor has had to say on a range of things, is extremely helpful. That said, I do not think there is a great deal I can add to what has already been said. We have to take a broad overview across all the effort and resources that need to be deployed on the various functions, only one of which is the production of data. I think the Secretary of State's letter provided to the Committee had that good overview.

Q482 **Chris Stephens:** I am sure that the Committee will take a view. This is my final question to you on this section. Earlier this month the Department published a large amount of data and contractual targets for PIP assessments in response to a parliamentary question. Can I ask why the Department chose that route rather than, for example, publishing that on GOV.UK?

Chloe Smith: I am always delighted to be held to account by Parliament and to answer parliamentary questions. That is a vital function of what a Minister does. Would you like to go into that data? We are here and ready and happy to do so.



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Chris Stephens: Yes.

Chloe Smith: What would you like to ask about that data?

Chris Stephens: The issue is, Minister, that it chose a parliamentary question to release that data, not on GOV.UK, so how does that fit in with the much-vaunted principles of openness and transparency that we often hear about?

Chloe Smith: The data were published. I am not going to enter into an ongoing row about the way in which it is done. The data have rightly been published in answer to a PQ, perfectly normal procedure, and we are happy to go into a discussion of that.

Q483 **Chair:** If there was to be a parliamentary question about how many work capability assessments have been undertaken by people applying for Universal Credit, would that question be answered?

Chloe Smith: That is an excellent hypothetical from the Chair. I would consider any question on its merits.

Q484 **Steve McCabe:** Good morning. Can I clarify one point before I go on? Do the figures that you quoted of the 5% and 3% at the tribunals include the tribunals that are abandoned because the Department decides not to offer any evidence when it gets to that stage?

Katie Farrington: Those are the overall figures. We do include what I think you are calling—are they called lapsed appeals?

Steve McCabe: I think it means the same thing.

Katie Farrington: Yes. We have made quite a lot of improvements to our processes to make sure that we are making the right decision as early as we can.

Steve McCabe: I only ask because it could give a different impression.

Katie Farrington: Yes, what I have given you is the—

Q485 **Steve McCabe:** You know as well as me that what actually happens is that people wait a long time quite anxiously for these tribunals and they sometimes turn up and then the Department decides not to pursue it. I have had a lot of constituency cases like that. It is purely why I raise it.

Katie Farrington: Generally, the approach we want to take is to make the right decision at the beginning and then through this process, through the stages, if we can correct the decision as early as possible through the appeal process.

Steve McCabe: I am not disputing that. I ask because when you said it, it struck a chord with many cases I have dealt with.

Chloe Smith: Briefly, there is a great deal of procedure around how the lapsing is done. It should not be the case that someone is taken by



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surprise by that. There is a great deal of communication that goes on with the claimant. If helpful, we could follow up to describe how that is done. It should not be the case that somebody turns up and is taken by surprise.

Q486 Steve McCabe: I think it would be good if there was an explanation. It would be great for me to have it in the office for my staff to refer to. I don't know if I am the only one in the Committee, but I certainly have this impression that it is quite common for people to turn up and be told on the day. I am seeing a couple of people nodding. That would be helpful, Minister, thank you.

Anyway, I wanted to ask a little bit about the health transformation programme. You touched on it in your opening answer. Your predecessor said in July 2020 that in developing this new service the hope was to create a transformation area, a defined part of the country, where these things could be tested out. You mentioned Kent earlier. Is Kent the transformation area or is there more than one?

Chloe Smith: No, it is a different thing, including Birmingham, you will be very pleased to know.

Q487 Steve McCabe: Yes, I heard Birmingham mentioned, but I was not quite sure what Birmingham was being used for. First of all, is there a transformation area or has that idea been abandoned?

Katie Farrington: Yes, there is.

Q488 Steve McCabe: Where is that?

Katie Farrington: At the moment Marylebone and Birmingham, and then we are looking to expand to—

Steve McCabe: The whole of Birmingham?

Katie Farrington: No, it is a set of postcodes within Birmingham. If you or any of the Committee want to come and visit either of those sites, we would be very pleased to—

Q489 Steve McCabe: As a Birmingham MP, I would be very interested because I did not know about it.

Katie Farrington: We would be very pleased. It is a set of postcodes within Birmingham. Would it be okay if I said a bit more about the health transformation programme and where we are?

Steve McCabe: Please do.

Katie Farrington: We have three elements to this programme. The first element Gill has talked about already. We call it FAS, the functional assessment service. These are contracts where we are taking the assessments that are currently being offered separately around the country and we are bringing them together in a single geography, so not one assessment but one provider in every geography delivering the



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different assessments. That is the first element. We are in a contractual procurement process on that element, which we expect to conclude later this year.

The second element is the IT platform to support that. We call it FAS IT, functional assessment service IT. The contract for that has been awarded.

The third element is the element you are talking about, the departmental transformation areas that would support the health assessment service, HAS. At the moment, we are quite small scale in the sites that I have mentioned. I am very happy to tell you which specific postcodes in Birmingham and very much welcome you. The team there is just looking at the process in detail to see how we can offer the service differently. For example, we are co-locating our case managers with clinicians, and the feedback from the case managers and the clinicians is that they are finding that helpful. We are experimenting with the way we offer appointments. Rather than sending out an appointment three weeks in advance, we are inviting the customer to ring up and book an appointment where they wish. We are also looking at the channels, so what method of assessment the customer would like. It is early days, but we are very happy to welcome you.

Q490 Steve McCabe: I would really appreciate that. I am very grateful for that. I also understand that it is early days, but if the Minister hopes to have a White Paper ready some time from September onwards, it is not that early; this is July. I am interested to know. I appreciate that it is ongoing work and I am not trying to be clever here. I am curious about it.

One thing struck me that I was a bit surprised about and had not appreciated. I noticed that RNIB in evidence, I think in response to the Green Paper consultation, said that there was not any provision for completing a PIP application process online and that the form can usually only be submitted in handwriting. Is that accurate and has anything changed or has anything been changed in the pilots we are talking about?

Chloe Smith: This is something we are working on. We are working on a digital application process for PIP. I think it is essential for the very reasons that you and the RNIB and many others describe and for the benefit of the people on whose behalf the RNIB is talking. That work is being taken forward by the health transformation programme. It consists of various strands and milestones in its own right, which we can either go on to more here or, again, provide more information to the Committee. Yes, we want to be able to reform the PIP process so that it is digitalised.

Q491 Steve McCabe: Minister, on that, I accept that it is early days but is that something that you have a notional timescale around? Is that something that you will be—

Katie Farrington: Shall I answer this? Yes, exactly as the Minister is describing, we have started what we call "PIP Apply", an online service. We started it in small scale in January of this year. We have taken small



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numbers of claims and then we are building up gradually. Exactly as the Minister says, we think this is an essential part of the future service.

Q492 **Steve McCabe:** Is that available in Birmingham in these postcodes we talked about?

Katie Farrington: It is a national service. Let me come back to you on the—

Q493 **Steve McCabe:** You see, I am trying to find out about this. I am not trying to be clever with you. How are disabled people currently involved in the development and evaluation of the health transformation programme? I think that was one of your big objectives at the outset as well, wasn't it?

Katie Farrington: Yes. We are working with disabled people in various ways. We are working particularly with the stakeholder representative groups, whom we meet regularly, and we are working with the customers who come through our service. One of the essential things—and this is why it is helpful to have the departmental transformation area—is that we can use that and do quite a lot of good user research with our customers to find out their experience of the service.

Q494 **Steve McCabe:** Would you have an idea of how many of the stakeholder groups you are working with? I am just looking at the numbers who replied to your thing. I wondered how many you think you are working with at the moment. Do you have a list that you could send the Committee?

Katie Farrington: We could definitely send a list, yes. We are working with large numbers of the groups. I know that some of the organisations that have given evidence to this Committee have talked a little bit about their involvement with that process. Yes, we are very happy to share that list of groups.

Q495 **Debbie Abrahams:** Good morning, everyone. We have heard in the evidence that has been submitted to the Committee about the issues that the health assessment process has in the work capability assessment and PIP. We have also heard from academics about the real issues that there are with both of those health assessments. Thinking about the data, which I think we have discussed before—certainly I have with the Secretary of State—the number of people who are dying after being found fit for work was 274 a month back in 2019, and it may have changed since then, and similarly for people who have been refused PIP, 60 dying within six months. We heard from Professor Barr that when people were being reassessed between 2010 and 2013 there were 6,000 additional suicides. It is quite clear from that stark evidence, as well as the qualitative evidence that we have seen, that the system is not working and it is not fit for purpose. In fact, it is actually doing harm. Is that the conclusion that you have also reached?



Chloe Smith: I welcome you asking these questions, Debbie, and the evidence that has been submitted to this Committee because it shines a light on a very important area and I wanted to discuss it with you very seriously this morning.

I know that we would all agree it is always tragic when a person dies and in this context when that occurs having been in receipt of benefits or in contact with our Department. We are extremely conscious, as Ministers and supporting officials, that people interact with this Department at some of the most challenging moments in their lives, often in very difficult circumstances, so it is absolutely incumbent on us to do everything we can to make sure that those interactions are well supported and that we get them right.

For us, this means learning lessons when we could have done things better and then continually improving what we do. We think that some of the most important ways of doing that are about how we identify and support people who are most vulnerable. If it is of help to the Committee, I would quite like to start here by talking about some of the ways in which we have done that because I hope that then gives rise to better outcomes and better results for people.

Q496 **Debbie Abrahams:** You gave some detail about the improvements you have made since 2018, so if you could just pick up on the key ones that would be great.

Chloe Smith: They are actually in addition to those points that I made at the beginning of the Committee. They are in a more specialised field. I am talking about the way in which we have improved the service that we give to people with mental health conditions. That includes mandatory mental health training for all new DWP telephony staff before they begin to handle calls from claimants. We are encouraging our staff to signpost the most vulnerable claimants towards support and to ensure that chances to flag concerns to agencies with statutory safeguarding responsibilities are not missed. That is, of course, essential.

We are ensuring that every jobcentre has a complex needs toolkit containing links to other local organisations that may be able to help and provide support. We are delivering wider training to all the work coaches and also to child maintenance staff to raise their awareness of related issues such as domestic abuse. We have a programme of advanced customer support senior leaders, and there are now more than 30 of those across Great Britain. Their remit is to reach across local communities to ensure that we have the right relationships and the right links with local organisations that, again, can provide support to our customers.

Overall, as I think the Committee will be aware, we have created a customer experience directorate focused on learning, with a team focused on supporting our most vulnerable customers. That directorate then links



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to the work that you are aware of in how we run our internal process reviews and the serious case panel.

Q497 Debbie Abrahams: Thank you. I have heard a lot of that before, yet just after we had the Secretary of State here a few weeks ago, data was published about the 140 deaths that are being investigated by the Department over the last three years. This has increased and obviously this is just the tip of the iceberg. From what I understand, the Department itself is not collecting and understanding the full scale of the deaths and the causes.

If we focus on the health assessment processes, one of the things that the academics we invited to the Committee last month focused on was the fundamental flaws in how the health assessments have been designed, structural flaws in that process, which are inherently negative in the impact that they have on the customers, as you call them—claimants, human beings, vulnerable human beings—who go through this process. They indicated that some of the disabled claimants that go through may not have had mental health problems before they go through the process but there is an increased risk of them developing those as a result of going through the health assessment process.

If I could mention very briefly, Chair, Dr Geiger said that the work capability assessment does not assess people's capability for work. It is set up to, "assess the genuineness of someone's impairment, but it does so without any transparency or any evidence base about the situations in which it overrules people's accounts of their own lives". It is inherently calling people out, "You are saying this but we don't think that". It builds up this conflict just in how it is designed.

He mentions a similar thing for PIP, which is meant to be there to provide additional financial support, recognising the additional costs that disabled people face, but it doesn't do that. There is again academic evidence that it is actually driving people into poverty, although I understand what you are saying, that more people are in receipt of support because we are an older population and that will happen, unfortunately.

On this basis, and this is something obviously that the Committee has to determine, there are clear indications that the process itself is fundamentally flawed. What are you going to do about it? Is this being addressed in the pilots that you have going on in Birmingham and elsewhere?

Chloe Smith: It is a very good question and I acknowledge all those arguments and, again, have taken time to reflect on the evidence that this Committee has had from the academics and from other sources as well. Indeed, I have spent time meeting with people and listening to them about this. For example, Rethink Mental Illness is an organisation that I have had a very similar discussion with on the back of reports that it has published recently.



The themes that you allude to, Debbie, are ones that we will be able to say a lot more on in the White Paper. As we said in the Green Paper, we want to be able to improve our assessment processes, of course, so that people have greater trust in them. We think that there are a number of things we can do to increase the transparency, some of which we have touched on this morning and, as I say, which we will be able to bring forward in more detail in the White Paper. Fundamentally, we want to get people the support that they need without it being in a situation of conflict or stress. Just as you describe, Debbie, we do not want that any more than anybody else wants that. We will be able to say more on the overall system improvements that we are looking to make in the White Paper.

We can also make improvements before we get to any stage of reform and we are doing that through the work of the serious case panel, which Katie sits on and may be able to add some more details on about what we are doing right now to improve things.

Katie Farrington: Thank you, Minister, I would be happy to add—

Debbie Abrahams: Very briefly, if you could. I have one more little question after that.

Katie Farrington: The Department has a serious case panel, as the Minister has described, attended by the Permanent Secretary and all of the directors general in the Department, chaired by one of our non-executive directors. We are looking at the system right now and at changes we can make. Some of the things that the Minister has described have come through that panel.

I will emphasise one that is particularly important and relevant to us, which is around stopping payments. We have made changes to the way in which decisions are made on stopping payments. As the Minister has described, we have these new advanced customer support senior leaders and they have a real role to play in joining up with the police and social services and supporting customers so that we make the right decisions.

Q498 **Debbie Abrahams:** The UK is an outlier in health assessments, according to the academics, who have done a huge amount in comparable assessments and analyses. The quote that stuck out to me is, "The UK system stands out as being particularly bad, causing particular distress". When we are looking at alternative models—the Danish and the Dutch model have been mentioned—they are very different. I think it is the Danish one that provides a wraparound service. It is a very holistic approach. That would need some investment but it is looking at the whole person, whereas the Dutch one is more about recognising and assessing people for work roles. Are they being considered?

When we visited Scotland we were impressed with the pilot that is going on there, particularly with a fundamental objective of the system for their new adult disability payment of developing trust between the claimant



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and the assessor. Something that is asked is, "Did you feel that you were treated kindly after going through the assessment?" Do you think this is what we should be trying to do?

Chloe Smith: There are always important lessons to learn from other countries and other systems. There are many ways in which I am working closely with my counterparts in the Scottish Government on the case transfer and also on other ways that we are serving our shared citizens. Of course it is a transitional scheme for now, but even after that particular benefit is fully devolved there will continue to be ways in which we have to work together for the very same people.

On the international side, there is a great deal of work going on to share experiences with other countries on how we support disabled people, not only through health assessments but on a broad range of points. I had the chance to do more of this when I was at the United Nations for the Conference of the State Parties on the UNCRPD in June. We will be following up with Denmark, and others besides, not just on health assessments but also, for example, on how we do occupational health, how we support people to start and stay and succeed in work and a range of other things to best support disabled people.

Q499 **Debbie Abrahams:** You are actively working with your Scottish counterparts. It would be interesting if we could have a note about the practicalities of that.

Chloe Smith: Of course.

Q500 **Steve McCabe:** I want to ask about your thinking around the advocacy service. You touched on it a little earlier. The easiest thing is to say: what work are you doing on this and where are you at at the moment?

Chloe Smith: I am very happy to do so. I think what we ought to do here is tell you a bit more about what we have been doing in Kent, and Katie might like to come in briefly about this as well. Essentially, we are doing what we spoke about in the Green Paper. We have been looking at doing that on a small scale. We are beginning to get some lessons back from it and there is more to do with that testing. Again, we will be explaining the full way forward in the White Paper. Katie, perhaps you could say what we are doing in Kent.

Katie Farrington: In paragraphs 87 onwards in the Green Paper, which I know the Committee will have had, we suggest various principles to test about helping people find information, providing practical support, delivering it in such a way that ensures and offers advice that people can trust, building on some of the comments we have heard, helping to make sure that we can help people to achieve outcomes and support to address wider issues in their lives, not just around accessing benefits.

As the Minister says, we have begun testing our advocacy service in Kent, looking at the types of support being offered and the types of



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people receiving it. We expect to come forward in the White Paper with more information on this.

Q501 Steve McCabe: At the point you come forward in the White Paper, are you anticipating that you will have a description of the advocacy service that the Department intends to promote?

Chloe Smith: Broadly, yes.

Q502 Steve McCabe: You mentioned the principles that are in the Green Paper. One of them is to help people achieve certain outcomes rather than being open-ended, which sounds sensible to me. How much do you think improvements in basic accessibility would mitigate the need for claimants to have this kind of additional support altogether?

Katie Farrington: That is an interesting question. One of the things that feels a bit relevant to your question is the help to claim service that we have been running in Universal Credit with Citizens Advice, looking at some of these very basic accessibility questions: how do you set up an e-mail address; how do you make your claim; how do you verify your identity? We have some useful learning from that that we should feed into the considerations in the White Paper.

Q503 Steve McCabe: I ask that because I took from the comment in the principles about achieving certain outcomes rather than being open-ended that you were trying to narrow and be specific about the kind of areas where advocacy would make a real achievable difference, but you were acknowledging that there must be some other things as well. I was trying to see where you were putting the weight on the two.

Katie Farrington: The other thing we acknowledge is that there are a number of organisations who work with customers to support them through this process, whether it is Citizens Advice or some of the charities I know you have taken evidence from. These are the principles we set out in the Green Paper. As the Minister said, we had 4,500 responses. People have commented on these principles and we will come back and say more in the White Paper.

Chloe Smith: May I add a point? It is something quite important to delineate here for advocacy and accessibility. They are not, of course, exactly the same topic and it might be helpful if we are clear. In my opinion, improved accessibility is essential and it is the right thing to be working on, but it will not reduce a need for advocacy entirely because not everybody with an accessibility need has an advocacy need and vice versa. Accessibility by itself may not be enough to support people with complex needs. They are different things and we should acknowledge that.

Q504 Steve McCabe: In the Green Paper, the set of principles says, "Evidence suggests that advocacy could benefit disabled people in particular". It goes on to say that it should not be limited exclusively to disabled people. In the Kent work, do you have a specific area of work where you are



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looking at disabled people?

Katie Farrington: The Kent work is focused on disabled people. It is focused on this group of customers. I think we should get some—

Steve McCabe: Is it exclusively focused on disabled?

Katie Farrington: Not exclusively, I don't believe, but we are targeting this group of customers because this is a piece of work that supports the Green Paper. We are principally looking at customers with health conditions and disabilities.

Q505 **Steve McCabe:** I am asking this because I am trying to understand how you are attempting to meet the principles that are set out in the Green Paper, and that was my curiosity about that. The last thing I want to ask is: if this advocacy service is developed, would it be available for all health-related benefits or would it be confined to PIP and ESA?

Chloe Smith: As Katie has explained, we are beginning our testing looking at customers who have health conditions or disabilities. We will then, in due course, set out how we intend to go further but, first, we are at a testing stage. We want to apply a test-and-learn approach rather than go wide straightaway.

Secondly, I think it is important to acknowledge the debate about universality, which is a different point from who is eligible. When I talk about universality I mean should everybody get an enhanced support service like this or should it be for those who have the most complex needs, regardless of which benefit line they have entered through. I am somewhat sceptical of universality in the sense that I recognise there is a need for advocacy to support people who are particularly vulnerable but I think we should acknowledge that more broadly the services of this Department do otherwise supply people's needs and that our customer satisfaction evidence that we spoke about at the start demonstrates that. I am somewhat sceptical of the universality argument that is sometimes made under this heading.

Q506 **Steve McCabe:** When do you think this scepticism will be resolved and you will have decided whether there will be—there are a lot of other benefits. I am thinking about things like industrial injuries, disability living allowance, a lot of other things where people say it is a bit of a minefield and they could certainly do with some support.

Chloe Smith: I hope I was clear. I was making two different points there.

Steve McCabe: Maybe it is just me having difficulty.

Chloe Smith: There was a point about which benefit somebody might be eligible for and then a point about universalism, as two different points that I hope I have been clear on. The answer to your question is that in the White Paper we will be able to set out the clear way forward.



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Q507 Selaine Saxby: What are you doing to reduce the stress and anxiety that people experience during the application and assessment for health-related benefits?

Chloe Smith: What a good question. There are a number of things, as demonstrated by the breadth of our conversation here today. I think all that we are talking about is the way in which we can get the right support to people as early as possible with, I hope, as little stress and anxiety as possible. As I acknowledged in discussion with Debbie, people turn to the services of this Department at some of the most difficult moments in their lives. It may be understandable that people are anxious and we want to reduce that as much as we can through how we work. We have covered a number of bases for that here today. The White Paper will take these themes further forward, I hope in a way that will bring it together.

Q508 Selaine Saxby: How do you check that the processes are not exacerbating people's health conditions?

Chloe Smith: There are a number of ways that we touch on that subject, although of course our service is not fundamentally a clinical service that is responsible for somebody's health condition. I stress that point.

We have a number of ways in which our assessment providers and our decision makers come into contact with somebody's health condition or the status of their health condition. One of the points we could have mentioned earlier was that if a member of staff in that process—particularly on the assessment provider's side—observes something or has concerns, they are encouraged to raise it with clinicians or with those who have safeguarding duties. Gill would be able to say a bit more about that, but that is one example of those touchpoints.

Q509 Neil Coyle: We have talked a lot about trust in this process this morning and despite the routine delays, the high error rate, the need for the Department to build a whole new mandatory reconsideration process since the contracts were first commissioned, and despite regularly and consistently not meeting key performance indicators, these outsourced contracts have been extended. What impact do you think that has on disabled people's trust in this process? Was that extension because there is no alternative?

Chloe Smith: I appreciate that there is a Labour party manifesto argument for in-housing everything, and I wonder if that might be what you are coming on to. I think that there is merit in using providers, just as a general point, the concept of doing everything in-house versus the concept of buying in expertise and capacity. There is a good argument for it. The statistics we referred to at the very outset of the session about the satisfaction levels or the service levels that are going on underline that it is absolutely reasonable to use providers.

Q510 Neil Coyle: And on the trust issue?



Chloe Smith: Again, the trust I hope is encapsulated within those statistics. If you have 70%, 80%, 90% of customers saying that they are content with the services they have, I think that is an expression of trust.

Q511 **Neil Coyle:** How much would it cost to bring the process in-house?

Katie Farrington: I wonder if I might say a bit more about this and Gill may wish to add something. Whenever we look at contracting we do a build versus buy assessment. Would it be better to bring it in-house or would it be better to go out to the market? Talking about the health transformation programme and this first element, the functional assessment service, FAS, we have made a judgement that the right thing to do is to go out to the market.

I do not have a figure for how much it would cost to bring them in. My sense is that we do not have a mechanism for in-house delivery of these services that is better value for money and more efficient than the external providers. If we did, we might have taken a different view on whether to contract for the service or not.

Q512 **Neil Coyle:** We have an assessment contract that is worth hundreds of millions. We have the contract management process in-house—DWP have to oversee that—which costs tens of millions. We have all the delays that that entails because any change the Department wants has to be filtered through in training and all the rest of it, costing tens of millions. We have the mandatory reconsideration process in-house costing tens of millions. We have the appeals process, because the system is not working properly, that costs tens of millions. We have this inefficient, slow, flabby process when, Minister, I think you said you wanted a quicker system with the most reliable decisions. That is not what we have. We need this sort of RAF Typhoon model and you have given us a Zeppelin. Are you seriously saying you could not do this in-house cheaper? Are you agreeing with Michael Gove's assessment that this Government cannot run basic processes?

Chloe Smith: I think that you are looking at an incomplete picture. If you look at, for example, the annual reports of this Department, or of any other Department, you will see that it takes a certain number of hands to be able to run services and a certain number of hands that we then spend on, in this case, what the welfare is. Those are the fundamentals of running the Department for Work and Pensions.

The costs you have just run through and illustrated would apply whether they were done in-house or out-of-house. You would still need assessment mechanisms; you would still want appeal mechanisms; you would still want all those mechanisms. That is the very business of running a Department. The business we are engaged in is trying to make those as good as they can be. I do not think, for the reasons I have given, in-housing is the silver bullet argument for that. There are a number of ways we want to make those processes better for claimants who are, in many cases, extremely vulnerable and in need of us doing



that job as well as we can, but I do not think the argument is particularly well made that in-housing is the silver bullet answer to that.

- Q513 **Neil Coyle:** When the Committee looked at this before we did not draw a conclusion, we did not say it should be brought in-house, but your point seems to be that the Department does not trust itself to do this better and more affordably than the current process. There is a comparator because we had a process before and that process did not cause a high level of appeals and did not have the mandatory reconsideration process. There is a direct comparison that was more affordable in-house. But the fact that you do not have faith in yourself to run the Department to deliver a more affordable, more effective process is a revelation.

Sitting here I think the focus should be more on what you call the customer wants. There is no market here; there is no customer. People cannot shop elsewhere if the Department for Work and Pensions fails. These are disabled people and vulnerable citizens who deserve a better system, but your lack of faith in yourself is a revelation.

Chloe Smith: You are characterising my words quite differently, Neil, than as I said them.

Neil Coyle: It is what I heard.

- Q514 **Debbie Abrahams:** A quick clarification. Minister, you just said that you thought that people's response to the internal satisfaction survey that you run is an expression of trust. Given our discussion a few moments ago when it was clear that that was the point that I was trying to make—obviously not very clearly—that is not there. There is a lack of trust, that is what is causing the anxiety, and partly also as a result of the transparency. Do you want to reflect on that and respond? Do you feel that people trust the system?

Chloe Smith: For me, this goes back to the discussion that we opened this session with. I would not dream of second-guessing what people freely tell us in response to those surveys. However, I absolutely acknowledge that there are people who have had difficulties with our services. I hope the broader answers I gave you go through some of the ways we are very seriously and substantially responding to those and trying to make improvements so that more people get the service that they require, that they need and that they deserve from this Department. But it is none the less a fact that, as I was saying at the outset of the session, something in the order of 750,000 people in the last year alone have received the services that they ought to from this Department.

- Q515 **Debbie Abrahams:** That is designed by you and delivered by you. Surely you would think that there might be a little bit of bias in that. The best way to deliver that will be to have independent, transparent data, would it not, and have that independently analysed?

Chloe Smith: There are a number of sources of data, and at the outset of the session we were talking about two different sources that related to a DWP survey but also via the assessment providers. But there are also a



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number of ways in which we have independent oversight of the Department. These are extremely important as well because I agree with the premise of your question. We want to be able to have independent oversight so that people get the best services. That is why we have things like the independent case examiner. That is why in the context of tragic deaths and harm we also have the involvement of the coroner, who is independent. Those are mechanisms that are very important in being able to create the overall picture, which I hope is one where people can get the service that they need as quickly as it ought to be done, and I hope will be able to have increasing levels of trust in this Department.

Q516 Chris Stephens: Let us continue the theme on trust. I noted your comments on outsourcing, Minister. Obviously Scotland is taking a different path, and I would certainly encourage other political parties to do likewise. Are you satisfied with the performance of the outsourced services that provide assessments? Are you satisfied with the performance?

Chloe Smith: I am. I will ask Gill to come in on that because she oversees this performance.

Chris Stephens: I am asking you, Minister, because I think this is important when it comes to trust. Are you satisfied and do you support the assessment services where a claimant with visual impairment is asked to read letters off a chart? Do you think that is acceptable?

Chloe Smith: I am satisfied with the overall service that is being provided by our contractors. I am satisfied that there will be, in short order, the next round of contracts that will continue to do the right thing by our claimants. If you give me an individual example where something has gone wrong, I want to deal with that through a robust complaints mechanism and I want to create improvements. We have spent a great deal of time this morning talking about improvements, which are a natural part of overseeing a system.

Chris Stephens: But you are the policymaker, Minister, so should someone with a severe visual impairment have to read letters off a chart at their assessment? Do you think that is acceptable? Do you think it builds trust?

Chloe Smith: I do not have the full details of that case so I am not going to—

Chris Stephens: It is cases, Minister.

Chloe Smith: I am not going to be able to comment on that specific case. It seems to me that there is something there that needs to be looked into—

Chris Stephens: It is widespread practice, Minister.

Chloe Smith: I am sorry, Chris, you are just interrupting me.



Q517 Chris Stephens: It is widespread practice that people with visual impairments are being asked to read letters off a chart. Do you think that is acceptable and do you think it builds trust between the claimant and the assessor?

Chloe Smith: I am going to take that example away and look into it. I do want there to be levels of trust between assessors and claimants and, as you are asking about a policy position, I can also say that these are the kind of themes that we will be dealing with in the White Paper. As you are also touching on operational matters, there are a number of things we can help the Committee with this morning about how we, right now and right here, are looking for that kind of improvement and performance from our providers.

Q518 Chris Stephens: Do you think that the assessors have the specialist knowledge on mental health conditions to carry out a reasonable assessment?

Chloe Smith: Yes, and we are ensuring they do by training and by many different methods of making sure they have the information that will keep them up to date.

Q519 Chris Stephens: Do you think the assessment companies have enough people with specialist knowledge on long, debilitating illnesses like, for example, multiple sclerosis? Do you think that assessors have the specialist knowledge on that to carry out the assessment?

Chloe Smith: Yes, I do. It is the same answer. We acknowledge that there is an absolute spectrum of medical conditions and concerns that need to be well understood. Having assessors who demonstrably understand and can also sympathise with the claimants will build trust. There are ways in which we do that; we have quite a comprehensive method of training and information on mental health and other conditions. We absolutely understand that we want to give people an assessment that is correctly responding to the needs of their condition and the functional effect that that has in their lives.

Q520 Chris Stephens: On the public engagement meetings, Minister, including the one a couple of weeks ago in Glasgow—the three examples that I have given you all came back from members of the public who had gone through the assessment services with visual impairments, mental health or with long, debilitating illnesses who say that they did not believe that the assessors had the specialist knowledge and that built up for them the high level of distrust in the system. I have to say to you, Minister, when members of the public say that to Members of Parliament at public engagement meetings we find it highly persuasive. What investigations is the Department currently conducting into ensuring that it is building trust in the system when we are receiving so much information at public engagement meetings, like claimants saying that they have huge distrust in the system?



Chloe Smith: Yes, I find this persuasive as well. I am absolutely determined to use that kind of feedback, alongside what we also had from 4,500 responses to our Green Paper, to improve the system. As I mentioned earlier, we will be able to say more about the concept of specialist assessment in the White Paper. That is because we have been able to reflect on exactly such feedback and what people have told us in a range of other fora as well.

There will be more to direct you to when the White Paper comes out, but the immediate improvements that we want to make I think reside in training and information, as I have been describing. That is how we can make sure that the assessment that might be taking place this afternoon or tomorrow is well equipped and able to help somebody.

Q521 **Dr Ben Spencer:** Building on the thing with trust, at the public engagement session that we did, I was quite concerned to hear evidence from the people who spoke to me about their perception that they were being covertly assessed as part of their PIP or WCA assessments. I will give you three examples that were raised with me.

One was there was water available at the assessment centre, the water cooler did not have any cups, but one down the corridor did. It was deliberate that the water cooler was broken or cups were not available to see if a person was able to walk beyond the first water cooler to get some water. Another one was that lifts were broken deliberately, seemingly to assess that people were able to use the stairs. One person described the assessor dropping a pen in front of them—I think it was a pen or something like that—to see if the person would pick it up as part of a covert assessment effectively of their mobility. Do you recognise this as part of the assessment process provided by companies?

Chloe Smith: In short, no, I do not. I am again concerned to hear about those examples. Katie might like to answer more on this.

Katie Farrington: I am concerned too. I think the assessment company said when it came and gave evidence before you that the individual assessors would look at the customer and how they present, how they walk, but would also be expected to ask more general open questions, "So I can see you are walking okay today, how do you walk on a normal day? How might it be on a good day? How might it be on a bad day?" I certainly do not think we should be in a place where people are going away feeling that the lift is deliberately broken or the water cooler is deliberately broken.

I think you are raising an important issue, about whether people have the right confidence in the process. The Minister has described that we are continuing to improve that, we are continuing to work to try to create as good a process as we possibly can.

Q522 **Dr Ben Spencer:** I am glad that you are both equally concerned by what I heard—and the Chairman was also on the same panel as me hearing



this evidence. Would you commit to urgently investigating this to confirm whether this is indeed an accurate reflection of practices that are going on at the assessments?

Chloe Smith: Yes, and if I may add on the example of the lift, I am also keen that all of our facilities are properly accessible. It would be unacceptable to have a deliberately broken lift so, yes, we will look into those.

Q523 Dr Ben Spencer: Secondly, and building on this point, I also found it quite interesting that when people were giving personal medical information to the assessors they felt quite violated and quite shamed. It was interesting for me that the content was not different from the sorts of discussions that people may have with their GP or their specialist but there was something about the assessment process where those discussions felt quite intrusive and quite shameful. It was a completely different narrative. I suspect that is probably because when you speak to your GP there is a doctor/patient relationship and you expect that your doctor is acting in good faith. There is this perception I think in this assessment process that effectively—and certainly that is the big feedback I got—the assessors are not acting in good faith. They are not on your side. This is the perception, that they are there to save having to pay money, to do what they can in giving you the score that leads to the minimum payment or support going forward. What is your response to that?

Katie Farrington: This comes down to the learning we need to make, to make a better system. One of the examples that we are looking at in these small-scale health transformation areas that I described is changing the way we ask the customer about the form. The person will have filled in the form about, “Can you wash yourself? Can you dress yourself? Can you cook independently?” and if the assessor asks exactly the same question, with good intent, sometimes the person on the receiving end of that might go away thinking, “They are trying to catch me out. I have already answered all those questions in the form, why are they asking me again? They do not trust me.” It could undermine the process.

One of the things we are testing, again small scale, is asking those questions differently. “Can you talk to me about how you cook? Can you talk to me about how you got up today?” It is a slightly different approach to the assessment to see if we get a better experience for the customer. I recognise that even if the assessor with good intent is asking the questions to try to secure the evidence to support the customer, it might be that the customer goes away with a different impression, as you are describing.

Q524 Dr Ben Spencer: What about using advocacy services? I know that we have spoken about advocacy more generally but, for example, patient support groups and so on for supporting or helping people go through the process or even doing an assessment in the first place. Since you are outsourcing, why not get MS support services, for example, to do the



assessments and support people through that?

Chloe Smith: There are ways in which—and I think we have touched on them in other conversations this morning—we are trying to get evidence in from any source that might be relevant. I think this is important, going back to your earlier point and Neil’s earlier point about not wishing to place reliance on the GP system, which has its own pressures. There are ways in which we can and should look at evidence coming in from such other sources. Whether that is quite the same thing as, if I understand you correctly, replacing the state’s assessment process with one operated by a different group needs a longer discussion.

Q525 Dr Ben Spencer: Do you currently have plans to carry out further reviews of the PIP-WCA systems, for example the descriptors and guidance in the assessment process?

Chloe Smith: We touched on this in the Green Paper. I have my Green Paper open here because there was something I wanted to mention to you under the previous point, which is about the employment and health discussion. The points made on page 53 may be something to look back to on what you were just asking about. On the descriptors, we asked these questions in the Green Paper because we were interested in whether there was a need for change and what the scope for that change may be. Again, we will come back on that in the White Paper.

Q526 Chair: On that specific point, can I raise with you something that Disability Rights UK said to us? It suggested that there should be a substantial health risk criterion in PIP, similar to the one that is in ESA, so that the Department could pay PIP to people who would otherwise not be entitled if there is a substantial risk to their health in not doing so, not brought out in the assessment. Is that a specific point that you are thinking about for the White Paper?

Chloe Smith: Have we looked at that with DRUK? It is not one I am personally familiar with but officials may have gone into it.

Katie Farrington: We meet DRUK regularly. The issue here is about the different purpose of the different benefits. The WCA is principally about work, your ability to work, whereas PIP is principally about helping people to live an independent life and the additional cost. Yes, as the Minister is describing, we asked questions in the Green Paper about the descriptors and we expect to come back in the White Paper. Of course we will be talking to DRUK as we continue to do that work.

Chloe Smith: Why don’t we offer to look at the specific point that they have raised?

Chair: We would certainly be interested to know what your conclusion is about that. Minister, thank you very much, and your colleagues as well. Thank you all for joining us. You have given us very full answers to our questions. We hope to publish a report of our conclusions about all of this probably about the same time as the White Paper, by the sound of it. I



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am not quite sure whether we ought to think about the timing of those, but we will certainly be very keen to see the White Paper. Thank you also for offering to send us additional information on some of the points that we have raised.