

Work and Pensions Committee

Oral evidence: Safeguarding Vulnerable Claimants, HC 402

Wednesday 8 January 2025

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Members present: Debbie Abrahams (Chair); Johanna Baxter; Mr Peter Bedford; Steve Darling; Damien Egan; Gill German; Frank McNally; John Milne; David Pinto-Duschinsky.

Questions 1 - 58

Witnesses

I: Sophie Francis-Cansfield, Head of Policy, Women's Aid; Carri Swann, Welfare Rights Adviser, Child Poverty Action Group; Minesh Patel, Associate Director of Policy and Influencing, Mind; and Tim Nicholls, Assistant Director of Policy, Research and Strategy, National Autistic Society.

II: Dr Gail Allsopp MBChB MRCS FRCGP MSc, Chief Medical Adviser, Department for Work and Pensions.

III: Dr Antonia Dietmann, Chief Psychologist and Head of Profession for Occupational Psychology, Department for Work and Pensions.cript



Examination of witnesses

Witnesses: Sophie Francis-Cansfield, Carri Swann, Minesh Patel and Tim Nicholls.

Q1 **Chair:** A very warm welcome to this safeguarding vulnerable claimants inquiry panel. Perhaps the panel would like to introduce themselves.

Tim Nicholls: I am Tim Nicholls. I am the Assistant Director of Policy, Research and Strategy at the National Autistic Society.

Minesh Patel: I am Minesh Patel. I am Associate Director of Policy and Influencing at the mental health charity Mind.

Carri Swann: I am Carri Swann. I am a Welfare Rights Adviser at Child Poverty Action Group.

Sophie Francis-Cansfield: Good morning. I am Sophie Francis-Cansfield. I am Head of Policy at Women's Aid, a national domestic abuse charity for women and children.

Chair: A very warm welcome to you all. I will hand over to John Milne.

Q2 **John Milne:** There has been a lot of discussion about whether to introduce a statutory safeguarding duty to the DWP. Broadly, as far as I can see, the Department is, shall we say, less keen and external bodies are more keen on the duty. Where are you coming from? What do you think? Do you think it will be a net positive or a negative or what?

Sophie Francis-Cansfield: From Women's Aid's perspective, we encourage the implementation of a safeguarding duty. For us, there are three core reasons.

The first is that it would meet a number of the Department's actual objectives, particularly maximising employment but also improving people's quality of life. I think it is well evidenced that applying for an array of benefits, but particularly Universal Credit, is incredibly stressful and has an array of negative impacts on individuals, particularly survivors of domestic abuse, who have experienced all sorts of horrendous traumas. They talk about how applying for the benefit and interactions that they have had with jobcentres recalls but also mirrors the abuse that they have experienced from their perpetrator.

It would also tackle some of the culture that we have long known exists within the Department. We have had former DWP employees tell us that there is no incentive to be curious, understanding or compassionate about what a claimant has experienced. I think some of the discretion that work coaches have available to them, the combination of not having that curiosity or understanding and discretion shows that through the decisions they are making they are not necessarily putting in the appropriate tailored approaches to a dedicated claimant.



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Then more widely, when we take a wider government lens, the current Government have pledged to halve violence against women and girls in a decade. If we are not taking into account women's and children's experiences of domestic abuse and their very specific economic needs, we are not going to make progress in that. Organisations like Women's Aid and others have long called for the Department to do a general assessment of the provisions it puts in place on survivors of domestic abuse, whether it is putting in additional barriers to prevent them leaving, and that would be at no cost to the Department, even before a broader safeguarding duty is put in place.

Carri Swann: Child Poverty Action Group supports the imposition of a statutory duty as well. Is it appropriate to impose that duty on a body like the DWP? We say yes, given the type and magnitude of the power that DWP has in people's lives and the harm and, unfortunately, deaths that we have seen sometimes associated with the use of that power or the threat of exercising that power in certain ways. Yes, we see it as appropriate. Would it be effective is a much harder question to answer.

We are a charity that uses the law to help uphold claimants' rights. We generally support the DWP's obligations being put on a legal footing, a statutory footing, so that it is very clear to everybody involved what the rules are so that there is accountability to Parliament and the public.

What could a safeguarding duty look like? Again, that is a very difficult question and quite a nebulous topic. In our submission, we suggested four types of duty that already exist in other public bodies. I will focus on two of those. One is a statutory duty of disclosure, a duty on the DWP to disclose to third parties—for example, support networks and other agencies—when there is about to be a risk to a claimant. The other is a duty of inquiry or an enhanced duty of inquiry so that the DWP has to make certain inquiries, seek out further medical information, for example, before making certain decisions about someone's benefits. Those two duties, the duty to warn and to consult with third parties, we believe could be particularly effective.

The bottom line for us, I will quickly say, is that although accountability is so important, we can see the downside of simply holding the Government accountable after the fact. We think beyond a safeguarding duty there should be upstream changes to benefit rules that prevent these very acute situations and risks from arising. I hope I will have an opportunity to talk more to that later.

Minesh Patel: Mind supports the principle of a statutory safeguarding duty and I agree with lots of what Sophie and Carri have said. We see that for people with a mental health problem where safeguards are applied, that can often be inconsistent across the application process for benefits and inconsistent across different benefits. We think having a statutory duty would help to ensure more consistency in the process.



Similar to Carri, for us, if somebody is identified as having a mental health problem, that in itself should act as a trigger for gathering information to understand more about the needs of that individual, and working closely with third party organisations. I hope that we will come on to this, but we see real challenges with how information is perceived, the credibility of information from third party organisations, but that is important to build up a holistic picture of somebody's needs and what support and adjustments they may need when applying for benefits.

Tim Nicholls: It probably will not surprise people but, in principle, the National Autistic Society can see the benefits of a statutory duty. However, I have three caveats that probably line up fairly well with what we have already heard.

One is that it very much depends on how that duty is framed and how the definition of "vulnerability" is framed as well. If you compare it with some other statutory regimes such as in social care, the bar there is incredibly high. We hear day in, day out, from autistic people who are not able to get support when safeguarding concerns are raised. I am sure as constituency MPs you have probably also been in the situation where you want to refer people to safeguarding support and have found that can be a tricky situation. We need a system and a duty that does not rely on people being fully in crisis before it is triggered.

The second is paramount, which other people on the panel have covered well so I won't go into it, but it is what that duty leads to. A safeguarding duty and acknowledging someone's vulnerability in and of itself would be pointless if it does not improve someone's experience of the pipeline of applying for benefits.

That leads me on to my third bit, which is the importance of it being underpinned by a solid awareness of people's disability. When we ask autistic people whether they feel that assessors within the benefit system understand what autism is and whether they feel they are able to make the right decision about an autistic person because of that knowledge, we get a resounding no. We did a recent survey where 70% of respondents—it was only a very small survey—told us they did not feel that DWP assessors had a sufficient understanding of autism. That completely lines up with historic surveys that we have done as well. In 2019, we had exactly the same from a survey of 10,000 people. Before that, in the early 20-teens, we did a similar one, so this is not a new thing.

It is time that we made sure that there is a solid understanding of disability and of people's needs throughout the benefit system because that is the foundation upon which any framework around safeguarding would be based.

Q3 **John Milne:** Thank you. That is a pretty unanimous verdict. The Government have already committed to introducing a general duty of candour, which relates to some of these issues. Would you say that that would not be sufficient in itself? Do you think we need to go further?



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Carri Swann: I am afraid it is not an area of our expertise, but I note in the earlier evidence from the then PHSO last year his quite dim view of the duty of candour in the NHS and the efficacy of that duty. It would have to go further from our perspective.

Chair: Does anybody else want to answer that?

Sophie Francis-Cansfield: Unfortunately, we regularly see the Department not meeting some of its current responsibilities and duties, the candour but also its public sector equality duty. As the panel has set out, there is clearly an array of key issues within a further safeguarding duty to address the existing issues that have long been held. Unfortunately, what exists is not sufficient and we are seeing harm happening to vulnerable claimants regularly and daily. There is a clear need for further action.

Q4 **Steve Darling:** Tim has already slightly touched on this area. I would be grateful if the panel can unpack what they see as the pros and cons of having a clear definition of what “vulnerable” is. Clearly, the DWP does not have that definition at the moment. What are the pros and cons of that? Then I will have a follow-up question after that.

Tim Nicholls: I can start by expanding on that a little bit. On the pros, it can give certainty to people and at least give clarity around what the process should look like, which for appeals and enforcement and being able to make complaints is an important thing. At the moment, people are very unclear about what level of support they would get. As they go through the process the focus is more much on the outcome. Offers even around reasonable adjustments are patchy within the benefit system.

As an anecdotal example, when Universal Credit was first rolled out you were allowed to ask for a different process because it requires a phone call and many autistic people might find a phone call very stressful and find it difficult to engage with. There was a reasonably adjusted pathway, but it was not advertised anywhere. That meant it was not actually, in essence, accessible.

There are pros in giving certainty, but for cons it is important to acknowledge that we have a system that is under significant strain. Whether the system will be able to effectively meet the requirements of a statutory duty without significant work in getting the system right will be an issue. When I say that, the pro could be that it makes it clearer and the con is that it could make it unclear. It very much depends on implementation.

Minesh Patel: To build upon that, similar to Tim, a pro would be a more consistent experience for claimants. If you have identified certain circumstances, certain situations, that acts as a trigger for thinking about adjustments and support. On the flipside and taking mental health, vulnerability is an individual and personal thing. What that means for one person is different for another person, so it is having enough guidance in



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what vulnerability is but that should not supersede still having an individual conversation with somebody. Vulnerability may not be immediately apparent. A framework of vulnerability to guide the conversation may not cover everything. The wording and the support and training that sits around any vulnerability framework would be important.

Carri Swann: I will build on Tim and Minesh's list of cons. What we know is that the most vulnerable claimants might be the least capable of registering their vulnerability with the DWP. I think that Professor McManus made a similar point to the inquiry last year. We should not underestimate that when vulnerable claimants self-register their vulnerability and request adjustments or flexibility, those requests are often refused. It is not simply an inability to self-register, it is that self-registration attempts are not always accepted. That is a problem with relying on a vulnerability flag or definition.

We should not rely on frontline staff to spot vulnerability either. There are issues, as Tim and Minesh have pointed out, about labelling, requiring people to identify as something that they might not identify as, something that could be quite disempowering. There are also problems with having a definition that is too narrow to be usable or too wide to mean anything. When the DWP has attempted to define vulnerability, for example, in its guidance to PIP assessment providers, the definition has sometimes been so wide as to almost lose its meaning.

Our recommendation would be not to attach safeguarding measures to particular types of claimant but to particular types of decision or action in the benefit system. There are particular types of decision or action that we can see would place even quite a broad-shouldered claimant at risk. Switching off the whole of someone's Universal Credit award while you investigate them for fraud, for example, is enough to render any person or family vulnerable. If they were not before, that does not matter any more. As I say, we would attach it to processes, to decisions, rather than to types of people.

Sophie Francis-Cansfield: A lot of the points that the panel has covered are very valid and true. Minesh's point in particular around vulnerability is true in the case of survivors of domestic abuse. Carri's point around some of the most vulnerable touches on those particularly marginalised survivors who face additional barriers, particularly language barriers if English is not their first language.

A lot of the points that have been discussed around the challenges of having a definition of vulnerability have been covered, so I will point to some of the Department's work on becoming trauma informed and how that work is explicitly linked to an understanding of vulnerability. If some of the processes, applications and decisions were more trauma informed and there was greater trauma awareness across the Department, I think some of the challenges that survivors of domestic abuse and wider vulnerable claimants face would potentially improve. We would potentially



not see as much inconsistency or unnuanced interpretation of certain processes and applications that currently happen.

Q5 Steve Darling: Thank you. Sophie, you have nicely cued me up for my next question. I wanted to unpack professional curiosity. I know that when Ofsted is reviewing social care—and although this is not social care it is not a million miles away from dealing with people who face challenges—quite often the lack of professional curiosity and having a culture around encouraging professional curiosity is important, particularly if you understand the trauma-informed world. I welcome your reflections on developing a culture within the DWP when dealing with claims around professional curiosity to try to drive better outcomes for claimants.

Sophie Francis-Cansfield: As set out in my response to the safeguarding duty question, I think there is a real need to tackle some of the culture. As a former DWP employee told Women's Aid, you are not incentivised to understand or be curious about the wider situation of a claimant because there is so much focus on driving claimants into employment, even if it doesn't mean they will be in it in the long term because a suitably tailored approach has not been taken.

When we speak to our members and survivors of domestic abuse, their experience can range from something that I do not think any of us would necessarily think is a response to someone who is particularly vulnerable. We had a survivor who had fled her perpetrator when she was two months pregnant and further down the line she was in the jobcentre. She felt a little bit dizzy and asked for a glass of water and was told no, she was not allowed a glass of water. That is even the basics of human decency, not necessarily additional measures you would take for a particularly vulnerable claimant.

There is clearly a general wider culture but then the culture of not having curiosity. I think that has been found by pretty much all the organisations represented here, but wider think-tanks such as IPPR and other reports have very much found that.

Carri Swann: I agree with everything Sophie has said. I will add that giving DWP staff the benefit of the doubt—many of them are doing very challenging jobs for all the right reasons—what is stopping them from getting it right in every case? I point to the question of caseload and the time available to dedicate to individuals. In the inquiry's own survey of DWP staff, which asked a few questions about, "Are you able to follow safeguarding guidance?" and so on, timing and having the time to carefully follow guidance was the one area where staff most strongly disagreed and said they did not have what they needed. There is clearly a gulf between what the guidance says should happen and what happens in practice. If we are looking for root causes, it is not my place to speculate—I do not work at the DWP—but time to dedicate to people seems as important as new guidance, new training and other measures.



Minesh Patel: To build upon that quickly, one thing that would help is making more decisions based upon a paper assessment. You have enough information there to determine whether somebody is entitled to benefits, what that award is, rather than making them go through a face-to-face assessment. We saw a lot of that during the pandemic and I think in the White Paper there is a willingness to explore doing more of that. That would help to then free up more of the time of work coaches to give more in-depth, holistic, personalised support to people for whom there is a need for face-to-face assessment.

Tim Nicholls: Not bringing in people for face-to-face assessments when they are not necessary is very important. The other thing that can be unnecessary is too frequent reassessments. Autism is a lifelong disability. While your needs may change throughout your life, for many people they will be relatively stable and they will be in the same situation for a number of years. To have to come back every two or three years is placing a burden on them and the system that could be avoided.

I very much agree with what the panel has said about professional curiosity. If we are looking at something like a duty of candour or just incentivising people, it will not work. The issue is that we have a system that is very robotic, essentially, and fundamentally un-person centred. That does not give space for professional curiosity. It does not allow any space. If you are looking to improve professional curiosity, a lot of work needs to be done around making the rest of the system work better. I think that point has been well made by Carri and Sophie.

Q6 **Johanna Baxter:** Good morning. How easy or not do you think it is for vulnerable claimants and those who support them to access the additional support measures that are available to them by the DWP?

Carri Swann: First, there is a question about how they can find out what these measures are. It has been said by other witnesses previously that it is not easy. The guidance and the information is quite piecemeal. It can be not in the public domain; it can be internal guidance. It can take a well-resourced expert to find the answers to what are quite simple questions about what support should be offered.

In 2023, I wrote a "Mental Health and Benefits" handbook, which I will wave at the Committee, with an author from Mind. We wanted to include a chapter on the additional support available in the benefit system. From the footnotes to that chapter, you can see how many sources we had to consult to answer what should be quite simple questions. In our submission, we called for a single safeguarding summary on gov.uk that could be accessed by claimants and by the people and agencies supporting them.

Looking at the flexibilities and additional support measures consistently applied, the short answer is that they are not, unfortunately. We have evidence of that from our work collecting case studies from benefits advisers. Our early warning system project, as it is known, has collected



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10,000 or more case studies now about issues in the benefit system. A lot of those are about these additional support measures not being applied when they should be.

Minesh Patel: I have similar points to Carri's. It can be quite fiendish and difficult to understand what support is out there. Mind has a national organisation and then over 100 local organisations that work directly with people across a range of issues, providing help and support. What we hear from local advisers is that when they are supporting people with their benefit claims, it is often when people are at the point of crisis, distress and really struggling. It can often be an independent adviser or a member of the local staff knowing what language to use; for instance, talking about the Equality Act and the duties of the DWP under that Act can kick things into motion.

It should not get to the point where you are using certain language and phrasing to get the support you need. It should be baked in and clear from the start, ultimately a system that offers choice and support from the start and then provides additional adjustments along the way. We observe that when you use the right language that can sometimes change things, but it should not be that way.

Tim Nicholls: The direct answer to how easy it is for claimants to get additional support, from what we hear, is that it isn't. Quite simply, they are not able to access it. In that small survey that we ran recently, almost all people, 97%, told us that it was either somewhat or very difficult to navigate the assessment process. While that is not a direct answer to your question, it points to the fact that they were not necessarily able to access the support they needed to make a claim. For some people, that will be because their first interaction at the front door has been particularly bad and they have either not got the information they need, had a very stressful experience or simply have not been able to get in.

To use a very real example of a young guy I heard of a few years ago, he had gone to the Jobcentre Plus to ask for support around his benefits. He is autistic. Making the journey in itself was stressful. His way of coping with the journey was hood up, headphones on to block out some of the sensory overload. When he walked in through the door of the jobcentre, the security guard told him to take his hood down. He had his headphones on. The security guard reached out and grabbed him and that was extremely difficult for the autistic person. He had a meltdown right there in reception. He was unable to then go in and get the support that he needed.

That is just one example, obviously, but there are so many different ways in which the first interaction at the front door can further render someone vulnerable or disable them from gaining the support that they need.



Sophie Francis-Cansfield: I agree with what everyone has said. It is not easy. When we have engaged our members on this, they have said they do not find that it is proactively offered.

Minesh touched on language. Particularly for our by-and-for member services, particularly those supporting black and minority survivors, the fact that often information is not available in any language other than English, the fact that we are not making it available in multiple common other languages—there is a pamphlet on the access to wider support that talks about access to BSL, but that pamphlet is not available in anything other than English. It is slightly contradictory to talk about wider accessible versions in an inaccessible document. There is no large print or other formats. For particularly marginalised individuals, we are making it incredibly challenging with language and communication barriers.

Q7 **Johanna Baxter:** That brings me quite neatly on. I was going to ask you about the pamphlet that was published in March 2024 on the additional support for DWP customers. Is that the pamphlet you were referring to?

Sophie Francis-Cansfield: Yes.

Johanna Baxter: That in itself is not available in other languages?

Sophie Francis-Cansfield: The online version is just available in English. More broadly, even as someone navigating it as a professional, it is hard to separate out what directly a claimant would be able to access versus measures the Department is undertaking more broadly in its work around vulnerable claimants. There is no contents page. If you were looking for information quite quickly, it would be quite hard to navigate as a document. Ironically, as I say, it talks about accessible versions within an inaccessible document.

Q8 **Johanna Baxter:** What is the view from others as to how helpful or not that pamphlet has been in trying to give people information about what support might be available to them?

Carri Swann: It is a brochure or a manifesto of the DWP's approach to safeguarding and some measures it has put in place. It is not structured. It is not in claimant-friendly language. It is not a guide. We would like to see a guide that people can use to look up particular problems.

Minesh Patel: I have no additional points to add beyond the fact that human interaction to understand what somebody needs is paramount, alongside any guidance and support that also exists.

Tim Nicholls: I think that last point is very important. If we are looking to a booklet to be the answer to accessibility, we are on a hiding to nothing. It has to be part of a wider system support and a culture change for all the reasons that the panel has already spoken about. However, when you are trying to figure out what support someone needs, you need to facilitate a good conversation generally. Not having that human element to it, frankly, puts all the onus on the claimant rather than the



system to navigate a system that is opaque, complicated and fraught with anxiety.

Q9 Johanna Baxter: If we put in place measures to improve communication about what additional supports are available, I am guessing that this will look very different for some people. Some people might be more comfortable looking to a guide rather than going in the front door. For others, it may be the opposite. How do you think the Department should square that circle in improving the communication with claimants about the support they can access?

Sophie Francis-Cansfield: One way would be to directly speak to people who have experience of the system or have experience of different vulnerabilities. For me, something that is also lacking in the brochure or pamphlet is the fact that it does not signpost to wider support. I would very much expect to see Mind and the National Autistic Society. I would expect to see those organisations listed alongside Women's Aid and homelessness charities. Claimants might be experiencing DWP directly. They might not necessarily have engagement with one of our services first before engaging with them. We hope that all Government Departments are signposting to the full breadth of support that is out there because they might not recognise their experience, particularly survivors of domestic abuse. We know how long it takes for them to leave and recognise their experiences, so we should be signposting at all opportunities. Those public-facing documents or conversations in a jobcentre are key opportunities for doing that.

Chair: We will have to speed up our responses slightly if that is okay, and I know that Steve Darling will set an excellent example in that regard.

Q10 Steve Darling: You have been helpful already in highlighting some barriers that claimants may face. Are there any barriers that you want to amplify or show to us that you are aware that claimants may be facing, particularly where their vulnerability may be exacerbated by the barriers that they are facing?

Minesh Patel: I will add one to begin with, and I will be brief. With the people we speak to with a mental health problem, there can be a range of challenges in engaging with the system, which I am sure are similar for other groups of individuals. That might be a real fear of receiving the brown envelope from the DWP, difficulty in understanding the information, challenges with the assessment method and type, but also when you are having a face-to-face assessment the trauma that can be triggered from talking about experiences relating to mental health or other conditions or impairments. That in itself can amplify somebody's mental health problem or even cause a mental health problem or mental health distress.

That leads me to the point I was making earlier about as much as possible trying to avoid a face-to-face assessment to simplify and



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streamline the process to avoid inadvertently causing additional risk or harm to claimants. That is specifically for mental health but I am sure that is similar for other conditions and experiences.

Sophie Francis-Cansfield: For survivors of domestic abuse, there are real, practical barriers such as lack of access to ID, either because their perpetrator has withheld it from them or when they had to flee they were unable to take it with them. That, of course, causes issues in setting up a bank account, making your claim and so on.

Other barriers, as I have touched on in previous answers, are language barriers and not having regular access to translators through the jobcentre. We know, for example, from our member Al-Hasaniya in London, which supports Moroccan and Arabic women, that the jobcentre just said it did not have budget for translators, even though it is part of its public sector equality duty. That then puts additional strain on frontline specialist services or it leaves survivors having to either make their own way through a claim and potentially miss out sections that they don't fully understand and then their claim is not continued or they are reliant on friends, family, strangers, professionals, and they might miss, again, key bits of information by the time it has reached them in translated form.

A final one from me is the lack of understanding of the psychological aspect of domestic abuse and how certain processes and stresses of going through different applications or reviews or assessments can mirror the abuse that they have experienced.

Tim Nicholls: I will briefly add two additional ones from the perspective of the National Autistic Society. The first is physical barriers around accessing Jobcentre Plus, for example, when you need advice. I have given one example of that already. We ran a good pilot with Jobcentre Plus before the pandemic on inclusion and accreditation, essentially. We piloted it with just over a dozen Jobcentre Pluses. The experiences of that were very positive, but the DWP has not been able to roll that out. I think that that would work for a wide variety of claimants, tackling the sensory environment, the physical environment and attitudes and understanding within the office.

The second barrier, as I think came out strongly in my first answer, is lack of understanding and awareness of autism and what autistic people may need. What that may mean for their day-to-day life so that you can assess their benefit situation is an incredibly important and significant barrier that people face.

Q11 **David Pinto-Duschinsky:** Thank you so much for your evidence. It is incredibly helpful. We have heard a lot about how vulnerable people interact with DWP and how the system can itself exacerbate, through its processes, some of the vulnerabilities that people face. My question then pivots to what we should do about that and I would like to focus on this. When developing new policies, how do you think DWP can ensure that it



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does not exacerbate vulnerabilities? How should the policy and procedure development process look? How should it look while simultaneously maintaining the integrity of the system? We appreciate that there does need to be conditionality and we cannot just do away with it and so on. How do you create a design process that strikes that balance?

Sophie Francis-Cansfield: Fairly succinctly, Women's Aid has long called for the Department to assess any change it makes to benefits or processes by the impact it has on a survivor's ability to flee and stay fled. Fleeing is incredibly expensive. Our "Price of Safety" report highlighted that on average it can cost a survivor £50,000 to flee. If they were able to access all the entitlements and benefits, which of course rarely happens, that would still leave a £10,000 deficit. For migrant survivors, that is a £20,000 deficit.

If we want to support survivors to flee for their safety and to stay fled and live stable lives where they are able to engage in employment, we need to be able to assess whether we are enabling them to flee. At the moment, because of the gaps in the system, we are very grateful to other Departments such as the Home Office, which is providing funding to the flexible fund, which is then making up for the gaps in the social security system for survivors.

Tim Nicholls: I would say that the biggest thing is to listen. Listen to the experiences of the people who are applying for benefits; for autistic and disabled and neuro-divergent people, listen to them in the creation of systems and policy proposals. That means going beyond typical government consultation. It means being open and honest. It could involve co-production and co-design. That would be the way you would shift to much better policy decision making that would meet the needs of people to a much greater extent.

The second thing to note is that many of the changes to the benefit system over the last 15 or so years have been driven by the bottom line. They have set out a financial target that they wish to achieve. There was one attached to PIP when it was first set up; it never met it because it was unrealistic. It means that you have the wrong incentives in the creation of the system. You will create a policy and a system that is designed to achieve the bottom line, not to improve people's lives. That is the wrong perspective to have. We need to look at what the objectives of policy are, and that will be important particularly as the current Government have said that they still anticipate making the savings that the last Government's Green Paper suggested but have not yet added the detail of how. That is all the devil in the detail there.

Carri Swann: I have two points. The integrity of the benefit system is such an important point. Rules come out of Parliament and we have to respect those. There are features that we cannot do away with in the benefit system. There will always be people who lose entitlement to sources of income. However, we also have to be able to spot avoidable harm, and I think that is the root of the question. We need to make sure



that internal process reviews and other safeguarding measures that the DWP already has feed into policymaking. They do not just feed back to operational teams who have perhaps made mistakes; they need to feed into policymaking. I do not think that is clear in their terms of reference at the moment.

Secondly, we need to do risk assessment in the way we do in so many other spheres. When we are producing a new rule or updating a scheme, we need to look at who it affects, what the magnitude of the risk is to that person or group and what the likelihood is of the risk. There may be a small likelihood but a very large magnitude if a risk materialises. We need to think about any new or reviewed policy that takes away income, particularly if it does that suddenly. As other witnesses have said, some of these policies make vulnerable people recount their own experiences or deal face to face or with professionals with whom they do not feel safe or comfortable.

Minesh Patel: I will add very briefly to what Tim and my fellow panellists have said on the point around listening and involving disabled people or people claiming and accessing benefits genuinely and shaping and co-producing the system. We welcomed the proposal in the Get Britain Working White Paper to create a disabled persons panel to shape the Department's thinking. We think that is a positive shift and a good start to build upon to genuinely ensure you have a feedback loop to inform policy decisions and not just the operational decisions, as has been said before.

Q12 **David Pinto-Duschinsky:** That is very clear. Thank you for that. DWP has talked about introducing a trauma-informed approach. Are you seeing these suggestions reflected in the trauma-informed approach? Are there any gaps that you think need to be addressed to improve its impact?

Minesh Patel: I will kick off with a point that has been raised several times. There is a big challenge with culture within DWP when it comes to assessments, a culture that is built around compliance and achieving the bottom line. Until we shift to a culture that is built around compassion, genuine engagement and believing what the individual is saying, that will undermine the good intent around trauma-informed approaches. That is quite a big concern for us at Mind, genuinely ensuring we are thinking about trauma when having conversations with people about benefits or employment.

Carri Swann: On the operational side, I am cautiously optimistic about a trauma-informed approach, but again I am thinking about the conflicting pressures on staff. Do they have a conflicting incentive to do something else? Do they have time pressures that mean they cannot put their training or their guidance into practice? On the policy side, will the trauma-informed approach feed through to policymaking? We have not seen that yet.



Sophie Francis-Cansfield: I agree with what Minesh and Carri have said.

Q13 **David Pinto-Duschinsky:** One very specific example of where these things could bite, where the rubber could hit the road, is in the managed migration of people currently on ESA and other forms of benefit to UC. Carri, I know that CPAG has talked about the fact that this migration poses serious safeguarding concerns, and you have laid some of them out. Could you touch on those concerns? Specifically, could we also touch on to what extent the enhanced support journey might mitigate those concerns and what needs to be done to make sure it does?

Carri Swann: Our major concern with managed migration is that it has been designed as a mass benefit switch-off. Claimants are being required to actively claim their new replacement Universal Credit benefit and their legacy benefits are then being switched off, rather than claimants being automatically moved from the old to the new, which was another choice open to the DWP and was not taken. That has created a risk. That is one of the avoidable risks I referred to earlier.

Other decisions have been made along the line that have done nothing to mitigate that risk. For example, we have seen scaling up of managed migration without robust evidence that it is safe and that the safety measures I will come on to are strong enough. We have also seen that the planned closure of the move to UC programmes, the policy side of managed migration, is this March, so at the very height of the move of ESA claimants, some of the most vulnerable in the system, to Universal Credit. Again, I think those decisions have done nothing to mitigate the risks.

You have mentioned the enhanced support journey, which I think is DWP's main concession to safeguarding in managed migration. The shortcomings of that journey are, first, that it does not apply to everyone. It applies to a subset of claimants, ESA claimants and some income support claimants identified by the DWP as particularly vulnerable, but we don't know how that identification takes place. Secondly, it is called a support journey but it is really a journey of additional reminders rather than active support. Some claimants will, for example, get a home visit to help them remember that they need to claim Universal Credit and that the old benefit is stopping. That home visit does not include help to make that Universal Credit claim. We say that is a real shortcoming.

Finally, the end of the enhanced support journey is where a claimant who has totally failed to engage, who has not made their Universal Credit claim and has hit the deadline for the switch-off of their old benefits, the DWP can exercise discretion about escalating their case. However, what we do not know is what criteria it will use to decide whether to escalate. Perhaps if there were a statutory duty on the DWP setting out in more detail its safeguarding responsibilities, we would not be quite so in the dark about when escalation will and will not happen. At the moment, we



are in a situation where ESA claimants are being moved in very large numbers, hundreds of thousands, by the end of this year. It is a huge source of concern and a timely point at which to raise those concerns.

Q14 Frank McNally: Good morning, everyone. We have spoken a little today around the training that staff have. I know that a number of members of the panel have highlighted that staff may not be getting the opportunity to put that training into practice. Training is an area I want to focus on in my questioning. The DWP has highlighted what it describes as a comprehensive training package for staff engaging daily with vulnerable claimants. Many of those will be multifaceted or complex. I am keen to get a sense from you as to how sufficient you believe the training for DWP staff is and if there are areas where there is a requirement for a much greater focus.

Tim Nicholls: To look at the impact of training, we have to start with the people who are going through the benefit system to find out what they think. The answer I gave to the first question about the number of people who do not feel that their assessors have a sufficient level of training being as high as seven in 10 suggests that it is not working.

What we might be looking at here is that, while I am sure the training package is sizeable and probably covers an awful lot of information, is it covering the right information? Over a series of years, the National Autistic Society has had some correspondence with DWP and providers around the scale and quality of its autism training. We have never been satisfied with the training materials that have been sent to us. We are listed as having been consulted in the development of them, but the extent of our consultation was to say that we are not satisfied and these need to be done again, just to put that on the record.

From when I looked at it, it was a lot of very clinical-style information. If we look at the types of assessments that people will need, it is about their day-to-day lives. There was very little information about that and how that might be an issue for autistic people, what support autistic people might need, what the struggles with day-to-day management of bills, getting up and ready for work or getting about might be. That is why, coming back to the previous answer I gave about how to do training properly, it is listen, co-produce, co-design. I think that would be the best way. You would end up with not only better satisfaction among claimants but probably much better satisfaction among the assessors in the workforce in DWP as well, who would feel that they are delivering a higher quality service and being in fewer situations where they feel out of their depth and unsatisfied with the information that they have at their fingertips.

Minesh Patel: I echo lots of what Tim has said. Training is not just a one-off thing. I think it needs to be repeated around mental health. We know that there are rising concerns around stigma about mental health. How to address the overall culture and training given to work coaches is important as well.



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Carri Swann: I have one point. Frontline DWP staff see so much, so many different people with different problems. One thing we would support is having in-house expert teams in DWP so that frontline staff, faced with a problem on which they have limited training, can escalate to an expert, someone with a higher level of training. From the evidence from advisers dealing with frontline cases, we are not seeing that happen enough.

Sophie Francis-Cansfield: I am wary when it comes to domestic abuse. This is an area that the Department has committed to regularly updating its training. I know that the Department refreshes its domestic abuse training six monthly. All staff get a refresher every two years and caseworkers get a mid-year check-in. On that basis, it is not the one-off approach that we sometimes see. As an amalgamation of the points that have been made, I agree with Tim that there is still a real need in what is included for there to be a greater focus on co-production and for that to be meaningful, not that you have been consulted and your name gets listed but you are not actually satisfied with the content and what is included.

As to what Carri said, there is so much and with all the other challenges that we have spoken about this morning, we think that while having champions and leads will not be the golden bullet, it is helpful in the wider challenges that exist. Having a domestic abuse lead in jobcentres would support with some of the breadth of challenges that they face daily and the issues that they are seeing.

Q15 **Mr Bedford:** Earlier in the session someone on the panel said that there was a lack of incentive to be curious. What are your views on how well the DWP engages with external agencies such as local authorities and charities, particularly with supporting vulnerable claimants?

Carri Swann: I think this is an area where there could definitely be improvements. I spoke earlier about the idea of a duty of inquiry, so the duty of the DWP to seek out information and views. I also talked about the idea of a duty of disclosure, so the DWP proactively going out and disclosing information about at-risk claimants. The DWP has guidance on both of those. There are reasons, which I will not speculate on, about why that does not always get applied in practice.

However, there are two points that our community of advisers tell us about that are particular problems. One is that if you are a third party trying to speak to the DWP about a particular case, you have quite limited routes in. There used to be direct forms of contact with the ACSSL group of professionals, so the advanced customer support senior leaders within DWP. For about two and a half years, stakeholders could refer cases direct to them. That option has been withdrawn and now stakeholder organisations are told to go through business as usual routes, so they have to knock on the same door as everyone else. Direct routes of contact with safeguarding teams would be so valuable for multi-agency working.



The second issue is around explicit consent for Universal Credit. Obviously, the DWP has huge data protection responsibilities, but it does have a choice about how it meets those. Previously, it has had a system of implicit consent, which allowed it to talk to bodies that could answer certain data security-type questions about a claimant. Now for Universal Credit it requires something called explicit consent. It needs the claimant to be there or the claimant to have put in writing their consent for their case to be discussed with this person. That system is not working.

Q16 Mr Bedford: As a follow-up question on that, you mentioned the need to have clear routes. How do you see those routes existing and being developed?

Carri Swann: In the past, there have been direct telephone lines into certain benefit agencies. HMRC, for example, used to have a direct telephone line for advisers and accountants to speak about tax credits and child benefit, shorter waiting times and straight through to someone who knew that you were a professional. An approach like that could be hugely valuable for multi-agency working between DWP and other organisations.

Chair: Thank you. That concludes our first panel. Thank you so much for a very informative session. Thank you for your time, and if there is anything else that you want to add to the evidence that you have submitted here, please let us know. Thank you very much.

Examination of witness

Witness: Dr Gail Allsopp.

Q17 Chair: A very warm welcome to Dr Gail Allsopp, who is the Chief Medical Adviser for the Department for Work and Pensions. Thank you so much for coming along to speak with us. I will kick things off. Could you explain your role and remit within the DWP, so that we understand more about that?

Dr Allsopp: First, I am a medical doctor and still work in the NHS as a GP but the vast majority of my time is spent at the Department for Work and Pensions. I am still on the frontline as a clinician.

I was appointed 16 months ago now, so I have been in the Department for 16 months. My role has three broad remits, and I think one of them—the first one I will talk about—is probably the most important for this Committee. I am the senior responsible officer for clinical governance across the Department. In the last 16 months I have come in and assessed the clinical governance, and we have put in place a whole new process that covers safeguarding. I think that it is probably quite important to talk about that.

I am also the professional lead for the clinical profession at DWP. There are 211 clinicians, as of today, who work across the Department. My role is to ensure that they are adequately qualified, making sure that they



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achieve their regulatory body status, and to bring the profession together so that we have a consistent voice across DWP.

The third part is I am the clinical policy lead. I have a team of the equivalent of 12 full-time clinicians who advise on policy changes from the clinical aspect but also then, once the policy is written, the implementation of that policy from a clinical perspective.

Q18 Chair: Can you explain a little bit more about clinical governance? I used to work in the NHS myself—a former NHS chair and public health consultant—so I have experience in that, but everybody else, including those who are watching, may not understand that.

Dr Allsopp: Clinical governance is a process of continuous improvement. The most powerful thing about clinical governance for me is that you never accept that you are at the gold standard. You are constantly being curious and trying to evolve the work that you do to improve things. Over the last 16 months we have aligned the clinical governance within the Department to that of the NHS, so following best practice.

There are seven pillars of clinical governance. These cover a multitude of things from the education and training of the healthcare providers who are undertaking the assessments, down to ensuring that we have service user involvement in the work that we do in making decisions and policymaking.

Q19 Chair: You mentioned that you are still working as a GP. How do you split your time?

Dr Allsopp: I am full time at the Department and I have one morning a week that I go into general practice in Derbyshire.

Q20 Chair: You were here during the first panel and you probably heard some of the comments from the previous witnesses. One of the things that struck me listening to that was the importance of a system-wide approach, that the safeguarding is important but there is the prospective analysis of how a clinical governance approach will be undertaken. For example, what is your role specifically in thinking about the work capability assessment and any changes that might be undertaken around that?

Dr Allsopp: From a work capability assessment perspective, my team works very closely with the WCA policy team. There are three members of my team who work specifically on the WCA clinical policy aspects and we do a number of things. When policy changes are considered or thought about they come to my team to talk about the potential changes and my team tend to do three things, and we focus everything on the effect on the claimant. That is the most important thing.

At the heart of every single thing that we do is how will these changes affect the individuals who are service users of the Department, not only in how the assessment will take place but also what the impact would be



on them as individuals. We often do case studies, for example, where we will write and bring to life the policy changes that are potentially being thought about in the Department, so that those who are making the decisions see the real-life people behind the policy decisions they are making. That is one thing we do.

We also think about how it will affect the healthcare assessors who are undertaking the health assessments, because that is important. If you are having a policy change and you are not able to roll it out because the healthcare assessors cannot do that within a consultation, it is important to think about that.

The third thing that we do is think about the impact on the wider system, particularly the NHS. I do a lot of cross-working across the Department of Health and Social Care and into the NHS, so that the changes we make or we think about making will not impact other services in a detrimental way.

Q21 Chair: Can I push you a little bit on that? Thinking about decisions that might be taken around specific policies, you have a team of 12; how many of that number would be involved in doing that prospective analysis of the health effects of a policy change?

Dr Allsopp: Most of the clinicians that work with me are part time, so we have a headcount of more people but it is the equivalent of 12 full time. It depends on the benefit line that is being worked on because they are all split across different benefit lines. If we are specifically talking about the WCA policy area, all three of them, as well as myself and some of the senior leaders in the team, will be involved in that. It depends on the policies that are changing.

Obviously if we are looking more at WCA we will bring more clinicians into that space but if it is more about PIP changes or the industrial injuries benefit changes we will move clinicians around into those spaces so that we have the right number of people working on the specific areas.

Q22 Chair: Can I ask you something that is very topical at the moment? Were you involved in the winter fuel payment changes?

Dr Allsopp: We were not involved in the winter fuel changes right at the beginning when the policies were being changed because it is not within the disability area. My role sits within the disability services area, whereas the winter fuel sat in a slightly different area. We were not involved initially, but I have subsequently been.

Q23 Chair: You do not cover all of the policy areas across the Department, just specific ones that relate to specific disability benefits; is that right?

Dr Allsopp: The biggest area that my team covers is the disability benefit services. We are looking at PIP, WCA, child, DLA, attendance allowance, the industrial injuries benefits. We also cross-work across the Department in other areas, such as our health transformation area where



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we are looking at prospective changes to policies, but mainly it is the disability benefit area.

Q24 **Gill German:** Welcome. Thank you for setting out the clinical governance work. The outline was helpful to get a better understanding of that. I will ask you more specifically about how your work feeds into safeguarding policy, in particular for safeguarding vulnerable claimants as we have been talking about today.

Dr Allsopp: Safeguarding is a really important part of my work, particularly from a clinical point of view. When I came into the Department 16 months ago, there had already been the beginnings of an external review on clinical governance. I came in and the report was issued in December after I had started, so about three months after I had started.

Looking at that clinical governance review, I have implemented every single recommendation. Some of those were safeguarding related. One of the immediate things I did was I appointed a safeguarding clinical lead for the Department. We now have a level 4 trained doctor working in the Department for the first time, which is an excellent addition. We have written a clinical safeguarding policy, which we share with our providers. The 4,500 clinical assessors that are out in the system also follow our safeguarding process.

We have changed the safeguarding training. Following looking at the report and talking to our educational experts, we have changed the mandatory training for all of our healthcare assessors. When the contracts changed over in September last year every single healthcare assessor—all 4,700-plus of them that work in the Department, within DWP but also in the assessment space—will now be level 3 safeguarding trained in both adult and children safeguarding.

I have also helped set up a cross-government safeguarding group because it is important that we learn from best practice across government. We work very closely with the Ministry of Defence, Ministry of Justice, Department of Health and Social Care, safeguarding leads as well, so that we are learning best practice and ensuring that we are rolling that out. We have made significant links with the NHS England experts who are helping to guide us.

Q25 **Gill German:** Are you confident that the health assessors are up to speed with what they need to know?

Dr Allsopp: When the contracts changed over, we launched our new clinical governance process, which includes the new mandatory training and it also includes the fact that we have taken over all of the education and training for the healthcare assessors now. There is a huge body of work to do.

We will give the providers 12 months, in the same way we would in the NHS, for people to come up to speed. At the moment everybody will be



level 2 trained, but by the end of this year they will be level 3 trained. We have developed a new digital dashboard, so all of the training will be monitored. We will be able to see compliance and track that in the monthly meetings that we have with the providers.

Q26 Gill German: As an additional question, we have talked about service modernisation, and of course the White Paper has been published by the Government looking at how we do things differently. How does your work impact on that, looking at the modernisation that might go ahead?

Dr Allsopp: My team will be involved in any changes that are put forward potentially with White Papers or Green Papers, as long as it is within that disability benefits area, and we will add our clinical advice. We are not the decision makers on those papers, of course—we are very much clinical advisers—but we will ensure that we have the clinical best evidence and best practice that we put in front of our Ministers and the senior leaders within the Department to help them make the decisions that they will then make based on the White Papers and Green Papers that come through.

Q27 David Pinto-Duschinsky: The previous Under-Secretary at DWP told the predecessor Committee that part of your role was to be responsible for reviewing all prevention of future death reports. Have you drawn out any trends or findings in this work?

Dr Allsopp: It was one of the first things that I asked about when I came into the Department and went straight to the team who oversee the prevention of future death reports. They are such important pieces of information that come from the coroner to make sure that organisations can improve. I have worked on them in previous roles in other organisations.

Not very many that come through to the Department. Finding trends out of prevention of future death reports is difficult with the low numbers that come through. However, as part of the clinical governance review, I set up a new clinical governance board. It is chaired by a non-executive director of DWP and it feeds into the governance structures. We have tabled this month—I think it is later this month or at some point at the end of the month—on our clinical governance board a summary of the prevention of future death reports that have come in over the last year where we will look to see if there are any trends identified. One of the decisions the board will be asked to make is how often we want those prevention of future death reports brought. The board sits every three months.

They go to our Serious Case Panel as well. This is an additional measure that we have put in place to start to look at those trends in addition to the Serious Case Panel that exists.

Q28 David Pinto-Duschinsky: When you say there are very few, how many is very few?



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Dr Allsopp: In 16 months I think five have come in. I have co-signed two of them. Two were already in train when I first started and there is another one in process at the moment.

Q29 **David Pinto-Duschinsky:** You mentioned they go to the clinical governance board and the serious review panel, but after that how does the Department use the findings that you produce?

Dr Allsopp: One of the things that I have been very keen to do in the clinical governance board is ensure that we are increasing our learning as an organisation. I have set two levels of clinical governance. The first one is the clinical governance board chaired by the non-executive director, which is a director level board that is cross-cutting across the organisation. It has our operations teams and policy teams within that, as well as other experts.

We also have a different level of board, which is more of an operational level board that also includes our provider organisations. Any learning that comes out of our clinical governance board is then passed to what we call our clinical policy expert group, our clinical policy sub-group. That learning is passed to not only the providers but also the operation teams and policy teams as well. We are trying hard in a clinical space to ensure that that learning is spread across the Department.

Q30 **David Pinto-Duschinsky:** Is there any follow-up to that? Knowing something about large bureaucracies, inputting the information is one thing, checking it has been acted on is quite another. What are the safeguards around that?

Dr Allsopp: Absolutely. The team that oversees the prevention of future death reports holds that data and is constantly looking to see whether the actions have been actioned and what the outcomes for those are. We bring that to the clinical governance board. I want to have visibility across director level so that we can see what has been done and what has not been done. That starts this month.

Q31 **David Pinto-Duschinsky:** Two final quick questions. One is picking up on Gill's previous excellent points around governance. Also you mentioned being a learning organisation. To what extent have you looked at other parts of the public services, other parts of the public sector—schools, medical and so on—to learn and incorporate best practice into these processes?

Dr Allsopp: I am bringing best practice from the NHS. I have worked in the NHS for 30 years in lots of different leadership positions but I have also held positions in arm's-length bodies and charities affiliated with the NHS. My expertise coming into the Department is bringing that wealth of my own experience but I think, more importantly than that, is the partnerships I bring to the Department. There is no way I can be a font of clinical knowledge for everything and I do not attest to be, but what I do have is connections with all of those experts. For safeguarding, for example, it is working with the NHS England safeguarding expert, but



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also within other Government Departments, making sure we are working across those Departments so that the best experts that I can have to advise us are there by our side doing that.

Q32 David Pinto-Duschinsky: Following the death of Errol Graham, we understand that the Department developed new advanced customer support guidance on supporting vulnerable claimants. Can you tell us about how that guidance is used and what impact do you think it has had?

Dr Allsopp: The ACSSLs are not within my remit and my sphere of working; they sit under the customer experience. There are two sides to DWP. I think, listening to some of the evidence earlier on, sometimes that gets a little bit confused. There is one side that is the Jobcentre side and the work coach side, which is where the ACSSLs sit. Then there is the assessment side, which is slightly different. We do communicate and work very closely together, but the ACSSLs sit on the side within the Jobcentres, which is outwith the remit where I work.

Q33 David Pinto-Duschinsky: Sorry, I am going to cheat and ask one further question. How then do you make sure that a proper clinical oversight is applied not just to the assessment side but to the other side of the house? It sounds like there is a risk of siloing there.

Dr Allsopp: You are absolutely right, it is a risk and I have worked in other organisations where that risk is absolutely live. That is one of the reasons we have set up the clinical governance board and we have set it at director level so that we have those absolute key people around the table and they are there. It is a decision-making board that then feeds into the executive team and the director general boards that sit there as well. We have been very careful at both levels from a clinical governance point of view, not only the clinical governance board but also that working-level board, to make sure that every side is there, so the operations team are part of that.

Q34 Gill German: Can you tell us a little bit about the role that you play on the Serious Case Panel and what you bring to the table from your position?

Dr Allsopp: I was very happy when I first started to meet the Permanent Secretary, who immediately invited me to join the Serious Case Panel, because it is such an important panel at DWP. As I am sure you know, it has most of the director generals sitting on it, and it is also chaired by a non-executive director. The Permanent Secretary sits there too.

My role is to bring the clinical side. Again, I bring that from three aspects. The first is the changes or the events that happen or the themes and trends that we see at the Serious Case Panel; how do they affect the claimants? Where is the claimant voice in that? Secondly, where is the health assessor voice in that? What are we seeing that will affect healthcare assessors? Thirdly, is the wider situation: how can we bring best practice from other organisations? How can we take the links and



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the wealth of the connections that I bring to the Department to make sure that we are bringing in best practice? It is that three-pronged approach that I bring to the Serious Case Panel.

Q35 Gill German: Of course the learning, as you have already mentioned, for prevention of future deaths from any kind of panel or piece of work is absolutely crucial. I know that the Committee in its previous incarnation received evidence to say that the Serious Case Panel is not sufficiently transparent. What are your thoughts on that and how much confidence can we have in the actions of the SCP?

Dr Allsopp: I think previously the Committee was told that it was not transparent, but I believe that the minutes are open on the website now, so the transparency has increased. I know that the Department, certainly over the last 12 months since I have been present, is talking much more proactively about being transparent. From my point of view as a clinician, it is absolutely key. I have to sign a probity statement every single year to maintain my registration. The transparency is important and the more of that we can do the better.

Q36 Gill German: You would say that transparency is crucial for proper scrutiny and building confidence in its work?

Dr Allsopp: Transparency, of course, is key to anything, but we have to be very clear. I know some of the people who gave evidence previously talked about sharing data outside of DWP. We have to be super careful when we are talking about vulnerable individuals. We have to make sure that we protect the vulnerable individuals.

After I came in we appointed a Caldicott Guardian. So Caldicott is the principles of how do we share data. We have lots of information transferred from the NHS to us. It is absolutely crucial that we look after that data in the right way, and make sure that we protect those people. We have to make sure that the transparency is at the right level. What we cannot be doing is divulging information that puts people at risk.

Q37 Gill German: Absolutely, and I was going to lead on to obviously there is a need for proper scrutiny but that can be difficult if you know that things are going out into a public forum. It is a fine balance, as you say. Would you have any thoughts on how that balance could be best achieved?

Dr Allsopp: That is why I appointed a Caldicott Guardian. We have an excellent data protection team working in DWP, a very, very good data protection team. The Caldicott Guardian brings the ethical side of it to that conversation, which I think is a real addition. The Department did not have to appoint a Caldicott Guardian. They have done it because they think it is best practice, and that is supported again by the clinical governance board and by the Permanent Secretary. Our Ministers were aware that we were appointing, and I think it is a really good addition so that we start to think differently. We can bring in ethical considerations as well. Rather than it being black and white, just data protection, we



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have to start thinking more holistically about the claimant who is at the centre.

Q38 Chair: I have a couple of follow-up questions. I absolutely share the importance of a Caldicott Guardian and what that means, particularly from the transparency aspect. Does that apply to the reports that you will do and your team will do to prospectively assess the health effects of policy changes? Will those also be published on the DWP website?

Dr Allsopp: There are limitations in what we can publish, particularly when we are doing policy development because, of course, if Ministers are still waiting to decide on making decisions, that is covered by certain data protection exclusions. It is important that the Ministers and the Department are able to make those decisions in a safe space. The evidence that we give to help make those decisions is available but will only be published because of ministerial approval or from a freedom of information if it meets the criteria to be released under freedom of information.

However, as a chief medical adviser, I am expected to provide an annual report each year, which goes to our executive team. I am in conversation at the moment with our Permanent Secretary as to whether the Permanent Secretary and Minister are happy for that to be published. I hope that that will be much more transparent about the safeguarding referrals that we do—something called our unexpected finding process, which is a safety net for claimants—and the progress that we have made, particularly from a clinical point of view, over the last 12 months.

Q39 Chair: A penultimate question specifically on the IPR process, which is identifying claimants who have died or been subject to serious harm. We believe, as indicated in the NAO report from 2020, which you are probably familiar with, that this is probably the tip of the iceberg. What is your view, having been in the post for 16 months, about the actual scale of the deaths of claimants?

Dr Allsopp: It is really difficult. I am very much aware of the criticism that is pulled to the Department, and we have heard some of that this morning. The thing that is super important whenever we think about a death is that it is normally incredibly complex, particularly if you are talking about suicide. I think you will see from most adult safeguarding review processes that there is never a single reason that somebody takes their own life or somebody dies. It is normally incredibly complex and is multi-agency.

In the prevention of suicide plan from the Government in 2023, there is a five-year plan to help suicide prevention. We are part of that work from the Department for Work and Pensions, and it is important that we work cross-agency.

The key bit for me is the prevention of future death reports. That is the point that a coroner looks at a death and says there is some aspect



where DWP was involved or DWP may be able to make changes to prevent deaths in the future. That is the absolute bit for me that is important. From what I have seen thus far, those numbers are certainly not in double figures. Like I say, in 16 months I have seen five come through the door, and they are the figures that I am going on for deaths that are associated from a DWP perspective.

Q40 Chair: Those PFDs are statutory reporting from a coroner. They are very rare reports, you must admit. I do not know how many you came across in your work with the NHS. They are incredibly rare. My concern is, first, it is only unexplained deaths that will go to a coroner, and we do not understand fully the detail of the scale of deaths. Errol Graham, for example, did not die by suicide; he starved to death. Anyway, I will leave that with you. Just a final question, who do you report to?

Dr Allsopp: I report into the policy director general, but have very close workings with most of the directors across the Department. I work within the disability and health services directorate with the policy director and with the disability lead, the director general there.

Chair: Thank you so much, Dr Allsopp. Thank you for coming to see us.

Dr Allsopp: Thank you.

Examination of witness

Witness: Dr Antonia Dietmann.

Q41 Chair: A very warm welcome to you, Dr Antonia Dietmann. You are the Department's Chief Clinical Psychologist, but you also have a number of titles: the Head of Profession for Occupational Psychology in DWP and the Head of the Government Occupational Psychology Profession. That is quite an extensive remit. Do you want to explain a little bit about that?

Dr Dietmann: Of course, yes. First, I need to make one correction. I am not a chief clinical psychologist. I am a chief occupational psychologist.

I am delighted to be here to present evidence to this Committee. I am bringing my evidence based on my psychology perspective, and that is in the remit of occupational psychology. I am the Chief Psychologist and the Head of Profession for Occupational Psychology and there are three key parts to my role, with the first two being under the remit of the Chief Psychologist.

First, I lead a scientific advisory team of four—including me—registered occupational psychologists and we provide advice to DWP's policy group on the design and development of all public policy for social security customers.

Secondly, I am the professional lead for the 85 psychologists who work in DWP's work psychology service. I do not line manage those work psychologists, but I provide the professional leadership to ensure that the



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service they deliver is appropriate, ethical, safe and in line with British Psychological Society and Health and Care Professions Council requirements.

That third role is head of professional responsibility, and that is a wider responsibility for the development of the whole profession, including people who are at the very start of their psychology training.

Q42 **Chair:** That is an extensive remit. How do you balance all the different jobs, and particularly your responsibilities at the DWP?

Dr Dietmann: It is hard to balance it but I love my job so I enjoy trying to find a way to balance it. Actually all of the three roles complement each other, so they are all drawing on my expertise as an occupational psychologist. My work within the policy group helps me understand the policy development process and then I can apply that to the work psychology side—that is the operational delivery of our psychology service—so they all overlap in some way.

Q43 **Chair:** What is the relationship between the chief medical adviser and the chief occupational psychologist?

Dr Dietmann: Gail and I work very closely together. She has mentioned the clinical governance board and I sit on that board, for example. We fall under the remit of clinical governance because we are regulated professionals. We are not clinicians, we do not call ourselves clinicians, but we are regulated by the Health and Care Professions Council, as are other clinicians in the Department and in the provider space. It is right and proper that we fall under clinical governance and we have the same training requirements and the same reporting requirements under clinical governance.

Q44 **Chair:** Dr Allsopp mentioned the analysis of policy and the system-wide approach to the impacts of policy on the health of claimants. Are you involved in that from an aspect of the impact on mental health?

Dr Dietmann: No, that is not our sphere of expertise in occupational psychology. The work of my policy advisory team is that we are a source of scientific advice for policy officials as they are developing a wide range of policies. It is for the policy officials to decide whether to take that advice, in balance with every other source of advice they get from internal and external sources.

Q45 **Chair:** Does that mean that for a policy you review, you undertake policy analysis and then feedback to them, “These are what we think the impacts will be on mental health”?

Dr Dietmann: Not exclusively on mental health. I will give you some perhaps more concrete examples of the work that we have done in our policy team. For example, we have provided advice on career development, career sustainability for the development of the new national jobs and careers service. We have explored an employment



intervention for customers who are 50-plus, for example. We tend to co-create with the policy lead and we work with them from the start of their policy initiative or their policy idea.

Q46 Chair: You also have a responsibility for the 85 psychologists across the JCP network. First, how are they distributed and what do you do to run their support and their training?

Dr Dietmann: There are 85 psychologists in the work psychology service and there is one representation in each Universal Credit region, including Scotland and Wales. We do not have one work psychologist in every jobcentre but rather one work psychologist will oversee a number of jobcentres and then a senior work psychologist will oversee a particular region.

I can share with you exactly what they do day to day. They support the employment journey of customers who have disabilities and health conditions. They do this not by addressing the health condition or disability directly but indirectly through helping them towards work so they can progress on their employment journey.

They do direct customer work one to one and in groups and all of those interventions will address at least one of four scenarios: building the belief in the customer that they can work, exploring their strengths and their interests to support work choices, exploring their fit with different work options and maximising the chances of securing that job. That is their direct customer work.

They also work indirectly with our DWP colleagues building their capability to support their own caseload. For example, the work psychologists provide knowledge-sharing sessions, upskilling sessions, literature and information that work coaches and disability employment advisers can use in their own service delivery.

Q47 John Milne: You have already partially answered my question. Obviously you have psychologists across a lot of jobcentres. What is the mechanism for referring claimants to them: how do they get involved and how are they brought in?

Dr Dietmann: Referral is by a work coach or a disability employment adviser. It is entirely voluntary, so the customer must consent to that referral. It is not tied to their receipt of benefits in any way. We have regulatory requirements from the Health and Care Professionals Council to get informed consent, and that is absolutely at the heart of the relationship between the work psychologist and the customer.

They have a structured pro forma to get that consent after the referral is made, and there is a conversation between the work psychologist and the work coach or disability employment adviser about whether that is an appropriate referral for that customer at that time. Once that is made, the consent will be obtained from the customer, as I say, a structured pro forma.



We also have access to easy-to-read literature, which is highly simplified for our customers with low literacy or cognitive impairments. That will explain the interaction and who the work psychologist is in simpler language.

Q48 John Milne: Do you feel that that system is working well enough that the right claimants are being identified by the staff on the frontline?

Dr Dietmann: We have done a huge amount of work to build awareness and understanding of what the work psychology service does, what type of psychologists we are and the appropriate customers that can be referred to us. They work closely in their local areas as well as more on a national level to explain that. I think that we are getting appropriate customers. We would not accept the referral if it was not the right customer who could be helped.

Q49 John Milne: It has been suggested to me that perhaps some psychologists are not always brought in at an early enough stage. We wait until claimants are a long way down the line before they get referred, they are already in a lot of trouble and then their difficulties have become greater. They have been out of work longer, perhaps their mental state has declined further. Do you feel that the system is bringing in support at an early enough stage?

Dr Dietmann: I think that there is always a conversation to be had with the work coach and disability employment advisers, but in one sense the scenario that you are presenting is also the strength of the service. We are often brought in to unstick where something has got stuck and we can use different techniques that a work coach would not have access to because of our special training. In some ways, helping the customers who have become stuck in some way is the power of the service.

Q50 Frank McNally: Building on the point made by John about the 85 work psychologists, in an earlier session we explored the range of challenges facing vulnerable claimants and a few moments ago you referenced the fact that the work psychologists have a role in supporting the customer but supporting Jobcentre staff. Given the demands that are being placed on the work psychologists, do you believe the number is sufficient?

Dr Dietmann: It is a good question. There are two factors when we consider the size of the work psychology service. First, is the availability of relevant graduates. There are only 23 British Psychological Society approved programmes in occupational psychology in the UK. They do not turn out a huge number of graduates and then there is the number who want to work in the civil service and in DWP's work psychology service, so we have the supply side. Then, of course, we have available funding in DWP. There are professional costs to growing an in-house, highly competent, registered occupational psychologist when the market just will not provide them for us. We have to balance those two competing factors in deciding on the size of the work psychology service.



We have designed a national service offer so there is consistency across the UK. Work coaches and disability employment advisers access the work psychology service consistently in the same way and through the same process, but we also complement the face-to-face delivery to our customers with our digital offer to colleagues with live broadcasts, knowledge-sharing sessions, but also importantly case conferencing. A group of work coaches can bring their cases to a work psychologist and work through their caseload and try to unstick some of their challenging situations.

Q51 Frank McNally: How does your role specifically support the work of psychologists in managing those competing demands? What is your exact role in supporting the service to prioritise?

Dr Dietmann: I have a number of ways to do that. I support the psychologists to develop the evidence-based and consistent set of toolkits that they can use. I support them to identify the service they offer, maximise resources of how can we best deploy those resources, and then also importantly to decline tasks that can be done elsewhere in the Department, things that fall outside of our remit.

It is very important for me personally, and for us as psychologists, to remain within our professional area of expertise so that the work psychology service keeps an employment first rather than a health first focus and that my leadership helps us do that.

Q52 Damien Egan: I am going to ask some questions that are focused on the work of the JCP psychologists with the work coaches. You have talked a bit about that already. What role do they have in ensuring the wellbeing side of the work coaches so they get involved in the occupational side?

Dr Dietmann: We do not have a role in welfare or wellbeing support. I do not have a role and the work psychologists do not have a role in that. That falls under DWP's wellbeing strategy and all of the support and provision that the Department provides through our HR processes. We have our employee assistance programme, for example, which colleagues can access. We have a whole range of resources on the intranet, including our wellbeing TV channel, which covers a huge range of wellbeing and welfare topics.

Q53 Damien Egan: The previous chief psychologist said that he was involved with helping DWP to develop improved guidance for frontline staff. How involved are you with the development of safeguarding policy for frontline staff? Can you point to any specific examples?

Dr Dietmann: I do provide advice to the people and capability team who have been developing training on topics that include safeguarding and vulnerability. I think I have provided advice on about nine different training products since I arrived about 23 months ago.

Q54 Damien Egan: The work psychologists mainly focus on the customers, which makes sense. John asked about the success that they have in



identifying people. How is the the success of getting people into work monitored and would you describe their work as being successful?

Dr Dietmann: We collect feedback from the customers and the colleagues that we see in the delivery of the interventions, whether it is case conferencing or training, but it is important to note that the customer remains on the work coach or disability employment adviser's caseload. The work psychologists do not caseload, so any success or outcome on their employment success is attributed to the work coach or disability employment adviser.

I wondered if the Committee might be interested in anecdotal feedback. It just came into my inbox this week and I wanted to share some feedback about a work psychologist. This is directly from a customer, "The work psychologist has helped me immensely. When I first met them, I didn't know what the future held for me with regards to work due to the long-term effects of mild traumatic brain injury. My sessions have helped me reaffirm my confidence in my abilities and find coping strategies to dealing with any significant changes that I can then bring to the workplace." We get that kind of feedback.

Q55 **Damien Egan:** That is really nice. Does that mean that we do not have a way, or can a way be developed, where we can quantify how successful that programme, the investment in those 85 work psychologists is? A slight follow-up to that, given you are talking about the supply issues of the number of graduates coming through. In the future, do these people have to be graduates—presumably psychology graduates—or is there an opportunity for work coaches to be brought up to that level and trained to give that support?

Dr Dietmann: I will take the first part first. Yes, we do track an awful lot of other metrics about our service delivery and we have more available. On the second part, I think it would be very hard to upskill a work coach to the same degree. A work psychologist has done three years of a BSc in psychology, one year of a master's in occupational psychology and between one to four years of a professional qualification to become a registered and chartered psychologist. It is a totally different route.

Q56 **Damien Egan:** Are we able to see the metrics that you use to successfully get people into the programme?

Dr Dietmann: I can follow up, yes.

Q57 **Johanna Baxter:** From an occupational health perspective, what do you perceive as the main barriers involved in moving people from being out of work on health or disability benefits back into the workplace?

Dr Dietmann: I am not an occupational health practitioner so I could not answer that question. It is outside my professional area of expertise.

Q58 **Johanna Baxter:** Several organisations have argued that removing the substantial risk descriptor from the work capability assessment would put



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vulnerable claimants at risk. In your professional opinion, is that claim warranted and, if the Government choose to go ahead with this measure, do you know of any ways in which that risk could be mitigated?

Dr Dietmann: Again, I am not a medical practitioner, I am not a medical doctor. That falls out of my professional area of expertise.

Chair: Thank you so much, Dr Dietmann, for providing evidence to the Committee. That concludes our oral evidence session in the safeguarding vulnerable claimants inquiry.