HOUSE OF COMMONS

Work and Pensions Committee

Oral evidence: Health assessments for benefits, HC 604

Wednesday 1 December 2021

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Watch the meeting

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

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Witnesses

I: Dr Paul Litchfield CBE, Leader of the 2013 and 2014 independent reviews of the Work Capability Assessment at Department for Work and Pensions.

II: Paul Gray CB, Leader of the independent reviews of PIP at Department for Work and Pensions.

Examination of witness

Witness: Dr Paul Litchfield CBE.

Q1 **Chair:** Welcome, everybody, to this meeting of the Work and Pensions Select Committee. A warm welcome to our first witness, Dr Paul Litchfield, who is joining us from home this morning. Paul, please briefly introduce yourself to the Committee.

Dr Litchfield: I am an occupational physician by trade. This is a doctor who specialises in the impact of work on health and health on work. I undertook the independent reviews of the Work Capability Assessment in year 4 and year 5.

Q2 **Chair:** Thank you very much and thank you for joining us this morning. I want to ask you first about the work that you did in those two reviews. You told our predecessor Committee in 2017 that your recommendations and those made previously by Professor Harrington in the earlier reviews had been largely accepted but not fully implemented. Overall, how far would you say your recommendations have been implemented in the seven years since 2014? Do you think it is time for another independent review now?

Dr Litchfield: It is difficult for me to answer that fully. As part of the year 5 review I could review where they had got with Malcolm's recommendations in years 1 to 3 and my own in year 4, but of course since then there is no mechanism, as far as I can see other than your Committee, to see what has happened. I have not stayed too close to the WCA but what I have seen suggests that by and large there has not been an awful lot of progress. I wonder, as I said last time, if some of that is down to inertia in the Department, which I find interesting, rather odd and different to other civil service Departments that I have contact with.

Q3 **Chair:** What things would you pick out that you are aware have not been implemented?

Dr Litchfield: In years 1 to 3 Malcolm focused very much on the health assessment aspects. I felt that he did a very comprehensive job with that and I did not feel the need to go into that very much during the reviews I did. I focused very much on the departmental end of it and the way that the Department staff operated in following through on the Work Capability Assessment. At a policy level the Department was very co-operative and very positive and enthusiastic. I constantly got the impression with the operational side, though, that it was all a bit of a nuisance and that when I made recommendations about ways that the process might be improved it was always pushed back quite quickly, saying that it is not cost effective or it is impractical or, "We will accept it in principle, provided—". Then you look at things seven years down the road and as far as I can see things have not been taken forward.

As I say, I think DWP is unusual. In the other Departments that I have had experience of it is the policy people who drive what happens, so the political decisions are made, the policy units put flesh on them and then the operational people implement those decisions, those policies. In DWP it seems the same process goes through, the decisions are made, the policy people put flesh on them, and then there is a sucking of teeth when it gets to the operational people. You get 12 reasons why they can't do it or it goes on to a priority list and you come back one, three, five years later and nothing much has happened. Of course the tenure for policy people is relatively short and the tenure for operational people is quite long. I wonder sometimes whether it is volitional or unintentional. I don't know, but I wonder if they just wait out the things they don't really fancy doing until a new lot come along. That is perhaps being unfair.

Q4 **Chair:** Remind us of one or two of the recommendations that you felt were important but that, as far as you can tell, have not been taken forward.

Dr Litchfield: It is things like in the year 4 review in the chapter on decision making. I won't trouble you to read it all but if you have time look at the two graphs in that chapter. I think it is chapter 5. There I found what I thought was a systematic bias in the way that claims were handled that led to some odd decisions being made. It struck me that a lot of that was down to the way that the Department sorts claims when it gets them back from the healthcare provider.

We get into DWP's very strange use of language. Non-complex cases are the straightforward ones where people are clearly extremely unwell and therefore there is little doubt that they cannot work. They are dealt with by administrative staff, AOs, and essentially all the AOs do is rubber stamp things and enter the stuff on the system. They don't really make any decisions at all. The complex ones in DWP speak are those that are actually simple where people don't have significant health problems. Those all go to an executive officer grade, EO grade, who looks at them all. When you look at the graph in that chapter you can see that as the points accumulate the chances of a decision being overturned increase dramatically. By the time you get to 12 points—at that time anyway—the chances of a decision being overturned by the DWP official on the basis of what was there already, sometimes on the basis of a telephone call as well, was over 50%. It is pretty odd to buy in professional advice and over half of the time not to abide by it, and in fact go against it.

I suggested the process was wrong: that you would be better, from a scientific point of view, to get the people who are really making decisions, the higher grade staff, to look at cases either side of the cut-off point so they got a better, more balanced view of what did and did not sit either side of qualification for the benefit. You are hardly ever going to change a decision on those at either end, either very low scores or very high scores, so get the lower grade staff to do those.

I was told it was not cost effective, which of course is arrant nonsense because whether it is cost effective or not entirely depends on where you put the cut-off between the different grades of staff looking at them. It is entirely down to the Department whether or not it is cost effective, but it would give the people who really are making decisions, the executive officers, a much better feel for the total caseload rather than as they currently get, or were getting at that time, a skewed view because they only see people who have something wrong with them but are not getting enough points to qualify for a benefit.

There is that sort of thing and a number of other things I suggested for process, which just appeared too difficult really.

Q5 **Chair:** Do you think that there should be another independent review?

Dr Litchfield: I think it would be useful to have another review, absolutely. If one were to do that I would go back and not just look at the Work Capability Assessment but look more fundamentally at the whole concept of what we are doing. It strikes me as a little odd that if someone can’t work because there is no suitable work for them, you pay them a different level of benefit to someone who can’t work because they have a disability or a health problem that impairs their ability to work. It may well be that people who have an impairment of that sort have additional financial issues but you would cover that in different ways. People who don’t have a health condition may also have things going on in their lives that mean they have additional financial issues to cover. Grading your benefit on the difference between whether somebody does or does not have a health problem appears to me to be judgmental inappropriately. It is for society, and of course the Parliament, to determine if that is right or not, but I think that should be part of the review.

The other part of the review, if society determines it wants to make the differentiation, is that the test that is used needs to accord with modern thinking and not thinking that was developed 40 or 50 years ago, which is where we are with the WCA. The WCA is simply an evolution of its predecessor, the Personality Capability Assessment, the PCA, that was used for incapacity benefit. That in turn came out of some work that was done largely in the States back in the 1980s, and even the 1970s. The thinking is very much around a biomedical model—in other words, that if somebody has an impairment, you can predict what that means for their ability to do work and how long that impairment is likely to last. Any clinician will tell you, and I am sure you will have seen the same in your own constituency surgeries, that there are people with really quite profound incapacity as a result of health problems or a disability who despite all the odds do struggle and hold down a full-time job. There are other people who to an external observer might appear to have really quite minor issues and yet they are totally incapable of any form of work. That is because the biomedical model is not enough, it is only one dimension.

People in the work and health ecosphere have been saying for 20 years now that you need to look at a biopsychosocial approach, in other words look not just at the medical elements but also at the levels of social support people have in the workplace and outside the workplace and also the psychological aspects, which is not their mental health. It is their attitude towards their health, their attitude towards work, their ethos. When you have that three-dimensional view, you get a much better assessment, a much better predictor of work ability than we have at the moment. As I say, the WCA is built on quite outdated thinking, so I think that any review should be empowered to look beyond just how the current test is working and look more fundamentally at what a different test might look like.

I think that it is not for an independent reviewer but someone ought to give thought to whether we really want to make the differential between people who can't work because of health and disability and people who can't work because there is no work and whether the level of benefit should be the same or different. I commented in one of my reports—I can't remember which one it was now—about what they do in New Zealand. They were just starting then and it struck me that had more logic to it than the way that we approach things here.

Q6 **Sir Desmond Swayne:** Was there any measurable improvement in the perception of fairness of the work capability test during and after your reviews?

Dr Litchfield: Not that I could elicit, I am afraid, no.

Q7 **Sir Desmond Swayne:** What do you recommend that the Department could do to secure an improvement in the perception of fairness?

Dr Litchfield: There is a range of things. As I said in the reports, simple things like the way that you position people in the room, which was very confrontational when I did the year 4 review—I think they have changed that now—allowing people to see what is being entered on the screen, which seems pretty basic to me. The response that came back was that that would take too much time, to which my response was, "Not if you get it right". If you are entering on the screen what people are saying, they are not going to quibble about it, they are going to agree with it. If you enter something that is not what they have said and they find out about it later, I would have thought you are pretty much guaranteed they are going to appeal the decision. Those simple sorts of things can make a difference. Some of them were done, as I say, some of them were not because they were considered too difficult or impractical.

There is the whole thing about communication, which is tough. In any organisation you always say, "We need to communicate better". I think that the Department has improved in that respect but it still has a way to go, and I know that is probably true of government generally. There does seem to be an odd use of language sometimes and the way that things come across, particularly in a written format like letters, can appear very threatening to people. I understand that you need to cover off the legal requirements in what you are saying but I think it is possible to frame things in a way that people find easier to understand and less threatening. There were some other things like easy read. I was particularly bothered in year 5 about the issue of people with autism and Down syndrome and other mental capacity issues and the Department produced some documents in easy read. I have lost track of how many they have done in that. There are various things that one can do.

I think that fundamentally the system is just too impersonal. One of the recommendations I made, perhaps not strongly enough, was that the decision maker should be the person who first sees the claimant. You see a person, talk to that person and the decision maker then decides whether they need additional medical evidence and will refer them for a Work Capability Assessment if they consider that appropriate. They might decide other forms of evidence are appropriate. That was dismissed pretty much out of hand as being impractical. Whenever you tuck people away in an office, hard as you may try they will still come over as faceless bureaucrats.

Q8 **Sir Desmond Swayne:** Can I take you back to the replacement of Atos by Maximus? Did the Department have sufficient control over its contractors? Does that have some input to the question of a perception of fairness?

Dr Litchfield: I think it does. I am agnostic about whether services should be in-house or outsourced. I think it can work either way. If it is going to work in-house or outsourced, the key thing is to be clear about what your aims are, to produce a specification for service that is clear and understood by everybody and does not change every 10 minutes, which I am afraid it tends to do or has done with the Work Capability Assessment and also in other arms of Government procurement. Sticking to a specification is important. If you change it constantly, you are working on shifting sands and adding cost and complexity. It is having a clear specification and then working with whoever you are working with, whether the professional is in-house or outsourced, as a trusted adviser and not as somebody who can’t be trusted, which is what had clearly developed by the time I was doing my reviews.

A lot of people in the Department at a working level just did not trust Atos, as it was then, and the people working for Atos, which was probably unfair—I don’t know at an organisational level—at a professional level, an individual level. The healthcare professionals I met with from Atos all seemed pretty genuine people trying to do the best job they could and yet that relationship had broken down and that did not help at all. I think restoring trust is important, and I don’t know how it has gone with Maximus and whether that is any better.

I have operated, as I think I said, in procuring services and in delivering services and whichever side of the house I have been on the key thing is to work with your client to understand each other's needs and to trust each other. That just does not seem to be there. I don't know why.

Q9 **Chris Stephens:** Following on, Dr Litchfield, from the questions that Sir Desmond has raised, the rates of overturn of DWP decisions at appeal have remained high. Are there steps that the Department should be taking earlier in the process to ensure that the right decision is made as early as possible? Could you talk us through any proposed changes you made to the Department and the response you had?

Dr Litchfield: We all make the assumption that the appeal is the right decision and the initial decision is the wrong decision. When you look at the way that the original decision is made, it is done by people who have extensive training. It could be better but it is extensive training. They work to very strict protocols. They are only allowed to fly solo after they have been supervised for a considerable time and their work is checked and audited regularly. When you go to appeals—and I went to a number—there is a degree of training, not to the same level. There are no strict protocols in the way there is for the initial assessment and the tribunal has much more discretion. I think that is why so many decisions are overturned at appeal on the basis of oral evidence. I witnessed that in the tribunals I attended. People were able to express how they were coping and the tribunal made a common-sense decision, built on compassion, which said that clearly this person is not going to be capable for work.

You are precluded from doing that as a healthcare professional in this system. You are obliged to work to the protocols that you are given. You have to give the scores that the protocols drive and if you try to go outside of that, you get into trouble. I have had doctors say to me, "I saw this poor soul. I knew that there was no way in the world he was ever going to get into work or hold a job down, but the system said he didn't make the points so I had to report it in that way or I would have got into difficulties when they audited my work".

I think the key thing is that we need to build in that common sense and compassion that if you apply a biopsychosocial model, as you could do in a different form of assessment, would be built in, but what we have at the moment is an attempt to produce something that is replicable and objective and that takes the humanity out of it. It is also founded on pseudoscience, I have to say. The scales are not scales in a scientific sense. The way that the cut-off point of 15 points was developed was purely that 15 points turns it one way, less than 15 points turns it the other way. You can't say that a person with 18 points is twice as incapacitated as someone with nine points. It does not work like that. I think we have applied a degree of pseudoscience and an overreliance on the numbers and the algorithms, which ultimately has proved to be unhelpful, even though I think it was well intentioned.

Q10 **Chris Stephens:** That is helpful. You have mentioned tribunals and your own experiences of being there. DWP says that overturned decisions at tribunal are frequently attributable to what it regards as new oral evidence obtained from the claimant. Are there other things that you believe the Department could do to obtain that earlier, for example a letter from a GP or a health professional, a consultant that the individual has seen? Are there other things, Dr Litchfield, that you believe the Department should get at an earlier stage so that it can make a correct decision?

Dr Litchfield: I don't think that is possible in the current system. If you changed the system and, for example, had a decision maker seeing the person in the first place, as I was discussing with the Chair, that would allow the claimant to give oral evidence to the decision maker at that point, but you don't have that. The decision maker is held back, deliberately kept away from the claimant. They might make contact on the telephone and when you look at the results of those telephone conversations they quite often do result in an increase in points, in other words to make people eligible for benefit who would not be otherwise. I don't think it is going to work under the current system that is so tightly regulated with these protocols.

Q11 **Chris Stephens:** What do you think is less cost to the Department? Is it allowing early assessment mistakes to be rectified by appeal or do you think there is less cost to the Department in increasing its efforts to get a decision right the first time?

Dr Litchfield: I think that is a slightly weighted question because, of course, one has to—

Chris Stephens: Well, that has never been known from me, Dr Litchfield.

Dr Litchfield: Clearly you don't want appeals. They are a waste of time and effort for everybody. Reducing the number of appeals has to be an objective but I think that needs to be done on the basis of reconfiguring the way that the process is done. When I looked at it, the Department had not going to appeal as a majority priority and I think that drove some rather odd behaviour sometimes in that decision makers would find points to make a decision that someone was granted benefit rather than denied it. I hope it has changed but at the time I was looking at it the performance management system in the Department seemed somewhat draconian, as it did in many organisations at that time. Some of the managers I spoke to, I would not say they were afraid but certainly felt under a lot of pressure to meet a number of performance measures and the number of appeals was one of those.

Q12 **Debbie Abrahams:** Good morning, Dr Litchfield. You won't know this but in May 2019 I wrote to the then Secretary of State asking whether you had received two prevention of future deaths reports that had been issued by coroners and a series of peer reviews, which are the predecessors to the independent process reviews that we have now. Those were related to the deaths of claimants in your 2013 and 2014 review. I got quite a strange response from the Minister for disabled people. They said that they would supply anything that you requested and that they had lost the peer review reports for 2013 and 2014. I did an urgent question on this and there were 49 peer review reports undertaken in 2014. Can you confirm if you received the coroners' letters and the 49 peer review reports?

Dr Litchfield: As far as I recollect, I did not receive either and I am pretty certain about that.

Q13 **Debbie Abrahams:** If you had received those PFDs and peer review reports, how do you think it would have influenced your report and the recommendations from your review?

Dr Litchfield: One of my objectives in both year 4 and year 5 was to focus on mental health. It is something that I have had an interest in and a commitment to for a very long time now. Clearly suicides are one aspect of mental health and, sadly, the least desirable outcome that one could have, I suppose. If I had had that evidence available to me, or indeed been told that it was there—because that is the other aspect; you can only ask for stuff if you know it exists—I would certainly have looked at it. On the basis of what it said, I would have decided whether to proceed with further enquiries or not and it might have influenced what I said. I can't say whether it would have influenced it or not but I certainly would have looked at it and taken it into consideration.

Q14 **Debbie Abrahams:** Thank you. Again, you may not be aware of this, Dr Litchfield, but as a result of freedom of information requests for data between 2014 and 2017 it was identified that during the assessment phase when people were going off flow, 274 people per month were dying at the same time. That is freedom of information to the Department. Is this information that would have been useful for your review then?

Dr Litchfield: I certainly would have been interested to know that. It is not something that was drawn to my attention. I must say it is not something that particularly it occurred to me to ask about, so there is a degree of culpability on me too. With the huge numbers you would expect some people to die in the course of that process, so I think it comes down to why they were dying. If it was an expected death because they had a terminal illness, you would want their case to have been handled much more quickly. To be fair to the Department, they did make efforts to speed up their treatment for people with terminal illness during the course of the five-yearly reviews. If it was a suicide, then that leads into your previous question; I would have wanted to follow that up a bit more.

Q15 **Debbie Abrahams:** So really, we do not have all the information that we need to make decisions, and it might have been useful if you had known about that data. You may not be aware of this but there was an academic report published a few years ago related to the period that you undertook the review. It identified that an additional 490 suicides were estimated between 2010 and 2013, and other mental health effects, including additional scripts for medication and so on. I appreciate it is after the fact, but there does seem to be emerging evidence around this.

Finally, you have already said that you think there should be another independent review, but we have seen an increasing number of claimant deaths. Currently the deaths that the Department has been investigating over the last two years has increased to 97, and there have been 27 reviews into serious harm. Is this a concern for you?

Dr Litchfield: Even one case would merit attention. Of course, the numerator intakes tells you half the story; the denominator is important too. What volume of cases does that relate to? One would want to look at that.

The issue of suicide is a complex one. I know there are people on the Committee who probably understand that even better than I do. I said at the beginning that I do some work with the Health and Safety Executive, with what is called their Workplace Health Expert Committee. We issued a report earlier this year that looks specifically at workplace suicides and there is an element in that that might be useful to the Committee. Part of that report talks about a model that Rory O'Connor, who is a very good psychiatrist in Glasgow and has done a lot of work on suicide, has put together, about the elements that lead people into suicidal behaviour. He calls it the Integrated Motivational-Volitional Model. Basically it is looking at: what are the things that predispose to suicidal behaviour? What are the things that precipitate it, and what are the triggers that are likely to take someone from suicidal ideation through to actually carrying it through? There are aspects of the process which probably do contribute to some of those things and with that academic foundation the Department, or any independent reviewer, would be in a better place to look at what elements might therefore be amenable to change.

Debbie Abrahams: Thank you very much. Can I just say, not all of these deaths were by suicide, although I have focused on the estimates in that particular academic paper. Thank you so much for your responses, Dr Litchfield.

Q16 **Selaine Saxby:** In the 2021 Green Paper the Department said it was intending to reform the Work Capability Assessment. Do you think it can be reformed within its current framework, for example by keeping things like the scoring and descriptors, or is a more fundamental overhaul needed?

Dr Litchfield: A more fundamental review is required. As I say, if we want a test, let's base it on modern thinking not 40 or 50 year-old thinking.

Can you make changes to what is there already? The trouble is that you change one bit of any complex system and it can have unintended effects on the other. Every change that is made to the WCA potentially takes it away from what it was originally designed to do. One of the things I said in year 5 was to stop tinkering, there seemed to be a lot of tinkering for the sake of it sometimes, and do that more radical comprehensive review of what we need to take us forward into the next few decades.

One of the problems with that, of course, is that it takes time. The WCA was cobbled together in about 18 months in order to meet the demands of the Welfare Reform Bill 2007. It was the best that people could do in the time available, but you need something like 10 years to put something like this together, which has a sound scientific basis and then is tested properly. I said that to a very senior official in the Department as I was coming towards the end of year 5. He said to me, "Don't bother putting that in the report because in Whitehall and Westminster, anything that stands more than two Parliaments is completely disregarded". That may or may not be true—if it is true, I find it rather depressing—but that is the reality of how long it will take to produce a robust new assessment, if that is what we want to do.

In the meantime, let's do things that make sense, as far as possible bring humanity and compassion back into the process, but do not keep fiddling with the descriptors and that sort of thing. It is ultimately probably not going to achieve an awful lot.

Q17 **Selaine Saxby:** Thank you. As you no doubt know, at present the Work Capability Assessment attempts to assess both the level of benefit support that someone needs, but also what they need to get back to work. In your mind is that the right mix of things or is there a better way of approaching it?

Dr Litchfield: When it was first designed there was a parallel assessment called the work-focused capability assessment—I think that was what it was called. The intention of the WCA was to determine eligibility for benefit. The purpose of the second parallel assessment was to help people to navigate their way back into the workforce. That was dropped pretty quickly by the Department because it cost money and did not deliver any savings on benefit, would be my interpretation of it—there might be other reasons that those within the Department could give you.

The WCA itself is not designed to help people back into work. We do need to do that. We are desperately short of labour; we need to get people back into the workplace. There are an awful lot of things that people can do despite significant impairment to their capability, provided you make the right level of adjustments but that requires a completely different approach, that is much more supportive. It is not about whether you get money or not, it is about trying to help the individual, and I do not think you could combine that with something which is an assessment for benefit.

Q18 **Selaine Saxby:** You spoke there about not combining it, and in the original incarnation of this that it was a parallel assessment. Do you think it should therefore happen later down the claim process, that we are trying to help people back into work?

Dr Litchfield: That is certainly what they do in New Zealand, or did when they were setting it up; it is a few years since I have looked at it. There they were having far less noise about their equivalent to the Work Capability Assessment, because the initial focus was about helping people back into work, it was about supporting them; and then later on, if there was the need for an assessment, they did the assessment. Yes, that would be a helpful thing to do but then there are technical things about: is the assessment rate enough to live on and all sorts of other issues that will feed into that.

Selaine Saxby: Thank you.

Q19 **Nigel Mills:** Dr Litchfield, earlier on when you talked about how we could reform this assessment you said it should take into account—I forget the phrase that you used: biopsycho-something-or-other—the ethos of the claimant. If you have some claimants who do not want to work but probably could if they wanted to, how do you change an assessment that takes that into account without risking losing the confidence of the public, so that people cannot just choose not to work and somehow bust the assessment in that way?

Dr Litchfield: In year 5 I got some very clever people together to give advice on that, because I am not an expert on the biopsychosocial model— which sounds a bit too much like psychobabble, doesn't it?. I got some very clever people in a room to talk it through, and there are people out there—organisations like the Institute for Employment Studies—that have done quite a lot of work on this. Stephen Bevan is particularly good.

They have ways to assess these things. It is about the way that people respond to their illness as much as the way that they respond to work. When you talk about the way one responds to work and work ethos, that can sound rather judgmental—that some people are lazy and others are not—but it is more their psychological approach to life, which you can assess, and you can also feed into that the level of support that they have in their lives and combine that with the biomedical aspects to produce a more rounded three-dimensional view of what they need, but that would take a bit of time. The academic part of it would probably take a year or two to do properly.

Q20 **Nigel Mills:** Thank you. A second topic: the Government have suggested that at some point they might like to combine the ESA benefit with the PIP one. Would that be a positive thing, in your perspective? People who have got a disability can probably claim once and they can then get support with disability and support if they cannot work, rather than having to go through two different assessments for two different benefits for what they see as the same condition.

Dr Litchfield: There are a couple of aspects to that. First, you certainly could devise the system where there was an out-of-work benefit, which was paid to anybody regardless of what was stopping them from being at work. Secondly, there could be an additional benefit on top of that that compensated them for the additional costs of their difficulty in dealing with life, which would include seeking work, for example. You could certainly do that and that would fall reasonably neatly into combining, in some ways, ESA and PIP.

The other aspect, which finally there might be a wee bit of progress on, is combining the information gathering. That was a huge frustration to Malcolm and to me throughout the five years of the independent reviews that the Department was gathering information about different benefits, and it was never shared. It is not just ESA and PIP; it is also Industrial Injuries Disablement Benefit.

As I understand it, there is now a new system which has the potential to make that information available to the person doing an assessment. If that happens—and I always hold my breath with IT in this context—I would see that as a significant advance.

Q21 **Nigel Mills:** Have you had a chance to look at any of the changes to the process that had to be brought in for the pandemic to see whether any of those have accidentally improved the system in a way that we ought to retain?

Dr Litchfield: I have to some extent. In occupational health we have been doing telephone assessments for 25 years, so I could never understand why that was not part of the armamentarium, particularly given that when you go for a Work Capability Assessment the degree of examination is essentially a "no touch" examination, which tells you a certain amount but is more limited than a traditional type of medical examination. Having the opportunity to do video calls with people would be an advance. It would clearly save time and trouble to people making a claim and, in many cases, it might well be that it gives you enough information to proceed. The downside, I suppose, is that you do it and there will be a proportion of cases, 5-10%, where you would then say, "No, you need to come in and you need to be seen". People might see that as an additional hassle but overall it has got to feature. Colleagues in general practice have taken it on too and it is the way that it is going to go. Why it did not happen years ago, I do not really understand.

Nigel Mills: Thank you. Can I just remind the Committee of my previous declaration that my wife receives PIP?

Q22 **Chair:** Thank you. Dr Litchfield, can I press you a little bit further on the very interesting suggestion you have made to us, that there ought to be a different model for these assessments from the one in use at the moment? You said that New Zealand had adopted that model. Is that correct?

Dr Litchfield: No. New Zealand has taken a different model in terms of the timing. There is a single payment for being out of work, as I understand it, and then you look at what support people need; and at the back end of that process you may do a Work Capability Assessment. It is done with a relatively small proportion of people and it is the equivalent to the decision maker to decide whether to call that in as an additional element.

If one is looking for a more biopsychosocial approach, of the places I looked at Denmark was the closest in terms of taking a more rounded view of what is stopping people from working. Scandinavia has gone down that route for a long time. I did not look at Sweden or Finland, but it would not surprise me if they had something similar too.

Q23 **Chair:** If this idea was taken up and adopted—and you said it could take 10 years to implement—do you have a sense of how the assessments would be different from what we have in place today?

Dr Litchfield: There would necessarily be more dialogue. At the moment it is almost interrogation. It would be more structured interviews than the more prescriptive process that we have at the moment. The advantage of a more structured interview is that people have the opportunity to say their piece much more than they get in the current system. That in itself would help with the perception of fairness, provided what they said was recorded properly and then acted upon properly. That would be one difference.

In terms of the outcome of how many people were on the benefit and how many were denied benefit, I just do not know; that would be one of the things to test in doing the pilots. But it would be important to pilot something like that very carefully and I said to do it in year 5. I do not think it is something the Department should try to build itself. It is something that it should get a reputable academic unit to produce and then to get it—or the scientific community, to do a lot of the testing.

When the Department pilots things, it tends to look at the operational implications of what they are doing, more than whether it is achieving what it is meant to do. That seems to be a mindset in the Department, which you would need to get around in introducing something like this.

Q24 **Chair:** If a more discursive approach was taken to these assessments—given that in the end there has to be a decision, "Yes or no, is this person going to get a benefit or how much benefit will they get?"—how optimistic would you be that reasonably robust procedures could be adopted to allow such decisions to be made on the basis of this new kind of assessment?

Dr Litchfield: You could make them as robust as they are at the moment, if not more robust. The other thing is, as part of that, almost certainly you would move away from the sheep-dip approach that we have, where pretty much everybody gets a WCA. You would select the group that you wanted to apply this assessment to because there are some people where it is blindingly obvious that they are not going to be able to work, so why are you putting them through this sort of assessment? There are others where you look at it and you think, "Really, there is no case here"; therefore, why would you put them through this assessment? You would be more selective in the way that you applied it.

That type of assessment does take longer, and therefore it is more expensive, but if you reduced the volumes, you could probably do it on cost-neutral basis. I have not done the maths, but there is no reason why you could not do it on a cost-neutral basis. Who knows, you might even be able to save a bit of money.

Q25 **Chair:** My colleague, Debbie Abrahams, wants to press you on that but first a final point from me. Do you think if we went down this road the upshot would be more people in receipt of benefit than is the case at the moment?

Dr Litchfield: That is impossible to say. To an extent it depends on where you put any threshold for how much of being unable to work is going to get you the benefit. That will determine where the line is drawn. But you can work that out; if you design something, you can then decide where you are going to set that dividing line. In a way, it is what they do with the WCA—it is bizarre, why 15 points? It is only 15 points because the PCA was 15 points. Why do you go up in divisions of three? I do not think the human race anywhere has devised a numerical system based on the number three, and yet that is drawn, again, from the PCA. The way that the test was tested was to say, "Do people meet this threshold or don't they?" The Department had decided where the threshold was going to be, so you could do that for a new test and that would determine who fell in and who fell out of the benefit.

Q26 **Debbie Abrahams:**. Just a couple of follow-ups, if I may. First, I do not know if you are aware that over the last five to 10 years there is an annual report that seeks to identify the extra costs that sick and disabled people face—and of course that covers a range of conditions and impairments. Currently it stands at about £570 a month. This is done by a team of academics and disability charities and DPOs, so it is quite robust, and I say that as a former academic and public health consultant.

I want pick up on one of my colleague's questions, which I take some issue with. The point of the data that I was trying to get out about the number of people who die at a similar time, coming off low to having an assessment, is to contradict the narrative and the rhetoric that has been established, again over a number of years, that people are shirkers and scroungers and trying to get off work.

You very rightly picked me up on the fact that instead of using ratios I was using actual figures, but I did produce a report in 2013 based on deaths of people on IB or ESA, which shows the death rate was 4.34 times higher than that of the general population. This is a sick and poorly group of people; it is not shirkers and scroungers, which is unfortunately what has taken hold in the tabloid press and elsewhere over the last few years. I would just like your comments on that, please.

Dr Litchfield: All I can say is that I saw quite a few people going through both the assessment itself and then the appeals, and the vast majority of them struck me as being perfectly genuine people. That accords with my experience over 40 years of seeing people who may or may not be fit for work in a workplace context.

I do think sometimes we try to devise systems to catch out the relatively small minority that is trying to cheat the system. By doing that we will quite often disadvantage vulnerable, very genuine people. If you devise a system like that, quite often the people who are most likely to fail are those most disadvantaged people, because they do not have the stamina—or sometimes the intellect—to be able to navigate the system. I am too old to qualify now, but I have little doubt that if I wanted to qualify for the Employment and Support Allowance, and indeed get into the support group, I could, because I would understand the system, I would know what you had to say and I could get in. People without my huge advantages are not in that position and the vast majority of them are genuine.

Debbie Abrahams: Thank you.

Chair: Dr Litchfield, thank you very much indeed. Thank you for the very interesting evidence that you have given us. It has been a very helpful start for our inquiry on this subject. Thank you for being willing to join us this morning.

Dr Litchfield: A pleasure. Thank you, Chair.

Examination of witness

Witness: Paul Gray CB.

Q27 **Chair:** We move now to welcome our second witness, Paul Gray, who I can see on the screen. Thank you, Paul, very much for being with us this morning. I wonder if you would just say a sentence or two to introduce yourself to the Committee?

Paul Gray: Thank you, Chair. Thank you for inviting me. My background career was in the civil service. Some many years now I did work in the DWP and was responsible for significant areas of disability benefit. Prior to that I worked in the Treasury, where I took an interest in these matters from maybe a slightly different perspective.

During the period that I was chairing the Social Security Advisory Committee, I was invited by the Department to undertake the two independent reviews of PIP, which had been legislated for in the Welfare Reform Act 2012. I undertook the first of those in 2014, and the second in 2016-17. I imagine the Committee has access to the reports and recommendations that I made at that time.

I should say, Chair, although I am very pleased to have the opportunity to give evidence this morning, I have not taken a serious look at these issues since I produced the second report in 2017. I apologise in advance that I have not been an avid follower of developments over the last four years, but obviously I will seek to provide responses to you to the best of my ability.

Q28 **Chair:** Thank you very much for being willing to do so. I am going to ask the first question. You referred to your two reviews. In the second of those you made 14 recommendations; nine of them were accepted and the rest were partially accepted.

Looking back, what would you say now were the main problems that you identified in that second review, and do you have a sense of how effectively the recommendations that were accepted and partially accepted have, in fact, been implemented?

Paul Gray: The central point that I highlighted in the second review—and that had been built on perceptions I had from the first review—was the serious lack of trust in the system from those who were going through the process of being assessed for PIP.

The recommendations I made were heavily focused on things that I felt stood a reasonable chance of rebuilding the trust. Critically, a number of my recommendations were focused on improving transparency within the system, and also seeking to provide greater assurance that the system was producing consistent and fair outcomes for claimants—and that in the context that the whole process of functional assessment for assessing eligibility for PIP is inherently a very difficult task.

One of the key things I had observed in the first review was that it was widely perceived to be a medical test, but that was never the intention. The intention was to assess the degree of people's functional impairment, which clearly has connections to underlying medical conditions but is not entirely driven by them.

In terms of my response to the effectiveness of the acceptance of the recommendations, on the positive side I was very pleased that the Department did take early action to introduce what was known as "function first" in the assessment process. What I had observed in both reviews, sitting in on assessments, was there was always heavy and early emphasis on underlying medical conditions and inadequate probing of the functional impact. I very much welcome the fact that the Department responded positively to that and turned round the whole basis of the assessments to focus initially and very heavily on the functional elements.

In terms of the whole range of the recommendations, as you say, Chair, nine were said to be accepted and five partially accepted. As I said to your predecessor Committee in 2018, I would judge one of two partial acceptances as being more like largely rejected than partially accepted.

The areas I was most disappointed in were the reluctance to introduce much greater transparency through automatic audio recording of assessments and automatic provision of the assessment reports to claimants. In both cases there were processes where people can ask for that, but it seemed the Department's reluctance to embrace transparency was always going to hold back the development of trust.

An area among my recommendations that was apparently accepted was doing much more work to assess the consistency of outcomes, and I advocated a lot more effort on that—what I termed deep dives of the Department, looking at a range of potentially comparable cases or similar cases and seeing what degree of consistency there was in the outcomes. I have not seen any publicly provided output on that process. It may be that in its auditing process the Department did more of that, but I looked with disappointment last week to see whether any research reports had been produced on that issue and I could not see any. It does not mean the work has not been done, but it does not seem to me yet to be publicly available and that is a big question the Committee may want to pose.

Briefly, in terms of other areas, I was disappointed at the slowness of the response to introduce digital processes in this area. I am pleased to see now there seem to be steps in that direction, but I think this area of the benefit system has always been a bit of a Cinderella in DWP in terms of investment. It certainly was when I was the civil servant responsible for it. One knows the Department has huge pressures on it and large numbers of priorities, but I was struck by the contrast between the focus as Universal Credit was being rolled out on digital by default and in relation to PIP it felt like "Digital when we can eventually get round to it". Hopefully that is now shifting.

The final point I would make is I made a recommendation that was said to be accepted for more work to be done on looking at the potential links between PIP and its potential for aiding employment retention of those who were suffering increasing functional impairment. PIP is not meant to be dependent on whether or not you are in work, but I discovered in the first review there was literally no recording of whether applicants for PIP were in employment or not. Potentially of some relevance to the report the Committee recently produced on the whole area of disability employment, I see significant scope going forward for looking at ways the different disability benefits, and this would take in evidence from Dr Litchfield on the other side of the house, looking in a more integrated way at the whole person the Department is dealing with, rather than having segmented product lines and not looking at the overall position of a particular claimant.

Q29 **Chair:** Have you had a chance to look at Marie Cavanagh's second review?

Paul Gray: Yes, I have had a quick look at it.

Q30 **Chair:** I wondered if, having had a quick look through it and it was published a year ago, there are points there you think might be applicable to the rest of the UK, and do you think there ought to be another independent review of PIP for GB?

Paul Gray: I think there was quite a lot of similarity between Marie Cavanagh's report and mine. Obviously, the whole Northern Ireland process was lagging several years behind the rollout of PIP in GB, but there were a number of recommendations she had made that were echoing things I had said, for example around transparency and automatically making available information. A number of reports around communications and improving those helpfully built on some of the similar recommendations I have made in that area. In my quick read of it, I was struck by the similarity of what she seemed to find in Northern Ireland a few years further down the track, given the different timescales for GB and Northern Ireland rollouts.

Regarding if there should be another independent review, they are a valuable process. Maybe I would say that, would I not? I think it is striking that the two reviews I was invited to undertake were a statutory requirement as a result of the parliamentary debates leading up to the finalisation of the 2012 Act. At the time I did my second review, the whole process of rolling out PIP was still at a relatively early stage. It is four and a bit years on and it is at a more advanced stage, so this would be a good time to undertake another independent review and have that extra look.

Let me immediately say that is not me putting my hand up to volunteer. I made the point, when I was approached about the first Northern Ireland review and whether I would be interested in doing that, that I felt then that it would be appropriate for fresh pairs of eyes to take a look. I have had two looks at it. I may have built up a certain amount of knowledge but I think there is always value in a different person coming in and giving it their perspective.

Q31 **Selaine Saxby:** One of the common problems we hear about is the quality and accuracy of assessment reports and how they are weighted in relation to other evidence. Do you think the measures the Department has agreed to in response to your reviews and our previous Committee's report are enough and if not, what else would you do in that particular area?

Paul Gray: They are a move in the right direction. One of the specific things I pushed for was to give more prominence and weight to evidence coming from those who knew claimants best, whether it is a formal carer or family members, and moving in that direction is helpful. I think the shift I referred to earlier—making sure the taking of evidence focuses very heavily on the functional impact and not relying too heavily on underlying medical conditions—is helpful.

Could more be done? Streamlining many of the processes of bringing together evidence, so it can all be assembled at the same time and in the right place—that can help. As I said earlier, being transparent about the outcome of the assessment reports and making that freely available to claimants alongside audio recordings of the evidence would massively reduce the potential after an assessment has taken place for people feeling, "This does not provide an accurate assessment of what went on in the assessment process." If it is very difficult for people to have access to that, it inevitably leads people to be suspicious, leads to more contention, and probably leads to more appeals, so being transparent about the whole process is integral to the point you are making.

Q32 **Selaine Saxby:** In 2021 the proportion of appeal decisions in favour of the claimant was 77%. What more do you think the DWP could do at both initial decision and mandatory reconsideration stage to make sure it is getting the correct decision as early as possible in the process?

Paul Gray: It is largely the points I have already touched on. I would also link it to the point I made to the Chair about the Department doing rigorous work to ensure there is reasonable consistency across cases. The challenges of the mandatory reconsideration and appeal process is inevitably that it is just taking individual cases as they come along and each one is being judged on its individual merits. If there were a more rigorous process, over time assessing consistency would undoubtedly help.

I note in the evidence the Committee has had recently from the Department that the number of mandatory reconsiderations that lead to a change of decision has increased. I am pleased to note that, because my observation at the time of my reviews of the mandatory reconsideration process was that it was not sufficiently rigorous, was not taking a sufficient second look at cases. I take modest encouragement from the fact that process appears to be undertaken more seriously.

Q33 **Chris Stephens:** Good morning, Mr Gray. Your reviews and several others have argued that DWP needs to improve the ways it gathers and uses third-party evidence to assess claims. Why has it been so difficult for the Department to do that?

Paul Gray: I am not sure I can give you the answer. You probably need to ask the Department that question. A point I made earlier to the Chair is that this is a complex process. It is not the easiest thing in the world to run, but I think the department could and should have put more effort into this. Streamlining some of the processes, making greater use of digital capability may be a way of helping this. At the time I was doing my reviews, the whole processes were very clunky, paper driven and not very well joined up, and if one could introduce more digital processes with appropriate safeguards, easier ways of sharing data between different sources, that could help.

Q34 **Chris Stephens:** You mentioned the 2018 enquiry from this Select

Committee. We recommended the Department should require contractors to specifically indicate how they have used all third-party evidence supplied and the resulting checklist should be supplied to claimants alongside a copy of their report. Could you explain what has happened with that recommendation and give your views on why that is the case?

Paul Gray: I cannot because I do not have access now to what has been done on that. I was very disappointed that the Department rejected my recommendation for automatically supplying copies of the assessment reports. I do not know what they did in response to provision of the checklist point, but going back to my central point earlier, if you do not have full transparency in these systems, you will breed mistrust and generate much more challenges and appeals in later stages of the process.

Q35 **Chris Stephens:** Your own second review asserted that a claimant's own declaration of the impact of their health conditions should also be given suitable weight. What stage are they at in seeing that implemented?

Paul Gray: I hope that is happening, is all I can say on that. You may have to pursue that with the Department.

Q36 **Chris Stephens:** In your second review you recommended to seek to ensure that evidence of carers and family members is given due weight, so is that the same again? Are we waiting to see that being implemented?

Paul Gray: Yes, that recommendation of mine was apparently clearly accepted by the Department. The introduction during the height of the Covid-19 period of more online processes possibly helped in that it meant that family members and carers could more easily connect into assessment processes. That may have been a slightly accidental outcome but I welcome the fact that—without, as far as I could see, any significant argument—the Department accepted my recommendation that those who know claimants best and see them most are best able to judge the degree of their functional impairment. That evidence should be given appropriate weight. It should be tested alongside all other evidence, but if it is not there in the first place, it automatically will not get the right degree of weight.

Q37 **Chris Stephens:** You spoke to the Chair about the Department's function first report and how PIP was there to assess functional impairment rather than offer a medical assessment. Do you believe that is sufficiently clear to claimants, and what are the implications for them if it is not clear?

Paul Gray: I suspect it is not yet clear enough. I have not spoken to claimants for the last four-and-a-bit years. It was really striking to me when I did my reviews and deliberately spoke to groups of claimants and potential claimants, that there was a deeply embedded, almost universal response of, "This is about me going for my medical". That was the language people used. I was also struck and disappointed that, even in talking to assessors and members of the Department, medical was the word that kept coming up. People always talked about further medical evidence. FME was an embedded acronym, which is why I put so much emphasis on it.

I hope the balance has shifted over time, but I think understanding that distinction between going for a medical and going for a functional assessment is quite difficult. What I have seen in the guidance—more recently both from the Department and looking at online guidance from organisations that seek to help and support claimants—is increasingly clear about that. I suspect this is a journey that is not yet complete and there is a difficult point for people to recognise that people with the same underlying medical conditions can have very different functional impacts.

That is not just a physical issue. There is often a motivational issue here. If you compare a successful Paralympian with somebody from a very deprived background and a poor background and very difficult life experiences, there will inevitably be a very difficult process of assessing between those two types of people what degree of functional impairment they have. Inevitably, some people are much more strongly motivated and driven to overcome those than other people who perhaps have more difficult life backgrounds. This is a very difficult thing to do and one has to bear that in mind.

Q38 **Chris Stephens:** Finally, has the Department taken any significant steps to clarify the priority of functional over medical in assessments?

Paul Gray: I think they have in response to my second report and some of the guidance I have seen. Have they done enough? I am not sure, to be honest. I think that is a good question to pose.

Chris Stephens: That is something we will certainly take up with the Department. Thank you, Mr Gray.

Q39 **Debbie Abrahams:** Good morning, Mr Gray. I do not know if you heard my previous questions to Dr Litchfield but I wanted to ask these before I get on to my substantive question. You may have heard about the tragic death of Philippa Day back in 2019. She died after complications with her transferring from DLA to PIP, unfortunately. She took an overdose of insulin. The coroner issued a prevention of future death report to both the Department and to Capita in relation to that.

I appreciate that her death was outside the timing of your review, but there were also some written questions more recently by my former colleague, Madeleine Moon, who looked at the period between 2013 and 2018, which did cover your review period. Between that time there were 73,800 claimants who died within six months of the PIP application being registered and 130 working-age people died every month, having being found ineligible for PIP following the initial assessment and died soon after. This is absolutely tragic for the individual and the family, but what do you think it says about the efficacy of the process?

Paul Gray: In quoting those figures it is extremely difficult to immediately attribute any issues of causation. I sought to give appropriate emphasis in my reviews to the need for people at all stages in the process to recognise that in many cases they are dealing with people at a vulnerable stage in their lives and the process needs to be appropriately empathetic. At the same time, it is an assessment process to judge whether or not it is appropriate for the provision of additional public money, and that is always going to be a difficult balance to strike.

Q40 **Debbie Abrahams:** Can I interrupt you there, if you do not mind? I understand absolutely what you are saying. It is public money and we need to make sure public money is allocated appropriately. But firstly, were you made aware of this data, and if you had been aware of the data, how would that have affected your interpretation of what you were seeing and the recommendations you would have made?

Paul Gray: I was not aware of that precise data. I was aware at the time that there had been publicity around a number of tragic cases of people who had gone away from a PIP assessment process and there had been very negative consequences. But in terms of the particular case you mentioned from 2018, if it was a coroner's report that indicated some degree of causation, then that was extremely sad.

Debbie Abrahams: They did find that it was causal.

Paul Gray: You cannot draw causation links between the number of people who happen, sadly, to have passed away within whatever period of having a PIP assessment process—

Debbie Abrahams: It is worth further investigation, is it not?

Paul Gray: I think the data you have quoted is very striking but I would advocate being a little cautious about automatically jumping to causational conclusions on generalised data.

Q41 **Debbie Abrahams:** I recognise all the things you say, but do you think the Department has a duty of care? It is not necessarily causal and you do not know, but does it have a duty of care, not just at an individual level but in trying to understand what is happening to claimants who are subject to policies of the state?

Paul Gray: Of course, there is a duty of care in any process of this sort to treat people fairly, appropriately and empathetically, ensuring, for example, that the logistical arrangements for people who are invited to attend face-to-face assessments are as convenient and appropriate as they can be. In the early days that was not working as well as it could be. I hope that has improved. Continuing always to improve the communication products that emphasise what this process is about in a fair and appropriate way is possible; going out of their way to make sure family members, carers, could be in a position to accompany or help people going through the assessment processes—those are all things that it is entirely appropriate for the Department to undertake, and my sense is the Department is aware of that sense of duty. Have they always got it right in every case? In the same way, do any of us ever get all these things right in every case? Possibly not.

Debbie Abrahams: It is a learning process and it absolutely should be.

Paul Gray: It is a learning process.

Q42 **Debbie Abrahams:** Can I move on, Mr Gray? You may have heard me mention this figure to Dr Litchfield—it is £583 per month on average of extra costs going back to 2019. There has not been an update in the last couple of years and we know how the cost of living has risen significantly since then. One in five of the more than 14 million disabled people in our country face costs of over £1,000 a month. What does that say about the adequacy of the PIP payment?

Paul Gray: Having an elderly family relative, I am well aware of the extra costs of disability and care. What that says is that any Government of the day has to reach a view about the level of additional extra cost support it will offer in a scheme such as this. It will often sit alongside other kinds of resources in care, not least the social care system. In my report I touched on the case for a little more co-ordination and inspiration across the benefits and social care system. Ultimately this is a political decision that Governments have to take as to how much they wish to commit. I note the total cost of PIP and DLA has continued to be on a rapidly rising trajectory; over £20 billion this year. I note from the tables in the detailed Budget documentation from this autumn that it is now projected to rise to over £30 billion by 2026-27. As a public expenditure programme, this is a very large one. This is larger than many other entire Government Departments. Those are the choices any Government have to make. It is a political question, frankly, not a question on which I as an independent reviewer think is possible to offer a view.

Q43 **Debbie Abrahams:** Point taken, although I need to say that £6,500 per disabled household has been lost over the last 10 years, but there you go.

Finally from me, could you explain a little bit about how you engaged with disabled people who were seeking to claim PIP? How did the principle of "Nothing about you without you" feature in your reviews?

Paul Gray: When I did my first review, when PIP rollout was at a very early stage, was very deliberately spend quite a fair proportion of my initial evidence-gathering by convening groups of claimants and potential claimants around the country. I went and talked to them about their perceptions and their experiences. I sought to give that direct claimant perspective as strong a profile as I could.

In my second review, I did not do quite as much of that. I felt I still had, two years on, a reasonable sense of perspective on that. I focused rather more of my time in talking to representative claimant organisations and gathering information from them, which obviously they were in a position to assimilate and pass on to me.

Debbie Abrahams: Okay. Thank you, Mr Gray.

Q44 **Shaun Bailey:** Mr Gray, how confident are you that the Health Transformation Programme is going to re-engender trust in the PIP process? In particular, I do not know if you heard Dr Litchfield's comments before, which I found quite interesting. When we look at these delivery programmes, the focus seems to be very operational as opposed to more on perhaps the broader holistic approach. What specific measures do you think need prioritising to ensure that it is as holistic as possible and achieves the aims that it intends to?

Paul Gray: I have read the written evidence that the Committee has had from the Department about its initial ideas under the Health Transformation Programme. I welcomed some comments that you have had about looking to potentially join up assessment processes or, at any rate, have a single set of assessors both across the WCA and PIP. I think that going down that route would be extremely helpful.

I would hope that as the transformation programme rolls out it does embed rather more fully than I suspect is the case at the moment the essence of the recommendations that I put forward back in 2017. What I am not able to do, I am afraid—again, I think this is something the Committee will need to pursue with the Department—is give you my own assessment at the moment of how successful I think it will be, because I have seen very little from the evidence that the Department has given you so far that is very concrete. It is, understandably I think, fairly high on generalities at the moment and relatively low on specifics.

Q45 **Shaun Bailey:** For you, what would be the metric of success for the programme, and what solid metrics would you expect to see in order to know that the programme was succeeding in what it was aiming to do?

Paul Gray: Going back to a point I made to the Chair, it would be demonstrating and making public more information that gave greater assurance about the consistency of outcomes across the process, and more emphasis on looking at the overall position of claimants through these different processes, so that rather than the Department predominantly taking, as it were, a product-by-product view of what the outcome is under the WCA, what the outcome is under PIP and what the outcome is under any other DWP product, there is a more integrated look at the position of disabled people, so that there was a clearer view about the overall needs of each claimant and the overall position that they face.

That kind of joining up would be highly desirable. The present processes are quite clunky and not terribly well joined up, and therefore I do not think they are providing as good a service either to claimants or to the taxpayer as would be desirable.

Q46 **Shaun Bailey:** That is really useful. As I have been doing my preparation, I have been looking at the procurement around this, particularly the Department's approach to taking things in-house. Interestingly, my understanding is that within the HTP areas the Department intends to recruit healthcare professionals employed by DWP to effectively carry out the assessments. However, it has issued out to tender, I think last month, November 2021, for companies to run the PIP assessments. In written evidence to this inquiry, the Department has made it quite clear that it does not intend to bring assessment services in-house. I suppose my question is: what do you perceive to be the balance to be struck in this between the Department bringing things in-house and still outsourcing? The impression I am getting from this is that maybe there is a degree of recognition from the Department that in order to join things up, things do need to be brought under that one banner. I do not know if you have any perspectives on that at all, Mr Gray, particularly from your time as a civil servant.

Paul Gray: I think it is a very interesting question. I got the same impression as I think you have from the written evidence you have had so far from the Department that this is very much a gentle dipping of the toe in the water in terms of potentially bringing it in-house.

I would say—it is not something that has come out so far during my evidence—that I was struck very strongly during both my reviews by the lack of joining up and regular dialogue between people doing the assessment, the current outsourced ones through Capita, Atos and so on, and the in-house decision makers. At the time of my first review, and I explored this in some depth, there was literally no dialogue going on at all. I would talk to a group of assessors and I would talk to a group of decision makers. Frankly, there was mutual suspicion between the two groups. There were no arrangements set up for dialogue. Each felt the other was part of the problem rather than part of the solution. I strongly recommended that there should be much more regular dialogue between those groups, again going back to the concept of a learning process that one of your colleagues mentioned just now—people learning the different perspectives.

That potentially I think was a fault line in the initial design of the process. I do not take a strong view one way or the other as to whether you should completely try to integrate them, completely bring everything in-house or not, but certainly on the basis of what I was seeing back in 2017 that was completely insufficiently joined up and integrated as a process and was inevitably likely to cause problems later down the track.

I think that it is an important area to explore. Whether it should be in-house or contracted out is only one part of that question, but if you stick with parts in-house, parts contracted out, you have to make sure those two fit together much better than certainly they were doing when I did my reviews.

Q47 **Nigel Mills:** Mr Gray, I think the previous time you appeared before us, four years ago, you said that one of the key issues with PIP was that it has very precise boundaries of entitlement and if you get one more point somewhere you can get a dramatically different amount of benefit. Is that something that you think could be addressed and changed, or is that just a fundamental issue with the system that you either are entitled or you are not?

Paul Gray: This is a very difficult issue and I certainly hold to the comments I made earlier that any cliff-edge system has that characteristic. I guess you could in principle introduce a slightly greater degree of smoothing, but I think it is very difficult to come up with a completely different system that would wholly overcome that problem.

I saw that very much as linked to my recommendation about much more rigour by the Department in assessing the consistency of outcomes. At the moment, both for the daily living and the mobility elements, eight points and 12 points are the key triggers: eight points to get the lower payment, 12 to get the higher. I think I am right in saying that all the individual descriptors attract a score of at least two. There are none, I think, that have as little as one. In order to get your eight points to get the lower rates of either, you need to get, essentially, four twos. The difference between somebody who managed to get three twos and somebody who managed to get four twos could turn on a very fine judgment of the evidence around that fourth descriptor.

I think the analytical job that needs to be done, to assess how much of a problem this is, is intensive evaluation of people at those boundary points. What I had in mind when I was recommending deep dives was, let's say, to take groups of cases that fell between, let's say, six and 10 points on the one hand and 10 and 14 points on the other, that straddled those cliff-edge points. If the evidence made publicly available provides reasonable assurance that, yes, there is consistency across the system, then maybe you can live with that. If it emerges that there is not that degree of consistency and it is a bit more of a random process about whether somebody ends up with six or eight points for a given broad degree of functional impairment, then to my mind that would very much strengthen the case for saying we need to look at some way of introducing a degree of smoothing.

I do not think, as I said earlier, there is an easy solution to this. In any system of this sort you are going to have points where eligibility is triggered or not triggered. To a large degree, I think it is inherent in the system. I would want to see much more evidence presented as to whether the outcomes are showing this is a real problem or not.

Q48 **Nigel Mills:** Thank you. I suppose you have had a few years to reflect on your views on PIP. Do you think PIP is just about the right benefit and the right structure or do you think that we should do something almost completely different, and that a benefit that has been around probably less than 10 years, hasn't it, was wrongly conceived and we should change it, or is it just about okay?

Paul Gray: Obviously, PIP introduced some changes from DLA, but in this regard I would say the systems are broadly similar. They both are based on the principle that you need a benefit that provides a contribution to the extra costs that people who have a degree of functional impairment face, and it is appropriate for the taxpayer to provide that. I think that philosophy underlying the benefit is a sensible one. I think it is the correct one. There are, clearly, people in our society who through no fault of their own do face additional costs, for whom it is appropriate for the state to give some degree of support. You can play around with the details of these systems, but on that fundamental design point, unless the political consensus is, "No, we're not going to do that, we're just going to expect people to rely on the same degree of state support whatever their functional abilities", then, as I say, you need a system of this sort.

What I would advocate, to come back to a point I made earlier, is to have more joining up or a more joined-up look at individuals who are going through the PIP process and what their overall position is, either in terms of employment retention or other parts of the benefit system, looking more at that whole individual. I had an interesting conversation during my second review with a quite enlightened jobcentre manager, asking him whether he thought it would help in the service that the jobcentres provides to people approaching the benefit system if he could have sight of the PIP position for that claimant as well as the other position. He was quite clear that that would be an effective way of looking in a more holistic way at the position of people with whom the benefit system interacts.

Q49 **Siobhan Baillie:** Thank you for joining us today. You will recall that when the PIP system was being designed and the changes from DLA were envisioned, the aim was twofold: first, to provide a more dynamic, fair and transparent system for claimants, but the second part was to create savings in the welfare benefits structure. I understand that there was an expectation forecast of around 600,000 fewer claimants, with about £2.5 billion in savings. That was 2011-12. Fast forward to 2015, and we were looking at a two-thirds rollout of the new system but an expectation that even with that rollout there was a 20% increase on the costs. Then the 2017 review reflected that the disability benefits continued to rise even with the PIP rollout. Do you have a view on why PIP has failed to achieve fiscal savings that were projected back in its conception?

Paul Gray: Yes, I do. I did focus on this in my 2017 report. Page 15 of that report produced a chart showing the successive variations and uplifts to the projections from one year to another—what I termed a porcupine chart, where the change in shape that was projected kept failing to materialise.

My blunt answer to you is that the projection of savings back in 2011 and 2012, when the system was being designed, was a triumph of hope over experience. As a former Treasury official for many years, I quite understand the concern of those sitting in the Treasury that DLA expenditure was going up very rapidly and they might wish to see some check to that. In terms of the way that the PIP parameters were redesigned relative to the DLA ones, with the benefit of hindsight, looking back on that, I think it was completely unrealistic to expect that change to generate the expenditure savings rather than to, hopefully, produce a better targeted system.

As I touched on earlier in reply to one of your colleagues, that steady upward growth would appear to be ongoing. The statisticians at the Office for Budget Responsibility, who are responsible for these projections these days, clearly think roughly the same rate of growth is going to carry on over the next few years, with a 50% increase over the next six years, which I think is broadly the rate of growth one has seen in this area of benefit expenditure.

Although I recognise the concerns of people who are claiming PIP and not getting it, the overall picture clearly is that since the introduction of PIP there has been a progressive growth in the number of people securing entitlement and the expectation currently appears to be that that will continue. That clearly needs to be borne in mind, alongside whatever concerns there are about the hardships that people are facing and so on and so forth.

Q50 **Siobhan Baillie:** Thank you. For my second question, and you may have heard us ask Dr Litchfield this, the Department has suggested that it might in the future look at introducing a single benefit to replace PIP and ESA. What is your view on that and the likelihood of its success if that was the step forward?

Paul Gray: Looking at integrating the two things more fully, as I said to some of your colleagues just now, I think is a good idea. Purely producing a single benefit rather than integrated processes for assessing them may have something in it, but I think the notion of identifying those people who do face additional extra costs because of their particular functional impairment is a strong principle: integrate the processes much more. Looking at whether you could possibly produce a single benefit—yes, but I am a little sceptical as to whether you would ever manage to streamline it sufficiently so that everybody was in receipt of exactly the same rate of benefit.

Q51 **Siobhan Baillie:** Finally, you were very honest at the outset that you have not been following every move of DWP following your reviews, for which I do not blame you; that is our job. Have you had any eyes on what the pandemic has brought to the Department? Digitalisation and the shifting around of civil servants to meet needs have been quite widely reported. Do you think any of those changes that you have heard about could be made permanent and would be of benefit?

Paul Gray: I think so, yes. I expressed my frustration at the earlier lack of progress on digitalisation in this area of the Department’s work. I recognise that it had to make priority choices. I think what we have seen, certainly around Universal Credit, is that the impetus that was given to different ways of doing things by the pandemic, whatever stresses and strains it brought, did accelerate some changes that maybe would have been desirable in any event. My sense is that that is similarly true of PIP. It has given a kick start to making greater use of online processes and seeing to what extent they can be successful, what benefits they bring and potentially what challenges they bring.

On the principle that every big cloud occasionally has a silver lining, I think that there is a silver lining here. I am pleased if that has given a bit of oomph to the process of looking at more modern, more streamlined and more effective ways of assessing this better.

Q52 **Chair:** Thank you very much. Finally, can I put to you a point that occurs to me arising from a couple of points you have made, particularly the point you made to Nigel Mills about jobcentres being in the loop on claimants' PIP status and the point you have just been making to Siobhan Baillie about integrating the process for ESA and PIP? At the moment, PIP is a very centralised process. If we have constituency queries about PIP awards, we write, I think, to Wolverhampton. If we have queries about ESA or Universal Credit, we write to the local jobcentre. Do you think that PIP should be administered on a more devolved basis by local jobcentres rather than the centralised set-up that is in place at the moment?

Paul Gray: I have an open mind about whether it should be administered differently. What I do strongly feel is that there should be more visibility across the different systems. We are all familiar these days in our private lives with the degree to which big private corporations are very effective at joining up different bits of our lives and offering us prompts. Amazon is very adept at watching my buying behaviour, observing links about things that I do and don't do and giving me prompts. The big supermarkets are very good at doing that. The insurance companies are getting increasingly good at doing that. It is a slightly scary world but as long as there is appropriate consent here for people to be joining up information about us, I think that is an entirely appropriate direction of travel in society.

My sense is that DWP has much more potential through the use of modern data analytics, which I do not remotely claim to be an expert on, but I have observed its operation via other people. I think there is much more potential for taking that whole-person view of people who are interacting with different bits of the benefit system rather than, as was certainly the tradition, Chair, when both you and I served in different capacities in DWP, it being very much a siloed, individual product focus. That is unfortunate because I think it is missing opportunities, both in the interests of the claimant and probably in the interests of the taxpayer, for taking a more joined-up look.

As I say, I do not think that necessarily says everything has to be administered in exactly the same way. DWP is a vast business. It does need to kind of chunk up the processes. What I strongly advocate is that it continues to learn from best practice, with appropriate safeguards, of what other large organisations are doing about appropriately joining up data about different parts of people's lives that are potentially connected.

Chair: Very interesting. Thank you very much indeed. That concludes our questions to you. You have given us a lot of material to think about as we go through this inquiry. This morning is our first evidence session on assessments for health benefits. Thank you very much for being willing to help us. We are grateful.

Paul Gray: Thank you very much.