HOUSE OF COMMONS

Work and Pensions Committee

Oral evidence: Personal Independence Payment, HC 1067

Monday 6 March 2017

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Watch the meeting

Members present: Frank Field (Chair); Heidi Allen; Ms Karen Buck; James Cartlidge; Neil Coyle; Craig Mackinlay; Royston Smith.

Questions 1-60

Witnesses

I: Sam Ashton, Senior Policy and Campaigns Officer, Z2K, Gary Edwards, Manager, Southampton Advice and Representation Centre (SARC), Kayley Hignell, Head of Policy (Families, Welfare and Work), Citizens Advice and Tony Lea, Lead Welfare Rights Officer, Benefit Resolutions CIC.

Examination of witnesses

Sam Ashton, Gary Edwards, Kayley Hignell and Tony Lea

Q1 **Chair:** Thank you very much for coming here at such short notice. We are immensely grateful to you. Sam, can we start with you and then go down the row? Could you say who you are, the organisation and what part of the country you are from?

Sam Ashton: I am Sam Ashton. I am the Senior Policy and Campaigns Officer at the Zacchaeus 2000 Trust. We are a welfare and benefits advice agency based in Westminster but we support low income households from across London.

Gary Edwards: My name is Gary Edwards. I am from Southampton Advice and Representation Centre and we support people who live in Southampton with all aspects of welfare benefits and employment law.

Kayley Hignell: I am Kayley Hignell from Citizens Advice. I work in our national policy team as the Head of Policy. I also volunteer at Camden Citizens Advice.

Tony Lea: My name is Tony Lea. I am a welfare rights advocate from Cornwall, representing Benefit Resolutions CIC, and we represent people nationally countrywide in representation at tribunal.

Q2 **Heidi Allen:** Thank you very much for coming, particularly at such short notice. I think we pretty much all know why we are here but just by way of an opening first question, talk to us about PIP as it works at the moment and what helps or does not help it for the right decisions popping out at the other end of the process.

Sam Ashton: I would say that, from our clients' experience, the only part of the PIP process that we are happy with at the moment is the appeals process. I think that is indicative of the appeal success rate of 60% or more but it is the only part of the process that is reaching a correct decision as far as our clients are concerned. At the heart of most of the problems we have with the PIP process is the assessment and the face-to-face assessment. We think it is an inherently flawed assessment. It does not accurately assess claimants' capabilities in reference to the descriptors. We believe that the system is not working on its own terms. It is not properly assessing whether people are capable of what the descriptors set out and that is without even talking about problems with the assessment as it is designed.

Gary Edwards: When you fill the form in there is a really good part on the first or second page of the form and it asks you who your current health professionals are. What happens is that that is never taken up either by Atos, which is our provider—Capita may be the same—or by the decision-makers. It is inherently flawed at the first stage because

decisions are being made without all the evidence. That is why we are all stunningly successful in appeals, because that is the first time that all the pieces of the jigsaw are put together. I think the question that needs to be asked of the decision-making process and the decision-makers is: why ask the question, "Who are your health professionals?" and then ignore it? We could save paper on the form, couldn't we?

Kayley Hignell: At Citizens Advice we see nearly 50,000 people a quarter about PIP. That is a huge scale; it is an awful lot of people. We have seen a 37% increase this year in the number of people who come to us. It is our biggest single issue, so it is fair to say we do have quite a lot of challenges with the administration of PIP and how it is working and how accurate those decisions are.

Q3 **Neil Coyle:** It has overtaken ESA, hasn't it?

Kayley Hignell: It has overtaken ESA more recently, although I would say ESA is starting to grow as well at this point in time. We have seen some improvements in the claim process, and you mentioned the form. We think the form has improved compared to DLA. Being able to make a claim over the phone and start your claim date from that point is very useful, and there have been some attempts at getting evidence about fluctuating conditions. But I would echo colleagues here to say accuracy of assessments is a real issue, use of and supplying or requesting medical evidence is a big issue. On accuracy, when we have asked our network about this, 88% of the network said to us they have seen cases with inaccuracies on the PIP assessment before and afterwards. Again, it is not a one-off case; it is quite systematic, potentially, or systemic within it.

Q4 **Chair:** Kayley, I didn't hear that properly. Might you speak up anyway, but what was that fact: your network will be covering how many bureaus?

Kayley Hignell: The network at Citizens Advice is nearly 300 local offices and, as I say, we see 50,000 people a quarter about PIP. We ask them each month questions about how things are going on different benefits, whether it is consumer or benefits, and on that 88% of the network told us that there were inaccuracies on the PIP assessment report.

Tony Lea: I think this is a very ambiguous question: is it conducive to people with a disability? Absolutely not. Currently, the DWP is using policy as law. Their policies are continuously harming people and every time I approach the DWP in individual cases, "Our policy is this". I then take it to tribunal and their policies get blown out of the window, absolutely blown out of the window. Until they start adhering to their own guidelines and to the law, to the letter of the law that each tribunal represents to prevent miscarriages of justice, this is never going to be conducive. Right from the beginning, these people have barriers at the start of the application form. There is no legal aid; there are no organisations apart from the very few that are here today and maybe a few you have seen before.

But this is not conducive to them. You are telling people they are not disabled; you are telling people, "You are lying". You are saying to people with arms and legs missing, "Grow them back. There is nothing wrong with you". For goodness sake, at Christmas we were in *Private Eye* to do with an 18-year-old with his whole intestine removed, the whole lot. "Our policy is". Well, "Our policy" has just made someone very, very ill and a week after we won at tribunal. They have now been diagnosed with Crohn's in the smaller intestine, in their lymph nodes and in their liver. How is this conducive? I am sorry that I have to be so vehement.

Q5 **Chair:** Tony, one of the things with the tribunal decisions—which the Government now wish to overturn with new regulations—has been that it particularly disadvantages people with mental illness.

Tony Lea: This is a big area.

Chair: Can I just finish the question?

Tony Lea: I am sorry, sir.

Chair: To what extent is it that the form is badly designed or the people reading the form do not know what the original policy of the Department is or was?

Q6 **Heidi Allen:** If I can I build on that exactly, is it the fault of the form filling, the assessor who looks at it or when it goes to the DWP decision-makers? These are different points in the process, aren't they?

Tony Lea: DWP decision-makers are not even medically qualified. They start reading these medical letters and half the terminology we don't understand because it is medical. These DWP decision-makers may know what a plaster is but when it comes to serious disabilities and mental health issues or these invisible illnesses, as we may call them—things like fibromyalgia, Alzheimer's, dementia—many of these people have to live in the community and, unless they hit crises where crisis intervention is needed, they have to manage their conditions. That means there is no medical evidence for years on end because all they do is take their medications, they are financially in their own little routine and they cope. Then someone comes along and says, "We don't think your functionality is impaired, that is what you are saying to us. We are going to take your money away".

Q7 **Neil Coyle:** Are you saying there is an incentive for not taking your medication if you have a severe—

Tony Lea: Why would there be an incentive not to take your medication?

Q8 **Neil Coyle:** In that it is only when your life is chaotic that you would qualify for PIP.

Tony Lea: No, rubbish. PIP is for people who can work. Many people with PIP can work.

Q9 **Chair:** Don't let's go down that route. Gary, will you come in, please?

Gary Edwards: Thank you. I think that the big key is making sure there is evidence at a very early stage. That is the real thing. I still have a fundamental issue about how fit the test is. We have had plenty of examples where people have serious mental health issues and they are being assessed by physiotherapists. I have real problems with that and I think the public needs to have confidence in the system.

One of the things that could be much better is the transparency, because what we are looking at is a legal test, aren't we? It is not necessarily a medical issue in itself. If the points were published in the guidance then people may have a clue when they are filling the form in as to what we actually look at.

One of the big issues we have in a lot of the cases that we have to take to tribunal is where the DWP has not applied its own guidance. For example, if there is a variable condition, they may be able to do things once or twice but you need to look at if it is repeatedly and within a reasonable timescale. Sometimes it is as simple as us pointing out to the DWP what its rules and regulations are that allow the cases to be overturned.

Q10 **Chair:** If we start with the form, is the form adequate enough?

Tony Lea: No.

Gary Edwards: With that guidance, let's be open and honest. Let's tell people how they are going to be assessed in the guidance. The form isn't terrible. There have been some small changes recently. One in particular was, "Do you use an aid?" when the actual test in law is, "Do you need an aid?" They have changed that, which we welcome.

Sam Ashton: One of the main problems with the form—I don't think the form is the worst part of the PIP process—is where it says, "Please provide contact details for your healthcare professionals". The impression is given to claimants that the DWP will definitely contact those healthcare professionals and get evidence. In all the cases we have worked on, we have never seen a case where the assessment provider has requested evidence from the healthcare professionals named on the form. Claimants don't necessarily submit evidence with their application because they are under the impression that that evidence will be sought. Even if they did understand the necessity of submitting evidence, they do face severe barriers. For example, people don't mainly know that GPs and other doctors charge claimants for providing. Something as simple as a letter can cost £60. If you are a low income PIP claimant that is an insurmountable financial barrier to accessing the support you need.

Q11 **Chair:** I am trying to be fair to the Department. Nobody comes to my surgery and wastes their time and my time to say, "Actually, this is working really well". They come to tell me it is not working well. It is possible that the Department does sometimes check up on those health professionals but they are not the people who come to us or to you.

Gary Edwards: Because it went well and a proper decision was made.

Chair: It means there is a lesson there.

Gary Edwards: I think it would be helpful if the Committee were to make an inquiry to say, "In how many cases did you get early evidence and was there subsequently a successful appeal lodged?" That might be the key in getting that evidence. It is evidence, evidence, evidence.

Q12 **Royston Smith:** We were talking about whether or not a physiotherapist is qualified to carry out a mental health check. Let me just expand this. If you are having a significant number of people who are going through, first from their assessment, then to DWP and then finally to appeal, there are also a larger number of people who are not doing that. Within that, we can assume that some people are physiotherapists carrying out mental health checks and doing them correctly. Isn't the question not about whether it is a physiotherapist or a paramedic or even somebody with mental health experience? Isn't it something about good people who do it right training the other people who are not doing it right so that we get a more consistent approach? Isn't there something in that?

Gary Edwards: I accept that and I can say I went for the very first time to a PIP assessment last week. There was a combination of both mental health and physical disability. It was someone who was previously on a Disability Living Allowance. They thought they had it for life but, unfortunately for them, they were two years too young for that.

I have to say that that examination was really good. I went there thinking, "This is going to be absolutely appalling" but I was surprised. They took two hours. There was also a physical examination. One of the issues we have is that, when we see the appeal papers coming through, there is a very detailed musculoskeletal report and it says, "This person can move their arm 50 degrees, 60 degrees" or whatever, and people tell us there is no examination. It doesn't happen. We have challenged Atos about that and Atos has said that the best observation is that it is a casual observation, which is not an examination that could give you such specific results. We checked that out with a local surgeon who said it would be impossible to give that level of detail unless it was a guided and instructed formal examination.

Yes, I think you are right, Royston. There are clearly some people who are doing their jobs very well but there is a need, isn't there, for the public to have confidence in the process? What happened before when we had DLA was there were a lot fewer assessments—it was more of a self-assessment benefit—but people invariably saw a doctor. People perceive that doctors can't be put under pressure from whoever their employer is or perhaps the DWP to deliver the results that they feel they want the Department to give. It is about that perception as well.

Chair: On this point, Tony?

Tony Lea: I come from Cornwall and I cover Cornwall and Devon. The rural locality is a nightmare. Last year Atos put an assessment centre in Cornwall—after our intervention with them—because people were travelling from as far as St Ives all the way to Plymouth for an assessment, which is about a 130-mile journey there and back, or approximately 110 give or take.

GPs are charging claimants between £30 and £130 for medical evidence. Some of these claimants have had their money stopped, so I don't know where they are getting the money from. It is just hard to know. I find it quite ridiculous in regard to you saying "physiotherapists" when it is musculoskeletal. I deal with a very small number of musculoskeletal things. Most of it is invisible: mental health, dementia, Huntingdon's disease, Crohn's disease, pancreatic cancer.

Q13 **Royston Smith:** Are you suggesting that people with mental health conditions should only be assessed by people who specialise in mental health?

Tony Lea: They should be assessed by a professional who understands that condition. It is a bit like me coming and overseeing you and saying, "You don't know what you are doing".

Chair: But you do that once every five years.

Q14 **Neil Coyle:** The Government are spending more money and one group that has benefited, because of communication descriptors, is people with learning disabilities. Do you think that is because those people tend to have more support as they go through the process? Linked to the point made about people transferring from the DLA, the Department for Work and Pensions often communicates to where it thinks someone might be over-claiming, so it tends to call people in for other assessments, but it does not seem to share the information particularly well that it holds on someone with DLA who is moving into PIP. Would that sharing of information within the Department help at all?

Gary Edwards: I have been to appeals where the appeal has been adjourned because the tribunal had decided that they needed to see the DLA packs. They are different benefits and they do have different criteria, so we can't lose sight of that. The thing with PIP is it is very prescriptive; it is points make prizes and it is as sharp as that. That is why 20,000 motability cars have gone back because they don't meet the criteria. We have had the crazy situation where the car has gone back and then a week later—it is a bit like they have won "Bullseye" again or something—they have got the car. It is a crazy situation.

Tony Lea: I had one similar to that.

Q15 **Chair:** What I don't want, Tony, is people repeating what we have heard. We are really anxious to develop a theme here.

Tony Lea: I was just going to give you another example.

Q16 **Chair:** Gary, generally speaking, all four of you think the form is adequate; is that right?

Gary Edwards: There have been amendments to it, but please tell people how they are going to be scored. Let's put in the guidance, let's put the descriptors down so they have a chance of knowing how it is scored. The Department might not like that.

Q17 **Chair:** All right, that is point one. The second point is: do people then have enough time to fill in the form and to collect the evidence before a decision-maker makes a decision? Is there a problem there?

Sam Ashton: There is a problem with that. You cannot send information by e-mail to the DWP PIP department. That is a fault. Sorry.

Q18 **Chair:** No, great. Kayley?

Kayley Hignell: Could you remind me of the question? Sorry.

Q19 **Chair:** I am trying to get to where problems are in the present system, even if it was not being overturned or challenged by the tribunal system and in the court and the Government then counter-challenging. For example, without any of this new stuff, why has it now become the number one topic for the CAB?

Kayley Hignell: Some of this is about the actual rollout of the benefit. People come to us anyway. When you change a benefit, people are unsure of what is going on. But I would stress that we also see quite a lot of evidence of challenges. With claim forms and evidence specifically, I would agree. On your specific question on time: do people have enough time to gather evidence or to fill out forms? We frequently do have to request extensions of time for submitting claim forms. To DWP's credit, they do generally grant that. I would say it is quite unusual to have a refusal on that.

Q20 **Neil Coyle:** What are the main reasons for the delay?

Kayley Hignell: Getting support to fill out the form.

Gary Edwards: Getting an appointment at an advice centre.

Kayley Hignell: Yes. It can take—

Chair: Getting people to help you?

Kayley Hignell: Yes, exactly.

Q21 **Neil Coyle:** It is more about the welfare advice than health advice; is that what you are saying?

Tony Lea: It is not advice. It is hands on giving people that ammunition. You have to think about this. When you give people this application form, many of the clients are on very high doses of medication. The beginning is the dreaded brown form. It sends people into a panic. That brown letter comes through and it is, "Oh, my God" and they don't get it. What I

say to clients is this is not about disability. This is nothing to do with disability. No one is saying that, "You are not disabled". What the Government are saying is, "Is your functionality that impaired to what you are saying to us? We want you to have an assessment. Can you do it repeatedly, reliably, safely, in an appropriate timeframe without fear, fatigue or pain involved?"

That is the crux of this form and these people don't get it. They will tell you everything and sundry about what their issues are, but they will not tell you anything about their functionality because their disability is ownership. They own their disability. They don't look at their functionality. All they care about is, "I am not very well. I want to be left alone". Brown envelopes come through the door, "Why are you picking on me? Why are you calling us liars?"

Q22 **Chair:** Changing that attitude is a huge task. But build it in stages: we have a form that generally speaking is adequate?

Tony Lea: No, it is not adequate.

Q23 **Chair:** Tony thinks not but three of you were nodding that it was. There is then the problem about the form defeating people themselves being able to complete it to their best advantage, and whether they can marshal the evidence during the time that is allowed, which is separate from the help with filling in the form.

Kayley Hignell: There are a few challenges with collecting evidence. Some people have evidence relating to conditions from specialists, for example. It can be a couple of years old but, in reality, people are not seeing specialists every month or every week. They are seeing their GP at most, so there are some challenges there in terms of the amount of time, the reliability or relevance of the evidence from a GP. People do struggle to get that within the timeframe so that it is appropriate and timely.

Then there is a bigger issue here, aside from costs, which is how frequently somebody can request that evidence. Do you do that at the stage of claim? Do you do that if you have to challenge? Do you do it for ESA or for PIP? Quite often it is hard for clients to get one piece of evidence let alone multiple pieces of evidence.

Chair: I am trying, Karen, to build up a picture. You are going to help, are you?

Q24 **Ms Karen Buck:** On that, I wonder whether your experience is that GPs, in particular, are good at being able to provide any supporting evidence, which is required in a way that meets the requirements of the benefit claim?

Kayley Hignell: Typically, your GP is giving a report of somebody's medical condition rather than looking at the descriptors in the condition.

Tony Lea: You pay £33 for a report by Atos GPs. They are paid £33 for the beginning of a report. Half the time they do not fill it out. Half the time GPs say, "We are not here to please the DWP. We are busy enough as it is. It is not our problem". I have had many an argument and have had to go to NHS England because of the behaviour of certain GPs, but they are paid a derisory £33 by Atos for a form that is not worth what is written on it, seriously.

Q25 **Ms Karen Buck:** Sam and Gary do you have a perspective on that?

Sam Ashton: Yes. One of the big problems about gathering evidence—and this comes back to the issue of mental health claimants—is that people lack insight into their own conditions and their own limitation on their capabilities. This also links to the question of medical expertise of assessors. A properly qualified assessor, who knows something about a particular medical condition, will know how that medical condition impacts on someone's capabilities and they will know what the correct questions are to ask.

This is very important with mental health conditions. If you have a mental health condition that means you don't understand the impact of that condition on your own life, you will not be able to volunteer that information. It needs a properly qualified assessor who will know what the correct questions are or will have an understanding of the condition and can delve into and explore those issues.

Gary Edwards: Certainly, in our advice centre we have to give very specific letters saying, "Here are the descriptors. This is what the client says affects them". Sometimes you can get some medical evidence that is meaningless if it does not talk in terms of the descriptors. The last thing I want to say is that, hopefully, you have seen that we did a study of 100 of the appeals that we did.

Chair: Yes. That is partly why you are here, Gary.

Gary Edwards: Yes, okay, thanks. But I have an update from that, because I think this really hits the nub of it. We sent that report to the DWP, which said, "Can you please give us specific examples, with client consent, so we can learn lessons?" We did that before Christmas. We sent off 15 cases and they have been looking into it. I chased them up last week and I got a really telling response from them. I was pleased because it was quite positive from the DWP. It took on board that there are lessons to be learned.

If I just read this. It will only take a second and then I will be quiet for a while, "Atos have identified that in the majority of cases additional evidence was submitted after the assessor had completed their initial report. In many cases this additional evidence would have supported the claimant's level of restriction and was of sufficient quality to support a higher award". What they are saying is: if only Atos had had that medical

evidence early, which they saw at the end of the process, then we can cut out all the pain and heartache.

Q26 **Neil Coyle:** But it is DWP that makes the decisions. Should Atos be able to make a recommendation to DWP that more information is collected before DWP makes its decision? You would welcome that?

Gary Edwards: I would love that.

Tony Lea: We work with Atos very closely now. Before any tribunal I can contact their clinical lead and say, "I have a case, such and such, and we have fresh evidence". I will send it to them and we have pulled back from tribunal on mandatory reconsideration. One of the biggest problems with this whole process is that I am able to communicate with DWP by e-mail. Atos, Capita, everyone else, are not allowed to communicate with doctors, surgeons or anyone else by e-mail because of confidentiality. I can communicate with the tribunal service with the same confidential material and I don't have a problem and yet the DWP will not let these organisations contact the professionals who are responsible for the welfare of these people to get the information they need. They have 40 days to get from application to the end, for a PA4, as it is called, on to the DWP's table, but it does not allow sharing by e-mail in the 21st century.

Q27 **Ms Karen Buck:** This is another way into the same point, I think, which is the extent to which individuals sometimes lack insight about autism or mental health issues, and sometimes GPs themselves not being clear about how to present their medical information in a way that meets the requirements of the process. Do we have data on the success rates at tribunal and how they vary between people who are represented and those who are not?

Sam Ashton: There isn't up-to-date success rate data on PIP. There was a Freedom of Information request on ESA a few years ago and it showed that people who were represented were far more likely, something like an 80% success rate, and it was below 50% for—

Q28 **Ms Karen Buck:** We don't have anything more up to date and we don't have anything on PIP. I wonder if that is something we could consider trying to find out.

Sam Ashton: It would be excellent if the Committee could find that information. We have tried to find that information and we have been told by the tribunal service that it would be too expensive to provide.

Q29 **Ms Karen Buck:** I think I am right in saying that would tell you something quite important about people's understanding of the—hang on, one at a time.

Sam Ashton: We do have one statistic available on tribunal success, which I think is particularly interesting and relates to this point about evidence. In a debate on PIP in Parliament, the previous Minister for

Disabled People said that in 75% of successful appeals the reason was the submission of new evidence. That statistic was explored a bit further in a parliamentary question that asked, "What kind of evidence?" It was revealed that only in 9% of cases was there any new documentary, written evidence, and in 66% of cases it was oral evidence. So what is happening here is that the tribunal is asking claimants questions about their capabilities. They are listening to those answers, paying attention—

Tony Lea: Yes, they—

Sam Ashton: Excuse me, sorry, Tony, you keep on interrupting people and there are four witnesses here and we all have an opinion and something to say. Thank you, Tony.

We had a recent judgment from a tribunal that I think is very interesting, if you would allow me to read it out, "The tribunal was disappointed to note that the appellant's evidence today is consistent with that which he gave to the healthcare professional, but much of that evidence was discounted for reasons that are difficult to understand". Here we have a case where someone is asked questions by a healthcare professional but their answers to those questions are not listened to and are not assigned proper weight. Basically, they are told that they are lying, but a tribunal judge listens to those answers, understands that they are truthful, and in that case the decision is overturned and the appeal is successful. This is what is happening in 66% of successful appeal cases.

Q30 **Chair:** Sam, can we keep with you and on this very point? We will try to get national data on this because it is very important. In your own experience, do you get a new decision at the review stage or at the tribunal stage? Which is the most important part of the machinery to get a decision?

Sam Ashton: Of the hundreds of PIP cases, we have only seen an award change that mandatory reconsideration twice. Although we try to submit new evidence and we put in the same arguments that we would in our appeal submissions of mandatory reconsideration, there is a complete failure by the DWP decision-maker to properly re-examine the decision.

Q31 **Chair:** I asked the person in our office who does all these cases and he said he never wins there. The wins are at the tribunal stage. One of the recommendations we might think about is abolishing that stage, isn't it, if those figures are borne out nationally from our constituents?

Sam Ashton: I would be delighted if that were a recommendation you would consider. If you look at the statistics, at mandatory reconsideration an award has only been changed in 15% of cases. That is out of 280,000 mandatory reconsiderations. If you compare that to the 60% success rate at appeal, it shows that the appeal is getting it right and overturning on vastly more cases than at mandatory reconsideration.

Q32 **Chair:** I don't know if it is getting it right but it is another outcome, isn't it? If you add the two together then the percentage is huge, isn't it?

Tony Lea: I think it would be for the Committee to go to Ministers and ask—

Chair: No, Tony, you have even got on the bad side of the actual witnesses, so I will call you in. Is that all right and being fair? Gary, on this aspect, what Sam has described, is that your experience in Southampton?

Gary Edwards: With the mandatory reconsiderations?

Chair: Yes.

Gary Edwards: It is interesting because I talked to my colleagues about whether mandatory reconsiderations should be abolished or not. I can think of about 20 cases in the last year where there has been a mandatory reconsideration and, to be honest, a bit of me thinks, "Well, hang on a minute, that is 20 people who didn't have to face the harrowing aspect of going to a tribunal".

Q33 **Chair:** Out of how many, Gary?

Gary Edwards: We went to 100 tribunals but the 100 tribunals were the only ones that went forward, and sometimes clients don't come back if you get an MR. It is a really difficult one but I think, on balance, our position would be we keep it but it needs to be a proper process. I can give an example of a health professional that did an assessment for daily living and the client was marooned on six points where she needed to get two extra points for daily living. The assessment was done. They have a narrative and then they tick a box on their report from the health professional. The health professional had said, "This woman needs to use continence pads for the majority of the time" but what she had done is ticked the box where you get no points. She had ticked the wrong box, so we thought, "That is going to be easy". We would do a mandatory reconsideration, point it out, quoting that error, what we thought was just a clerical error, and, lo and behold, nothing changed on the mandatory reconsideration.

We had to go all the way to lodge the appeal and they read the appeal submission that said, "How has this happened? Three people should have looked at this and that clerical error should have been sorted", so I think there is an argument for having mandatory reconsideration still. I understand where Sam is coming from but I think our experience is we would like to keep it, because it does mean that some people don't have the trauma of going to an appeal.

Kayley Hignell: I would agree with colleagues here that there are a lot of problems with mandatory reconsideration, such as pure process, people knowing that they have fulfilled the process of submitting a mandatory reconsideration, knowing when the mandatory reconsideration is completed, knowing that it is not an appeal. A lot of our clients think that they have appealed when they go to mandatory reconsideration.

I agree with Gary in that I think we do need a place in the system that requires DWP to look again seriously at a decision. It used to happen before mandatory reconsideration. You would get a notice in appeal papers, which was DWP looking at their decision. Mandatory reconsideration gave us some hope that that stage of the process would be given more time and attention. What we are seeing on the ground is that is not consistent, and I would stress—and I think Gary mentioned—we don't see when it is successful. We do see when it goes wrong, but I would say it goes wrong too often for it to not need looking at again.

I would not abolish it for the same reasons as Gary, in the sense that we do want DWP to look at these decisions seriously and avoid delays.

Q34 **Chair:** They could do that pre-appeal stage, couldn't they, which they used to?

Kayley Hignell: Yes, so you could have a check at any point. The crucial bit is that there is another check on the decision, somebody independent from the first decision-maker.

Chair: Tony, what is your answer on reconsideration?

Tony Lea: I have discussed this with the DWP in Atos. Atos themselves personally think that it should go back to them instead of the decision-makers, which I agree in regard to the decision-makers not getting the decision right in the first place. They are not medically qualified to read these assessments. The whole idea of these assessments is to make an informed and educated judgment on what has been presented to them. Evidence is being ignored by these people. The facts are being ignored by these people. They have no interest in taking the evidence. They ignore the evidence again and again. It needs to go back to the assessors and they are the ones who should be saying, "These are our recommendations", not coming from someone who is not medically qualified to make decisions on disabilities.

Chair: Atos might be interested if they were paid on the basis that their decision—

Tony Lea: They should be fined for—

Chair: —was upheld by the tribunal. Heidi, you want to come in.

Heidi Allen: Thank you. If I can, I want to try to draw us—not totally but partially—in the direction of these rulings that have triggered this whole thing. I am surprised that I did not hear more about this, so I want to check my understanding. We were talking earlier—and this might be a question for you, Kayley, having more of a natural picture, I don't know, and I am interested in any views—about the fitness for purpose of the form and the Atos assessor or the Capita assessor, so before it gets to the DWP decision-making level, of people with mental health conditions. I have sat through PIP assessments myself, both a mock one and a real one, accompanying somebody. In my limited knowledge, I have not

found the PIP process or form, in any way, shape or form, to be fit for purpose for people with mental health conditions. It is all about musculoskeletal: how you move. How you get about. How agile you are. I am interested in your comments on that and whether there is any link to that statistics-wise, or whether it is another statistic we need to ask for about the appeals and the relation to mental health conditions.

Chair: Can we keep that, Kayley? I want to bring Craig in because he has to go off to another Committee. Then we will come back to that.

Q35 **Craig Mackinlay:** In your experience, if people go to an assessment day, whether it is by Atos or Capita, somebody with a mental health issue or somebody with a physical issue, would it be the same assessor or is there an attempt to try to stream towards the most appropriate assessor on the day they turn up? Or could it be you just see the one assessor? That is the only one on duty that day and every case goes to them.

Gary Edwards: If you look at the report that we have given you—

Craig Mackinlay: We would like it to be right first time, which is what I am driving at.

Gary Edwards: The majority of people in our 100-person survey have a combination of both mental and physical. I am not aware of any particular schooling one way or the other when they book the appointments. Perhaps they could do that better.

Heidi Allen: I can respond to that. I asked Atos and they said that there is no streaming.

Q36 **Chair:** Is that what you find, Kayley? No streaming?

Kayley Hignell: What we see is a kind of coincidence, perhaps, between wrong decisions and wrong specialisms, definitely. We are unaware of streaming for people going to different appointments. We do have quite late notice cancellation of appointments so I can see why that happens.

What I would stress, though, in talking about specialisms around mental health and physical health, the specialism we need most is occupational health within these assessments. They are the specialists who can then look at what somebody needs, what adaptations they need, what reasonable adjustments they might need. It is a bit of a plea here: let's champion occupational health in this equation because they are the ones who look at the functionality and function of somebody more.

Chair: Tony, streaming or no streaming?

Tony Lea: I am not aware of any streaming. All I know is that people get a phone call, they have to attend and it is whoever it is on the day. The problem with this is they are unknown. These people are unknown assessors. They are not armed with evidence. They are armed with a PIP that may have been ambiguously filled out by the claimant, so they have no previous knowledge of who these individuals are. Then they are

expected, in a 40-minute snapshot, to make an informed and educated opinion on these people's functionality.

Q37 **Chair:** You could not have a system where you turned up and the person there knew you, could you?

Tony Lea: No, but you could have the evidence in front of you. This is one thing. When you get your pack through it states right at the beginning—

Q38 **Chair:** Sure, so in answer to the question you are not aware of streaming?

Tony Lea: No.

Sam Ashton: I think it comes back to the nature of the operation that Atos and Capita have to run in order to make a profit. As far as we are aware, the assessor does not even know who they are assessing until the day. We have seen assessors come to the assessment and they have not read the PIP form. They have no prior knowledge of the claimant. They are just given the pack an hour before the assessment. That really is not enough time to properly understand the person that they are meant to get to the bottom of their capabilities in a very short space in time.

Chair: All right. We have an answer to that question. Heidi, your question again, and we are going to start with Kayley.

Q39 **Heidi Allen:** Yes. It is around the fit for purpose of the form and the assessor for mental health conditions and any relation to appeals.

Kayley Hignell: On the form around mental health, I think the crucial bit is the bit in the text rather than the question that talks about, "Can you do this reliably? Can you do it safely?" That is more specific to drawing out some of the challenges that people with mental health conditions have, so that is a little bit hidden within the text and isn't a specific question targeted at mental health conditions.

What I would say on the assessment is the challenge here is we quite frequently see reports citing physical attributes of mental health, or trying to attribute mental health to a physical attribute, "They maintained eye contact. They looked well kept. They managed to continue a conversation" and really struggling to find something of physical evidence of mental health. I am absolutely certain that if you spoke to any mental health professional that is not a good indicator at all of mental health.

Going back to Sam's point here about clients' own testimony, or claimants' own testimony, the system is not necessarily set up in a way that takes that point of view as weighted, as a piece of evidence around a physical movement, for example. That creates a disadvantage for people who have hidden conditions, like mental health. I would stress on evidence here that what we have started seeing more frequently on reports is something like, "Client reports severe mental health conditions but isn't seeing a mental health specialist". I would caveat the kind of

comments we have made here about evidence to say that there are so many people who need that support who aren't getting it. It really is crisis support when it comes to mental health, so therefore it is so much more difficult to provide another piece of objective evidence. Hence why people I think are reaching to more physical attributes.

Q40 **Heidi Allen:** Dare I say, not wishing to be cruel, the purpose of PIP and what we are talking about is people are known. The world should not be fixed through PIP. That is an NHS debate possibly.

Sam Ashton: Just to support Kayley's point, what we see is that the lack of specialist support for mental health conditions is taken to mean by assessors that people don't have significant limitations in terms of their capability. We have had clients who have been referred to psychiatric help but they are on the waiting list. They have been waiting six months for their referral, and then in their PIP assessment the assessor says, "You are not seeing a clinical psychologist, therefore, your condition cannot be that bad".

Also, to support what Kayley says, the assessors use this thing that they call the Mental State Examination. It is not a test that they announce to the claimants that they are undertaking but it says in the guidance, "Is the person sweating? Do they make eye contact with you? Do they seem orientated in time, place and person?" If you were to show this Mental State Examination to a mental health expert they would laugh you out the door. It has no basis in any sort of clinical expertise. It is all based on informal observations.

Q41 **Neil Coyle:** My mum has schizophrenia and I know where she lives. She is discharged from being seen after six months, which is a standard discharge. If you are not seen for six months you are automatically discharged. Is that fairly standard across the people you are seeing and trying to support?

Sam Ashton: We have lots of clients with schizophrenia and this is the exact problem that they have experienced. Schizophrenia is relatively untreatable and if they arrive at a situation where it is stable they don't get the support they need. Somebody who has been a paranoid schizophrenic for 30 years of their life is not receiving specialist mental health support. That is taken by Atos to mean that they are okay and that they don't need PIP.

Tony Lea: I have dealt with 19 suicide interventions since 2012. I am assist-trained in regard to suicide. I have dealt with 19 since 2012, two in January this year so far.

Q42 **Chair:** How does that relate, Tony, specifically to the question?

Tony Lea: With mental health we have DWP and Atos, who have been contacted by CPNs and psychiatrists saying, "Please do not contact this claimant. If you need to speak to this claimant speak to their representative". Within five days I have had a phone call from various

claimants saying, "DWP or Atos have been in contact with us" and we have gone back and asked, "Why are you ignoring mental health specialist letters stating, 'Do not—'"

Q43 **Neil Coyle:** This is about accessibility of the process. DWP get things wrong in terms of accessible formats for somebody who is blind and so on.

Tony Lea: We see it day in and day out.

Q44 **Neil Coyle:** How would you improve the process, be it the application forms, be it the interview, that actually changes—

Tony Lea: One point is that, when you get the pack in the pack it shows you a log of everything that DWP have done from the application form all the way up to tribunal. What we suggest is that Atos and Capita, because they are legally and contractually obliged to get this evidence—which they are not following through half the time—have to have a form like for the DWP, for the tribunal, stating the time and who they contacted, when they contacted them, who they received the response from, when that response was, with the evidence present. The DWP do this with every single action they take. Atos, Capita and the rest, there is none of that. There is no evidence of who they have contacted in their report and what evidence it has come from.

Q45 **Ms Karen Buck:** In the cases that are either failing to transfer from DLA to PIP or at appeal stage, are you seeing different patterns according to whether the condition was physical, sensory or a mental health condition?

Gary Edwards: Yes, as I said, if you have a look you will see the mix in your report. A lot of the clients that we see do have a combination of mental health and physical health, and I think one follows the other sometimes. The real issue is—almost like the poor relation—people that have episodic conditions. In Southampton we have an assessor that we refer to as the "yes/no" man. Three clients have told us that he will ask a question and he will say, "You are only allowed to answer this question yes or no". He even got a translator to say that to a claimant, and it is never that. There is always that grey area, so it is looking at what the frequency is, whether it is more days in the week or it could be over a longer period that we need to look at. Mental health and episodic conditions are the ones that really are up against it. One other point I did feel, which—

Q46 **Ms Karen Buck:** Sorry, I was trying to drill down with a little bit more specificity. It is a perfectly reasonable point that you are making, but in your experience are the cases that you would take to appeal more or less likely to succeed if they have particular characteristics; would a mental health case or particularly an episodic condition be less likely to succeed at appeal?

Gary Edwards: What happens is: if there is a mental case issue that we are taking forward, after we get a really good letter from a psychiatrist

then it is game over. That is it, and again it is back to the evidence. If a senior psychiatrist puts a letter down then that is accepted. It is as simple as that, but it is getting that evidence.

Also, we have to think about the extra strain this whole process is putting on the wider health economy and the cost of that, so it may save some money on the PIP awards, but it may cost society a much bigger cost.

Q47 **Chair:** They don't save that much because most of them are overturned, aren't they, on appeal?

Gary Edwards: No. What I am saying, Mr Field, is the actual cost of making wrong decisions must cost the NHS thousands of pounds of extra interventions when people are at crisis point.

Q48 **James Cartlidge:** I want to explore this mental health point because it does seem to me a point of fact that mental health is harder to assess. However you look at it, it is a greyer area. Just give me a minute to speak. It is a grey area. Gary, your main recommendation is simply that you ask for evidence from the beginning?

Gary Edwards: Yes, if they say they are with a psychiatrist or a CPN ask them.

Q49 **James Cartlidge:** Should there be two different forms?

Gary Edwards: There could be. To elicit reliable evidence on mental health issues you have to speak to the health professionals whenever you can. The other thing we get is where people who have serious mental health problems go for their assessment, it is done very insensitively, it is done very badly, and it makes their mental health very much worse. I have seen one case where, before a decision was made, a telephone call was made to the CPN that was named. It meant that that person did not have to go through the horror of the assessment and a decent award was made, so it is within their capabilities to exercise that discretion to do it. I don't know how many more times I need to say it is evidence, evidence, evidence.

Kayley Hignell: I would say it is not just the claim form. It is the amount of time allocated to the assessments as well, so you do see variation in how much time somebody spends with a claimant. In my own experience of doing claim forms with people, or looking at eligibility, I do spend longer with people who have mental health conditions because I have to ask a lot more questions. It takes a lot more time to establish trust and rapport so that they will disclose that information.

Q50 **Royston Smith:** Can I just clarify that? Is that anecdotal how long someone spends in an assessment, or is it recorded anywhere how long Mrs X takes or Mr Bloggs takes?

Kayley Hignell: I am not sure if it is on official data.

Sam Ashton: Yes, it is recorded. When we get the appeal packs it tells you how long the assessment took. It also tells you how long it took the assessor to write up the report.

Q51 **Royston Smith:** Are there variations in that?

Sam Ashton: Yes, they can vary hugely, anything from half an hour to two hours.

Q52 **Chair:** Do they record the division of mental and physical health?

Sam Ashton: We have not done an examination of that.

Q53 **Chair:** We could ask for a division.

Sam Ashton: Yes, I think that would be very interesting.

Kayley Hignell: I think it would definitely make a difference. The problem is with a physical assessment for a physical condition you can do a lot more of this informal observation, even though I would stress that it should be a medical examination in some way and it should look at facts and allow people to give their explanation. In a mental health condition you cannot do that. You have to ask so many more questions to be able to get to the bottom of it. You have to repeatedly ask, "Can you do it safely and reliably?" all of those things.

I do think the amount of time is crucial and I think the success rate at tribunal probably speaks to this as well. In my experience, tribunals are more likely to be an hour than 30 or 40 minutes, so I do think that makes a massive difference to the success on accuracy.

Q54 **Chair:** Tony, do you agree or not?

Tony Lea: I come from a different angle, or would like to, with regards to the law, the Mental Health Act 2008 and the Mental Capacity Act 2008. Why are these organisations interviewing people with severe mental health or limited capacity without an appropriate adult in attendance? We made these laws because people were being abused and to protect them. Yet we have come along with the DWP and we have said, "There goes the Mental Health Act. There goes the Mental Capacity Act. I am going to interview you on your own and I am going to write down what I wish".

Q55 **Chair:** Are you saying that they should not be, for example, interviewing people with mental health conditions to help them complete their forms?

Tony Lea: Yes, basically. Even I should not be. I always work paired up. It is something we should not be doing because mental health is to do with mental—

Q56 **Neil Coyle:** The point though, Tony, I would suggest is that many organisations would say it is about an individual's declaration and who you choose to take with you is equally a barrier, because there are people who would say they don't want anyone with them.

Tony Lea: Yes, but we are talking about autism, so—

Q57 **Neil Coyle:** Linking back to the question, do you have a breakdown by health impairment of the people you are supporting who go to and have success with appeals, bearing in mind what Gary said about the number of people with multiple impairments?

Kayley Hignell: Yes. When I looked at our data in terms of our national dataset, particularly at mandatory reconsideration and appeal, I looked at the differences between mental health and physical health, so how many people come to us. There is not a huge difference in that. I think it is about 26% for physical health and 28% for mental health. I would stress that that data is quite under-recorded and does come to multiples, so I would not put too much weight on that. Again, our qualitative evidence suggests that there is more of a struggle when it comes to hidden conditions, fluctuating conditions or, as you say, around episodes.

Q58 **Neil Coyle:** When you think about prevalence among the general population that would tip mental health into quite a significant proportion of the workload.

Kayley Hignell: Yes, if you scaled it up; two percentage points, yes.

Q59 **Chair:** Sam, what about James's question?

Sam Ashton: It is very interesting when you compare an appeal hearing to the assessment. One of the things is that a tribunal panel has to have a doctor on it. The doctor does ask very precise questions of the claimants, the kind of questions that should be asked in the assessment that really do explore their capabilities and follow them up. That can be very stressful for our clients. They find it quite upsetting, but it does get to the root of their capabilities. It is really that exploration rather than relying on informal observations or, "The client made eye contact with me, therefore, their mental health is fine".

When it comes to the question of evidence, it is not always just having the necessary evidence there. We have had a situation where we had a client with a mental health condition. We submitted their psychiatrist's letter that said explicitly, "This person presents well, but they have severe mental health problems and you should not take how they present on the day as indicative of their capabilities". That evidence was not listened to by the assessor. It was not listened to by DWP. The only thing that they based their decision on was how they presented themselves in the assessment.

Q60 **Neil Coyle:** The problem is looking at who should not go through routine reassessments for WCA. Do you think that should filter through into PIPs so that we don't repeat mistakes?

Sam Ashton: I think there should be lifetime awards for Personal Independence Payments, the same as there was for DLA, particularly when it comes to the issue of progressive conditions. Someone with a

progressive condition that is not going to get any better, why do they need to be put through the stress and strain of this process again?

Gary Edwards: Can I make one point? You have heard that we all go to appeals regularly. What is really frustrating is that the DWP have the right to send a presenting officer. We never see them. I think there were some announcements made in Parliament and we saw someone once, the next day. I honestly think that, if the DWP observed the tribunals and in some way had to explain or justify their decisions, they would feed that back up the line and we might get better quality decisions.

The last thing I would say is that I have the real feeling that the DWP have abdicated their responsibility to Atos. In our experience, when we speak to the DWP and we try to challenge a decision, they are almost afraid of overturning it. What the Atos person has said is almost taken as gospel. Then, when we go to the hearing, a lot of clients say they do not recognise what is in the report as to what they are alleged to have said at the hearing. You can record the assessments but it is a very restrictive process. Some people go in and do it illegally, like the "Man from UNCLE", which they should not be doing. There could be some merit in recording it. Then we could all learn from it and then the professional standards of the assessors would be there.

Kayley Hignell: I would agree that, if we are making rules in ESA that allow for not repeating assessments, they should carry forward. It is the same person, fundamentally. It is really confusing to individuals to have one set of rules in one instance and another in another instance.

I cannot stress the importance of how many tests people are going through, not just in terms of a single person, and how many reassessments. For ESA, PIP, social care, health, support work, all of those things have eligibility requirements, tests, assessments, and the poor individual is quite often left in the middle repeatedly going through some form of assessment or other. Lining up these systems is absolutely crucial.

We do have some optimism around the work, health and disability Green Paper that is going to look at it, but I do hope they look again at the regulations that are potentially coming in, as Heidi mentioned, and also at the PIP situation. PIP is a crucial benefit when it comes to health and work. It is not just ESA. There are a lot of people on PIP who are in work, so I hope it is part of that conversation.

Chair: Tony, last word to you.

Tony Lea: Yes. Recording, we went and bought a PACE 1984 machine, dual recording, untamperable medium. We take that to assessments with us. We have found it does help. It removes the, "He said, she said" scenario. In the tribunal service in Cornwall they have just brought it out. From 1 February, all tribunals in Cornwall are now to be recorded to stop complaints against the tribunal staff, the judges; the lot.

That would help at mandatory reconsideration. If it were recorded a mandatory reconsideration were required, you would have a recording of that assessment, which someone could then transcribe and say, "They did say this and it was omitted from the report". It is all about transparency. If we can get this transparent where policy is not being used as law, then I would say this could be conducive. I am not against reform. I don't think any of us are but it is the implementation, how it is being done, that is harming the genuinely vulnerable. Thank you.

Chair: We are very much looking at that, Tony. Thank you all very much for coming today.